National Quality Forum
Measure Applications Partnership (MAP)
Coordinating Committee
Virtual Review Meeting
Wednesday, January 19, 2022

The Committee met via Videoconference, at 10:00 a.m. EST, Charles Kahn and Misty Roberts, Co-Chairs, presiding.

Committee Members:

Charles Kahn II, MPH, Co-Chair
Misty Roberts, MSN, Co-Chair
David Baker, MD, MPH, The Joint Commission
Mary Barton, MD, National Committee for Quality
Assurance (NCQA)
Leah Binder, MA, MGA, The Leapfrog Group
Heidi Bossley, MSN, MBA, American Medical Association
Katie Boston-Leary, PhD, RN, MBA, MHA, American
Nurses Association
Margareta Brandt, MPH, Covered California
Dan Culica, MD, PhD, Individual Subject Matter Expert
David Gifford, MD, MPH, American Health Care Association (AHCA)
Elizabeth Goodman, JD, MSW, DrPH, America's Health Insurance Plans (AHIP)
Emma Hoo, Purchaser Business Group on Health
Libby Hoy, Patient & Family Centered Care Partners
Rebecca Kirch, JD, National Patient Advocate Foundation
Kacie Kleja, HCA Healthcare
Parul Mistry, MD, MA, AmeriHealth Caritas
Carol Peden, MB ChB, MD, FRCA, FFICM, MPH, Blue Cross Blue Shield Association
Amir Qaseem, MD, PhD, MHA, FACP, American College of Physicians
Clarke Ross, DPA, American Association on Health and Disability
Julie Sonier, MPA, Network for Regional Healthcare Improvement
Janice Tufte, Individual Subject Matter Expert
Ronald Walters, MD, MBA, MHA, Individual Subject Matter Expert

Non-voting Federal Liaisons:

Jeff Brady, MD, MPH, Agency for Healthcare Research and Quality (AHRQ)
David Hunt, MD, Office of the National Coordinator for Health Information Technology (ONC)
Michelle Schreiber, MD, Centers for Medicare and Medicaid Services (CMS)
Arjun Srinivasan, MD (CAPT, USPHS), Centers for Disease Control and Prevention (CDC)

NQF Staff:

Katie Berryman, MPAP, PMP, Director, Project Management
Tricia Elliott, DHA, MBA, CPHQ, FNAHQ, Senior Managing Director
Victoria Freire, MPH, CHES, Analyst
Ivory Harding, MS, Manager
Joelencia LeFlore, Associate
Rebecca Payne, MPH, Senior Analyst
Udara Perera, DrPHc, MPH, Senior Manager
Matthew Pickering, PharmD, Senior Director
Ashlan Ruth, BS IE, Project Manager
Dana Gelb Safran, ScD, President and CEO
Susanne Young, MPH, Manager
Gus Zimmerman, MPP, Associate

Also Present:

Katie Balestracci, PhD, MSW, Yale CORE
Andrea Benin, MD, CDC
Susannah Bernheim, MD, MHS, Yale CORE
Maureen Bisognano, MS, Institute for Healthcare Improvement
Allison Bryant, MD, MPH, Massachusetts General Hospital
Mandy Cohen, MD, MPH, North Carolina Department of Health and Human Services
Kathleen Conroy, MD, MSc, Boston Children's Hospital
Patrick Conway, MD, MSc, UnitedHealth Group

Raymund Dantes, MD, CDC
Caitlin Drumheller, American Society of Clinical Oncology
Ghinwa Dumyati, MD, Society for Healthcare Epidemiology of America
Stephanie Franklin, MPS, Humana
Lisa Marie Gomez, CMS
William Lawrence, Jr., MD
Alan Levitt, MD, CMS
Joseph Messana, MD, University of Michigan Kidney Epidemiology and Cost Center (KECC)
Rebecca Onie, The Health Initiative
Rocco Perla, The Health Initiative
Gary Price, MD, FACS, The Physicians Foundation
Ronen Rozenblum, PhD, MPH, Brigham and Women's Hospital
Ben Shirley, Pharmacy Quality Alliance
Evan Shulman, CMS
Karen Smith, MD, FAAFP
Richard Thomason, Blue Shield of California Foundation
Sylvia Trujillo, JD, MPP, OCHIN
Joseph Valenti, MD, The Physicians Foundation
Ronald Wyatt, MD, MHA, MCIC Vermont

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(10:01 a.m.)

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

Ms. Elliott: Good morning, everyone. My name is Tricia Elliott. I'm the Senior Managing Director here at the National Quality Forum. Welcome to today's meeting.

A few housekeeping reminders while we admit folks into the meeting. Please mute your computer when you're not speaking. This reduces the background noises for those who are speaking. The system will allow you to mute and unmute yourself and turn your video on and off throughout the event. We encourage you to keep the video on throughout the event and we will do a full roll call once the meeting begins.

Feel free to use the chat feature to communicate with NQF staff if you're having any troubles. We will be sure to -- we will be using the hand-raising feature during our open discussion.

Next slide, please. Once again, welcome to our virtual meeting today, the Measure Applications Partnership. This is a Coordinating Committee and today is January 19th. I would like to call to your attention the funding for this meeting is provided by the Centers for Medicare and Medicaid Services with the task order listed there on the slide.

Next slide, please. Our agenda for today we will do some welcome remarks, introductions, disclosure of interests, and review of the meeting objectives. Dr. Michelle Schreiber is on the line today and she'll be providing opening remarks from CMS.

We'll do an overview of the pre-rulemaking approach, as well as pre-rulemaking recommendations. There will be a lunch break. We will then continue with the pre-rulemaking recommendations.

We will have opportunity for public comment at the end of the day, but during our pre-rulemaking recommendations we will have opportunities for public comment throughout each of the sections that we'll be presenting. We'll have closing remarks and next steps to close out the meeting. Then we'll be adjourning ideally by 6:00 p.m. Easter Time.

So, once again, my name is Tricia Elliott. I'm the Senior Managing Director here at NQF. At this point I would like to turn things over to our Chief Executive Officer Dana Gelb Safran to give some opening remarks.

Dana.

Dr. Safran: Thank you very much, Tricia. Good morning to all of you. It's really my pleasure to welcome you to today's MAP Coordinating Committee Review Meeting for the 2021/2022 cycle.

NQF is really honored to continue our longstanding partnership with CMS and the MAP Coordinating Committee on what is a tremendously important part of our work. Through this committee and through the committees that have met over the month of December, we had the privilege of working to provide input on performance measures that CMS is considering for use in public reporting and performance-based payment programs.

As all of you know, the MAP brings together a unique multi-stakeholder set of perspectives including quality measurement research and improvement experts, purchasers, providers, public health agencies, and community-based organizations, health professionals, health plans, consumers and patients, suppliers, and subject matter experts. Through this diverse array of stakeholders, we are able to ensure that the federal government receives varied and thoughtful input into its final rulemaking process.

We heard tremendously rich feedback from our MAP colleagues in December. We started with the Rural

Health Advisory Group and the brand new Health Equity Advisory Group. They reviewed all measures under consideration lists and provided their perspective across those lists to the setting-specific MAP workgroups whose recommendations you'll be reviewing today.

We heard themes from these workgroups around health equity reporting outcomes and evaluating measures across programs and settings that we'll share with you in more detail today.

I'll just close by thanking all of our committee members and federal liaison for their tremendous amount of time and effort that they spend in reviewing measures and participating in this meeting. Particular thanks to our committee co-chairs Misty Roberts and Chip Kahn for their ongoing leadership of this important work of the MAP Coordinating Committee.

Thank you also to our colleagues at CMS and to the measured developers who have joined us to help inform our discussions. Lastly, a sincere thank you to the members of the public who take time out of their busy schedules to provide comments before and during this meeting. This collection of voices is really what enables this process to be rich and informative to CMS and this very important part of their work.

So looking forward to today's conversation and hearing all of your feedback on the measures under consideration, let me turn it back to you, Tricia.

Ms. Elliott: Thank you so much, Dana Appreciate you assisting us in opening our meeting today and for the warm welcome to all.

At this point I would like to hand things over to Chip Kahn and Misty Roberts to provide -- as our co-chairs to provide a welcome to the meeting as well.

Chip.

Co-Chair Kahn: Thank you, Tricia, and thank you, Dana. Thanks to everyone on the line. I so deeply appreciate the time and effort that all of those in the advisory groups have taken leading to our consideration today. All the time and effort that CMS has put into this, and then today all of our Coordinating Committee members who will spend a long day doing very important work.

I actually look forward to this every year because I learn a lot, and also I really appreciate and deeply respect that CMS takes us so seriously. I was at the beginning here being on the Coordinating Committee since the beginning and, frankly, was very involved with Janet and others in the original legislation that was written in the ACA that set up this process. It's gratifying to see so many years later that we're playing this critical role in the development of clinical and performance measurement policy.

With that, I'll pass the baton to Misty and I look forward to the day.

Co-Chair Roberts: Thanks, Chip.

Welcome everyone. Good morning. I would definitely echo Chip's appreciation for kind of everything that leads up to this meeting. There's, again, a lot of work in the background through the various workgroups, NQF, CMS leading up to this, measured developers, etc. Definitely appreciate all the hard work that happens before this meeting.

I'm very thankful for the opportunity to continue to co-chair this workgroup. I do think it's such an exciting time in healthcare and for us to be a part of some of these decisions that are made. I think it's a great opportunity for all of us.

I want to say -- I will also echo what Chip said. I do always learn something. It doesn't matter, I think, how long you are kind of doing this. There's always something to learn throughout this. I do want to thank you for your time today. I recognize it's going

to be a long day but your input is very important and feedback so please speak up and I look forward to the conversation today. Thank you.

I'll hand it over to Tricia now.

Ms. Elliott: Yes. Thank you, Misty. Okay. Next up -- next slide, please. We're going to do the roll call and disclosure 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 any 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 how our language and opinions may be perceived by others. We'll combine disclosure 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.

I'll start with the organizational members. Organizational members represent the interest of a particular organization. We expect you to come to the table representing those interests. Because of your status as an organizational representative, we ask you only one question specific to you as an individual. We ask you to disclose if you have an interest of $10,000 or more in an entity that is related to the work of this committee.

We'll begin by going around the table. We'll begin with the organizational members only. I will call on anyone in the meeting who is an organizational member.

When I call your organization's name, please unmute your line, state your name, your role in your organization, and anything that you wish to

disclose. If you do not identify any conflicts of interest after stating your name and title, you may add that I have nothing to disclose.

I'll begin with the American Academy of Hospice and Palliative Medicine.

Next up the American Association on Health and Disability.

Member Ross: Hi. This is Clarke Ross. I'm the Public Policy Director at AAHD. I'm the father of a 31-year-old son with co-occurring disabilities and I have no disclosures.

Ms. Elliott: Thank you, Clarke.

Next, American College of Physicians.

Member Qaseem: Good morning, everyone. Amir Qaseem. I'm Chief Science Officer here at the American College of Physicians and no disclosures here.

Ms. Elliott: Thank you, Amir.

American Health Care Association.

Member Gifford: Hi. My name is David Gifford and I do have retirement funds which are invested in healthcare which is impacted by some of these which is over $10,000. I don't know which associations. And we are a measure steward of one of the measures under consideration today so I will recuse ourselves from voting on that one measure.

Ms. Elliott: Okay. Excellent. Thank you very much, David.

Next up is the American Medical Association.

Member Bossley: Good morning. Heidi Bossley, consultant to the AMA. Dr. Suk will join us for a portion of this afternoon. Otherwise, it will be me and I don't have any conflicts.

Ms. Elliott: Thank you, Heidi.

Next the American Nurses Association.

Member Boston-Leary: Hi. My name is Katie Boston-Leary. I'm the Director of Nursing Programs and Healthy Nurse, Healthy Nation at the American Nurses Association. I have nothing to disclose.

Ms. Elliott: Welcome. Thank you very much.

America's Health Insurance Plans.

Member Goodman: Hi. I'm Liz Goodman. I'm Executive Vice President of Government Affairs and Innovation at AHIP and I have nothing to disclose.

Ms. Elliott: Thank you.

AmeriHealth Caritas.

Member Mistry: Hey, good morning. My name is Parul Mistry. I'm the Senior VP for Medical Excellence and Clinical Solutions at AmeriHealth. I have no conflicts of interest.

Ms. Elliott: Thank you, Parul.

Blue Cross/Blue Shield Association.

Member Peden: Good morning, everybody. Carol Peden. I'm Executive Director for Clinical Quality and no associations to declare. Thank you.

Ms. Elliott: Thank you, Carol.

Covered California.

Member Brandt: Good morning, everyone. Margareta Brandt, Quality Improvement Manager at Covered California and I have nothing to disclose.

Ms. Elliott: Thank you, Margareta.

HCA Healthcare.

Member Kleja: Hi. Kacie Kleja. I'm the Vice

President of Clinical Data and Analytics at HCA Healthcare and I do have more than $10,000 in HCA stock.

Ms. Elliott: Excellent. Thank you, Kacie.

The Joint Commission. Dr. Baker, if you're speaking, we can't hear you.

Member Baker: My apologies. Good morning, everyone. David Baker. I'm Executive Vice President for Healthcare Quality Evaluation at the Joint Commission and I oversee our performance measure development. No financial conflicts of interest but we do have a measure that's under consideration and I'll recuse myself from the discussion of that.

Ms. Elliott: Great. Thank you very much, Dr. Baker.

The Leapfrog Group.

Member Binder: This is Leah Binder from the Leapfrog Group and I have no conflicts.

Ms. Elliott: Thank you, Leah.

National Committee for Quality Assurance.

Member Barton: Good morning. This is Mary Barton. I'm Vice President for Performance Measurement at NCQA. NCQA is a measure developer and that's my employer so I guess that's the interest that I have. I don't believe that there are any NCQA measures on the agenda today but I will certainly note if there are and recuse myself from those discussions. Thank you.

Ms. Elliott: Thank you, Mary.

National Patient Advocate Foundation.

Member Kirch: Good morning. Rebecca Kirch, Executive Vice President of Policy and Programs with NPAF. No disclosures.

Ms. Elliott: Thank you, Rebecca.

Network for Regional Healthcare Improvement.

Member Sonier: Good morning, everyone. This is Julie Sonier representing the Network for Regional Healthcare Improvement. I am the CEO of one of NRHI's member organizations and I have no conflicts to disclose.

Ms. Elliott: Thank you, Julie.

Patient & Family Centered Care Partners.

Member Hoy: Good morning, everybody. It's Libby Hoy, Founder and CEO of PFCC Partners and I have nothing to disclose.

Ms. Elliott: Thank you, Libby.

Purchaser Business Group on Health.

Member Hoo: Morning. Emma Hoo from the Purchaser Business Group on Health and nothing to disclose.

Ms. Elliott: Excellent. Thank you, Emma.

Thank you for those disclosures. We'll now move on to disclosures for subject matter experts. Because subject matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume.

Instead, we are interested in your disclosure of activities that are related to the subject matter of the workgroup's work. We are especially interested in your disclosure of grants, consulting, or speaking arrangements but only if relevant to the workgroup's work today.

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

are not only interested in your disclosures of activities where you are paid. You may have participated as a volunteer on a committee where the work is relevant to the measures being reviewed by MAP. We are looking for you to disclose those types of activities as well.

Finally, just because you have disclosed does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency. When called upon, please tell us your name, what organization you are with, and if you have anything to disclose. I'll call your name so that you can disclose.

I'm going to begin with our co-chairs. Chip Kahn. If you're speaking, Chip, you're on mute.

Co-Chair Kahn: Chip Kahn, President and CEO of the Federation of American Hospitals sitting as an expert. I have nothing to disclose other than my day job that I know of. Thank you.

Ms. Elliott: Thank you, Chip.

Misty Roberts.

Co-Chair Roberts: Hi. Misty Roberts, Vice President Quality and Performance with Onehome, now part of the Humana family. I do apologize, Tricia. I can't remember if we are supposed to disclose any sort of financial disclosure or is it just around the other elements?

Ms. Elliott: Around the other elements.

Co-Chair Roberts: Okay. Nothing to disclose.

Ms. Elliott: Okay. Hold on one second. Is there any funding?

Co-Chair Roberts: Yeah, I do note no funding.

Ms. Elliott: Okay.

Co-Chair Roberts: I'm just going to disclose that I

do have equity and trust in Humana stock.

Ms. Elliott: Okay. Perfect. Thank you. Appreciate that.

Next up we'll call upon our individual subject matter experts.

Dan Culica.

Member Culica: Good morning, everyone. Happy New Year. I'm with the Medicaid program, Health and Human Services, for the State of Texas. I have nothing to disclose.

Ms. Elliott: Thank you, Dan.

Janice Tufte.

Member Tufte: Good morning. I guess what I should disclose is I've advised on multiple social determinants of health levels so I've been very involved with that for over a decade. Not a lot of money but a lot of advising.

Also on the measure that I'm actually going to be a lead discussant on, care goal achievement, I have worked on multiple projects on that capturing goals -- preferences, values, and goals. I don't think it's direct. I was advising some years ago. Thank you.

Ms. Elliott: Thank you, Janice.

Ron Walters.

Member Walters: I'm Ron Walters. I'm a medical oncologist at the MD Anderson Cancer Center in Houston for 42 years. Also for our more months Chair of the Board of NCCN, the National Comprehensive Cancer Network which does not develop measures. I have no grants, relevant disclosures other than those two things. Very interested in the cancer measure but not a measure developer. Thank you.

Ms. Elliott: Excellent. Thank you.

At this time I would like to invite our federal government participants to introduce themselves. They are non-voting liaisons of this workgroup.

First, the Agency for Healthcare Research and Quality.

Dr. Brady: Good morning, everybody. I'm Jeff Brady. I direct AHRQ's Center for Quality Improvement and Patient Safety. Happy to be with you today.

Ms. Elliott: Thank you.

The Centers for Disease Control and Prevention.

Dr. Srinivasan: Hi there. This is Arjun Srinivasan. I am in the Division of Healthcare Quality Promotion at the CDC.

Ms. Elliott: Excellent. Thank you.

The Centers for Medicare and Medicaid Services.

Dr. Schreiber: Michelle Schreiber from CMS. We have a number of other folks from CMS on the line as well. Besides the fact were are government employees nothing else to disclose.

Ms. Elliott: Thank you, Michelle.

The Office of the National Coordinator for Health Information Technology. Okay.

I just want to circle back and see if the American Academy of Hospice and Palliative Medicine was able to join. Okay.

I think Arif Kamal is typically their representative and he may be jumping on and off the call today due to some competing clinical demands so we'll have him disclose as he joins.

Okay. Next slide, please. I would like to share with you the NQF team that is supporting the meeting today and working diligently behind the scenes. In

addition to myself, Tricia Elliott, you'll hear from Matt Pickering today. He's the Senior Director serving the MAP team.

Katie Berryman is our Director of Project Management. Udara Perera is Senior Manager. Ivory Harding, Susanne Young are both managers on the team. Ashlan Ruth is a project manager. Becky Payne is a senior analyst. Victoria Freire analyst, and Joelencia LeFlore and Gus Zimmerman are associates on the team.

A very robust team and very excited to be on the call with us today and supporting. When you have questions, some of those folks may be responding to your questions in the chat. Thank you so much to the team for getting us to this point today and a lot of the preparations.

Next slide, please. I would also like to recognize the contracting officer representatives on the call today that we worked closely with on the MAP, Measure Application Partnership. First is Kim Rawlings. Second we have Gequincia Polk. So thank you so much to both of them for the collaborative work that we do in preparing for all of this MAP work.

Next slide. So our objectives for today is to finalize recommendations on the measures for use in the federal programs for the clinician, hospital, and post-acute care, long-term care setting. And we'll be considering strategic issues that span across the MAP workgroups and advisory groups.

Next slide, please. At this point I'd like to hand things over to Dr. Michelle Schreiber to provide some opening remarks from CMS.

Michelle.

Centers for Medicare & Medicaid Services (CMS)
Opening Remarks

Dr. Schreiber: Thank you. Good morning to everybody. Good morning to the group and Happy

New Year to all. I know many of you but for those of you who don't know me, I am the Deputy Director for the Center for Clinical Standards and Quality at CMS and also the group director for the Quality Measures and Value-Based Incentives Group. I'm also a former practicing primary care physician for many years in the City of Detroit. I've been involved in quality also for many years.

It really is a pleasure to be with all of you today. I, like others who have mentioned this before, always learn something when I'm on these calls. This is now my third year at CMS. Obviously we had always hoped to have this meeting in person but Omicron hasn't cooperated with us and we look forward to the time when we will actually be in person.

Along the lines of Omicron, I want to be sure that I represent on behalf of all of us at CMS and, frankly, all of us across the government -- Arjun, I'm sure I say this on your behalf, too -- to thank you and your organization for the really incredible work and heroic work that all of you are doing in supporting the COVID-19 pandemic. Certainly to your frontline caregivers a special note of appreciation.

A couple of other thanks that many have said before to the committee. Certainly our committee co-chairs, Chip and Misty, we know we are in your very capable hands and we look forward to that.

But really to everybody who has been part of the other MAP committees that have informed today's meeting; hospital post-acute care, the clinician, the Oral Health Committee, the new Equity Committee have all had a lot of wonderful input to consider and valuable comments and feedback.

To the NQF staff, Tricia, to you, to your staff, and certainly a warm welcome to Dana in her still sort of new role. Thank you for all the work that you guys do. This is a tremendous effort actually to organize the MAP meetings, especially in a relatively short time.

To our measure developers who are here to answer questions, thank you. And, of course, to the many CMS staff who participate, as well as our government colleagues from CDC, AHRQ, ONC, and others. Thank you for participating today.

The MAP, as you know, is statutory. Chip, thank you for that history because now I know who actually put it there so thank you. It is a process whereby you recommend to CMS measures that we may be considering for rule writing.

We can't comment on rule writing and what goes into a rule or not, but you can understand that these are measures that we think are those that we would very much like to consider for rule writing either in this upcoming cycle or in the following years.

We really value the opinion of the MAP. I want you to understand that. Your incredible intentions and insights and experience that all of you represent strongly influence CMS and its decision making. But, in the end, it's also CMS' final decision about what does go into rules.

I just want to share that it's not because we don't value the MAP that perhaps you don't always see what you have recommended going into, or not going into, a rule but because there are many factors that also influence rule writing.

As measures and proposals go through CMS they are looked at by all sectors of CMS by HHS across the government with all of our government employees -- not employees but all of the government agencies that weigh in on measures, the Office of Management and Budget, all of whom weigh in to these rules.

In addition, rule writing is meant to be public so that we get public input as well and that's why we have proposal periods and public comment periods. There are many people who weigh into the measures, but it really is the MAP and your

recommendations that highly influence the decisions that we make and take. So thank you all for your really hard work and your expert opinions that you bring to bear.

You know, today, I think, we have some unique opportunities as we move forward in many of the rulemaking proposals. We are going to be looking at measures to be considered for an expanded skilled nursing facility value-based program. As you know, there's only one measure there now and we have the authority from Congress to expand up to 10 measures so your input on which of these do you think are most appropriate is really very valuable.

We'll be introducing equity measures, as you know. We are very excited about that because we think it's an incredibly important direction for CMS quality programs. We are also bringing forward advanced patient reported outcome measures.

We're moving along our commitment for digital measures, advancing safety measures, particularly around maternal safety, but also in our digital strategy for safety measure collection. We are really very excited about what we're bringing forward for your consideration and, again, look forward to your comments.

I do want to present a little bit of additional framing from CMS based on some of the feedback that we have on measures. This is not here to influence opinion or votes. You recognize that we think your independence is extremely important, but just to provide some framing.

The first is around the measure that will be coming up today that is a structural measure. In this case it's a structural measure for equity that we recognize was not supported in part because there's a feeling that structural measures aren't truly quality measures.

I just want to comment that we believe structural measures actually do have a role and they influence

behavior. Attestations and commitments to doing quality actions are very important because they are really the foundation of any quality improvement project that we undertake and we would like to encourage, perhaps not at the committee meeting but in the future, that we all have a conversation about structural measures.

The second is there are two measures that are coming forward that were approved in multiple programs but when it came to promoting the interoperability program, the original recommendation was not to approve because there was a thought that these measures didn't belong to promoting interoperability.

While we really appreciate that comment and feedback and, frankly, take it seriously and are looking into it, whether or not a measure technically can sit in a program; in other words, does it fit the statutory requirement of the program, is something that we believe CMS with our attorneys need to weigh in on.

So we would ask if that's really the question about whether or not it fits structurally into a program from a statutory point of view that you would maybe -- that you would consider voting either to not support with the mitigation that CMS will look at it from a legal point of view, or constitutional support with the same condition rather than just saying no, it doesn't belong because we actually think that is something that our attorneys need to weigh in on.

We would never propose a rule into rule writing that our attorneys have not fully vetted and approved so please rest assured that process is very robust across CMS.

Finally, I just want to comment there are two social determinants of health measures that are coming forward today and I, unfortunately, may not have a conversation for that. My deputy director, Tamyra Garcia, will join this call from time to time. There

was support for the screening of social determinants of health but there were a number of questions of how CMS might use the screen positive rate.

I do want to assure the Committee that CMS has no intention of putting forward a measure that would in any way penalize an organization for having a high percentage, for example, of those who screen positive and that we would have to consider exactly how that measure might be used and reported. I just want you to be aware that those conversations are ongoing with CMS put the intent would never be to penalize or poorly reflect upon a hospital that they have a vulnerable population.

So, with all of those comments and the framing, I just want to say again thank you so much for your participation. I learned so much from all of these meetings, from everybody's opinion. Really this is what makes policy better, that together we can have these conversations and together we support the highest quality healthcare in America. Thank you very much.

Tricia, I turn it back to you.

Ms. Elliott: Thank you so much, Michelle. Really appreciate the comments.

I want to pause here for a moment to see if there's any questions from the Coordinating Committee for Michelle. Okay.

I just want to mention we'll be using the hand raise feature throughout the day and you can find the hand raise feature either at the bottom of the WebEx screen. There's a smiley face button called a reaction button and that has a function -- a hand raise function within there. Or if you have a participant list open and hover over your name, you can raise your hand that way.

Michelle, we do have one question from David Gifford.

David, go ahead.

Member Gifford: Sorry, it took me a while to find the hand. Michelle, I appreciate the overview and review in thinking about how we should be deciding when to put conditions or do not support.

I think the charge that we have from Congress is not the measure does not meet statutory requirements for a program that your lawyers reviewed because often these statutory programs are broad and everything else.

Do they meet the intent and purpose and are they a priority if they did for the program?

So, I would respectfully appreciate that input but I think that's not the purpose and that's not a criteria we've had before for deciding whether something shouldn't fit in.

I do appreciate that because we're in the middle of rulemaking, you can't always tell us how the measures are planned in the views and the rule, but many of these programs are now pretty well established in the rule.

I think it would be more helpful to have how the existing program operates and how measures in that rule are used in general to understanding that.

Because what I've seen over the years evolve now is the programs were pretty well established and now you're just adding and tweaking the measures where you're modifying the rule specifications a bit.

And that actually has a lot of meaning as to whether the measures are appropriate for use. Clearly, if the measure is not NQF-endorsed or doesn't meet reliability or validity from basic performance issues, I think we all have concerns with that.

But really, I think the next evolution of this Committee is really talking about how they fit into the different programs you have. Certainly, for

public reporting and quality improvement, many of these measures are very appropriate and fine but as soon as you move into the payment issue or even into some of the rating programs, given the importance of rating programs, to providers for participation in MA plans for HUD loans, for all sorts of other programs outside.

It certainly changes the dynamic of how the measures might be used and I think it would be helpful as we think about that, to get more of that process.

And notice the wealth of information that we get and the NQF Staff, and I know what your Staff goes through, is really impressive and very, very helpful for making thoughtful decisions.

And I hate to say we need more but in some ways we almost want to shift away from the validity and reliability issues.

Because if it's NQF endorsed, I think the question is really is there something unique about that measure's performance that makes it inappropriate for the rulemaking rather than generic discussion we have about reliability and validity.

So, I think that would be a helpful tweak in the preparation work for the Committee's work.

Dr. Schreiber: Thank you, David, for your comments.

Regarding what fits in statutorily or not, the reason I said that is the decision around those two measures that were or were not appropriate for the promoting of the interoperability category in particular, that actually was what came forward.

It really was a question on the hospital committee of whether or not it fit in to the program because of that reason. So, that's just why I wanted to reflect that.

I fully appreciate, David, that the role of this Committee is to weigh in on obviously the appropriateness, whether or not it fits in.

But if it really is this technical question of does it meet the intent of what is in the program, I think others have to weigh in on that as well. That was my point and it was specific to the interoperability program.

Regarding your desire to have more conversation about how these programs are used, we would be happy to engage in those conversations. I recognize we're not going to be able to do it in just the one meeting of the MAP.

But if there are additional meetings that the Committee, for example, wanted to talk about the programs writ large, we're getting into that more and more with the removals conversation that this Committee had to really try and understand what's the intent of the programs and how they're used.

CMS would be happy to participate in those conversations.

Member Gifford: Yes, I think it would be more than just outside because it helps understand the measures. Because if a measure might be reliability, validity, NQF endorsed for public reporting purposes.

But if a program is based on payment where it's ranking providers, it's assuming an ordinal difference between them and payment actually varies on what are really not meaningful differences.

And so they are suddenly a measure that's very appropriate for a 2RP program or public reporting. It may not be very appropriate for a payment program, the way it's used in the payment issue.

And so that's where I'm thinking of where we need to -- we're not voting on whether the measure is

good and you should use it. It's is the measure good for the program that you're specifying?

That's why we had some measures come before us twice, because it was approved for one program and now you're asking us for advice on another program that's different.

So, I think that's missing from the dialog on this.

Dr. Schreiber: We're happy to engage in those conversations so thank you.

Co-Chair Kahn: I don't know a way to lift my hand, I can't find it. I want to add to this.

I think in this very specific situation, I've been all along very concerned that this interoperability program would be used for adding a bunch of measures on top of other measures that you're already given in other programs.

I think there is a question here, we can argue back and forth about intent but whether it is appropriate in terms of fit for purpose, to me the interoperability program ought to be about interoperability.

And getting into these kinds of measures inside of that adds a new layer which I would argue is piling on. We'll leave that for later for the discussion.

Dr. Schreiber: Thanks, Chip.

Ms. Elliott: Clarke Ross has his hand raised. Clarke?

Member Ross: Hi, thank you, I just wanted to share as a consumer beneficiary patient representative, I'm a little uncomfortable with the idea that any measure related to payment and rating should be diminished in some way.

We have the Star Rating system, which is based on precise measures, and our role is, is this measure helpful, appropriate, valid, reliable, will bring health and wellness, et cetera?

So, I just wanted to express the view of at least the disability groups and the Consortium for Citizens with Disabilities that we should not avoid a measure just because it has some relationship to either payment or rating.

Thank you.

Ms. Elliott: At this time I do not see any other hands raised. Thank you so much, Michelle, we really appreciate your comments and the opportunity to provide some Q&A. Thank you.

Dr. Schreiber: Thank you, Tricia.

Ms. Elliott: Before we move on to our next topic, I just have a couple more statements related to disclosure of interest that I neglected to mention to close out that section.

I wanted to remind everyone that if you believe you might have a conflict of interest at any time during the meeting, please speak up. You may do so in real time at the meeting.

You can message the Co-Chairs, who will go to the NQF Staff or you can message the NQF Staff directly.

If you believe that a fellow Committee Member may have a conflict of interest or is behaving in a bias manner, you may point that out during the meeting, approach the Chair, or go directly to the NQF Staff.

So, if there's no questions related to disclosure of interest, we can proceed with the meeting. Feel free to throw out a raised hand if there are any questions.

I do not see any questions that have come in. At this point, I'm handing things over to Susanne Young, who will be providing the overview of the pre-rulemaking approach.

Susanne?

Overview of Pre-Rulemaking Approach

Ms. Young: Thanks, Tricia. We want to start with an overview of the pre-rulemaking approach this morning. Next slide, please.

Starting with the charge of the MAP Coordinating Committee, this Committee provides input on the coordination of performance measurement strategies, along with measure-set review across programs and setting up of care.

The Committee also set the strategic direction for MAP and the Committee gives direction to and ensure alignment across three setting-specific Work Groups, clinician, hospital, impact LTC, and two advisory groups, Rural Health and Health Equity.

Specifically, the role of the MAP Coordinating Committee review meeting is to ensure measures across settings are evaluated using the same standards, identify and correct any procedural mistakes and/or inconsistencies and account for public comment in the recommendation of measures.

And now we would like to do an overview of the preliminary analyses. Next slide, please. Each measure under consideration received a preliminary analysis, also referred to as a PA.

This PA provided MAP Members with a profile of each measure and served as a starting point for discussions during Work Groups.

NQF Staff utilized an algorithm developed from the measure selection criteria to evaluate each measure under consideration.

Now we will review this algorithm on the next few slides.

This slide and the next few slides indicate the preliminary analysis algorithm utilized by the NQF Staff.

The left column indicates the assessment criteria, of which there are seven, the center column indicates the definition of the corresponding assessment, and then the right column is the outcome that resulted from the assessment.

The first assessment indicates whether the measure addresses a critical quality objective, not adequately addressed by the measures in the program step.

The outcome is a yes or no answer and for this first assessment, if the answer was no, then the measure received a do not support outcome. The second assessment is whether the measure is evidence-based and is either strongly linked to outcomes or an outcome measure.

Again, if the answer was no to this assessment, the measure received a do not support outcome. The third assessment addresses a quality challenge.

Again, if the answer was no to this assessment, the measure received a do not support outcome.

Next slide. The fourth assessment indicates whether the measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.

The outcome is also a yes or no answer. If the answer to this assessment was no, the highest outcome potential was do not support with potential for mitigation.

The fifth assessment indicates whether the measure can be feasibly reported. Again, if this assessment answer was no, the highest outcome potential was do not support with potential for mitigation.

And the last two assessments, the sixth assessment, addresses whether the measure is applicable to, and appropriately specified, for the program's intended care setting, level of analysis, and population.

If the answer was no to this assessment, the highest outcome potential was conditional support. The seventh and last assessment addresses implementation.

If the measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified. If implementation issues were identified, the highest outcome potential was conditional support.

Next slide. Now we want to review the voting decision category. Next slide. This slide indicates the MAP decision categories.

The columns to the left are the four decision categories, the center column is the definition of the corresponding decision, and the right column is the evaluation criteria.

The first decision category, support for rulemaking, maps and supports implementation of the measure as specified. The next decision category, conditional support for rulemaking, MAP supports implementation of the measure as specified.

That has indicated certain conditions or modifications ideally addressed prior to implementation. The third decision category, do not support for rulemaking with potential for mitigation.

MAP does not support the implementation of the measure as specified. MAP agrees with its importance but has suggested modifications. Such a modification would be considered a material change to the measure.

The final decision category, do not support for rulemaking, MAP does not support the measure. Next slide, please. Now we want to review the MAP coding process.

Starting with the key coding principles, 4M is defined as 66 percent of voting members of the Committee present for live voting to take place.

Form is established prior to voting.

The process is won by taking roll call, a survey completed earlier than our reading today, and two, determining if form is present. At this time, only if a member of the Committee questions form is it necessary to reassess its presence.

If form is not established during the meeting, the vote will be held via electronic ballot after the meeting.

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

Abstentions do not count in the denominator and every measure under consideration will receive a decision.

Let's review the Coordinating Committee voting procedure. One, NQF Staff will provide a brief introduction to each measure under consideration.

NQF Staff will also provide any emerging themes that came out of the public comments submitted to NQF during the online commenting period.

Two, the Co-Chairs will ask for clarifying questions from the MAP Coordinating Committee including discussants who may have clarifying questions.

Committee Members and discussants should withhold other comments at this time. In the web environment, the Co-Chairs will address questions one by one.

Measure developers will respond to clarifying questions on specifications and NQF Staff will respond to questions regarding the decision.

Three, after clarifying questions, the Co-Chairs will open for a vote on accepting the Work Group decision. This vote will be framed as a yes or no vote to accept the decision.

If greater than or equal to 60 percent of the Committee Members vote to accept the Work Group decision, then that decision will become the amount recommendation.

This will end the discussion of this measure and the Committee will move on to the next measure. If less than 60 percent of the Committee vote to accept the Work Group decision, further discussions will open on the measure.

Four, if the Coordinating Committee did not vote to uphold the Work Group recommendation as in Step 3, Co-Chairs will open discussion and further voting on the measure.

Co-Chairs will first ask discussants to review and present their findings. The Co-Chairs will then open discussion among the MAP Coordinating Committee. Committee Members should participate in discussions to make their opinions known.

However, one should refrain from repeating points already presented. After discussion, Co-Chairs will open the measure for a vote. Co-Chairs will summarize the major themes within the discussion.

Co-Chairs will determine what decision category will be put to a vote first based on any potential consensus emerging from the discussion. If there is not a consensus position to be used to begin the voting, the MAP Coordinating Committee will take a vote on each potential decision category one at a time starting with support.

And five, if a decision category puts forth receives greater than or equal to 60 percent of the vote, the motion will pass and the measure will receive that decision.

If no decision category achieves greater than 60 percent to overturn the Work Group decision, the Work Group decision will stand. And now at this time, we would like pause to conduct a test question on the Poll Everywhere platform.

Voting members were sent an email this morning with information regarding the Poll Everywhere platform. We would like you to open up the Poll Everywhere and we will make that test question and active.

We can share. Let us know if you have any questions. I'm bringing up the test question. That test question should be active, I see some results coming in.

Let us know if you're having any problems accessing poll everywhere.

Member Mistry: This is Parul Mistry. I am having problems accessing.

Co-Chair Kahn: What's the username?

Member Tufte: It's in the email but if you try to cut and paste the poll, 593 or whatever, it won't go in, you have to type it in.

Ms. Young: You can't copy and paste it, Janice?

Member Tufte: Yes, I tried it a couple of times.

Member Mistry: Yes, I tried the link as well and it still won't take me.

Co-Chair Kahn: Let me join on my email.

Ms. Young: And Heidi, we are sending you the link.

Member Bossley: Thank you.

Ms. Young: No problem.

While some individuals are still accessing, do we have any questions up until this point about voting, the voting process, procedures for today?

Member Ross: Sorry to interrupt, this is Clarke. I haven't been able to access the poll either. If you could send me the link?

Ms. Young: The team will send you the link.

Member Ross: What's the password?

Ms. Young: It should be in the email link.

So, Chip, you shouldn't need a password to access. If you are able to put that URL that we have sent privately in the browser, you should just have to enter your name and hit continue.

Member Ross: It says do you like tea?

Ms. Young: That is the test question, perfect.

I will give clarification at this point, also, while the question is activated an unlocked, if you make a mistake and you want to change your answer, you are able to clear out your answer and resubmit.

Until the question is actually locked, you can make changes.

Co-Chair Roberts: Will there be an abstain option for actual voting or is that just to be announced verbally?

Ms. Young: You mean on the question? Yes, there's no answer for abstain. That would be just let us know you're abstaining and we will factor that into our calculations.

Co-Chair Roberts: Okay.

Ms. Young: Thanks, Misty.

Ms. Elliott: And Susanne, it's Tricia, just additional clarification on that. Since we don't have the abstain buttons, anyone that needs to recuse themselves for a measure should just not vote.

I think we're trying to get to 22 for total results, just to make sure everybody can connect. So, it looks like there's still 3 folks that need to connect. Can everybody double-check that they've submitted a vote?

Is anyone still having trouble getting in?

Member Ross: Yes, this is Clarke, I'm still having trouble getting in. None of my usernames work. My name, my email address, the 593.

Ms. Elliott: We'll see if we can do some troubleshooting behind the scenes, Clarke. Anyone else having issues?

Member Tufte: I can see clearly your last response. I did that and revoted.

Ms. Elliott: Yes, you can do that because the call is open, you can change your response while it's open.

Member Tufte: So, you just leave it, right?

Ms. Elliott: As you can see, Susanne is navigating, we can lock the vote and at that point, folks cannot make any changes.

Ms. Young: Once it's locked in, we will reveal the answers to that. Clarke, the team is going to reach out to you so we can try to troubleshoot behind the scenes.

Member Ross: Thank you.

Ms. Young: You're welcome.

Co-Chair Roberts: And when we do have real voting, just to clarify, we're expecting the 22 votes. Is that how many voting members there are?

Ms. Elliott: Currently, yes. During the day we're keeping track of folks that may need to step away at different points. So, the number may be a little bit lower but for quorum we would need at least 16 and there's a few measures where there's recusals.

So, it could go as low as 15 on a measure and still meet quorum based on quorum plus recusals.

Member Tufte: Can you tell who is unable to vote so you might be able to help them? Didn't Jess vote on the back end?

Ms. Elliott: I'm not sure if we can tell specifically but we'll continue to work. If anyone was having issues with voting, please feel free to reach out to the Staff.

Clarke, we'll send you some emails. We'd prefer that votes not be captured in the chat, we'd like to maintain anonymity.

Member Tufte: We vote after each MUC, is that correct?

Ms. Elliott: Correct.

Member Tufte: Not as a block?

Ms. Elliott: Correct, there may be situations where we have measures in multiple programs and we'll talk you through that process as we may carryover votes if it's the same measure or different programs.

We'll discuss that when we get there. So, at this point, I think the team is working behind the scenes with some folks who may have trouble with voting but we'd like to keep the meeting moving along at this point.

So, at this point, I'm going to hand things over to Matt Pickering, our senior director, as we'll be doing the pre-rulemaking recommendations for hospital programs.

Matt, are you set to start?

Dr. Pickering: Yes, I'm here, can you hear me okay?

Ms. Elliott: Yes, we can.

Dr. Pickering: So, we're going to start off with the hospital programs and thank you, everyone, for your time and attention and engagement today.

It's good to see everyone and I share in some of the comments of welcome and happy new year to you all.

If we go to the next slide, I think at this point we wanted to open it up for public comment for those members of the public that like to provide any comments for the measures under consideration for the hospital programs.

So, just as a reminder, there will be opportunities throughout the discussions today for public comment, including at the very end of the meeting today on all of the MAP Coordinating Committee deliberations.

So, this is just for public comments right now for the hospital programs and the measures that were under consideration for those hospital programs.

So, we will pause and see if there's anyone from the public who would like to voice any comments for those programs? You can use the raised-hand feature within the planning itself or you can take yourself off mute and chime in and we'll recognize you.

Misty, I think I'll turn it over to you to facilitate that and if you have any other guidance for public comment?

Co-Chair Roberts: Just one quick reminder on the public comment, I think you mentioned this is specifically for the hospital programs right now, but there will be other opportunities.

Please limit your comments to two minutes to make sure we can stay on task and allow the opportunity for others to comment. That's the only other thing I would add.

I'm not seeing anything in the chat function but let's say we give it another few seconds. I think we also have people on audio that do not have that option, so they would just need to speak up, is that correct?

Dr. Pickering: That's correct, you would take yourself off mute at this time for the hospital program's public commenting. We'll just give it a

little bit.

Co-Chair Roberts: Not hearing any public comment, I will turn it back over to you, Matt, to present an overview of the hospital measures and discuss some of the themes from the Work Groups.

Dr. Pickering: Thank you. There was a question in the chat directed privately to me about comments that have been submitted prior to this meeting. Will they be summarized?

They will, so we will be summarizing in aggregate a lot of the comments that were received prior to this meeting for the MAP to consider.

But there still are opportunities for those that didn't submit comments or would like to provide any additional comments during those portions of the meeting as we just did for the public to raise any comments to the MAP as well.

So, going into the MAP hospital programs and the measures under consideration, you can see the total number here in this table and all of the different programs where measures were submitted.

So, there is 23 measures total. There are some measures that were submitted to multiple programs as Tricia had mentioned, and you can see those indications and asterisks there where you have the measures under consideration crossing Work Group settings.

So, you can see there's a good number of measures that do cross workgroup settings. And as we get to those types of measures, the MAP Coordinating Committee may carry over the votes.

Say we vote on the inpatient quality reporting program a measure that was submitted there but was also submitted to the interoperability program.

If you vote one way on the inpatient quality reporting program, as we get to the interoperability

program you may decide to carry over the votes, so the vote being the same on the decision category that was made for the inpatient quality reporting program.

It just takes one MAP Member to voice opposition to that carryover decision in order for the measure to be discussed and voted on separately.

That member may voice the concern on the call and directly message myself to say that you would want to vote on that measure separately and not carry over the votes.

It just takes one person to do so. So, 23 measures total, the largest number of measures going to the inpatient quality reporting program. As you can see, it kind of drops down from there and the next is interoperability and so forth.

So, there aren't any measures that were submitted for the bottom portions of the program. It was largely what you see at the top there.

Going to the next slide, I just wanted to touch on a few themes that came through the hospital Work Group meeting. You can see those listed here, one being the measures for health equity that inspire action.

And so, as you heard from Dr. Schrieber, and as you saw from the measures under consideration in the materials, there's a series of measures that are trying to promote health equity and also to reduce disparities in healthcare.

So, we'll be discussing those today and these were definitely of interest and of importance and were recognized as such by the hospital Work Group.

However, the Work Group did encourage CMS to consider measures for health equity that really show a strong connection to outcomes, or that would ensure action or actionable interventions could be in place to support what is being reported out on those

measures.

The next is risk-adjusting stratification for measures.

This also goes with the health equity theme but the Work Group really emphasizes that there needs to be risk adjustment or include risk adjustment in some of these measures, and stratification.

So, stratifying by populations or subpopulations of interest, such that providers or those healthcare-accessible entities could actually see how well they're performing on those subpopulations of interest.

And this is really important for providing those results back to those facilities so that they can improve on those scores and those subpopulations of interest over time.

Lastly, the third thing was the implementation of measures was the Hospital Inpatient Quality Reporting Program, or IQR program, before the use in Hospital Value-based Purchasing Program, or VBP program.

So, there were a series of measures that came through this cycle in which they were submitted to the IQR program as well as the VBP program.

And there was clarification during the call that CMS provided, and others from the MAP, in clarifying that by statutory requirement, any measure intended for the VBP program must be implemented for at least one year in the Hospital IQR Program first.

And so there was the consideration of that when we see these measures coming through for the IQR program and also being submitted to the VBP program.

There are statutory requirements explaining why it needs to go to the IQR program before going to the VBP program.

Pre-Rulemaking Recommendations for Hospital Programs

And going to the next slide, and those were the themes, we'll then start going into our first measure under consideration, which is for the End-stage Renal Disease Quality Incentive Program, or ESRD QIP.

MUC2021-101 Standardized Readmission Ratio (SRR) for dialysis facilities

The measure under consideration here is MUC2021-101. It's the Standardized Readmission Ratio for dialysis facilities.

This measure is a ratio of the number of observed index discharges from acute care hospitals to that facility that resulted in an unplanned readmission to an acute care hospital within 4 to 30 days of discharge to the expected number of readmissions, given the discharging hospital's characteristics of the patient and based on the national norm.

So, the MAP did not support this measure for rulemaking.

The Work Group acknowledged the measure addresses a high-priority area of care coordination for the ESRD QIP program, however, this measure was submitted for NQF endorsement in spring of 2020.

It lost its endorsement due to not passing scientific acceptability, specifically the validity criteria within NQF endorsement. So, it lost its endorsement because it did not pass on validity during that spring 2020 measure evaluation.

And thus, the MAP did not support the measure for rulemaking for that purpose. And when discussing this measure, the MAP did seek clarification on the rationale for consideration of the program.

CMS noted that the measure creates accountability

and could assist with the evaluations of readmissions across programs.

But further, CMS and the developer clarified that this updated version of the measure corrects biases inherent to data collection and the older version.

So, again, there was an older version that was already used, this is a newer version, however, it did not pass NQF endorsement and the MAP again did not recommend it for rulemaking because of that.

Regarding the comments that have been received, there were some comments that agree with the MAP decisions of do not support due to the scientific acceptability issues not passing validity.

Some comments did not agree with the MAP's recommendation for the measure.

The recognition that both the MAP and the NQF Standing Committees that evaluate this measure for endorsement, recognizing those concerns are valid, but encourages that the MAP offer mitigation opportunity for the developer and the steward to revise the specifications and resolve those NQF concerns of validity.

So, moving from do not support to do not support with the potential for mitigation. And then evidence suggests that pre-imposed discharge inventions by dialysis providers may reduce the risk of unplanned readmissions with ESRD chronic dialysis population.

So, that's the overall summary. Misti, I'll turn it back to you to see if there are any clarifying questions.

Co-Chair Roberts: At this time, we'll open it up for any clarifying questions from the Coordinating Committee.

Member Tufte: This is Janice.

Dr. Pickering: Sorry, Janice. I saw David Baker had

his hand raised and maybe Janice.

Member Tufte: Thank you, go to David.

Member Baker: Thanks for a nice summary there, Matt. My question was also about why there was not an opportunity for mitigation. You addressed that and I'd like to hear more about that.

The other question I wasn't sure of this was a revision of an existing measure. So, does this mean that existing measure will stand?

Dr. Pickering: This would be an update to the measure that's currently within the program. So, if this measure does get used within the program, then that other measure would be replaced with this updated measure.

The Work Group did consider that there were some validity concerns here and there were some questions related to what the validity concerns were.

It really came back with the Scientific Methods Panel, which is our methodology panel that evaluates validity and reliability for NQF endorsement.

And there was identification by that Scientific Methods Panel that the correlations for validity testing just were not adequate. They didn't demonstrate measures for validity to a sufficient degree and so they did not pass that measure on validity.

Thus, it didn't pass on endorsement. The Work Group agreed with that assessment and held it to do not support without potential for mitigation.

Member Baker: So, they think there are non-correctable problems so that makes sense to me. My question was on the first one was actually the opposite.

If we vote to do not support this measure, does that

mean the previous measure will continue to be in effect?

Dr. Pickering: I think that may be a question for CMS potentially. If someone from CMS could answer a replacement of those updated measures with the measure in the program?

I'll just clarify that it wasn't that the MAP Work Group didn't think there were any potential changes to the measure that could be done but they really recognized that since it lost endorsement, this was why it was not going to be voted on -- did not support it to be used within the program.

It wasn't a discussion about there's just not any potential for any changes to the measure. They really just relied on what the NQF Standing Committees had evaluated, recognizing that the measure lost endorsement and thus not supporting the measure based on that.

Sorry, Michelle, go ahead.

Dr. Schreiber: If I may answer David's question? Thank you very much. Yes, David, the current measure would stand in the ESRD QIP program unless we proposed in rule-writing to remove it.

That's something certainly that this Committee in its removal process can talk about but it would still stand, you are correct.

Member Baker: Thanks very much, because readmission is just such an important issue. Thanks.

Co-Chair Roberts: Janice, did you have a question?

Member Tufte: It was more of a comment. I just wasn't aware of how much this happened and recently it's been brought to my attention.

Sometimes I think part of it is because individuals aren't able to make it to where they might normally have dialysis and they end up in the hospital for dialysis at times too, isn't that true?

Is that part of what this is about? Does anybody know?

Co-Chair Roberts: Do we have the measure developer on that might be able to comment to that?

Dr. Messana: Hi, this is Joe Messana from University of Michigan, Keck. We're under contract with CMS to develop this measure. Could the question be restated?

I'm not 100 sure I understand what the question is you're driving at.

Member Tufte: I'm a patient and I realize not a dialysis patient but I'm a bring in the public patient perspective here.

I did not realize, and recently it's been brought to my attention from some ESRD folks, that individuals end up in the hospital because they were unable to continue their dialysis outside of the hospital.

That is one reason they end up in readmission. I was wondering if that is taken into account here or recognized?

Dr. Messana: The population this measure is based on are Medicare dialysis patients, it does not include uninsured patients or people with emergency coverage Medicaid.

This is Medicare-only patients, both Fee For Service and Medicare advantage.

So, I don't think that's applicable and the measure evaluates the 30-day or up to 30-day window excluding the first 3 days after qualifying discharges from acute care hospitals for Medicare patients only.

So, it has nothing to do with inpatient dialysis and I believe without checking specifically, the emergency dialysis patients who go to emergency rooms or get admitted to hospital because they don't have a dialysis unit for lack of insurance or whatnot would

not be included.

Member Tufte: I think part of it had to do with transportation and issues like that, trying to get to the facilities and they ended up in the ER. Anyway, thank you.

Dr. Hunt: This is David Hunt from ONC but I also do vascular access for haemodialysis patients.

It's not uncommon that someone will get to the dialysis facility and find their hemodialysis access is not functioning, the graph is clotted or there's a problem associated with it.

In which case they have to go over to the hospital to get it repaired and taken care of, and if that can't be done expeditiously then the patient ends up coming in or having their dialysis session in the hospital.

Almost all, I don't know of any uninsured dialysis patient, I think that's not a possibility. Dialysis is almost exclusively Medicare patients. I hope that helps.

Member Tufte: That's what I thought. The issues can occur.

Co-Chair Roberts: Thanks, David. Do we have any other questions or comments from the Coordinating Committee?

(Simultaneous speaking.)

Member Goodman: Right, I just was wondering if the measure developer could talk a little bit about how they intend to address the validity concerns.

Our plans would like to see conditional support for the measure but they do think the validity concerns are reasonable and would like to figure out how they could be mitigated.

Dr. Messana: This is Joe Messana again in response. This is my opinion listening in to the methodology

panel and the Hospital Work Group.

The validity concerns I believe were based largely on concerns about the strength of the correlations. All of the correlations that we presented were statistically significant and in the direction that was expected.

Several of them were weaker in terms of magnitude than with the previous submission in 2014, 2015. We believe there were several reasons for that.

Our risk adjustment changed, we believe, and the comparisons were made to measures that had also changed and were somewhat different. We think that some of the change in the strength of the coefficients were related to that.

So, we think that rather than presenting a simple correlation which does not focus on outliers, there are other ways to present the information and we actually sent some information back to the methodology panel.

But it didn't fit within the operational construct for review of these measures so it was not considered.

We think there are potentially opportunities to, and I'm going to use the word tweak or game the correlation analysis and what comparisons are made.

So, if it comes down to just the strength of the validity correlations, we would have opportunities to potentially take another shot at convincing the appropriate experts.

I would point out that the most important consideration, the correlation between mortality and hospitalization, were not dissimilar from the previous submission.

The correlations with some of the intermediate outcomes related to dialysis processes of care were somewhat weaker than in the previous one and I

think that may be part of the basis for the decision that was reached.

Co-Chair Roberts: David Gifford, you had your hand raised?

Member Gifford: I just wanted to discuss this and whoever assigned me, thank you for assigning me a complicated, challenging one.

I think it's clear that, as everyone has said, readmission is an important clinical outcome and important issue we should be looking at.

But I think, really, the question is, is the measure ready for rulemaking in a payment program? As was just said, the validity failed because of the correlation with hospitalization, not rehospitalization, was 0.4, the correlation for mortality was 0.1, and then the correlation for two other measures was 0.04 and 0.06.

So, it fails on validity. It originally failed on reliability but then passed, but about two-thirds of the variation was due to noise in there.

And so the other thing is I think the public comments were pretty compelling and that one comment was from 32 different professional trade and provider associations, all raising concerns about the reliability and validity of this measure in the payment program.

The other thing is that this payment program has over 22 different measures in it and it's unclear how this measure correlates with the other measures in the payment program and what the loss would be for removing.

But I think it's really hard for us. It's clear it's an important program and I think the message back to CMS is they have to figure out how to make this measure a better measure.

But it couldn't pass the reliability and validity. And

the reliability and validity test were just one or two and were not very complex or in-depth compared to other measures we've seen.

I think that's why it's failed.

As the measure developer said, there may be ways they can rectify that but I don't see how we can support a measure that fails NQF endorsement coming in with such broad public concerns against the measure, and not understanding how this measure is impacting the overall program.

I think if we just vote on the measure of the importance than I think we can just block for every measure that's presented to us because they're all important and they all have a good gap and they all have good quality improvement opportunities.

But I don't think that's our charge for the Committee.

Co-Chair Roberts: Thanks, David. I am not seeing any other hands. So, with that, it looks like there may be some conflicting, whether it's do not support or do not support with potential for mitigation.

So, maybe what we should do is just start out with voting on the Work Group recommendation. Does that sound reasonable, Chip, Tricia?

Co-Chair Kahn: Yes.

Co-Chair Roberts: Great.

Dr. Pickering: Before we go to a vote, Misty, there was a comment in the chat about how health equity was factored into the measure. I think I can address this.

Just a reminder to the Coordinating Committee, this year we had a health equity advisory group, which was the first time we convened this group to look at all of the measures under consideration in the lens of health equity.

So, can they promote health equity? Can they reduce healthcare disparities?

A lot of those discussions with those measures centered on stratification, so stratifying by certain subpopulations, and whether or not these measures can actually identify and then actually there will be some sort of action that can be done to mitigate any of those social needs that have been identified through the measure.

So, the MAP Work Groups, clinician, PAC LTC and hospital, considered those inputs that were provided by the health equity advisory group during those deliberations and during the recommendations. I just wanted to mention that.

Co-Chair Roberts: And now that you mention it, I do see another question from Julie, it looks like, that wants to better understand the difference between this version of the measure and the one currently in use.

So, Joe, are you able to answer that?

Dr. Messana: I think I can, yes.

The fundamental differences are that the technical aspects of the modeling have changed a little bit for computational efficiency but that only has a mild effect on any of the reporting statistics or the association statistics.

We revamped and updated the categorization for comorbidity assessment to utilize AHRQ CCS categories rather than hierarchal

condition categories from an older program because we thought they were both clinically relevant.

And we utilized a forward selection approach to identifying comorbidity risk adjustments based on their impact on a model rather than the old approach, which is was not empirically derived.

We also included a co-variate for Medicare

Advantage status because of potential biases related to collection of only implementation claims in the Medicare Advantage program or shadow claims.

So, our access to claims-based comorbidities is different for Medicare Advantage patients and for Medicare Fee For Service. And the fraction of Medicare Advantage patients is growing in the chronic dialysis population.

We limited to inpatient claims sources for the comorbidities as opposed to the entire universe of Medicare claims to minimize the bias inherent in including Medicare Advantage and Medicare Fee For Service patients together.

All these were largely technical and were intended to try to improve the risk adjustment and reduce biases associated with the need for risk adjustment based on comorbidities.

Co-Chair Roberts: Thanks, Joe. Chip, did you have your hand raised?

Co-Chair Kahn: Yes.

Looking at the chat box, which is one of our duties here, one, I'll take the question, are we going to have in every measure that we consider then this issue of health equity being a question as to whether it's a factor or not?

That's the case? I guess I'm asking Michelle. And how do we appraise that?

Dr. Schreiber: Chip, it's an interesting and important question.

I think part of the reason for the Equity Committee as part of the MAP process is to actually look at all measures and see how it applies to equity and whether or not there are any new considerations that have to be given to it.

I think we've talked about this in many ways and

certainly during the NQF process of evaluating measures, there's also the conversation of risk adjustment for things that may be social determinants of health or other equity factors.

But there's not a clear and consistent way of doing that necessarily. There was discussion earlier about stratification and whether or not all measures should be stratified for equity.

And as you saw in the RFI that was in 2021 rulewriting, we sought comment about that and we continue to seek comment.

Many people may recognize would like to stratify all measures, certainly, all appropriate measures and whether or not that is actually the direction that we will or can go in.

I think frankly Chip is still up in the air but I would say the intent is there to do additional stratification of appropriate measures.

I don't quite know how to answer your question except to say that these are still ongoing issues and concerns.

Co-Chair Kahn: So, from our standpoint then, we just need to raise it in its discussion so that we at least examine it?

Dr. Schreiber: I think that's a reasonable approach.

Co-Chair Kahn: In the chat there are a number of other comments directly on this measure. I don't know, Misty, rather than going through all of them, I commend the chat to the group so you can look and see.

Ron made a comment, some other people made comments. Why don't you look there and see people expressing positions on this measure?

And I think there was discussion of the comparison of this measure to the other measure, which is another question.

I think I've covered everything.

Co-Chair Roberts: I think it's mostly comments as opposed to questions. Okay, I don't see any other hands raised and if there are no other questions or comments, let's open it up for voting.

Dr. Pickering: So, just a reminder, what the Coordinating Committee will be voting on is whether or not you want to uphold the Work Group's decision for this measure, which was a do-not-support decision.

So, it's a yes or no vote and that's the first question you'll be asked. If you vote no and if we do not achieve equal to or greater than 60 percent upholding the Work Group decisions, then the measure will be open for further discussion.

And independent votes from the MAP Coordinating Committee on the new recommendations will proceed.

Ms. Young: Voting is now open for MUC-2021-101 standardized readmission ratio for dialysis facilities, or ESRD QIP.

Do you vote to support the Work Group recommendation as the Committee recommendation as do not support for rulemaking?

Co-Chair Roberts: It looks like we have 20 votes. Do we want to give it a little bit more time or end the voting?

Co-Chair Kahn: I think we need to get moving.

Co-Chair Roberts: Yes.

Ms. Young: Voting is now closed for MUC 2021-101. The results are 17 yes and 3 no. The Coordinating Committee supports the Work Group recommendation as the Committee recommendation or 85 percent.

Dr. Pickering: Misty, you should go to the next one.

Co-Chair Roberts: Yes, that sounds good, did we just skip a slide though? No, this is it. Sorry, go ahead Matt.

Dr. Pickering: Yeah, that's what I was wondering. Did we skip one, are we on -- no, okay. Now I've got it in my notes here, this is -- sorry, kind of jumbled with my notes at this point.

Co-Chair Roberts: No worries Matt, I'm sure everyone -- we started out with a little bit of a complicated one, even though we agreed on the workgroup recommendation, and as you can see there's a lot that goes on behind the scenes to get here, a lot to kind of aggregate before the discussion.

MUC2021-091 Appropriate Treatment for Patients with Stage I (T1c) through III

Dr. Pickering: It does, okay. So, this measure is now for the Prospective Payment System PPS-Exempt Cancer Hospital Quality Reporting Program. So, this measure is MUC2021-091, Appropriate Treatment for Patients with Stage I through III HER2 Positive Breast Cancer. And this measure is the percentage of female patients aged 18 to 70 with Stage I through III HER2 positive breast cancer for whom appropriate treatment is initiated.

So, the MAP did provide a conditional support for rulemaking for this measure, and I apologize for just jumping to my notes here with this specifically, and so they recognized that this measure did not necessarily align with the 2021 needs, and priorities for the program, however that this measure does align with CMS's meaningful measures framework in that it is an eCQM, and may support greater access to life saving diagnostics, and therapies during the COVID-19 public health emergency, and beyond.

I also recognize that this measure aims to identify the percentage of female patients age 18 to 70 with Stage I through III HER2 positive breast cancer for whom appropriate treatment is initiated. The MAP

did also acknowledge that there's studies that have shown that overall survival of patients with high risk HER2 positive breast cancer significantly increased with administration of these targeted therapies, and that's provided additional support pending NQF endorsement for this measure.

There were some comments that I've received that were in support of this measure for inclusion in the program, and supporting an agreement with the MAP's recommendation for additional support, recognizing again that there is importance of this measure in this disease area, but recognizing that it needs to have NQF endorsement for the review of the various criteria, including scientific acceptability.

So, Misty, I'll turn it back to you to see if there's any clarifying questions from the Coordinating Committee.

Co-Chair Roberts: Thanks Matt. All right, we'll open it up to questions, or comments from the MAP Coordinating Committee.

Dr. Pickering: I don't see any hands raised, nothing coming through the chat.

Co-Chair Roberts: Okay, so with that, it looks like Ron just posted something. Ron mentioning it's a process measure, not an outcomes measure, likely topped out for the program. Said the chance of NQF endorsement is not high. Thanks Ron.

Dr. Pickering: And then there's a hand raised from David Baker, and just a reminder for everyone, this is a point for any questions, any clarifying questions from the Coordinating Committee.

Member Baker: I will just say that I agree with Ron's concerns, I don't have a specific question. They claimed that the adherence to this measure was only about 45 percent. There was a new guideline that was released, and I was not able to find it online, so I don't know whether the measure aligns with that new guideline, but it just seems

very questionable to me that the adherence is actually that low among this great group of hospitals that are the best cancer care in the country.

So, I'm willing to go along with conditional support, and let NQF do their job, and I suspect as Ron said, that the chance of endorsement is not going to be high when all is said, and done. They've had very little testing of this measure.

Co-Chair Roberts: David, I think you bring up a good point if there is a new guideline, can the measure developer speak to whether or not this aligns with the new guideline?

Member Baker: It does, they made that claim.

Co-Chair Roberts: They made that claim, okay, sorry, I didn't hear that.

(Simultaneous speaking.)

Member Baker: -- being evaluated, because it was supposed to be published this summer, and I wasn't able to find it. So, if the measure developer is on and can point us to that, that would be helpful. They're going to need to do that for NQF.

Ms. Drumheller: Hi, this is Caitlin Drumheller from ASCO. Yes, we can definitely take a look and see if we can find that and maybe provide a link to it in the chat.

Co-Chair Roberts: Thanks, Caitlin.

Member Baker: Tom Ross just said our perception is that this is an issue with EHR documentation, and not a performance gap, which is exactly my suspicion. And I suspect when all is said and done NQF won't support it for that.

Co-Chair Roberts: Chip, I think you have your hand raised.

Co-Chair Kahn: Yes, this raises an issue for me. I

mean, we've got a number of comments that this wouldn't pass muster. What worries me with this recommendation, and with the topic that it is, and it gets put in regulation, is that sort of a done deal? Even if later it doesn't get endorsed, it's then got to come out, right? Which is not necessarily an easy thing to do.

I guess in terms of our vote, I just wonder whether people are that convinced that it wouldn't get endorsed, do we want to recognize that in our recommendation now? It's just a thought.

Co-Chair Roberts: Yeah, Michelle, can you speak to that any? If we did support the workgroup recommendation, conditional support for rulemaking, what would happen? Would CMS wait for that NQF endorsement, what's likely to happen? Or go ahead and submit for rulemaking, and then we would have to reconsider it in the future if it did not receive endorsement? Maybe you can clarify that.

Dr. Schreiber: Most likely this will wait at least a year before it is proposed, and during that time it would go through NQF endorsement. But I can't guarantee you that either, Misty. So, you're right, there is the circumstance that could happen, that this would get proposed in this year's rule writing, it would be adopted and finalized before it had gone through the NQF process.

In this case I don't think that's what will happen, but I can't make you that guarantee. And once it's in the program, you're absolutely right, if it were to meet NQF endorsement because of the concerns that are being voiced on this committee, I think we all recognize what happens to try and get a measure removed. So, my only advice would be for the committee to maybe think about that in your deliberations for voting.

Co-Chair Roberts: Yeah, I mean obviously this isn't the only measure that we're going to have to consider that, because there are probably going to

be multiple other measures, but I do think though, with the new process that we have to look at removal of measures, if that were the case, then we would likely see that in that new process, right? In the future.

Dr. Schreiber: Correct, absolutely correct.

Co-Chair Roberts: Okay. David Gifford?

Member Gifford: Yeah, related to that, I guess to Michelle, is there a statutory requirement, or a very pressing public health need like we've done with COVID, or other issues that require this measure to go forward without NQF endorsement? Historically --

Dr. Schreiber: No David, there isn't.

Member Gifford: We created this category for conditional for rulemaking, as many of these VBP programs, QRP programs, and other programs were new, they had statutory deadlines that CMS had to meet, and you couldn't meet them by getting NQF endorsed, and going through the MAP process in the timeframe. And so to accommodate that, we created this category of conditional support for NQF because of the time pressures -- recognizing the time pressures that Congress created.

Or when things have come forward because of really clearly critically pressing public health, or clinical quality gaps that just really require to move forward quickly while it goes through the NQF endorsement process. I think we're in a different position now, and so the question really -- I think the question that Chip and David have raised, is there a pressing need that this measure goes forward?

Because you're right, once we recommend it for conditional support for rulemaking, at least in the past it often showed up in the rules. Sometimes it would wait a year, or two to work through, other times it didn't. So, I'm questioning whether this category, the way we've considered in the past

makes sense for the future for this.

I mean if you're saying that CMS's position is that unless there's a deadline, conditional support for rulemaking generally will be deferred until it gets NQF endorsement, then I think that's a helpful input. But if that's not the policy of CMS, then I want to raise the question about whether we should continue on with this conditional support for rulemaking given the history and what's going on.

Dr. Schreiber: Yeah, there's no question David, that we prefer measures that have been NQF endorsed, but you're right, it's not absolute, and it's not 100 percent. And there is not something that is statutorily, or time pressing about this particular measure. There's no statutory requirement that we're trying to meet for example.

Co-Chair Roberts: So, I certainly don't have as much history with this group as Chip does, and I would love to better understand kind of where that conditional support for rulemaking came, because this is a pretty substantial topic of discussion, and could impact the other measures that we're going to discuss today. So, Chip, you have your hand raised, I don't know if you want to comment on that, or ask a question.

Co-Chair Kahn: Well, I agree with the genesis of this category. I have reticence to revisit our structure, because I think our structure, which developed over time, and this is part of it, really allows a great deal of flexibility for us. So, I guess my judgement model, my recommendation would be if we think this isn't a good measure, and we can't get 100 percent confirmation that it won't go forward, then we should take that into account, and not vote it on this category, vote it on one of the other categories rather than revisiting our structure at this time.

Because I can't say that there won't be future legislation that would drive us to be in the situation that was described in the past. And there might be

other situations where this category makes sense. So, rather than revisit the category, my bias would be to maybe vote for a different category to this measure.

Member Gifford: Would you like a motion to that effect?

Member Binder: I have my hand raised, if I can say --

Dr. Pickering: I think that was Leah. And I'll just mention that appreciate the comments about the decision categories; however, we have to use what we have today, as these are what we have been using for this cycle. I think any of these changes to decision categories, or the utility of them does occur during our strategic discussions, which happen prior to when the MUC considerations kick off.

I appreciate this great commentary, and it's definitely something the staff is taking down, and jotting notes about, but we should continue to use the decision categories as they are, and again reminding that at this point, we're doing some clarifying questions about the measure, just we have a lot to go through today. So, recognizing that these are important conversations, but those strategic types of discussions on whether decision categories have utility will be something we want to reserve for those strategic meetings that we have with MAP. Sorry Misty, I think Leah had her hand raised next.

Co-Chair Roberts: Yeah, just quick comment, I appreciate your kind of grounding of us on that. I do just want to add though, that I agree, we can't make those decisions today, we do have to have those strategic conversations. But if there are considerations that, as Chip suggested, that we're considering as we're voting on recommendation of conditional support.

And at the end of the day we disagree with a lot of conditional support for rulemaking because of those

additional considerations, I just think we need to -- let's keep that in mind as we have our next strategic meeting, and really keep track of where we may not agree with these conditional support for rulemaking. Does that make sense?

Dr. Pickering: Yes.

Co-Chair Roberts: Okay, Leah, go ahead.

Member Binder: I just wanted to say that -- I just wanted to actually reinforce a point you made Misty, which is that we do now have a format where we can remove measures, which is a good thing. And the second thing is I just always want to reinforce what I think is important, is that only when we feel very strongly about something should we overrule a workgroup.

So, I just want to kind of caution us not to over think, otherwise the process is just so cumbersome, and I think people come to these workgroups, and they put a lot of time, and energy into them, and that's why we need them. So, I would like us to try, and lean toward supporting the workgroup, unless we have strong feelings, which there are certainly some measures today that I'll have strong feelings against the workgroup, but otherwise I think we should lean toward the workgroup.

Co-Chair Roberts: Thanks Leah. David Gifford, do you still have your hand raised, you have another?

Member Gifford: Yeah, I just wanted to respond to Leah's comment. I would agree that we have adopted that principle in the past, and would concur that we shouldn't be -- it should be compelling why we're overriding the workgroups. However, I will say that I sat in on a lot of the workgroups this year, and I've sat in in the past, and this discussion that we're having about rulemaking, and other issues does not often come up in those workgroups.

I think we need to think about the direction we as the coordinating body give to the workgroups

addressing it. That goes back to my original comments at the very beginning of this meeting to Michelle, about the importance of understanding the context of where they sit with the rules, because most of them have just been really about is it NQF endorsed, is it reliable validity, and is there base validity that this is an important measure has been 90 percent of the discussion in most of the workgroups.

There's no consideration for what it means in rulemaking, or other processes. So, that's the only caveat I would say Leah, to accepting what comes forward, is we're looking at it as a committee from a different perspective than the way that I've seen the workgroups look at the measures.

Dr. Pickering: And Misty, I don't see any other hands raised. Go ahead.

Co-Chair Roberts: Okay, yeah, I just do see a comment around suggesting voting on do not support with opportunity for mitigation, with that mitigation being full NQF endorsement. And it did raise a question for me in terms of the difference between the support with potential for mitigation versus do not support with that opportunity.

So, I might ask, because it seems like if we're talking about the full NQF endorsement, it should fall under that conditional support. What are some of those material, can you give an example of maybe the material modifications for the do not support for rulemaking with potential for mitigation? It mentions a material change, but I guess I'm trying to figure out what would something like that be?

Dr. Pickering: Yeah, material change would be a significant change to the specifications of the measure. That even could include risk adjustment, if there is risk adjustment, or not risk adjustment, or changes to the risk model, things that would obviously impact the result of the measure. So, largely that's going to be some sort of specification

change in which the measure itself, and the result of the measure changes significantly, so that's a material change.

That could include risk adjustment, especially if the measure doesn't have a risk adjustment model, and the committee feels it should have risk adjustment, those are material changes. And that also then would lead to the bringing it back to NQF endorsement specifically, because if there's a material change it would flag for a reevaluation of the measure going back through NQF endorsement, because it would be a different measure, different specification that would need to be evaluated, et cetera. So, those are material changes.

Co-Chair Roberts: Okay, appreciate that clarification. So, understanding that, I don't see any other hands raised, or questions. With that I would actually propose that we move forward with voting on the workgroup recommendation.

Dr. Pickering: Okay, so we'll proceed to voting. And this is to vote whether or not you support the workgroup recommendation of conditional support pending NQF endorsement.

And I'll turn it to Susanne. Susanne, are you there? Not sure we have Susanne's audio.

Ms. Payne: Matt, I can go ahead, and read that audio. I believe Susanne might be having some issues. Or are you back, Susanne?

Ms. Young: Sorry.

Ms. Payne: All right, thanks.

Ms. Young: It's been quite a day. The portal is now open for MUC2021-091: Appropriate Treatment for Patients with Stage I T1C through III HER2 Positive Breast Cancer for the PCHQR Program. Do you vote to support the workgroup recommendation and committee recommendation as conditional support?

Voting is now closed and locked for MUC2021-091. The results are 17 yes, and 2 no. The Coordinating Committee conditionally supports rulemaking for MUC2021-091.

Co-Chair Roberts: Thanks, Susanne, we'll move to the next measure. And Matt, if you want to present any themes that came from the workgroup and discuss the rationale?

MUC2021-122 Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)

Dr. Pickering: Sounds great, thanks Misty. So, the first measure on the slide here that we'll talk about for the Hospital IQR Program, the Inpatient Quality Reporting program, is MUC2021-122, which is Excess Days in Acute Care, or EDAC After Hospitalization for Acute Myocardial Infarction, or an AMI. And this measure estimates the days spent in acute care within 30 days of discharge from an inpatient hospitalization, or AMI.

The measure is intended to capture the quality care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute outcomes that occur post discharge in settings like emergency department visits, observation space, unplanned readmissions at the time during the 30 days post discharge.

The MAP workgroup supported this measure for rulemaking, and the workgroup considered how the hospital performance in treatingworkgroup discharging patients with AMI varies considerably, with outliers yielded hundreds of excess days in acute care relative to their peers. The workgroup recognized that this measure is currently included in the hospital IQR. The measure under consideration updates the minimum admission threshold, strengthening the reliability of the measure result.

The measure distinguishes itself both of its condition specificity, and the inclusion of other healthcare

visits beyond hospital readmission. As far as the comments received leading up to this meeting, there's comments that urge MAP to consider the unique circumstances that providers such as large hospitals face that might post challenges to timely discharge, such as conditions related to COVID-19.

Large hospitals for instance, who are otherwise ready to discharge the patients to another healthcare setting are constrained by the inability of other healthcare settings to properly accept patients due to concerns related to the COVID-19 pandemic. There are also concerns shared from the public that the measure does not meet the acceptable interclass correlation coefficient threshold of point six.

And this is reliability assessment, because the minimum number of cases that would be required to achieve this threshold is 300, there is concern that it will significantly reduce the number of hospitals to which the measure can apply. There is some support for the MAP's recommendation, because of revisions to the measure's specification improved its reliability, however there's still some skepticism about the overall value of the measure, and encourages CMS to consider removing it from the IQR in the future.

And there has been some evidence that have been cited from some commenters suggesting that following readmission rates are not offset by increases in the use of observation states and ED visits, which undermines the justification for the use of excess day measures.

With that summary, Misty, I'll turn it to you for any clarifying questions from the Coordinating Committee.

Co-Chair Roberts: Thanks Matt, we'll open it up for clarifying questions.

Dr. Pickering: Misty, David Gifford has his hand raised.

Co-Chair Roberts: All right, go ahead David.

Member Gifford: I was an assigned discussant for this as well, and I think the summary was accurate. So, the changing of the denominator size from 25 to 50, which was the major change, did not really appreciably change the reliability much. It went from .38 to .40, and it was a reasonable move in the right direction. I think it makes sense to support the measure going forward, it's in use.

I think CMS, they need to look at it, the challenge is with the rulemaking. I think it would be helpful to look at how this measure correlates with all the other measures in the IQR program, because as some of the commenters pointed out, there are other measures similar to this, this is an aggregate measure of any days in the ER, or hospital, or observation status, whereas there are other hospitalization measures.

So, the question really is how much added value is this measure? It's sort of like a semi composite measure that's there, but I think that would be the feedback I'd give as CMS considers it in rulemaking. But I didn't see anything in the whole review that would suggest we need to change anything from the workgroup recommendation.

Co-Chair Roberts: Thanks David. Any other clarifying questions?

Dr. Pickering: And I don't see any hands raised.

Co-Chair Roberts: Okay, with that, I propose we vote on the workgroup recommendation.

Dr. Pickering: Okay, and I'll switch to voting. And you're voting whether or not to support the Hospital Workgroup's recommendation of support for rulemaking for this measure.

Susanne, I'll turn it to you.

Ms. Young: Voting is now open for MUC2021-122:

Excess Days in Acute Care After Hospitalization for Acute Myocardial Infarction for the Hospital IQR Program. Do you support the workgroup recommendation as the committee recommendation support for rulemaking?

Voting is now closed for MUC2021-122. 19 committee members voted yes, 1 committee member voted no. The Coordinating Committee supports the workgroup recommendation of support for rulemaking.

Co-Chair Roberts: Great. Matt, if you want to speak to the next one?

MUC2021-106 Hospital Commitment to Health Equity

Dr. Pickering: Sure, all right. So, the next measure within Hospital IQR Program is MUC2021-106 Hospital Commitment to Health Equity. So, this structural measure assesses hospital commitment to health equity using a suite of equity focused organizational competencies aimed at achieving health equity for racial, and ethnic minorities, people with disabilities, sexual, and gender minorities, individuals with limited English proficiency, and rural populations.

The measure will include five attestation based questions, each representing a separate domain of commitment. Those domains being equity as a strategic priority, data collection, data analysis, quality improvement, and leadership engagement. So, a hospital will receive a point for each domain where they attest to the corresponding statement for a total of five points.

For questions with multiple elements, attestation of all elements is required in order to qualify for the measure numerator. The workgroup did not support the measure for rulemaking. The measure assesses whether hospitals have developed plans to address health equity issues, collected, and analyzed the data needed to act on that plan, and evaluate the

progress towards obtaining their objectives.

However the workgroup considered that while reducing healthcare disparities would represent substantial benefit to overall quality of care, the measure itself is not closely linked to outcomes, or clinical outcomes. Likewise, a performance gap at the individual hospital level on these specific structural elements has not been established.

So, the workgroup expressed that the measure was a structural checkbox measure that may not lead to changeable action. And the measure includes many components that may be subject to interpretation, so the MAP did note the importance of the measure concept, and one MAP member actually specifically noted the structural measure was a step in the right direction, however concerning that it wasn't linked to outcomes, the MAP decided to not support the measure for rulemaking.

As far as the comments that have been received, there was quite a few. There were some that were supportive of the MAP recommendation of this measure, of do not support. They also recognize the importance of the hospital commitment to health equity, and the role that structural measures can play as a bridge to more meaningful process measures, however an attestation of commitment is really not sufficient.

There is support for the integration of health equity strategies, and initiatives throughout the hospital leadership, and into the overall structure, and practices, but there's concern that the development of a structural measure, particularly one that primarily looks at the presence of equity focused documents in the absence of any demonstrated linkage to patient outcomes should not be pursued.

There were some disagreements to the MAP recommendations. So, disagreements with the MAP recommendation suggesting that the introduction of a measure like this takes a step forward moving federal quality programs forward, especially when

seeking to drive hospitals towards inclusivity of health equity. There's recommendations that the MAP revise its recommendations to conditional support for rulemaking pending NQF endorsement.

The commenters state that structural measures are a key component to a comprehensive quality program, and the development of structural, and process measures is a start to using quality measurement tools to improve health equity. There was also some suggestions to change to do not support with a potential for mitigation.

While there is limited information to evaluate the potential impact of this measure on quality of care, this measure has potential for future use in CMS programs, because it fills a critical gap. And lastly, because the measure is so early in development, the measure steward has not yet field tested the measure, or engaged stakeholders to determine the usability, acceptability of face validity of the questions informing performance.

So, once these activities have been conducted, and completed, CMS will have more information to hone the measure, and consider it for future programs. Misty, I'll turn it back to you for clarifying questions. I think Chip has his hand raised.

Co-Chair Roberts: Thanks Matt, we'll open it up for clarifying questions. I am going to also assume that this might be the measure that Michelle was alluding to in the beginning around the structural measures. So, CHIP you have a question?

Co-Chair Kahn: Yeah, let me say a couple of things, actually I just have comments. One, I think CMS is going to do this no matter what we do, so I think that's important. And I think they're doing it for a very important reason. This is not an area where there is a lot of good work yet, but they, as a policy want to get hospitals focused.

So, I think from that standpoint, I think as a matter of implementing their policy regarding equity, it's a

good start. However, I think that this notion of it somehow being comparable to other structural measures that are somehow a bridge is lacking. I see this as, in a sense, the worst kind of structural measure, because it's simply asking whether -- you're attesting to an activity, you don't know whether that activity will lead to better outcomes, or not.

You don't know whether that activity will actually lead to any implementation in the hospital other than having a bunch of pieces of paper, that's the negative side of it. The positive side of it is it will force in hospitals conversations that CMS, and the government want them to have, and I think that's constructive. I see this as constructive, but in terms of it being a bridge, I think that's an overstatement.

Because I doubt that anything that comes from this measure will bridge into another measure, or that it will do a good job of informing other measures that will develop regarding equity. All that being said, I don't know where that gets us in terms of how we vote, because I see no way, at least from my understanding, that this would ever get endorsed.

It's just not that kind of measure, it's not going to have the right statistics, it's not going to pass muster. So, if we support with the condition, I guess the one condition I would have, which isn't NQF endorsement, but some assurance that this measure would only be used -- I guess in hospital compare as a measure that would be reported on, and would never go into any other aspect of the program, because it's clearly not appropriate for that in terms of being involved in payment, or anything else. So, other than simply a prod, that's my two cents.

Co-Chair Roberts: Thanks Chip, it looks like we have several hands raised. We'll start with Parul.

Member Mistry: Hey, I was listed as one of the discussants. Pretty much agree with some of the comments that Chip made, the two additional things

that I would add to this one is that definitely as we're looking to kind of mitigate some of the risks that are outlined, passively considering also sharing the data around health equity through HIEs, and other information sharing exchange.

Because definitely health equity is something that is an issue that health systems across the country need to work on, including payers, providers. So, everybody having their own information is going to move things in different directions. So, definitely I would be looking to recommend something where the information can be exchanged across the entire universe of healthcare.

Then the other piece I would say is frequency at which the information should be captured. Do you just, once you document the information, is this one, and done? Or do you have to frequently keep updating, because we know that the information changes. Thank you.

Co-Chair Roberts: Can we clarify from the measure developer, would the frequency of the attestation be yearly for this?

Dr. Bernheim: Hi, this is Susannah Bernheim from Yale CORE, yes that is the idea. And the concept is that as you guys noted, attesting that there are certain capacities, and certain activities in use such as having a strategic plan, having leadership looking at measure results that are stratified, having a way to collect data, and that would be updated yearly.

Co-Chair Roberts: Thank you. I think we also have a hand raised from Ron.

Member Walters: Thank you. I'm not going to repeat much of what Chip said, but there's a lot to say. This may be the most important measure of all time that's never going to get endorsed, and has no chance of getting endorsed. Now, how you accomplish it is a whole different matter. Because as much as I don't like structural measures, you frankly need them sometimes.

So, I think the throwback, I support the workgroup recommendation, but I'm not thrilled about it. And I think a throwback to CMS, this needs to be a part of surveys, this needs to -- maybe in extreme, a part of conditions of participation, this has to become part of the joint commission process, et cetera, et cetera, et cetera.

And then as time goes on, we'll get some of the outcomes linkage that might well result in endorsable measure. But sorry, we just can't right now.

Co-Chair Roberts: Thanks Ron. Libby?

Member Hoy: I put my hand down, but I guess I just want to emphasize the need for the prod in the environment. And so I think while certainly not perfect, I don't necessarily see the downside. I understand that this isn't going to be the end all, and be all, and hold hospitals accountable for implementing what they've said they've done. But particularly in light of the fact they are going to be renewing, and reviewing these annually, I do think that it aids this kind of a prod.

Dr. Pickering: This is Matt. I just wanted to do a time check, so we're at 12:15, we're still behind our schedule for our agenda. So, just trying to see if we can maybe keep the comments to clarifying questions at this point. Just to see if we can get to a vote on the workgroup recommendation. And obviously if less than 60 percent do not support the workgroup recommendation, some of the additional comments where the decision category should be can occur at that time.

But just seeing if we can kind of get through clarifying questions on the measure so that we can try to get a little bit back on track with our agenda. Sorry Misty.

Co-Chair Roberts: That's okay, definitely appreciate the reminder on that Matt. I think that the hard part around this is that sometimes these initial

comments do help to inform our decision, but I also recognize that there is so much work done from the workgroups to get to this recommendation, that there may be some things that we have to remove ourselves from. I'm honestly a little bit torn. Chip, I think you have your hand raised.

Member Ross: Misty, I've had my hand up since --

Member Binder: I have my hand up also.

Member Ross: And Chip's already commented --

Co-Chair Kahn: I was going to comment on what Matt said, which is Matt, I completely disagree with you. I understand our timing, but on this particular measure, one, because of its import, one because it was such a strong reaction from the task force that's counter to what we know CMS policy is, I think this warrants the discussion. I think after we get through this we can start rolling. But this is really imperative that we have the thorough discussion here. I'm sorry, that's what I wanted to say.

Co-Chair Roberts: And I do apologize, it used to be that the hand raised function would automatically bring those hands to the top, I have a lot of scrolling to do to figure out who has hand raised, so it's a little different than it used to be, so apologies. Clarke, go ahead.

Member Ross: So, the bottom line is I actually support Chip's earlier comments. I think we need to have a vote on either mitigation, or conditional support. I'm in my 51st year with my 6th national disability and mental illness organization here in town, and after 51 years of being told wait, we can't do this until it's perfect, that argument rubs a little bit of the wrong way.

But I also agree, it's not ready for endorsement in a typical way that we consider, and endorse measures. So, I want, as an affirmative support as we can have within the limitations that have been

identified. Also want to just share with you that CMS, through the MMCO, the Medicare and Medicaid Coordination Office, and the Administration on Community Living have invested a lot in the last two years, two, and a half years on disability competent organizations.

So, there's this whole training orientation going on as a commitment of CMS, and ECL. So, this is needed, it's not ready for the typical kinds of measure endorsement, but I want to see if we can find some way to show how important this topic is, and affirm that. Thank you for listening.

Co-Chair Roberts: Thanks Clarke, Leah?

Member Binder: Yes, I also think that Chip has raised an important point, and so Leapfrog has looked at this issue, we've looked at measures similar to this ourselves, and it's been tested on the Leapfrog survey side, it's not a full testing, but it's been on the Leapfrog survey. So, here's the confession, I am really feeling ashamed personally that we never looked at this issue of health equity at Leapfrog until last year.

Like, it took us 21 years to figure out oh my God, this is a really important thing, we never looked at it. And it is, and I truly feel like this is a huge shortfall to my organization. But then I thought well everybody else must be working on it, because it's such a big thing, everyone talks about this is a big issue. So, we did a lot of homework, and a lot of research to find out what are the measures that are out there, what's the data?

How does it all come together, so we can figure out what we can do? There's nothing. I mean it is like starting back at the beginning of Leapfrog with patient safety, where we had nothing, no data, no one was tracking the stuff, there was no reliability, there was no testing, there was nothing. Hospitals don't even have a reliable, or valid way of collecting this data completely, I mean that's still up in the air.

This measure even asks for that, it says you have to be able to figure how to ask people what their race, or ethnicity is, and how to train people to ask it, that's where we are. So, yeah, this is not a measure that's going to pass endorsement, but this is a measure we absolutely have to have to get started. We have to start from the year 2000, when we had nothing.

And we have to start to say okay, we need the push from CMS, a historic moment when we have an administration now that sees this as a priority, and is willing to put some real chips on the table to say we're going to collect this data, we're going to all learn how to figure out what it means, and we're going to figure out what are the best practices to address it. Because we don't know that, which is actually shameful, and we have to get there.

So, what I would suggest, and I also think that we should be supporting, we all support this effort, we know this is important, I would hate to have the MAP say to CMS at this historic moment no, just do your more homework. I'd rather, especially because there's no data, and we can't get started, just can't get started. I would say let's start them, but maybe the condition would be that CMS -- and I don't know how you do this -- but that CMS produce a much better measure three years down the road.

Like right now, this is what we've got to get us started, but that they commit to the resources needed to get us to an outcome measure, or a stronger structural measure that is tied to outcomes. So, I think we should just say to CMS go forward with this, we don't like this measure, get a better one. But you've got to get going, you've got to get started, push the market, let's go.

Co-Chair Roberts: Thanks Leah. Let's see, Dan, you have your hand raised.

Member Culica: I did, but I think that I am becoming part of the choir, the echo. I think that in my own opinion it's more of a vote of confidence,

and I think it should be viewed as such. Thank you.

Co-Chair Roberts: Heidi?

Member Bossley: I dropped my comments in chat. Thanks.

Co-Chair Roberts: Okay, great. Yeah, I am seeing a few comments around maybe this would be better in a conditions of participation, or best addressed through collaboratives outside of national accountability programs. So, it does seem that we may have some mixed opinions here. Julie, did you also have your hand raised?

Member Binder: I did. Just wanted to -- I agree with everything that's been said about the importance of the measure. I wanted to make an additional comment that there was some feedback in the commentary about concerns about the clarity, and consistency, and how to interpret what the measure is, right? So, it has like five dimensions, and so it's five questions, but what does it mean to check off two of the five things, and how would that be interpretable to the public?

And that's because the measure is proposed in this sort of public reporting. But I do totally support that this is the direction we need to go. And like others, I have some questions about what that really looks like, and how it gets implemented, and is this program the right place? But wanted to make sure that that's part of the landscape that we're considering, is what does it mean in the end?

So, there's some additional questions about consistency of the measure, right? Will people interpret the five questions in the same way? Some may consider it check the box, and some may do like a really deep dive, and tons, and tons of work, and we won't really be able to know that from the measure.

Co-Chair Roberts: Thank you. Rebecca?

Member Kirch: Very briefly, because I know we're behind schedule, but patient advocate foundation that I represent here, patient, and care givers, especially those from limited resource populations, the sentiment here is very sincere, and we've been doing health equity before it became a hot topic, providing direct services to patients, and families. This is a potential for a checkbox and/or making a very clear endorsement for something that we all hold in our hearts as very important.

But I think what I would love to see NQF acting on is the opportunity for measures that get to these populations feeling heard, and understood, the types of measures that make sense for NQF to advance. And we can all advocate as well for condition of participation, the other mechanisms for advancing what this rule is intending to communicate.

So, I just wanted to speak up on behalf of those patients, and care givers to say we need to see, and push for measures that have patients responding from their perspective about whether they're heard, and understood, and the outcomes in health equity, and think about creatively about how we build measures that fit within the NQF framework. This doesn't get there, but it's the right statement for the vision, but it's not getting us to what we need from NQF's perspective.

Co-Chair Roberts: Thank you. David Baker?

Member Baker: So, we like structural measures at the Joint Commission, we call them standards. CMS calls them conditions of participation. The most important thing is for them to really be valid, they need to be directly observed. So, we've been working now for over two years on standards that actually parallel this measure pretty closely. They'll be released for field review fairly soon, and we think that that's the direction that our country needs to go.

We need to be actually looking at the action plans,

and what organizations are doing. It's going to be hard to come up with a measure that is reported. I think it's more something that has to be assessed on site, and fully support this. But this is not -- I don't think this is going to push things forward, to have an attestation.

Co-Chair Roberts: Thanks David. I feel like this group always throws me for a loop, this has been a lot of robust conversation. If I might summarize it seems that there is strong agreements that a commitment to health equity is important, there has to be a starting point, but this definitely isn't the end point, because we do want to get to the point where we're actually looking at outcomes.

So, there does seem to be some mixed opinions, and in terms of how to move forward, I am going to suggest that we, I know there have been proposals to maybe vote on something differently, but I'm going to propose that we continue to vote on the workgroup recommendation unless there's strong opposition, I'm going to recommend we continue with that. And then we can move forward to lead discussants if need be.

Co-Chair Kahn: I think that's fine, but I think we need to make it very clear what the no vote is, and what the yes vote is so that everybody understands that.

Dr. Pickering: Yeah, and Leah has her hand raised too, Leah did you still have a question? Leah, are you there?

Co-Chair Roberts: You're on mute Leah?

Member Binder: Sorry, sorry, the mantra of our years, you're on mute. I really like David's comments, and I agree that having observation on site is the gold standard. But I do think, and I have seen it, that have a standard, certainly by CMS, even by Leapfrog, has had real impact, and does drive change, and gets the attention of the C suite sometimes, where it might not have before. So,

there is a real advantage to having this on the quality reporting.

Again recognizing we have a long way to go, it's the first step in a thousand mile journey, but it is a critical first step though, we should have taken 20 years ago.

Co-Chair Roberts: Thanks Leah. Let's move forward with the vote, and as Chip said, be very clear on what we are voting for.

Dr. Pickering: Okay, so what you will be voting for is whether or not you want to support the Hospital Workgroup's recommendation of do not support for rulemaking for MUC2021-106: Hospital Commitment to Health Equity.

So, a yes would mean that you are supporting that recommendation of do not support for rulemaking. A no would mean that you do not support the Hospital Workgroup recommendation. So, you disagree with the do not support for rulemaking. So, yes would mean you agree, that you do not support for rulemaking. A no would mean you do not agree with that decision, and that would potentially open it up for a different decision category by this Coordinating Committee. Susanne, I'll turn it to you.

Ms. Young: Voting is now open for MUC2021-106: Hospital Commitment to Equity for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of do not support for rulemaking?

Co-Chair Roberts: Okay, it looks like we are probably ready to close.

Ms. Young: The voting is now closed for MUC2021-106: Hospital Commitment to Equity for the Hospital IQR Program. 10 committee members voted yes, and 10 committee members voted no, for 50 percent, so the Coordinating Committee did not reach a consensus on that.

Co-Chair Roberts: So, with that, I think that the -- is the next step for the lead discussants to discuss?

Dr. Pickering: Yes, now there is further discussion that can be had. I would maybe encourage that if there's anything new that hasn't already been discussed, that would be an opportunity to continue those discussions for this measure, since there's been a lot of discussion already for this measure. If there are certain members that would like to propose a decision category to start with, maybe some discussion around that.

If there's no decision category that is proposed, we would start at the top with support for rulemaking, and then going all the way down until consensus is reached. So, if the lead discussants have anything in addition to what's already been discussed, we can do so now. Or if they'd like to propose where we would want to start for a decision category.

Co-Chair Roberts: I like that Matt, I do think we've had some robust conversation, so maybe if nothing additional, start with a proposal for voting. It looks like the lead discussants for this, if I'm looking, is we have Julie from the Network for Regional Healthcare improvement.

Member Sonier: Yes, and I think that the discussion so far has been very thorough, and some of the comments that were received, I think particularly after the workgroup discussion, there were a number of proposals to revise to a different decision category. Some saying that we should revise it to conditional support for rulemaking pending NQF endorsement. And some saying that it should be kind of a do not support with potential for mitigation.

My own personal opinion is that based on the current state of development on the measure, that I would lean more toward do not support with potential for mitigation, and the mitigation would be additional information, some testing of the measure to better understand how people interpret the

language in it, and to really understand, to get it to a place where we have some confidence that it's going to be interpreted consistently across hospitals.

So, that would be what I would propose having read very thoroughly, the full sort of material that was provided on this measure.

Co-Chair Roberts: We also have, let's see, Parul?

Member Mistry: Yeah, I would -- nothing more to add to the discussion, but I was leaning towards conditional support as a potential proposal.

Co-Chair Roberts: And Michael?

Member Bossley: It's actually going to be me Misty.

Co-Chair Roberts: Sorry.

Member Bossley: That's okay. I think I would be leaning more toward where Julie is, where there just needs to be more specificity, some pilot testing, some guard rails around what would, or would not satisfy each of the different components. And if I could just take a second, I saw a few people reacting to the AMA's comments.

I think it really just comes down to in order to move the needle in a meaningful way, similar to how we did it with the maternal morbidity, and mortality, these collaboratives, if there's a structure, and a shared goal, can move the needle in a way. So, maybe one thing to think about, is there a way for this structural measure to build some components around a collaborative, or some type of approach that pulls in the community, pulls in the patients, and care givers, and adds a little bit more specificity to it? So, perhaps that could be one of the other conditions.

Co-Chair Roberts: Chip, I think you have a comment.

Co-Chair Kahn: My own opinion is it's very

important that we support this. I think conditional support, there's never going to be any perfection here. So, mitigation, I mean obviously there needs to be further development. I don't think this is a measure, I mean obviously it's going to be publicly reported. I think this is a measure where they're publicly reporting to their peers, to the media, I don't think frankly from a consumer standpoint, this is a make, or break to be so perfect.

So, I think the conditional support is that they mature it as much as they can, and that it get out there, and it be a bridge to something else, and that it not be used for any other aspects of the program that could penalize anyone, that we don't do that until it gets ready for prime time. I think that's the condition, because it's not going to obviously get NQF endorsement, but I think it's very -- I think in terms of the perception of the Coordinating Committee, and the MAP process, that it's very important that we endorse this in a positive way rather than the negative to mitigation.

Because that's just putting it, saying -- we don't have time, we need to proceed on this issue. So, that's my two cents.

Co-Chair Roberts: Thanks, Chip. Carol?

Member Peden: Yeah, I think the Blue Cross Blue Shield Association would strongly support getting started on this. We've got so far behind, we just need to get going. I think in relation to the collaborative -- I'm hugely supportive of collaboratives, but the data shows that only one third of participants in collaboratives perform well, one third go along, and one third don't do much. So, it's and collaboratives I think, rather than either, or.

Co-Chair Roberts: So, I am going to propose that we move forward with voting on conditional support with potential for mitigation based on the discussion that we're having, and some of those potential for mitigation would be around maturing the measure,

providing additional information, I would even suggest a commitment to look at outcomes, measures for replacement in the future. Do we have to vote on a motion to vote, or can we just begin voting on that?

Dr. Pickering: So, yeah, there should be a motion, and a second to the motion. So, just to recircle back on what the conditions should be. So, the conditional support means there's some sort of condition that you would like to see with this measure, sometimes that could be NQF endorsement, and just a reminder, NQF endorsement will consider the evidence for the measure, it will consider the reliability, and validity of the measure, the feasibility of reporting the measure, as well as use, and usability if the measure is to be used.

What sort of considerations of unintended consequences that the measure may have if it's used. So, those will be looked at for NQF endorsement, so that could be a condition that we want to see this measure being NQF endorsed. If it's starting to get to more significant material changes to the measure, like we talked about earlier around specification changes, or something else that changes the actual numerator, denominator definitions in some way, or any sort of tie in to some other outcome within the measure itself, like you want to see that included in the measure, that's a material change.

And we're starting to get into that mitigation opportunity. So, I just wanted to circle back, if there's a motion for conditional support, we're going to start there, we'll need to be clear on what the conditions should be.

Co-Chair Kahn: I think Misty gave the conditions. Are those not appropriate?

Member Binder: Misty gave them.

Dr. Pickering: And so, Misty would you mind just

repeating them once more?

Co-Chair Roberts: Yeah. So, what I heard in the discussion is that we have conditional support for mitigation with that mitigation being -- sorry, let me see my notes here. The opportunity to mature the measure for one, I think potentially -- sorry, I've now lost my notes here. With commitment to looking at an outcome measure in the future, and also I think just providing additional clarity, and consistency in the measure.

Go ahead, Tricia, did you have something to add?

Ms. Elliott: Yeah, we just wanted to add clarity to the category, Misty. So, it's either voting on conditional support for rulemaking, or do not support for rulemaking with potential for mitigation. So, just adding that clarity as to whether you want to add conditions, or whether you want to add mitigations.

Co-Chair Kahn: Well, I think I had offered -- I think we're talking about conditions, we're not talking about mitigate. Because the mitigation, you're going to vote negatively. Here we're voting positively with conditions, that's what --

Ms. Elliott: Okay, I just wanted to add that clarity, because you used mitigation in your description, so I just wanted to make sure on what we were voting for.

Co-Chair Roberts: Got it, apologies for that. So, we are saying, and Chip just to clarify, conditional support for rulemaking, right? Yes.

Ms. Elliott: Okay, perfect, thank you.

Dr. Pickering: Those conditions would be the commitment to look at outcomes in the future, and the other being opportunity to mature the measure, were there any others?

Member Binder: Commitment to improving clarity.

Co-Chair Roberts: Yeah, I think just providing more clarity on the measure.

Dr. Pickering: Clarity. Could we get a little bit more detailed about what the mature of the measure would be, and the clarity that is being sought after?

Co-Chair Roberts: Yeah, so I think some of the clarity, from my understanding, someone had actually put in the comments, or had discussed that there's concerns about how to really interpret the measure, that there's five questions in the measure, but what does that really mean?

So, I think additional clarification around interpretation of those five questions was one of the things that I took out of it.

Dr. Pickering: Okay. Additional clarification.

Member Sonier: And this is Julie, I think on the clarity, it also includes field testing to confirm that there's a common understanding of what the measure components mean.

Dr. Pickering: Okay, and what about the maturity of the measure? Opportunity to mature the measure, can we describe that a little bit?

Co-Chair Roberts: In my opinion I think that ties into the commitment to look at outcomes, because we talked about how this is kind of a starting point, where you've got to start somewhere to make any sort of traction, but eventually we need to get to outcomes measures. Feel free to add if anyone has additional comments.

Member Sonier: Yeah, and/or structural measures with correlation to outcomes, or with tested correlation to outcomes. That would be the goal for maturing the measure.

Dr. Pickering: Okay, so if I may, thank you for providing that additional detail. So, what I was hearing was conditional support for rulemaking, and

the conditions being commitment to look at outcomes in the future, specifically an opportunity to mature the measure, to correlate the measure to outcomes. And then also providing additional clarification for the measure, and this is inclusive of field testing the measure to supplement the interpretation of the measure, and its results.

Co-Chair Kahn: I don't think, when you say correlate the measure to outcomes, this measure I don't think is ever going to be correlated to outcomes. This is a bridge measure to other measures that would be used -- that would provide the means to have a real outcome assessment. I think you're putting too much into the -- I think that the issues that Julie raised about clarity, and consistency across what's being asked are very important, and CMS should do.

I think to anticipate that this is anything more than a bridge is asking for too much. There will have to be other measures.

Member Sonier: It's a commitment to ultimately an outcome measure.

Co-Chair Kahn: Right.

Member Sonier: Yeah, that makes sense.

Dr. Pickering: Okay. So, conditional support for rulemaking, and a condition being a commitment to look at outcome measures in the future, as well as providing additional clarification on the measure, which is exclusive of field testing the measure to supplement that interpretation, and including interpretation of the result. Okay. And lastly, I do see a hand from David Gifford.

Member Baker: Given the comments that people have had, is it possible to suggest that CMS talk about somehow that they verify the information that's provided by the -- I suppose that could be done by the joint, or NCV, or NRV, whoever is coming out, and doing their inspections to verify the

information. Because I think as Leah, and others pointed out, this could just become a check the box phenomenon, and then this actually undermines I think the important topic that we've all talked about.

So, if this is going to be a measure, and they're going to attest to it, I think we need to have some verification that they're at least doing something on site with it. That would help me move with this off of do not recommend.

Member Sonier: And they have clarification processes including inspections, et cetera. So, I would support having a verification of response as a condition.

Co-Chair Roberts: Yeah, I think that is an important component David.

Dr. Pickering: Okay, adding that condition of verification of the attestations from accountable entities.

Co-Chair Roberts: Yeah. So, I make a motion to vote on conditional support for rulemaking with the conditions that have been outlined.

Dr. Pickering: And those conditions are the commitment to look at outcomes in the future, providing additional clarification of the measure, which is inclusive of field testing the measure to supplement that interpretation with the result, as well as a verification of the attestation from those accountable entities.

Co-Chair Roberts: Yes.

Dr. Pickering: And I heard a second from Chip, I believe on that one. Was that right, Chip? So, I see a second from Ron in the chat, so maybe I'll go with Ron's second. Thank you.

Co-Chair Kahn: That's fine, whatever.

Member Tufte: I would, too.

Dr. Pickering: Okay, great, thanks Chip as well. All right, so with that we will move to a vote for this measure. So, this measure is now the conditional support for rulemaking, which I mentioned previously, those conditions being a commitment to look at outcome in the future, providing additional clarification for the measure, inclusive of field testing the measure supplements, that interpretation with the results, and a verification of the attestations from those accountable entities. Susanne, I'll turn it to you.

Ms. Young: Voting is now open for MUC2021-105 Hospital Commitment to Health Equity for the Hospital IQR Program. Do you vote conditional support for rulemaking? Voting is now closed for MUC2021-106 Hospital Commitment to Health Equity for the Hospital IQR Program.

The Coordinating Committee votes were 18 committee members voted yes, and two committee members voted no, 90 percent the Coordinating Committee voted to conditionally support for rulemaking.

Co-Chair Roberts: Thanks Susanne. So, I know we are way behind, and we were supposed to start lunch already. I do think that it is time for us to go ahead, and pause here, and break for lunch. I would suggest that -- let's discuss -- what time were we supposed to come back from lunch? 1:05, so do we want to extend that just a little bit, recognizing that we are already behind? What do you all think?

Dr. Pickering: Yeah, maybe propose just extending it to 1:10, that gives about 20 minutes for lunch. Would that be okay?

Co-Chair Kahn: Yeah, I think that's good.

Co-Chair Roberts: I think that's reasonable.

Dr. Pickering: Okay, so we'll convene -- thank you all. We'll back up with MUC2021-120 after lunch. We'll reconvene at 1:20 p.m. Eastern -- excuse me,

1:10 p.m. Eastern. Gives 20 minutes for lunch.

Co-Chair Roberts: Thanks, everyone, appreciate the discussion.

(Whereupon, the above-entitled matter went off the record at 12:50 p.m. and resumed at 1:11 p.m.)

MUC2021-120 Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or knee arthroplasty (THA/TKA)

Dr. Pickering: So, thank you all very much for coming back from that quick lunch. So, as we get started here, we're going to be starting with MUC2021-120, but I know that we're behind schedule, and really appreciate the lively discussion, and the very important discussion that's been happening for these measures. Just going to try to circle back with just our process with voting, and the procedure here.

I know that there's going to be a lot of comments shared in upcoming measures, but if we could try to reserve the first type of discussion with the committee just to be clarifying questions. This is just to try to speed up through the MAP workgroup vote, and so voting on the workgroup decisions. If there are any discussions that happen after that, that's when the lead discussants will have the opportunity to share any of their comments, as well as the rest of the committee.

So, just trying to see if we can move through this, our agenda a little bit quicker, just to pick up some time. So again, after there's an introduction of the measure, any clarifying questions related to the specifications of the measure, or workgroup decisions being made, we'll go to that next. And then from there, we'll vote on supporting workgroup decision. If there's no support, obviously we'll open it up for more discussion starting with lead discussants.

So, if lead discussants could hold off their commentary until after the workgroup votes to support, or not support the workgroup, that may help speed this along a little bit too. Additionally there's going to be measures coming up that we could carry over votes, so keep that in mind, measures that were submitted to multiple programs. So, their discussions may be similar across those programs, so we may be able to pick up some time there.

Lastly, there are some slides in your slide deck that we didn't touch upon, it was related to the advisory groups, we would encourage you to look at those for your reference. Those slides are starting at slide number 28, so it's the rural advisory group, and the health equity advisory group. Again, both of those advisory groups reviewed these measures under consideration.

And those inputs from those advisory groups were fed into all of the workgroup decisions, and discussions, so you can refer to those as well.

Okay, Misty, should we kick off now with MUC2021-120?

Co-Chair Roberts: Yeah, sounds good.

Dr. Pickering: All right. So, I'm going to ask Jolencia, the team to -- yeah, thank you very much, started the recording. So, now we're picking back up from MUC2021-120: Hospital Level Risk Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty.

So, this measure estimates hospital level risk standardized payments for an elective primary total THA, or TKA episode of care starting with the inpatient admission to the short term acute care facility with extending 90 days post admission for Medicare fee for service patients who are 65 years of age, and older. The rationale here for the MAP conditionally supported this measure for rulemaking

pending NQF endorsement, and review of the 26 codes that have been added to the mechanical complications definition.

So, this is an update to a current measure, and the MAP recognizes this measure addresses risk standardized payment for elective THA, and TKA, and this recently updated measure was designed to be used with harmonized complications, and readmission measures, and aspires to drive quality improvements in care coordination post acute cost, and resource use.

There were some comments received for this measure, and so the comments here that support the MAP recommendation for conditional support pending the standing committee's review of the 26 codes representing complications to be added to the measure's numerator. So, the standing committee would be NQF standing committee for endorsement. So, supporting the MAP's decision making here, and the recommendation to conditional support pending NQF endorsement.

Misty I turn it back to you to see if the Coordinating Committee has any clarifying questions first, again, lead discussants holding off any additional comments until after we vote on whether or not to support the workgroup decision. Any clarifying questions, I'll turn it back to you Misty.

Co-Chair Roberts: Yeah, thanks, Matt. So, again, open up to clarifying questions.

Dr. Pickering: And Misty, I'm seeing no hands raised.

Co-Chair Roberts: Okay, so then let's vote on the workgroup recommendation, the conditional support for rulemaking. And just to summarize Matt, I think that conditional support is NQF endorsement, correct?

Dr. Pickering: That's correct, NQF endorsement, which would include the review of those 26 codes

that have been used to update the measure. Okay, so I'll turn it to Susanne, and we'll move to the vote of whether or not to support the Hospital Workgroup's decision. Go ahead, Susanne.

Ms. Young: Voting is now open for MUC2021-120: Hospital Level Risk Standardized Payment Associated with an Episode of Care for Primary Elective THA and/or TKA for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of conditional support for rulemaking?

Co-Chair Roberts: Okay, looks like we have quorum.

Ms. Young: Voting is now closed for MUC2021-120: Hospital Level Risk Standardized Payment Associated with an Episode of Care for Primary Elective THA and/or TKA for the Hospital IQR Program. 19 committee members voted yes, and zero committee members voted no.

Co-Chair Roberts: Okay, so we will move onto the next one, which I think might be similar about addressing a complication rate. Matt, I will let you summarize the workgroup rationale, and any things. Matt, you're on mute.

Dr. Pickering: My apologies, thank you. Yes, as you can see this does say hospital cross cutting measure. So, this means it was submitted to two different programs. As you can see, the Hospital IQR Program, and then the VBP program. The MAP will first consider the Hospital IQR Program, I'll review the rest now, and comments shared, and then we'll vote to support, or not support the workgroup recommendation.

If you do support the workgroup recommendation, we'll have the opportunity to carry over those votes to the VBP program. Again, it takes one member to oppose that carry over. You can voice up you oppose that, or you can directly message me to oppose that. If there's no opposition, the votes will carry over, and then we'll move on. If there is

opposition, obviously we'll vote separately on that measure.

MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

So, starting out with the hospital IQR for this measure. This is MUC2021-118 Hospital Level Risk Standardized Complication Rate Following Elective Primary Total Hip, or Total Knee Arthroplasty. So, this one here, the MAP conditionally supported this measure for rulemaking pending NQF endorsement, and review of 26 codes that have been added to the mechanical complications definition.

The MAP here recognized the measure addresses risk standardized payment for elective THA, and TKA, and the recently updated measure was designed to be used with harmonized complications similar to what we experienced, and discussed on the last measure. But during the meeting, the MAP did seek clarification on the additional codes being added to this measure, and representatives from the developers shared the complete list during the meeting, which covered topics such as fractures following orthopedic implants, and prosthetic fractures, excuse me.

And that this measure was also submitted for consideration in the VBP program. The MAP, and CMS clarified that by statutory requirement, any measure intended in the VBP program must first be implemented for one year in the Hospital IQR Program first. So, recalling the themes that the Hospital Workgroup discussed, this was one of those themes, being that going to the hospital IQR first before being implemented in VBP.

As far as the comments being shared for this IQR program, it was very similar to the previous measure. Again, this is the complication rate measure, in which the comments support the MAP recommendation of conditional support pending the

committee, or NQF review of the 26 codes, so pending NQF endorsement of the measure. And with that, Misty I'll turn it back to you to see if there are any clarifying questions from the Coordinating Committee for the Hospital IQR Program for this measure.

Co-Chair Roberts: Thanks Matt, any clarifying questions for this one? Okay, I am not seeing anything in the chat, or any hands raised. So, we will open it up for voting on the workgroup recommendation, which is conditional support for rulemaking.

Dr. Pickering: Great. All right, I'll turn it to my colleague Susanne. So, the Coordinating Committee is voting on conditional support for rulemaking pending NQF endorsement. So, just whether or not you support that workgroup recommendation.

Ms. Young: Voting is now open for MUC2021-118: Hospital Level Risk Standardized Complication Rate Following Elective THA and/or TKA for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of conditional support for rulemaking?

Voting is now closed for MUC2021-118: for the Hospital IQR Program. Committee members, 20 Coordinating Committee members voted yes, and zero Coordinating Committee members voted no. The Coordinating Committee conditionally supports MUC2021-118 for the Hospital IQR Program.

Co-Chair Roberts: Thanks, Susanne, we'll move onto the next one. Hold on, we voted on the IQR, so now we also have to vote for the VBP for each of these, right?

Dr. Pickering: So, we could have the opportunity to carry over a vote on this. So, what will happen here is I'll just read off what the MAP did for this measure, as well as any comments for this measure, and see if there's any clarifying questions. And then we can see if there's any opposition to

carry over the vote. So, for this measure the MAP Hospital Workgroup, following discussions that happened for the IQR measure, this Hospital Workgroup also had the opportunity to carry over the vote, and they did so.

So, they carry over the vote of conditional support for rulemaking from the IQR to the hospital VBP for this program. So, that's why it still says conditional support under the VBP, because the workgroup carried over their votes. Regarding the comments received, it was very similar to the IQR, in which there was support of the MAP recommendation for conditional support for rulemaking pending that NQF endorsement, which would consider the review of those 26 codes that have been used to update the measure.

With that, Misty, I'll see if there's any clarifying questions. There was a question that I had received, and maybe CMS could help answer this, in which for those measures -- with these measures in the future for VBP, with a legacy measure, will the legacy measure remain in the VBP program during the year in which the measure must be in the IQR before inclusion in the VBP?

So, will the legacy measure remain in VBP while this new updated measure comes through? I don't know if CMS has any --

Dr. Schreiber: I can answer that one for you Matt, so the answer is yes. And I'm sorry to say that, but it is a statutory requirement that any measure introduced into the VBP program first be in the IQR program, and publicly reported for at least a year. So, it is correct that there will be both measures running concomitantly for at least a year.

Dr. Pickering: Thanks Michelle. Okay Misty, turn it back to you for any other clarifying questions.

Co-Chair Roberts: Do we have any other clarifying questions? Okay, not seeing any hands raised, or comments. So, does anyone object to carrying the

vote over from the Hospital IQR Program? And Matt let me clarify, do we still have to do it one measure at a time, or can we ask to carry over both measures?

Dr. Pickering: So, it would just be for this measure, for this program.

Co-Chair Roberts: That's right, okay. Sorry.

Dr. Pickering: Yeah, no worries. That's right Misty, so does anyone oppose the carry over of the votes that just occurred for IQR to VBP? You can voice up now, or you can directly message me through the chat, and it just takes one person to oppose. We'll give some time. So, if you oppose, you can speak up now, or directly message me.

Okay, I don't have anyone messaging me, we also don't hear anyone speaking up in opposition, so we will carry over the votes from hospital IQR for MUC2021-118 to the VBP program. So, there will be conditional support for rulemaking pending NQF endorsement.

Co-Chair Roberts: Okay, so we'll move onto the next measure, which is Medicare Spending per Beneficiary hospital. Matt, if you want to give a summary rationale of the workgroup recommendation, and comments?

MUC2021-131 Medicare Spending per Beneficiary (MSPB)

Dr. Pickering: Certainly. So, just like the previous measure, so this measure was submitted into two programs. We'll first be looking at the IQR program, and then there'll be an opportunity to carry over those votes to the VBP program. So, this measure, MUC2021-131 Medicare Spending per Beneficiary for the hospital setting. So, the workgroup supported this measure for rulemaking.

This measure will continue to incentivize hospitals to identify methods of cost savings such as care

coordination initiatives, and patient safety initiatives to reduce the number of costly adverse events. The MAP acknowledged that this is an updated version of the risk adjusted, and payment standardized MSPB hospital measure that has been in the VBP program since 2012.

The measure was reevaluated last year with two refinements that were informed by a technical expert panel, and previously stakeholder comments to include episodes that are readmissions, and to adjust the measure calculation. The developer did note that costs are only ever included once per episode. So, there is no double counting of costs with this refinement.

This updated version of the measure was reviewed by NQF, and received an endorsement, I think I mentioned, a few months ago. The MAP acknowledged that this measure is under consideration for both IQR, and VBP, as there are statutory requirements around both programs that have been mentioned by Michelle, and us previously. Prior to the inclusion of the VBP, the updated measure must first go to the IQR for public reporting for one year.

It would then be able to replace the version of the measure currently in the VBP program. So, by statute there must always be a cost measure in the VBP program, so the process of going through IQR first is the only way for the updated version of the measure to be incorporated into VBP. So, the MAP during the meeting did raise two primary concerns about the measure that facilities may be double counted for rehospitalization, and that the measure does not include social risk stratification.

The developer in CMS during the meeting did clarify that the focus of the measure is cost rather that readmission, and the measure has expected readmission costs built in. So, double counting should not occur. CMS also clarified that adding social stratification would be creating a new

measure. CMS is currently considering ways to provide measure stratification information back to hospitals more broadly.

Finally, the MAP recognized that endorsement of this measure was retained during the last review in June of 2021, a few months ago. And performance data from prior years of implementation of this measure indicate a substantial opportunity for improvement. So, that was for the IQR discussion. Related to public comments, there was agreement in support of the MAP's decision to support rulemaking for this measure, recognizing importance of evaluating, and understanding care costs.

There was recommendation that the measure receive the designation of conditional support for rulemaking, noting concerns regarding duplication, and consistency across programs. Specifically the proposed revision to this measure would allow readmissions in the 30 days post discharge episode to trigger a new episode, and that the commenters do not believe that the measure -- that this detail aligns with the windows used in other measures.

There are also concerns about how this measure is specified, and that there's an inadequate risk adjustment testing, and request at the highest level of the MAP provide this measure, recommend this measure is do not support with the potential for mitigation. So, with that, Misty, I'll turn it back to you for any clarifying questions from the Coordinating Committee.

Co-Chair Roberts: Okay, I'll open it up for clarifying questions. I actually have a quick clarifying question, is this NQF endorsed?

Dr. Pickering: Yes it is.

Co-Chair Roberts: Okay, does anyone else have any clarifying questions? Okay, not seeing any, I will open it up for proposed to move to voting on the workgroup recommendation to support for

rulemaking, and specifically for the IQR program.

Dr. Pickering: Great, thanks Misty. Susanne, I'll turn it to you.

Ms. Young: Voting is now open for MUC2021-131 Medicare Spending per Beneficiary Hospital for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of support for rulemaking? It looks like we have quorum. Voting is now closed for MUC2021-131. 19 committee members voted yes, 1 committee member voted no, for 95 percent. And the Coordinating Committee supports for rulemaking MUC2021-131 in the Hospital IQR Program.

Co-Chair Roberts: Great. Go ahead Matt, any additional information now for the VBP program for the same measure?

Dr. Pickering: Great, thanks Misty. So, the workgroup also carried over their votes for the VBP from IQR. So, there wasn't any discussion, they did just carry over the votes, so it was support for rulemaking. Related to the comments received for VBP, it was very similar to what we received for IQR.

So, agreement with the MAP's decision to support for rulemaking, recognizing the importance of this measure, and then there were some comments, or a comment related to concerns on how the measure is specified, noting the inadequate risk adjustment testing, encouraging the highest level of MAP recommendation to be do not support with the potential for mitigation. So, again this measure is NQF endorsed, and those aspects of scientific acceptability were reviewed, and the measure maintained its endorsement.

So, at this point I'll see if the Coordinating Committee Misty, has any clarifying questions related to the VBP program.

Co-Chair Roberts: Okay. I'll open it up for clarifying questions. Okay, not seeing any. Does anyone object to carrying over the same vote as the Hospital IQR Program? Which Matt, or Susanne, you want to summarize the vote?

Dr. Pickering: Yeah, that was 19 yes, and 1 no for support for rulemaking from the IQR program. So, if anybody opposes, you can speak up now, or you can message me directly. Again, that's opposing, or carry over of those votes to the VBP program for MUC2021-131. Just give it a few more seconds.

Okay, seeing no opposition in chat, as well as not hearing any, we will carry over the votes of MUC2021-131 Medicare Spending per Beneficiary for the hospital setting from the IQR to the VBP program. Okay, we can go to the next measure.

Co-Chair Roberts: Okay, next measure is a cross cutting measure, Hospital Harm - Opioid Related Adverse Events. Matt, if you want get a summary of the workgroup recommendation, and any themes, or comments?

Dr. Pickering: Thanks Misty. So, we'll start out with IQR first, and then go to the interoperability program. Again, it's similar, has an opportunity to carry over votes here. So, for the Hospital IQR Program the MAP workgroup supported this measure for rulemaking. The MAP recognizes this measure addresses a critical, and preventable safety event in Hospital IQR Programming.

The program does not currently include a measure that addresses OPR related adverse events, and subsequent administration of naloxone in the inpatient setting. The measure was submitted for endorsement reviewed to the patient safety standing committee in spring 2021, and did receive endorsement. So, received recent endorsement this past review cycle. During the workgroup deliberations, the MAP asked the developer for clarity on the 12 hour window with this measure, and the exclusion of operating rooms.

The developer did state that the time limit was shortened based on suggestions from the NQF standing committee reviewing the measure for endorsement, and that the ORs, or the operating rooms were excluded to account for administrations of naloxone that may be part of an intentional anesthesia plan. Regarding public comments for this measure, there was support for the recommendation.

So, supporting the MAP recommendation to include this measure in future rulemaking, so long as the measure developer takes into account locations where opioids may be administered as part of a procedure in a non-operating room setting. There was some concern with the lack of clarity regarding burden of manual data collection, about how the data will be collected, and harmonized across work flows to avoid divergence of the outcomes of the measure across the IQR interoperability measures set.

And finally there was concern whether this measure has sufficient variation, and performance to support its use for accountability application. Really noting the recent submission to NQF for endorsement on giving performance scores across six hospitals that range between .11 to .45. And so due to this, there was a request that the highest recommendation be do not support.

And so just a reminder that NQF endorsement does look at performance, and variation around performance in their endorsement criteria. And again, this measure did receive endorsement just recently this past cycle. Misty I'll turn it back to you to see if there's any clarifying questions.

Co-Chair Roberts: Thanks Matt -- sorry, it muted me again. Thanks Matt, do we have any questions, clarifying questions from the group? Okay, not seeing any, I propose we move forward with voting on the workgroup recommendation to support for rulemaking for the Hospital IQR Program.

Dr. Pickering: Okay, so Susanne, I'll turn it to you.

MUC2021-084 Hospital Harm - Opioid-Related Adverse Events

Ms. Young: Voting is now open for MUC2021-084 Hospital Harm - Opioid Related Adverse Events for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of support for rulemaking? Voting is now closed for MUC2021-084. 19 committee members voted yes, 1 committee member voted no for 95 percent. MUC2021-084, the coordinating committee supports recommendation for rulemaking.

Co-Chair Roberts: Okay, great, thanks Susanne. Now, any additional information to share for the Medicare promoting interoperability program Matt?

Dr. Pickering: For this measure, not really. The Hospital Workgroup also carried over the votes from IQR to the interoperability program, so that's why you see support for rulemaking as well, this was a carry over. So, not much discussion here. And for the comments that have been received, very similar to what I shared for the IQR program.

So, there was some support for the MAP recommendation of supporting for rulemaking, some concerns related to a harmonization across work flows, and then also some concern with actual performance variation for this measure, noting that range of .11 to .45 again, and request for a do not support recommendation. And again, that performance score variation is reviewed during NQF endorsement, and this measure did receive endorsements this past cycle. Any clarifying questions? Misty, I will turn it to you.

Co-Chair Roberts: Yeah, any clarifying questions from the group? Okay, with that being -- not seeing any, does anyone object to carrying the voting over to the same as that IQR program, which was to support the workgroup recommendation, a vote of

19 to 1, which was support for rulemaking?

Dr. Pickering: And if there are any objections as well, you can message me directly if you'd like, or speak up. And we'll just give it a few seconds. So, it looks like, Katie, you have your hand raised?

Dr. Balestracci: I'm very sorry, that is an accident, and I'm trying to undo it.

Dr. Pickering: Okay, thanks Katie. So, Misty, I don't see any objections in the chat to me. And Katie, it looks like you're still sorting out the hand raised. Hearing none, we will go ahead, and carry over the votes from IQR to the interoperability program of support for rulemaking. That's 19 yes, 1 no to uphold that workgroup recommendation for MUC2021-084: Hospital Harm - Opioid Related Adverse Events.

MUC2021-104 Hospital Harm - Severe Obstetric Complications eCQM

Co-Chair Roberts: Great. Moving right along, and while I'm happy that we're moving right along, I'm getting tired of hearing myself. So, but let's move onto the hospital cross cutting measure MUC2021-104 Hospital Harm - Severe Obstetric Complications eCQM. Matt, if you want to give a summary of the of the workgroup recommendation and any additional comments?

Dr. Pickering: Great, thank you so much. So, we will start out with the IQR, and similar approach as we've been doing thus far, have an opportunity to carry over votes if needed. So, the IQR program, the workgroup conditionally supported this measure for rulemaking pending NQF endorsement. The MAP recognizes this newly developed measure as an outcome eCQM, a high priority area for the Hospital IQR Program, and it addresses a meaningful measures area for patient safety.

During the meeting deliberation, the developer addressed several questions and comments from

the MAP, noting that ICU admissions are not included as numerator events, and that blood transfusions were addressed with two separate outcomes to account for times when transfusion is the only reason a patient would reach the numerator.

The developer added clarifications about the risk adjustment of the measures, specifying that housing and security was selected as a risk factor, because it was one of the most consistently captured SPOH factors in electronic health record systems. The MAP questioned if the measure would be able to reach a significant sample size given the rarity of the events.

And CMS and the measure developer did confirm that the events were occurring with sufficient frequency for the measure calculation. So, for the comments shared for this program, there was comments that were supportive of the MAP's recommendation of the conditional support for rulemaking pending an NQF endorsement. The measure has the potential to be useful and meaningful to patients, especially in conjunction with recently instituted maternal morbidity structural measure in the inpatient prospective payment system.

And did encourage that the developer -- there was encouragement for the developer to further examine social risk factors beyond housing that can be incorporated into the risk adjustment model for the measure, such as food insecurity. And there were concerns with how the measure is specified, such as how anesthesia related complications are defined in the measure. They may be required to know the availability of these data in routine work flows.

Noting that there are many comorbidities, whether preexisting, or developed over the course of pregnancy that contribute to severe obstetric complications without any proven preventative

strategies and interventions. So, with this information in mind, and those concerns, there were additional suggestions for exclusion of additional conditions that are categorized as severe morbidities.

So, with that, Misty I'll turn it back to you for any clarifying questions on this measure.

Co-Chair Roberts: Thanks Matt, we'll open it up for clarifying questions, but I think I'm still unclear on what the actual conditions were Matt. Could you please maybe reiterate those?

Dr. Pickering: Yes, I apologize if I kind of mumbled through that. The workgroup conditionally supported this measure for rulemaking pending NQF endorsement, and that would be where you see testing components, et cetera. So, it's pending NQF endorsement.

Co-Chair Roberts: Okay, thank you.

Dr. Pickering: And I see Julie has her hand.

Dr. Balestracci: I'm so sorry, this is Katie Balestracci, representing the measure developer. If I may, the preliminary analysis document does have a couple of errors in terms of numerator specifications. And I'm wondering if it is useful for me to just clarify so that that the committee knows exactly what the measure specifications are for this measure. Should I just move forward? It's a quick clarification.

Dr. Pickering: Yeah.

Co-Chair Roberts: Yeah.

Dr. Balestracci: Sorry. So, Matt you noted the ICU admission came up during that meeting in December. So, the preliminary analysis document notes a couple of numerator specifications that were removed from this measure. The MUC list was updated about this in early July, but it appears that

they did not get into the documentation. So, this numerator for this measure is specified by ICD10 conditions and procedures as defined by the CDC severe maternal morbidity classifications.

As well as mortality during the delivery hospitalization. The preliminary analysis document notes ICU stay, POA2, platelet count, and creatinine as four additional numerator definitions. Those were removed from the numerator after considerable testing either because cases did not appear with these particular individual events to represent SMM, or cases with these events also met other numerator criteria, and were not needed additionally.

The only other correction I'd like to make from the preliminary analysis document is that it notes exclusions for patients with trauma codes. In testing, these codes seemed far broader than were indicated, and did not meet the purpose, so that this measure does not have a denominator exclusion. So, I just wanted to make sure that the MAP committee had those corrections in mind, and were clear on the specifications. Thanks for the opportunity.

Co-Chair Roberts: Thanks Katie. So, it sounds like some of the discussion items that came up may have been already addressed and were not reflected within that preliminary analysis.

Dr. Balestracci: That is correct, thank you.

Co-Chair Roberts: Okay, thank you. I will open it up quickly for clarifying questions, and I did see -- yeah, I do see a couple. Carol.

Member Peden: Yeah, thank you Katie, that's very helpful. So, can you just for clarification, if you have a code of eclampsia and you end up in the ICU, that's why the ICU stay would be excluded, is that correct?

Dr. Balestracci: Yes, the reason the ICU submission

did not remain as a numerator specification is because in testing, many of the cases that were identified with an ICU admission exactly had another numerator event.

Member Peden: So, severe sepsis would get you into the ICU, otherwise you would be double counting.

Dr. Balestracci: Not necessarily double counting, but unnecessarily adding a measure specification and adding burden to providers unnecessarily.

Member Peden: Okay, thank you.

Co-Chair Roberts: Chip, I see your hand raised.

Co-Chair Kahn: Yeah. I guess I understand this process when we're considering measures that were fully supported by the workgroup. I don't understand it in terms of conditional support, because theoretically -- if we go with the process we were just doing, we would immediately go to a vote, and I have a problem with that. I think if there's any support other than full support, I think we should at least hear from the -- give the opportunity for the discussants prior to the vote to tell us some things.

Because I feel unformed, with respect to the measure developer, and Matt, I guess I want to hear from our discussants if there's something here that should be noted. It's not technical, but the reason the task force, or the workgroup took the position they did.

Dr. Pickering: Yeah, I appreciate that comment Chip. This is how our process is laid out, so one, we're just trying to keep it to the process, and I agree that it's good to hear some discussion points. If there are questions from those who have reviewed the measure and have some concerns, maybe raising those as clarifying questions so that maybe the developer, or NQF, or CMS potentially could address some of those clarifying questions

related to the measure.

We do have to consider that step in the process, and then vote on whether or not we want to uphold the committee's decision. And that's where it would open up for further discussion on other decision categories that MAP committee members would like to see this measure come in at. But at this point we do try to maintain the process --

Co-Chair Kahn: Matt, Matt, Matt, stop giving me this bureaucratic stuff. A rose by any other name would smell the same. We didn't do that earlier this morning, I just want to know if it's something I should be worried about as a committee member. You can call it technically, you can call it whatever you want. The discussion right now is very technical, and that's fine, if that's all it is, then that's fine.

But I guess I'm a little bit worried about this process when we don't have something that's just fully endorsed. And maybe this measure's fine, but to vote before you have full knowledge is problematic if there's any question there's a problem. I don't know, that's my two cents. When I chair in a few minutes, we're going to at least get a sense, because I know on a lot of the pack ones, they're conditional, and I want to at least hear what the situation is, as to why they're conditional. But let's go on.

Dr. Pickering: Yeah, well, in this case -- and in some of the other PACs there is, too -- but in this case the condition here is NQF endorsement. So, the workgroup really found interest in the measure aligning with the program, but they recognize that it's not endorsed, as you're stating Chip. You understand that NQF endorsement has that seal of credibility, and so does the workgroup.

And so the condition here was that pending NQF endorsement. And so this is that opportunity for our Coordinating Committee members to ask any clarifying questions related to that if they so choose,

or any specifications that they'd like to get some clarity on from the developer, or CMS potentially.

Co-Chair Roberts: I thought I saw -- Julie, is that still raised from earlier, or did you have a --

Member Sonier: So I wanted to ask a question. I wondered if you could tell us what the Rural Advisory Group had to say about this measure because one of the things that occurs to me is that low volume could definitely cause some fluctuations in this measure.

And so I know that was a question that was asked, and the workgroup received reassurance about appropriate volume. But I'm curious to know more about what the Rural Report Group had to say about this measure.

Dr. Pickering: So, for this measure, the Workgroup -- so when they scored this measure, as far as how relevant it is or how it can impact rural providers, it was on a one-to-five scale, so five being the highest, meaning that it can impact or have relevancy for rural healthcare. It received a 4.1, indicating that it was suitable for use with rural providers within the Hospital IQR Program.

And so that was for rural. And so they also noted that there was -- communities tend to have higher obstetric-related mortality rates, and the measure did not consider population prevalence and express concern that the measure cited blood transfusions as a severe complication rather than early intervention. But again, the Rural Advisory Group, the average score on a one-to-five scale was 4.1, indicating suitability for rural providers for this Hospital IQR Program.

Member Sonier: Thank you.

Co-Chair Roberts: Okay. I am not seeing any other hands raised. Let me double-check.

So, with that, should we move forward with voting

on the Workgroup recommendation?

Dr. Pickering: Let's do it. So, Susanne, I'll turn it to you.

We may be experiencing some technical difficulties. Oh. There we go.

Ms. Young: Voting is now open for MUC2021-104, Hospital Harm, Severe Obstetric Complications eCQM, for the Hospital IQR Program. Do you vote to support the Workgroup recommendation as the Committee recommendation of conditional support?

Ms. Elliott: And, as noted in the chat, we do have one recusal for this measure vote.

(Pause.)

Ms. Young: Voting is now closed for MUC2021-104. Nineteen Committee members voted yes; zero Committee members voted no, or 100 percent. The Coordinating Committee conditionally supports the MUC2021-104 for the Hospital IQR Program.

Co-Chair Roberts: Thanks, Susanne. I think we are now on our last measure for the Hospital Program, and that's a cross-cutting measure -- oh, is that -- I don't think we've moved forward yet, have we?

Ms. Elliott: We have to do the interoperability on this --

Co-Chair Roberts: Oh. Sorry.

Ms. Elliott: -- subject measure.

Co-Chair Roberts: That's right. Real quickly, any clarifications or additional information for the Promoting Interoperability Program?

Dr. Pickering: Thanks, Misty.

So the MAP Hospital Workgroup carried over their votes from the IQR Program to this program, so maintaining that conditional support for rulemaking

pending NQF endorsement. As far as the comments received, they were supportive of that MAP recommendation, recognizing the measure has the potential to be useful and meaningful to patients, especially in conjunction with other measures, such as the recently instituted maternal mobility structural measure in the Inpatient Prospective Payment System.

So, Misty, back to you for any clarifying questions for this measure for this program.

Co-Chair Roberts: Great.

Any clarifying questions from the group?

(Pause.)

Co-Chair Roberts: Okay. I'm not seeing any hands raised. Do we have any objections with rolling over the vote for the Promoting Interoperability, which I think was 19 to 0 in favor of the Workgroup recommendation?

Dr. Pickering: Correct. So, if you oppose a carryover, you can voice up or you can message me directly.

(Pause.)

Dr. Pickering: Okay. Misty, I don't have any messages in the chat, and I don't hear anybody. So I think we can carry over the vote.

Co-Chair Roberts: Great.

MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

Okay. Now we are on the last one for the Hospital Program, and this one is MUC2021-100, Cross-cutting National Healthcare Safety Network, Hospital-Onset Bacteremia and Fungemia Outcome Measure.

Dr. Pickering: Great. Thank you. So this measure was considered for four programs within the Hospital Workgroup. So I'll start with IQR, and then we'll do the carryover, except for the last program on the next slide. But we'll get to that here in a little bit.

So, for the IQR program, the MAP conditionally supported this measure, also pending NQF endorsement. And the Workgroup recognizes this measure tracks the number of hospital-onset bacteremia or fungemia infections indicated by positive testing results among patients but excluding those present on admission or for which no treatment was administered.

The measure corresponds to the patient safety focus within CMS's Meaningful Measures 2.0. And during the meeting, the MAP did seek clarification on the overlap of this measure with central line-associated bloodstream infections, or CLABSI, and methicillin-resistant staphylococcus aureus, or MRSA, measure in the program, asking if the two measures would eventually be retired.

The developer acknowledged that if a patient had MRSA bloodstream infection, it would count towards all three and that collaborative decisions would be made over the time about other metrics as understanding how this measure might evolve.

As far as the IQR comments, there was agreement with the MAP's recommendation for conditional support for this measure. Some commenters raised concern about further action on this measure in light of the significant burden that would be imposed for hospital infection preventionists at the time when the pandemic conditions have already taken a significant toll on the element of the workforce, and then urged CMS to exercise caution in the adoption of this measure, as a concept for a broad-based bacteremia measure carries inherent risks and trade-offs, noting that this measure of new bacteremia and fungemia infections would

include nearly all CLABSI and MRSA infections. And that would overlap with existing measures evaluating these occurrences.

So, with that, Misty, I'll turn it back to you for any clarifying questions for this measure for this program.

Co-Chair Roberts: Thanks, Matt.

Do we have any clarifying questions from the group?

Dr. Pickering: I see David Baker has his hand raised.

Member Baker: Is the measure developer available, Matt? The question --

Dr. Pickering: Yes.

Member Baker: The question --

Ms. Schreiber: CDC is on the line, yes.

Member Baker: Excellent. The first question that I had that wasn't clear is -- this goes above and beyond the existing measures, the MRSA measure and the CLABSI. But the question I had was those non-CLABSI/non-MRSA -- what do we know about the preventability of those events?

We know that CLABSI and MRSA can be prevented -- because if we're adding in things that hospitals don't really have control over, then it just is kind of adding noise to the signal from those other two. And I didn't see that information anywhere.

Dr. Dantes: Thank you very much for that question. My name is Ray Dantes. I'm representing the CDC here today.

So we have three large studies that are in the process of being wrapped up. We'll have data from over 400 hospitals by the time we submit our NQF application. That will be looking at -- in addition to

other aspects of the HVBP measure, we'll be looking at the preventability and sources of hospital-onset bacteremia events, including those that are not related to CLABSI and those that are not related to MRSA.

Our preliminary data suggests that it's probably in the 40 to 50 percent preventable range when adjudicated by infection prevention experts.

Member Baker: That's great. And then your thoughts, as well, on whether this -- and this is -- for those who've been on the Coordinating Committee for a long time, you may remember. I mean, these measures were removed from HIQR so that there wouldn't be double counting. And now it seems like we're taking that step backwards, that this would be something that would be in HIQR, but it would also be in the Hospital-Acquired Condition Reduction Program.

So I'm not sure who should be answering that question, but that just seems like it's problematic and going against a previous decision that was made.

Ms. Schreiber: I'll answer that one, David, if I may. It's Michelle.

It is largely because, traditionally, we have brought almost all measures or all measures into IQR for at least one year of public reporting and experience before moving them into the payment programs.

Now, for HVBP, we've heard earlier today that actually is a statutory requirement that we must do that. It's not a statutory requirement for HAP, but it has become a tradition that we have followed so that hospitals have the opportunity to have some experience with these measures before they go into a payment program.

Member Baker: Great. Thanks.

Co-Chair Roberts: I saw Leah's hand up earlier.

Member Binder: Yes. I have a question. Is the intention to replace CLABSI and MRSA measures with this, or is this an intention in the long run to have this as a supplementary measure?

Ms. Schreiber: Leah, I know CDC can answer this, but it's Michelle and I'll take this up again. We think that this is broader than CLABSI and CAUTI. Don't know if over time it would be a replacement. I think that is indeed a legitimate possibility, but I think we have to see how they play out, too, as we start getting data in.

I recognize that one of the issues would be organizations want to see, and probably consumers want to see, CLABSI and CAUTI. People have become very familiar with that as very specific reasons for healthcare-acquired infections.

That being said, we actually think this one is broader, and it doesn't relieve the hospital of the obligation to figure out, if you've got hospital-onset bacteremia, where is it coming from and what exactly is wrong, and how can you prevent it?

And so I think it remains to be seen, but I'm not going to lie to you. It could be a possibility because we think it's broader and easier to collect because these come directly from the electronic medical record or the lab information reporting system.

Member Binder: Thank you.

Co-Chair Roberts: Carol.

Member Peden: Thank you. Just a clarifying question for the measure developer, really. Did you consider unintended consequences, that there may be less lab cultures done if people know these are going to all be reported?

Dr. Dantes: That's a very good comment. Thank you very much. So, separate from what is going to be reported to regulatory authorities, we are going to be having a suite of balancing measures that the

CDC will be collecting.

So we'll be looking at blood culture utilization as one of those kind of balancing measures so we understand what kinds of effects this may have prospectively on blood culturing practices.

Member Peden: That's great. Thank you.

Co-Chair Roberts: David Baker.

Member Baker: My question was answered. Thanks.

Co-Chair Roberts: Okay. And I think I saw Katie's hand up.

Ms. Elliott: Actually, Misty, before Katie, Libby Hoy --

(Simultaneous speaking.)

Ms. Elliott: -- had her hand up for a while.

Co-Chair Roberts: Okay.

Libby.

Ms. Hoy: Oh. Thank you. Yeah. I had the same concern about the unintended consequence. So I guess --

(Simultaneous speaking.)

Ms. Hoy: -- the question --

(Simultaneous speaking.)

Ms. Hoy: I'm sorry?

SPEAKER: -- the email --

Ms. Hoy: Is there somebody else talking?

Ms. Elliott: I believe there's someone off mute. So we'll look for that. Go ahead, Libby.

Ms. Hoy: Yeah. I just had concerns about that same unintended consequence, so just raising that as a

concern. Also concerned that there was no person/family input on the development of this noted in the documents sent over.

And then, finally, just recognize in some of the comments the need to plan for small and rural health adaptation if moving forward. So just wanted to raise those concerns.

Co-Chair Roberts: Thanks.

Katie.

Member Boston-Leary: Was my name said? I know my access went off a little bit. I got a little blip.

Co-Chair Roberts: Yep. Katie, I think your hand was raised.

Member Boston-Leary: Yeah. So I do have a question similar to the sentiment from my colleagues because I'm also thinking about how, with a number of programs that are in place to manage sepsis -- and I don't recall where that fits into value-based purchasing right now or whether it does, but the similar process to manage this is that, right? Early blood cultures and everything else.

So I'm also thinking about how this overlays with what already exists and whether this creates additional reporting management burden or regulatory burden for organizations. It's a good thing, but I'm just concerned about the intent versus the actual impact.

Dr. Dantes: I could try to answer the question. This is Ray Dantes from the CDC. I'm also one of the CDC's sepsis subject-matter experts, and I also lead sepsis efforts at Emory University Hospital.

And hospital-onset bacteremia takes into account the development of hospital-onset becteremias and fungemias that develop after hospital day four. But we know from other epidemiologic studies that I've been involved with for the CDC that about 80, 85

percent, maybe up to 90 percent, of sepsis is actually present on admission, that these patients for the vast majority of sepsis cases are coming into the hospital with that infection or that sepsis event.

And so, while many of the hospital-onset bacteremia and fungemia patients may have sepsis, it will not overlap with the vast majority of patients presenting to the hospital with sepsis.

Member Boston-Leary: Yeah, but my question is -- on the back end, there probably shouldn't be, but on the front end, wouldn't there be some -- even though I guess a lot of this reporting doesn't impact practitioners as they're trying to practice, but I'm thinking about it from a data collection standpoint and what it would look like for folks that's trying to manage this data. But I hear what you're saying. Thank you.

Ms. Schreiber: It's Michelle. I would also add that the burden of collecting this data is really pretty minimal. It comes directly from the electronic medical record or the lab information system as opposed to sepsis, which does require a lot of extraction.

Member Boston-Leary: Thank you, Michelle. That's helpful.

Co-Chair Roberts: I am not seeing any other hands raised. Anyone else?

Okay. With that, I propose we move forward with voting on the Workgroup recommendation of conditional support for rulemaking. And if I recall, that conditional support was NQF endorsement.

Dr. Pickering: Yes. That's correct.

Co-Chair Roberts: Okay.

Dr. Pickering: Okay. Susanne, I'll turn it to you.

Ms. Young: Voting is open for MUC2021-100, National Healthcare Safety Network, Hospital-Onset

Bacteremia and Fungemia Outcome Measure for the Hospital IQR Program. Do you vote to support the Workgroup recommendation as the Committee recommendation of conditional support for rulemaking?

(Pause.)

Ms. Young: Voting is now closed for MUC2021-100. Eighteen Committee members voted yes, and one Committee member voted no. So --

(Simultaneous speaking.)

Member Tufte: I couldn't vote for some reason. I came in late, I guess. Anyway, it wouldn't click.

Co-Chair Kahn: Yeah. I couldn't vote. Mine disappeared.

Member Tufte: It didn't disappear. Just -- I couldn't even click it. Yeah. It doesn't make a difference, I don't think.

Dr. Pickering: So, if you're having -- Chip, you also had some difficulties? Maybe we can do a revote real quick.

And, Janice, if you're having difficulty, we can --

Co-Chair Kahn: You don't have to revote. I don't mind that.

Dr. Pickering: Okay.

Co-Chair Kahn: But I need to get fixed for the next go-round.

Member Tufte: Yeah. Mine -- it just clicked on it, but at the same time, you said it was closed. But it wouldn't click.

Dr. Pickering: Okay.

Ms. Young: We will make sure for the next one.

So, for MUC2021-100, the Coordinating Committee

upholds the conditional support for rulemaking.

Co-Chair Roberts: Thanks, Susanne.

So, now, are there any additional comments, Matt, around the Hospital-Acquired Condition Reduction Program?

Dr. Pickering: Yes. No additional comments from the Workgroup. They decided to carry over the votes from IQR to this program.

As far as the public comments received, similar comments for IQR. As stated previously, agreement to support the MAP's decision, some concern, as we mentioned previously, and then related to urging CMS to exercise caution adopting this measure, as a concept of broad-based bacteremia measure carries inherent risks and trade-offs, but noting the CLABSI/MRSA infections and this would overlap with existing measures.

So those similar comments there as well. Any clarifying questions?

(Pause.)

Co-Chair Roberts: I am not seeing any. So are there any objections to rolling over the vote for the IQR program to the HACRP program? And I think -- can't remember the exact vote, but it was to support the Workgroup recommendation, which is conditional support for rulemaking.

Dr. Pickering: Correct. And it was 18 in favor and 1 opposed for that vote. And you can directly message me if you oppose that decision, or speak up now.

(Pause.)

Dr. Pickering: Okay. Hearing none -- and, Misty, I don't see any messages directed to me about opposing a carryover. I think we can carry over those votes to the Hospital-Acquired Condition Reduction Program.

Okay. And then I can move to the next program, same measure. So the next program is the PCHQR program. The MAP Hospital Workgroup again carried over the votes to this program, so those being conditional support for rulemaking pending NQF endorsement.

As far as the comments that have been received for this, for this program specifically, there was agreement of the MAP's recommendation of conditional support for this measure pending NQF endorsement.

So, with that, Misty, any clarifying questions for this program for this measure?

Co-Chair Roberts: I'll open it up to the group with any clarifying questions.

It looks like David Baker has his hand raised.

Member Baker: Yeah. Just a question for Ray.

For these cancer hospitals, the issue about fungemia, particularly in these patients who are treated with intensive chemotherapy, is a big one and it's less preventable. Are you looking into that issue at all?

Dr. Dantes: I don't think we have those particular hospitals included in our exploratory studies, but there is certainly a focus on that population of patients going through chemotherapy and neutropenia. And we're exploring various ways, especially for those events that are not thought to be preventable, of excluding those patients from the final numerators.

Member Baker: Thanks. Yeah, and it's a tough one.

Co-Chair Roberts: Okay. I am not seeing any more hands raised or anything in the chat. Are there any objections to carrying over the vote for the PCHQR program?

(Pause.)

Dr. Pickering: And no direct chats to me in opposition. So it looks like we can carry over those votes to the PCHQR program, Misty.

Co-Chair Roberts: Great.

Dr. Pickering: All right.

Co-Chair Roberts: I think the next one is where it gets a little tricky, right?

Dr. Pickering: It gets a little tricky. But keep in mind that even though there's a To Be Determined here, which we'll be talking about here, there could be a consideration to carry over what the MAP has already voted on -- oh, excuse me. We have to vote separately. I apologize.

Okay. So, for the IP program, the Interoperability Program, the MAP did carry over votes as --

(Simultaneous speaking.)

Dr. Pickering: Oh. Sorry. Oh. Okay.

So the MAP did not carry over the votes for this measure, as the measure had a preliminary analysis rating of Do Not Support for this program specifically. The measure is not an eCQM, although it is a digital measure.

During the deliberations, the Medicare Promoting Interoperability Program for Hospitals was interpreted to exclusively contain eCQM. Due to this interpretation, the MAP did not support this measure for rulemaking.

CMS provided clarification after the meeting on the interpretation of the statutory requirements for the program --

(Simultaneous speaking.)

Dr. Pickering: I'm sorry. Is there --

(Simultaneous speaking.)

Dr. Pickering: -- background?

Co-Chair Roberts: Yeah. Can we ask that everybody go on mute?

Dr. Pickering: And maybe we can have the team sort of --

(Simultaneous speaking.)

Dr. Pickering: There we go. Thank you.

Co-Chair Roberts: Thank you.

Dr. Pickering: So, again, CMS provided clarification after the meeting on the interpretation of the statutory --

(Simultaneous speaking.)

Dr. Pickering: I'm sorry. We're still -- there we go -- requirements for this program and clarified that the measure does not satisfy the digital measure requirement for the program. So, given this clarification, the decision category for these measures was changed to To Be Determined, and the measures will be reevaluated by the MAP Coordinating Committee for the final recommendation.

So the Coordinating Committee should focus their review of the measure solely on its specifications and appropriateness for the program. CMS will continue to review and ensure compliance with statutory requirements for the Medicare Promoting Interoperability Program for Hospitals.

Regarding the public comments that came in for this program, there were concerns with the decision to override the votes of the Workgroup is unprecedented, and we believe or the commenters believe that it calls the integrity of the measure applications partnership process into question. And there's an urge for NQF to uphold the decision of the MAP Hospital Workgroup to allow the MAP Coordinating Committee to review additional

information at the time of the MAP Workgroup meeting, which -- today is January 19th.

So it urges CMS to exercise caution in adopting this measure, as the concept of a broad-based bacteremia measure carries inherent risks and trade-offs, and similar comments. We've heard that the -- noting that this measure of new bacteremia and fungemia infections would include nearly all CLABSI and MRSA infections and thus would overlap with existing measures evaluating these occurrences, as we've heard previously.

So, again, just circling back on what happened here -- so there was a preliminary analysis rating of Do Not Support because the interpretation of this program was considered to be exclusive to eCQMs. And after the meeting, there was further clarification of the statutory requirements for this program, and not just be exclusive to eCQMs.

And in this case, this measure is a digital measure which would then fit into the program. So the decision category of Do Not Support was then changed to To Be Determined. This would be the only instance that NQF staff will do this.

So, moving forward, we will not be changing to To Be Determined. But for this cycle, it was changed for the MAP Coordinating Committee to consider and provide a vote based on the new clarification of the program and the statutory requirements for the program.

So, with that, we'll follow the process in which they'll see if there's any clarifying questions related to this measure and this program. And rather than voting on whether or not to uphold the Workgroup's decision, it would be to vote separately on what a decision category will be for this program.

And I apologize for the dog in the background.

Co-Chair Roberts: Thanks, Matt. And I think we are also going to open it up to the lead discussants, if I

recall. But first let me just open it up for clarifying questions.

(Pause.)

Co-Chair Kahn: Well, is there a recommendation from the staff for where we open up in terms of the recommendation with everything we know now?

Co-Chair Roberts: Were we going to open it up to the lead discussants and then make a motion for a recommendation?

(Simultaneous speaking.)

Co-Chair Kahn: I mean, is there a staff recommendation, though? That's what I'm asking.

Dr. Pickering: So there isn't a staff recommendation, Chip. No. It was changed to To Be Determined. The Workgroup may consider continuing on with what's listed in the previous programs, which is conditional support for rulemaking. Or if there's any other considerations based on lead discussants and what they propose, there could be a different decision category for this program.

Co-Chair Kahn: Okay.

Dr. Pickering: Or the Workgroup may feel -- or the Coordinating Committee may feel that conditional support for rulemaking does fit for this program, and it's similar to the other particular programs as well.

Co-Chair Kahn: Okay.

Co-Chair Roberts: So I do see a hand.

Heidi.

Member Bossley: Yeah. I think we're going to go through this with this next measure, too. So I'm just wondering -- it troubles me to see a workgroup's decision overturned. And is it better

that the Coordinating Committee vote it down and then consider whether we would just take a conditional or something now that we have a clarification?

It's just the process is -- it might be cleaner and save us time and follow what we've done in the past. Just a thought.

Co-Chair Roberts: NQF, if you all want to address that.

Dr. Pickering: Yeah. I appreciate that.

(Simultaneous speaking.)

Dr. Pickering: Yeah. Sorry, Tricia. Were you going to say something?

Ms. Elliott: No. Go ahead, Matt.

Dr. Pickering: Yeah. I appreciate that, Heidi. And we recognize that this is not what we've been doing throughout the course of today. It was changed to To Be Determined based on that clarification. That happened, and this is something that we did this cycle. It wouldn't be something we'd continued to go forward with in future cycles.

But due to the short turnaround time in getting materials out to Coordinating Committee and the public for public comment, we wanted to at least draw attention to that the MAP Hospital Workgroup did have a Do Not Support For Rulemaking on this measure.

However, based on further clarification on the interpretation of the statutory requirements, it was changed to the To Be Determined, and thus having the Coordinating Committee determine where the decision category would lie based on that clarification on the statutory requirements -- so not that it's solely exclusive to eCQMs, but also to digital measures, in which this measure does fit.

So the Coordinating Committee may determine that

it could be conditional support, as it has with the other programs, or if there's a strong opposition to that and voting on another decision, now is the opportunity for discussion on that. But if they would like to propose a conditional support for rulemaking, we can propose that and motion for that and second, and then we can move to vote.

Co-Chair Roberts: Ron.

Member Walters: So yeah. I've listened to the explanation of the clarification a couple times now, and I think I fully do understand what happened. We should do what's right in this Committee from a measure perspective, and sometimes that's going to be a timing issue, although this is the first time that seems to have come up.

But there will be issues that arise where we just plain have more information than they had before. And I support voting down the To Be Determined and to instead propose conditional support. Of course, the condition is endorsement. And that's not disavowing what the Workgroup recommended.

It is just because we have more information now. And so this is kind of a unique circumstance, but there's no question in my mind it's the right thing to do.

Co-Chair Roberts: Thanks, Ron.

We do have a question in the chat box, and I think I actually asked a similar question when we met with NQF prior to the meeting. Is there an option to do an ad hoc revote of the MAP with the new information and then having us come back for an ad hoc vote to this group?

Dr. Pickering: So, given some of the time constraints, it may be challenging for an offline vote or an ad hoc vote to reconvene the Workgroup to then bring that to the Coordinating Committee for another ad hoc vote, considering that we are obligated to get these recommendations to CMS by

February.

So that's the time constraints that we find ourselves with with these review cycles, and thus bringing the information as it stands to the Coordinating Committee to determine what the new decision category should be, given the new information.

Again, this was something that was instituted this cycle. Moving forward with these comments and considerations, it will be something that we would reconsider how this is brought to the Coordinating Committee in future cycles if this was to happen again.

Member Baker: Can I make a comment? I agree with Ron. We have an established process for this. Roll it back and go with the Workgroup's recommendation of Do Not Support. Vote that down because we now have more information. And then, as our established process, make a motion for a new decision category and vote on that.

Co-Chair Roberts: Well, I think we can make a motion without actually voting down the original decision. Is that correct? I think we can just --

(Simultaneous speaking.)

Co-Chair Roberts: Yeah. So I think that we can do that, and I would definitely motion to vote on conditional support for rulemaking with that support being NQF endorsement.

I do quickly want to ask if there are any additional items from our lead discussants to help inform a motion.

(Simultaneous speaking.)

Ms. Elliott: Misty, it's Tricia. I'm sorry. Before you move to that, we have Liz Goodman, who's had her hand up for a little bit.

Co-Chair Roberts: Go ahead. And I am apologizing for missing hands. My computer is not doing what it

used to do. So apologies, Liz.

Member Goodman: Thank you both. Sorry about that. So I know part of the additional information -- I'm just trying to understand what the differences are, and perhaps the lead discussants can share that.

I know that part of the additional information is it doesn't have to be an eCQM to be recommended for the Promoting Interoperability. But there is also a collection burden associated with putting it in the Medicare Promoting Interoperability Program.

And so I'm trying to understand, as I think about -- let's say we follow this process that's being recommended, which I support as well -- that you revive the recommendation of the Workgroup and vote it down and move to a different one and vote on that.

I'm just trying to understand, from a substantive standpoint, what would -- other than it doesn't have to be an electronic quality measure, what else is determinative from the standpoint of putting it in the Promoting Interoperability Program?

Ms. Schreiber: Michelle. If I could just comment for a moment, what CMS has tried to do all along is align the measures that are in the Promoting Interoperability Program, which are eCQMs, with what is in the other programs. So if there is an eCQM in IQR or HVBP, it has always gone into Promoting Interoperability so there's no misalignment.

This is that exact same philosophy. This is a digital measure. This is a fully digital measure. And the question was can a digital measure -- and an eCQM is a type of digital measure. Can a digital measure actually be included in Promoting Interoperability?

So there's no additional work. There's no additional burden. What we're really attempting to do is to align measures in the programs.

Member Goodman: That's helpful, Michelle.

Dr. Pickering: David Gifford has his hand raised.

Co-Chair Roberts: David.

Member Gifford: Yeah. Michelle, maybe you partly answered it. I was just trying to understand what -- I'm trying to Google at the same time. What are these two programs, and what's the statute that's saying it? Because it goes back to my earlier comment earlier this morning: what's the intended purpose of the programs?

It's nice that you're trying to align measures, and I think we all support that and giving that feedback to CMS. I'm just trying to understand, does this -- yes, legally, the lawyers might say they can do it. Lawyers can tell you a lot of times you can do something legally, but they would say it's not probably a good thing to do.

And I'm just trying to understand that dynamic of do we know what the statute says on the programs or what you say in the rules of the intent and purpose of the programs, and how does that fit within that? That, I think, is what is for me a factor in the vote here.

Ms. Schreiber: So the intent and purpose of a measure like this would actually be in the HACRP. Right? So, in the program that links payment to how one performs with complications and healthcare-acquired infections, that is the absolute intent of where the measure belongs. It has to go into IQR because, as we've discussed, things go into IQR first.

In the cancer programs -- we have these healthcare-acquired infections in the cancer programs, so we're aligning that. The intent of promoting interoperability is to ensure that organizations are robustly using their electronic medical record technology, they're promoting interoperability, driving towards sharing data,

driving towards the use of digital data.

And this does that, also, because these measures are derived from fully digital data. It's really driving programs to use digital data. So they do align, but the use case, so to speak, is really in the HACRP program. But it certainly is supporting the Promoting Interoperability Program.

And, again, we try to keep those measures fully aligned so that if they're required for HACRP in their eCQMs for promoting interoperability, they are aligned.

Member Gifford: How is the NHSN data digital -- isn't that manually entered, or is there an ability to digitally interface with EMR for it for interoperability sake? Because most of the NHSN data I'm familiar with requires SAMS Level 3 and an individual person to enter it in.

Ms. Schreiber: That actually is what one of the advances here is that these data come directly from the lab system.

Member Gifford: Okay. So that's how you interoperate with the digital? It's no longer manually entered into the NHSN?

Ms. Schreiber: Yeah. But I will say -- and this is something that we're still investigating, and I thank NQF, actually, for raising the issue. One of the issues in promoting interoperability is for the hospitals to calculate their data and the outcomes. They can preliminarily calculate their data and the outcomes, but NHSN does perform another calculation because these measures are standardized in standardized ratios.

So that's actually, to be technical, what the conversation is all about. And it's a really technical question.

Co-Chair Roberts: Okay. I am not seeing any other hands raised. For the sake of time, I would like to

make a motion to vote on conditional support for rulemaking similar to the other programs based on the conditional support of requiring NQF endorsement.

Dr. Pickering: And so -- Misty, sorry. I was trying to message you a little bit. So, based on some of the comments that have been shared, it seems like the Coordinating Committee would like to vote down or at least vote on the Do Not Support For Rulemaking to stay to what we've done previously.

Is there any opposition --

Co-Chair Roberts: But let me just -- well, I'm just -- for the sake of time, I guess I'm trying to figure out why we would do that instead of just going --

(Simultaneous speaking.)

Member Baker: -- vote and ask if anybody's opposed to moving forward?

Co-Chair Kahn: Yeah. I mean, I think it's just respecting the process. I think that's --

Member Baker: But we don't need to necessarily do the electronic voting. That's why I was asking.

Co-Chair Kahn: Yeah. That makes sense.

Co-Chair Roberts: Yeah.

Co-Chair Kahn: Just ask if anybody objects.

Member Baker: Right.

Co-Chair Roberts: Exactly.

Does anybody object to not voting down a recommendation of Do Not Support and then moving forward with a different recommendation to vote on?

(Pause.)

Dr. Pickering: And I don't have any chats myself,

Misty. So I think we're good.

Co-Chair Roberts: Okay. Good. So I make a motion to vote on conditional support for rulemaking, with that conditional support being NQF endorsement.

Dr. Pickering: Chip, was that a second?

Co-Chair Kahn: Second. Second.

Dr. Pickering: Okay. Okay. So let's move to that vote. This is for the Interoperability Program for MUC2021-100, and this is to vote for conditional support for rulemaking pending NQF endorsement.

So, Susanne, I'll turn it over to you.

Ms. Young: Voting is now open for MUC2021-100, NHSN Hospital-Onset Bacteremia and Fungemia Outcome Measure for the Medicare Promoting Interoperability Program for Hospitals. Do you vote conditional support for rulemaking?

(Pause.)

Co-Chair Roberts: Looks like we should be able to close voting.

Ms. Young: Voting is now closed for MUC2021-100. Nineteen Committee members voted yes; one Committee member voted no, for 95 percent. The Coordinating Committee conditionally supports MUC2021-100 for the Medicare Promoting Interoperability Program for Hospitals.

Co-Chair Roberts: Okay. Looks like we're going to move over to crosscutting measures, and I'm actually going to hand this over to Chip.

Co-Chair Kahn: Yes, and thanks, everybody, for meeting us here at 1:05. We're a little behind, but we'll catch up.

Okay. So, Matt, do I turn it over right to you for the opportunity for public comment?

Dr. Pickering: Let's go to the next slide, Chip. Yes. So now is an opportunity for public comment on this measure. So this measure was also submitted to multiple programs.

So if there's any member of the public that would like to provide any comments verbally now, you can do so by taking yourself off mute. You can use the raise-hand feature using Webex platform, or use the chat feature as well if you do have any comments you'd like to provide to the Coordinating Committee for this measure, MUC2021-98.

Co-Chair Kahn: Any comments?

Dr. Pickering: I'm not seeing any hands raised, Chip.

Co-Chair Kahn: And that's when you take it back to do your description or -- is that what we do next?

Dr. Pickering: Yeah. That's what we'll do next. I'm seeing no hands raised as well as nothing coming through the chat. I'm not hearing any members of the public voice up. We can go to the next slide and get into where this measure goes across these programs.

You can see the slide listed here. You can see all the programs that this measure has been submitted to, and we'll be going through a similar process in which you have the opportunity to carry over some of the votes for the program, keeping in mind that for the Medicare Promoting Interoperability Program, it'll be the same situation we just went through.

So we'll probably do the same process. If there's any opposition to not voting on the MAP Workgroup recommendation, we'll move forward with doing a motion for a different decision category.

Co-Chair Kahn: Okay.

Dr. Pickering: So, going to the next slide -- so,

Chip, here's the first series of programs. The first one is the long-term health -- long-term care. Would you like me to kick it off?

Co-Chair Kahn: Yes, please.

Dr. Pickering: Okay. So, again, this is for MUC2021-098, National Healthcare Safety Network Healthcare-Associated C. Diff Infection, and it's an outcome measure.

The first program under consideration is the Long-Term Care Hospital Quality Reporting Program, or LTCH QRP. The MAP recommended conditional support for rulemaking pending NQF endorsement and successful testing of reliability and validity. So, as a reminder, that is a part of the criteria for a new NQF endorsement, is looking at reliability and validity.

The Workgroup recognizes this MUC measure would modify the existing healthcare-associated C. Diff surveillance measure in the Long-Term Care Hospital Quality Reporting Program by only counting cases where there was evidence of both a positive test and treatment.

This may mitigate potential unintended consequences from the current measure's design counting a case that is based on a positive test only, which may have led to a historical undercounting of observed healthcare-associated C. Diff infection.

This updated measure is consistent with the program's priority to measure healthcare-associated infections, and aligns with Meaningful Measures 2.0 area of patient safety.

During the meeting deliberations, there was some discussion about reporting burden on behalf of infection control practitioners, citing hours and resources necessary for NHSN data reporting.

Related to the comments that have been received for this measure for this program, they were in

agreement with the MAP recommendation for conditional support for rulemaking pending NQF endorsement.

So, with that, Chip, I'll turn it back to you to see if there's any clarifying questions for this measure for this program.

Co-Chair Kahn: Okay.

Are there any comments? Anybody?

So let me ask a question, Matt. Is this the same -- is the conditional support throughout all the different programs?

Dr. Pickering: Yes, it is, Chip. It's conditional support for rulemaking pending NQF endorsement for each of all the programs except for the Interoperability Program because that was that situation we just went through with the other measure. But for the other programs that are listed -- that would be for Long-Term Care, Inpatient Rehabilitation, the Skilled Nursing Facility Quality Reporting Program, the Hospital IQR Program, Hospital-Acquired Conditions Program, and the PCHQR, all of which received conditional support for rulemaking pending NQF endorsement.

Co-Chair Kahn: Well, is it possible for us to package all that together without -- I guess with the exception of the interoperability, which we would discuss separately because we've got that other issue? Because unless there's some kind of an objection to that -- is that possible to make some progress by doing that?

Dr. Pickering: I will confirm with the team briefly on that. And, Chip, maybe if there's any -- I do see there's a couple questions from Amir and David. So I'll confirm that with the team, and then we can see if we can answer some of those questions, and we'll circle back to your question, Chip. Is that okay?

Co-Chair Kahn: Okay. Great.

So Amir.

Member Qaseem: Yeah. I was just thinking, Chip. A lot of discussion this morning happened that -- one of the conditions have been NQF endorsement, which I'm very supportive on. But I think we're going to probably benefit more that we separate up the couple of issues by saying that, for example, in this case, we need the measure testing data plus NQF endorsement.

I feel like we're tying NQF endorsement as a condition a little bit too much over here.

Co-Chair Kahn: Okay.

Member Qaseem: I understand the desire, but I want to make sure that MAP is not saying that MAP believes that NQF endorsement is the goal criteria, because it has started sounding like that. Right?

So I want to separate those two issues. So, in this case, I suggest we can have that bullet point. I'm all for it. The NQF endorsement is accurate. But I also want to get specific that, for example, there is no testing data. You need to test. Show me the testing data before it's going to be reviewed or approved or whatever by MAP and MAP's working groups.

Member Binder: But wouldn't that be part of the endorsement process? Do we really need to separate out every aspect of the endorsement --

Member Qaseem: Yeah. So --

(Simultaneous speaking.)

Member Binder: -- in order to be conditional?

Member Qaseem: Yeah. Yeah. So that's a fascinating question, right? So what the separation is that we would like to also look at the testing data ourself. We are not just entirely relying on NQF to look at testing data and make the judgment call whether they think it's good enough or not.

I'm saying that I think we need to -- because otherwise, if MAP is saying that we are just going to go with NQF endorsement, then basically we won't need to discuss any of the measures anymore. If NQF has endorsed a measure, that's an automatic in. And I don't think we're saying that.

Co-Chair Kahn: Well, let me say this. I think we're looking at fit for purpose. We're looking at a lot of issues. I mean, for example, we had some discussion this morning about a measure, and we were really looking at it a different way than endorsement.

On the technical side, I think we have to lean back on endorsement because -- well, a workgroup, I guess, could take a technical look at it. I don't know if this MAP -- I don't know if the Coordinating Committee -- by the time --

Member Qaseem: Yeah.

(Simultaneous speaking.)

Co-Chair Kahn: -- the Coordinating Committee, I'm not sure we're --

(Simultaneous speaking.)

Member Qaseem: Yeah. Exactly. Well, what you're saying is right. Right? So when MAP working group is going to look at it, NQF endorsement criteria is one of the variables they're going to look at, but that does not mean that we are saying that MAP working group should not be able to look at the testing data themselves and be judge of what happened and what didn't happen.

So this condition of us simply using the term, the NQF endorsement, are we saying that from here on, the working groups -- once they see an NQF-endorsed measure, it's an automatic in or not? It's not. That's what my understanding is. Correct?

Co-Chair Kahn: I mean, it's not a given, no. But I

think it's --

Member Qaseem: Exactly. Right? And that's --

(Simultaneous speaking.)

Member Qaseem: That's what my point is. What I'm just saying is have NQF endorsement in there as well, but add what else, what are the real conditions, which we have started missing that completely, which we didn't used to do in the past.

Co-Chair Kahn: Well, I think we pretty much depended on the endorsement. But I -- well, how is that -- let's get -- was it David? Let's get his comments, and then we can sort of see where that gets us on this because we really need to roll.

Member Gifford: I hate to do this to you, Chip. But I have some specific concerns to raise about the SNF on one of the measures. The other two, I don't.

Co-Chair Kahn: Go ahead. That's what we're here for.

Member Gifford: Well, do you want to do that now, or do you want to go through -- you were just talking about your proposal to bundle them all together and go. I was saying I'd like to pull the SNF one out.

Co-Chair Kahn: Oh. Okay. I mean, I guess we need to make a quick decision --

Member Gifford: And we --

Co-Chair Kahn: We can just go one by one. Is the SNF one -- I mean, Amir, I didn't hear you have any specific objection, right?

Member Qaseem: No. No. I don't have any objection. No. I was just saying just to separate out the condition part of it; be more specific.

Co-Chair Kahn: Okay. So let me ask Matt.

Can we go to his discussion about the SNF and still see if we can package together? Or are you saying, David, that would mean we couldn't package together in terms of the way you're going to ask us about the SNF?

Member Gifford: No. You can package them together, depending on how you package them together. I just want to have a more robust discussion about the SNF one rather than just vote all together en bloc. It sounded like you wanted to vote all en bloc. That's all.

Co-Chair Kahn: Well, I was trying for that. But if you -- if anybody objects, I can't do it. So it's -- well, let me ask you this.

Member Gifford: Sorry.

Co-Chair Kahn: If we go to the SNF discussion and see whether we can satisfy you or not, can we then sort of see whether we can go en bloc or not?

Member Gifford: Sure.

Co-Chair Kahn: Is that okay, Matt? Can I do that?

Dr. Pickering: So, I mean, if we wanted to vote on the SNF or try to go to the SNF one first to see what the issue might be there, potentially, then we can go back to doing a bloc vote.

Co-Chair Kahn: Okay.

Dr. Pickering: Unless there's any other opposition to doing a bloc besides what David is wanting to talk about.

Co-Chair Kahn: Okay.

Is there any other opposition to a bloc?

Okay. Well, let's deal with David, then, and see whether we can include the whole thing or whether we need to vote for SNF separately.

David?

Member Gifford: So, on the SNF side of the measure, our concern is that the measure was introduced to NQF in April of 2020, and it failed for liability and validity in the nursing home side. And I don't know -- I could not find in any of the documents any changes in the measure specification from that April '20 submission, though I've been told there were. But I don't know what they were. So my concern is that this is a failed measure.

The other issue is that it doesn't appear in what I can read from it that it takes into consideration C. diff cases that were acquired in the hospital prior to discharge. So I know in talking to the CDC team, they say they are, but I just can't see that anywhere in the documentation.

In fact, most of the documentation I read appears to have been cut and pasted from the long-term care -- other long-term care settings. So the exclusions in this setting and the risk adjustment are all things that are unique to the hospital, like neonatal cases are specified, and I can't find anywhere what the risk adjustment is.

I know in the past there were some challenges with how to do the risk assessment given the information that was available in the CDC NHSN. And then there's this enormous reporting burden on this side because of -- it requires a SAM Level 3 approval, which CDC has had huge trouble getting nursing homes at that level.

I fully support trying to move everyone to get that level. It's just that making this a requirement and the way it's going in the program, it is then tied to payment is a -- seems too fast and to excessive at the moment.

So we were advocating to not recommend this for rulemaking at this time and to continue to work through the specifications on it.

Co-Chair Kahn: Matt, how would you answer? And do we have the developer? Is that a developer question, too?

Dr. Pickering: It may be a developer question. But it sounds like if there's a -- from what, David, you're saying a different decision category you'd like to see -- it sounds like we wouldn't necessarily be able to do a bloc vote on all these programs because it could be potential for voting down the Workgroup decision.

Co-Chair Kahn: Okay. Well, why don't we do this? Are we ready to roll, then, I mean in terms of if we vote on each separately and just vote as fast as we can?

Dr. Pickering: Yeah. We can -- as long as there's no other clarifying questions from these programs. So we can go back to the long-term care, and if there's no other clarifying questions for that program for this measure, we can move to upholding the Workgroup's decision, which was conditional support for rulemaking pending NQF endorsement.

Co-Chair Kahn: Okay. Let's go ahead and --

Member Baker: But we didn't get an answer, did we, to David's question from the measure developer?

Dr. Pickering: So can we come back to that question when we get to the SNF program?

Member Baker: Well, my question is whether the concern that was raised about SNF may apply to the other ones. And I don't think I can know the answer to that until I hear the response.

Co-Chair Kahn: Okay.

Member Gifford: And I've not heard that -- I'm just -- having been involved in this, I've not heard that from the others, and most of them, I think, already have SAM Level 3 and have a process going

through. And I think more of the focus, as is often, nursing homes are left on the side. The focus was all about validity and reliability and risk adjustment in those settings.

And I said, well, it's got to apply to nursing homes. And let's do it that way. That was my impression.

Co-Chair Kahn: Do we have the developer, Matt, available?

Dr. Benin: Yes. This is Andrea Benin. Can you hear me?

Co-Chair Kahn: Yes.

Dr. Benin: Great. Thanks. This is Andrea Benin from the CDC. A couple of clarifying comments, hopefully.

This particular metric is a revamped metric of one that has existed for a long time and has been in the LTCH and IRF -- on this page here that you're showing, has been in the LTCH and IRF programs. It has not been in the SNF program, I don't think.

But this is a revision, essentially, of that measure and had moved it to being an electronically based measure similar to the hospital-onset bacteremia as far as being a digital measure. The existing measure is also based on laboratory data and is, by many places, vastly electronic but allows for, as was referenced, some manual input.

The measure does require that facilities have full security access in order to be able to enter data, and that's really the security access that's appropriate for this kind of data collection.

At this time, virtually all of the skilled nursing homes that have been referenced do have that level of security access. There may be about 1,000 out of the 15,400 that do not yet have that access, but by and large, as far as the skilled nursing homes, they do have that level of security access. And there are

new CDC mechanisms for maintaining it that make it easier.

But certainly, the LTCH and IRF have been submitting measures to NHSN using that type of security access for a long time, and that has not been -- while it requires them to participate and to be active about it, that is part and parcel of being part of these programs for them, similar to how the hospitals handle that.

So I just want to make sure that that's clear. In the past, that has been something that was an obstacle for the nursing homes, although I do think that by and large we've gotten past that with the -- certainly with the weekly COVID reporting that they've been doing.

So just to put that to rest, and then for the nursing homes, the extent of the electronic data that's available in the nursing homes does make it a slightly different electronic environment than some of the other environments.

And so we are starting in 2022 here -- we're doing extensive validation in the hospital environments, and we are over the next handful of months working on validation in the other settings. And so, by the time this new updated metric is submitted, hopefully for the August deadline to NQF, we will have the additional validation and reliability work completed.

We've spent the past three years doing extensive work in the hospital environment, and the next step is to extend to make sure that it holds up in the other environments. But the idea here is that we're taking the existing measure, which is based on the laboratory test data, and adding in medication administration as a proxy, essentially, for clinical decision making that if you had a laboratory test and you also treated it that you thought you had an infection, that's the high-level concept of it.

And the existing measure has really just been a

laboratory test being positive. So that's the sort of context there. And we're finding really, in some of our existing reliability and validity work, it's looking very promising. And that data will be available soon.

And I see -- just asking about the question about how would nursing homes be able to submit a laboratory-based metric, and we are in some conversations with some of the electronic health records to better understand the electronic environment available because we do understand that nursing homes will sometimes receive their laboratory tests in a fashion that may be really difficult to collect it electronically out of their system.

And so there's some evolution in that space that we're following closely, and part of the testing that we'll need to perform will be to sort out exactly what that looks like as far as the feasibility for those facilities.

Co-Chair Kahn: Okay.

Dr. Benin: Otherwise -- yeah. Sorry. I'll let you --

Co-Chair Kahn: Okay. I think -- David, where are you on --

Member Baker: I would strongly recommend that we dissociate the voting for the LTCH and the IRF from the SNF. As Andrea said very nicely, the LTCH and the IRF -- this is a fairly straightforward and really valuable revision to an existing measure and one that's currently in use.

And on the SNF side, there's a whole bunch of challenges with the testing and the implementation. So I see very different issues, and I think the voting should be separated.

Co-Chair Kahn: Okay. If there are no objections, then, Matt, let's just go bang, bang, bang down each of these and try to get them voted as fast as we can.

Member Baker: We could bundle LTCH and IRF.

Co-Chair Kahn: Okay, if -- Matt, if there's no objection, then we'll bundle LTCH and IRF. And let's go ahead and vote.

Dr. Pickering: Okay.

Any objection to bundling LTCH and IRF?

(Pause.)

Co-Chair Kahn: Let's go ahead.

Dr. Pickering: Okay. So we're voting to uphold the Workgroup's decision here, and what we'll do is we'll have -- you're voting on the Long-Term Care Workgroup decision, but just know that that will be carried over to IRF.

So you're voting that there's conditional support for rulemaking pending NQF endorsement. So you're voting first on this LTCH program, but those votes would carry over to the IRF program based on no objection in the comments that have been shared.

So, Susanne, I will turn it to you.

Ms. Young: Voting is now open for MUC2021-098, NHSN Healthcare-Associated C. Difficile Infection Outcome Measure for the Long-Term Care Hospital Quality Reporting Program. Do you vote to support the Workgroup recommendation as the Committee recommendation of conditional support for rulemaking?

Dr. Pickering: And that condition would be pending NQF endorsement.

Co-Chair Kahn: Okay. We're at 16. I think that's a quorum. That's the number.

Anybody else? Okay.

Anybody else? Okay. Let's close it out. So let's get going.

Ms. Young: The voting is now closed for MUC2021-098. Seventeen Committee members voted yes; zero Committee members voted no, for 100 percent. The Coordinating Committee conditionally supports MUC2021-098 for the Long-Term Care Hospital Quality Reporting Program.

Co-Chair Kahn: Thanks.

Dr. Pickering: And as mentioned before the vote, those votes would carry over to the IRF program. So the IRF program also received that conditional support for rulemaking with the same number of votes, pending NQF endorsement.

Co-Chair Kahn: Okay. And so now we need to vote on the SNF. Do we need any more discussion, then, with that? Okay --

Dr. Pickering: Are there any other clarifying -- Leah Binder has her hand raised.

Co-Chair Kahn: Yeah.

Member Binder: Just to say I'm not persuaded that this program should be not applied to skilled nursing facilities. I think that the endorsement process should iron out some of the difficulties, potentially, or at least address them and test them. But this is an extremely vulnerable population and an extremely dangerous infection, and it's time.

Co-Chair Kahn: Okay. Any other comments?

Matt, why don't we go ahead?

Dr. Pickering: Okay. We're now voting on the SNF program. So, Susanne, I'll turn it to you.

Ms. Young: Voting is now open for MUC2021-098, NHSN Healthcare Associated C. Difficile Infection Outcome Measure for the Skilled Nursing Facility Quality Reporting Program. Do you vote to support the Workgroup recommendation as the Committee recommendation of conditional support for rulemaking?

Dr. Pickering: And, again, that condition is pending NQF endorsement.

Co-Chair Kahn: I think we had 17 votes before. Are there any other votes? Fifteen. Okay. Nineteen. People came back. Let's see if we get to 20. Okay. Let's go ahead.

Ms. Young: Voting is now closed for MUC2021-098. We have 14 Committee members voted yes and five Committee members voted no. That is 74 percent. So the Coordinating Committee conditionally supports MUC2021-098 for the SNF QRP program.

Co-Chair Kahn: Okay. Thank you.

So, Matt, now can we try to combine the next three? I guess we have to do the interoperability separately. Is that okay?

Dr. Pickering: That's right. So the next three that have the conditional support for rulemaking is the IQR Program, the Health Acquired Conditions Program, as well as the PCHQR program.

The Hospital Workgroup did carry over votes of conditional support to the PCHQR and Hospital-Acquired Conditions Program from the IQR Program, so that conditional support pending NQF endorsement.

So we can start with the IQR Program, and we can see if there's any clarifying questions for this IQR Program from the Coordinating Committee -- really nothing that's been any different from previous discussions.

There was some discussion during the Workgroup proceeding about asking the developer to clarify the start date of the measure, and the developer didn't know that the dates helped to clarify inherent imprecision of the C. diff diagnosis.

The MAP also advised that the developer consider collecting patient consumer input as part of the

measure development process, and the developer noted the measures arose from provider feedback requesting more algorithm-based measurements.

As far as comments for this, there was some concern related to substantially different -- that this measure is substantially different than the current existing C. diff, and there's been some discussion today about some of those differences.

There was some concern about the potential use of FHIR standards to extract information, electronic health records, that providers would then submit through the existing NHSN platform, suggesting that there's some burden here because this platform has experienced some issues in the past.

Those were the comments for the IQR program. But, again, it's conditional support for rulemaking pending NQF endorsement.

So if we wanted to do a bloc on this one, Chip, for Health-Acquired Conditions and PCHQR, if there's no opposition to doing a bloc, we can vote on the Hospital IQR, and those votes will carry over to those two programs.

Co-Chair Kahn: Is there any objection?

Okay. Anything on your chat or anything?

Dr. Pickering: I don't have any objections.

Co-Chair Kahn: Let's do it, then.

Dr. Pickering: Okay.

So I'll turn it to Susanne to vote on this measure for the Hospital IQR. It's conditional support for rulemaking pending NQF endorsement. If the Coordinating Committee upholds this vote, they will also carry over those votes to the Hospital-Acquired Conditions Program and the PCHQR program.

Ms. Young: Voting is now open for MUC2021-098, NHSN Healthcare-Associated C. Difficile Infection

Outcome Measure for the Hospital IQR Program. Do you vote to support the Workgroup recommendation as the Committee recommendation of conditional support for rulemaking?

(Pause.)

Co-Chair Kahn: Eighteen. Any more votes? Nineteen. Any more votes? I think we can close it out. Okay.

Ms. Young: Now closed for MUC2021-098. Nineteen Committee members voted yes; zero Committee members voted no, for 100 percent. The Coordinating Committee conditionally supports MUC2021-098 for the Hospital IQR Program.

Co-Chair Kahn: Okay. So, Matt, would you explain this? Is this the exact same issue we just adjudicated?

Dr. Pickering: That's correct. It's the exact same issue that we adjudicated for the previous measure, which was MUC2021-100. There was just that interpretation of the program for eCQM versus digital. Clarification was received after the meeting, which is that to be determined, as we've mentioned in the previous measure.

So, in this case, there's nothing in addition to what was mentioned in the previous measure that should be mentioned differently for this measure related to what the MAP discussed. As far as the comments, just similar comments. There was just concern about making that a To Be Determined decision and urged NQF to uphold the decision of the MAP Hospital Workgroup and allow for the Coordinating Committee to review additional information during this meeting.

So the additional information is that clarification of the statutory requirements for that interoperability program. So, if there's no opposition to not voting to support or not support on the Workgroup recommendation, we can then move to proposing a

decision category, and then we can vote on that decision category.

Co-Chair Kahn: Okay. I don't hear any opposition.

Okay. So we're respecting the MAP process by proceeding beyond the Committee -- the Workgroup with no objection, and then we're going to conditional support for ruling, which is what we did on the others. And if there's no discussion, we can go right to a vote, can't we?

Dr. Pickering: So is that a motion to do conditional support for rulemaking pending NQF endorsement?

Co-Chair Kahn: I move.

Dr. Pickering: Is there a second?

Member Binder: Second.

Dr. Pickering: Okay. And I think that was Leah. Thank you.

Co-Chair Kahn: Yeah.

Dr. Pickering: Okay. So we'll move to vote on conditional support for rulemaking pending NQF endorsement for the Medicare Promoting Interoperability Program for Hospitals.

Susanne?

Ms. Young: Voting is now open for MUC2021-098, NHSN Healthcare-Associated C. Difficile Infection Outcome Measure for the Medicare Promoting Interoperability Program for Hospitals. Do you vote conditional support for rulemaking?

(Pause.)

Ms. Young: Okay. Voting is now closed for MUC2021-098. Twenty Committee members voted yes; zero Committee members voted no, for 100 percent. The Coordinating Committee conditionally supports MUC2021-098 for the Medicate Promoting

Interoperability Program for Hospitals.

Co-Chair Kahn: Great. Thanks, everybody. So now it's -- let's see. What time is it? It's 1:25, and we're going on to the pre-rulemaking recommendations for PAC/LTC. Is that where we --

Dr. Pickering: Yeah. We are. And, Chip, would the Coordinating Committee like about just a little less than ten-minute potty break or bathroom break, and maybe reconvene at 3:25 p.m. Eastern? Would that be okay?

Co-Chair Kahn: I think it's a good idea, but we're going to really -- it'll be 3:25 sharp because we've got to get moving.

Dr. Pickering: 3:25 sharp. Right.

Co-Chair Kahn: Okay.

Dr. Pickering: So we'll just take a quick break. Reconvene at 3:25 p.m. Eastern. See you all in a little bit.

(Whereupon, the above-entitled matter went off the record at 3:17 p.m. and resumed at 3:26 p.m.)

Dr. Pickering: Okay. So one minute past 3:25 Eastern, so we're going to reconvene and get back to this. So just as something that we want to propose to the Coordinating Committee just based on our time right now and our agenda. So we do have -- we do know that there's going to be some significant amount of public comments toward the end of our agenda today related to the last two measures.

So we want to keep that in mind and make sure that we're trying to keep on time. Also, based on some of the discussions we've had previously with some of these carryover votes and block sort of voting, we wanted to propose to the Coordinating Committee a consent agenda on the next two sections of the agenda, both the PAC/LTC programs

and the Clinician programs. We'll do that separately.

But this will be a consent agenda. And so what we'll ask of the MAP Coordinating Committee is after we go through the opportunity for public comment on both of those programs, we'll ask if there's any opposition to consenting to having that consent agenda. So if you oppose just consenting on what the MAP workgroup had proposed for their recommendations or those measures in those programs -- if you do not oppose, we'll just move forward and those recommendations will stand from what workgroup had proposed.

However, if you do oppose on the consent agenda, please call out the measure and the program specifically that we would then discuss and vote on separately outside of the consent agenda. So again, we'll go through opportunity for public comment for those programs, and then we'll do a consent agenda. If there's any opposition, it would be opposition to what specific measure or program that you would like to draw attention to and discuss. If you do not oppose, then the workgroup recommendations will stand for those programs.

And we'll start with PAC/LTC, and then we'll move to Clinician. And we'll do the same thing, opportunity for public comment. And then there'll be a consent agenda there. There is a specific case in there that Tricia will talk about for those programs. There's a specific measure there, but we'll start with PAC/LTC. Okay.

(Simultaneous speaking.)

Dr. Pickering: Julie, I think you had a question. Sorry, Misty.

Member Sonier: So it's a question about the consent agenda. And I assume that I'm not the only person who took a very deep dive into the measures where I was assigned as a discussant but much less so on the others. And so it would make me feel more comfortable if we had at least the overview from

staff so that we are certain that we do consent to what we're voting on.

Dr. Pickering: Sure. We can definitely provide an overview for those measures and programs when considering the consent agenda. Thanks, Julie, for the question. Any other questions before we proceed?

Dr. Schreiber: It's Michelle. I have a question. Are we going to exclude the one clinician measure? I think it's 063 where the MAP Committee had not supported it so that this committee can weigh in on it?

(Simultaneous speaking.)

Dr. Pickering: Yes, that's correct, Michelle, yes.

Co-Chair Kahn: I mean, by definition, the consent agenda are all the items where it's the same recommendation, right, Matt?

Dr. Pickering: Essentially, yes. For the PAC/LTC, there are two measures of conditional support. Both of those are pending NQF endorsement. The others were support for rulemaking.

Co-Chair Kahn: Okay. We can package all those together unless there's any objection.

Dr. Schreiber: But I thought there was one that didn't have support. I think it's 063.

Dr. Pickering: That's for the Clinician.

Co-Chair Kahn: That's the Clinician.

Dr. Schreiber: Yeah, okay. Got it. Thank you. That is correct.

Dr. Pickering: Okay. If there's no other questions or comments. So right now, we'll do the PAC/LTC. So we can go to the next slide. So this is now an opportunity for members of the public to mention any comments or would like to disclose anything to

the Coordinating Committee for the PAC/LTC programs and the measures under consideration for those programs.

So you can use the raised hand feature. There's the chat box, and you can take yourself off mute if you would like. Opportunity for public comment for PAC/LTC programs and measures under consideration for those programs. Let's just give it about a minute. And I see there is a hand raised, and I apologize. Is it Ghinwa Dumyati?

Dr. Dumyati: Yes, that's right. And I'm talking from the Society for Healthcare Epidemiology of America. And I'm specifically kind of concerned with the HAI nursing home measure.

Our main concern is that this measure relies on a patient who is in a nursing home who went to the hospital. And it is based on the ICD 10 code that the hospital kind of puts on the record on first admission to the hospital without all the information. And then some of the diagnoses that are listed at HAI include a long list of infections.

Some of them are not preventable. And then some of them have an incubation period more than four days. And some of them are really not related to the care that they have received in the nursing home.

And then the last thing, the measure is like a composite of all infection together. So you wouldn't know if you are scoring high if -- what would you do? Would you do antibiotic stewardship, hand hygiene without knowing exactly why your rate is high, what infection that the patient is readmitted with? It's kind of how would you make your data actionable.

And the last thing we have concern that there will be a disincentive for the nursing home to transfer sick people back to the hospital, especially that this is focused on, like, the population that has been recently hospitalized where the risk factor really is not just limited to what happened to them in the

nursing home but also includes factor that happened in the hospital such as antibiotic cues, the risk of C. diff, surgery and so forth. So I just have to -- kind of this a comment from the Society for Healthcare Epidemiology of America or SHEA. Thank you.

Dr. Pickering: Thank you.

Co-Chair Roberts: Thanks. And it looks like David Gifford says HCA shares some of those concerns as well.

Dr. Pickering: And Misty, I don't see any other hands raised.

Co-Chair Roberts: Okay. So with that, how do we move forward? Are you going to --

Dr. Pickering: Okay.

Co-Chair Roberts: -- give an interview of the measures, Matt?

Dr. Pickering: Yeah, I'll do a high level review of them. So if we can go -- yeah, thank you. So here's just a listing of these measures across the programs. So you can see there's eight total, some of those measures being within multiple programs you can see listed there.

Largely, we have a lot of measures for the skilled nursing facility value-based purchasing program due to recent expansion of that program to consider additional measures. I believe it's up to nine now. So there's definitely more measures being considered for that program.

Going to the next slide, just a couple themes. One was patient reported outcome measures being a theme for the PAC/LTC, recognizing the importance of these measures, being more person centered and getting to more patient reported goal setting. Worker members agree to the importance of these in capturing those events in future measurements.

And then infection control is also another theme considering the COVID-19 pandemic, really uncovering underpreparedness and lack of resources related to infection control. So there's several measure discussions that have some considerations of infection control and agreeing that there needs to be alignment of ongoing measurement that reflects overall infection control performance. And then going to the next slide, I'll just touch on these measures here.

So the first was 124, Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization. The MAP did give a conditional support for rulemaking for this measure and that condition being pending NQF endorsement. During the meeting, the MAP asked for clarification regarding time frame for infection reporting and it's reasoning. And the developer, CMS, the infection reporting begins on day 4 after admission.

The time frame was an element of initial testing and discussions with a technical expert panel to balance the attribution of concerns of taking up enough infections. The developer, CMS, indicated a claims-based approach with the most reliable data source but noted an electronic medical record might be better for the future. So again, conditional support for rulemaking pending NQF endorsement.

For total nursing hours per resident day also received conditional support for rulemaking pending NQF endorsement. And MAP recognizes this measure adds value to the SNF VBP program by adding a measure not currently addressed in the program itself. They acknowledge that the COVID-19 is a public health emergency which brought nursing home staffing to the forefront of an already frequently discussed topic.

And there is a variation of performance of this measure within this skilled nursing facilities. And these facilities do have the ability to address these processes to improve staffing. During the meeting,

the MAP did seek clarification on the type of nursing hours measured.

And the developer responded that the combination of registered nurse, licensed practical nurse, and nurse aide hours to look at the whole picture. And the MAP noted that's important for the measure indicating it needed not to be perfect but it's a step in the right direction. Going to the next slide and just talking about the next three measures or next series of measures.

Support for rulemaking for this next measure. This was Measure 130, Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities. They did support this measure for rulemaking and recognized this measure adds value to the program.

It aligns with CMS' quality measure plan to build value-based care by addressing several goals included and measures focused on key quality domains and acknowledge that empirical evidence demonstrates improvement in successful discharge of community rates among PAC settings and PAC patients. It's possible through modifying provider-led processes and interventions with PAC setting. During the meeting deliberations, the MAP did seek clarification of exclusions of the measure, specifically the Medicare Advantage beneficiaries and nursing home residents.

And the developer did clarify that Medicare Advantage exclusion was due to concerns with data comprehensiveness but noted that CMS can consider this moving forward. Going to the next measure was short stay discharge measure. This also receives support for rulemaking, and the MAP recognized that per the Consolidated Appropriations Act of 2021, there's an expansion of this measure set this program specifically that will add more measures to the program.

And they consider that there is a range of variation of performance with this measure within skilled nursing facilities which does allow the facilities the

opportunity to make improvements on this measure. The MAP voiced several positive responses for the CoreQ survey but acknowledge that there is a lack in guidance on facility improvement. The MAP noted the length of the CAHPS survey poses a poor return rate.

And so overall, the MAP indicated the CoreQ was short, to the point, and gets to what consumers really want to know, so support for rulemaking. If we go to the last slide here, the last measure for the PAC/LTC was MUC-123, Influenza Vaccination Coverage amount Healthcare Personnel. Again, support for rulemaking analysis, this adds values to this program, recognizing that vaccination coverage among healthcare personnel within SNFs is important, especially with recently adopting COVID-19 vaccination measure for healthcare personnel.

Vaccination coverage amount healthcare personnel within these facilities can really decrease biotransmission along with a decrease in morbidity and mortality. So that is a quick summary of the decisions and some of the discussions that happened during the PAC/LTC workgroup. Again, three of these measures being support for rulemaking, two of them being conditional support for rulemaking, both of which pending NQF endorsement.

So at this time, we can do the consent agenda. So if there's anyone that opposes the consent agenda, please speak up now. And you can message me directly. So opposing, if you do so, please call out the measure specifically that you would like to be pulled out. And if you do not oppose, then all of these measures will have the workgroup recommendation upheld. So a couple hands raised. I see David Baker and David Gifford.

Member Baker: I'd like to see the 2021, 137, Total nursing hours per resident day pulled out for discussion.

Dr. Pickering: Okay.

Member Baker: I think both PAC and LeadingAge raised concerns that should be discussed.

Dr. Pickering: Okay. Thanks, David. David Gifford?

Member Gifford: Ditto to Dave. I guess my question was procedural to, Chip had said that the (audio interference) should be all the same recommendations or that was wrong. We're going to bundle them all. Some were support for rulemaking. Some were conditional support with NQF endorsement.

Dr. Pickering: That's right. So in this case, we do have two measures that are conditional support for rulemaking. One is going to be pulled out for discussion, the total nursing hours per resident day.

The other is the healthcare associated infection that had conditional support. It is pending NQF endorsement. Whereas the other -- the remaining three are support for rulemaking.

So it wouldn't be the exact same recommendations. But what we're doing for consent agenda is to uphold the workgroup recommendations as we've described. But we're going to be pulling out total nursing hours per resident day for discussion.

Member Gifford: Okay, perfect. So four will go on consent and one will get pulled out?

Dr. Pickering: Correct. Anyone else?

(No audible response.)

Dr. Pickering: Okay. Seeing no chat, Misty. So we will move forward with the work recommendations for those four measures. We're pulling out 137, Total nursing hours per resident day, for discussion. And Misty, maybe we can just start with clarifying questions from the Coordinating Committee.

Co-Chair Roberts: Sounds good. Any clarifying questions for any of those measures other than 137. I think we're going to hold those.

Dr. Pickering: So yeah, well, clarifying questions for 137.

Co-Chair Roberts: Oh, we are? Okay.

Co-Chair Kahn: I'm sorry. So we're doing a discussion on 137 first. Is that what you're saying?

Ms. Elliott: There was no opposition to the consent agenda on four measures. So we're going to consider those moving forward with the workgroup recommendation. So now we've pulled that 137 for discussion.

Dr. Pickering: Maybe David --

Member Gifford: So are we have a discussion or clarifying questions? I'm reserving my comments till discussion. I'm trying to follow the process. I don't have clarifying questions. I have comments and concerns.

Co-Chair Roberts: Let's start with any clarifying questions. And it looks like Mary has her hand raised.

Member Barton: Yeah, I'm curious. So is this a measure that has a right or wrong? Is there an optimum number of nursing hours per resident day that we know? Or is it more is better and even more than more is great? I'm just curious because I'm not familiar with the measure.

Mr. Shulman: Hi, good afternoon. This is Evan Shulman from CMS. In short, the latter. So more is better, and even more is great.

Member Baker: I don't know if -- I don't know this literature very well, but I follow it a little bit. And I'm not sure I would agree with that interpretation of the literature. They're probably -- it's more like there is a threshold that's been shown in studies that I believe particularly for RNs which is better than (audio interference). But the idea that more is better, there is definitely a threshold.

(Simultaneous speaking.)

Member Gifford: That's right, David. There was a CMS study that looked at this that established the original relationship of staffing and quality that showed a generally linear relationship that wasn't totally linear up to about 4.1 HPRD a day. And then it flattens out. There's no more correlation.

So once you cap out at a high, and at the bottom, there was a similar flattening out. Once you get really low, you can get worse than really bad. So there's sort of a -- it's sort of an F-shaped curve on that with that. So we have 4.0 -- and you'll often hear a lot of states and Congress talk about trying to set a minimum staffing ratio of 4.1 on the measure. So they're based on that literature.

Mr. Shulman: And this is Evan Shulman again. And that is correct that it was a study that was done. It's quite old, I think, David. It was 2003 I think that study is from.

There have been numerous studies since that point that have identified that in general more is better. But yes, that is true. At that one point in time, that was one study. But again, there's been many others since then.

The other thing I'd point out is that I don't think we're driving towards -- I don't think this -- and my CMS colleagues can correct me. I don't think we're establishing cut points or thresholds here. We're merely establishing the measure by which we would calculate that.

Member Baker: If somebody knows, I think there was something in the documentation that said that the best evidence was really for RN patient ratios. Is that correct?

Mr. Shulman: The strongest correlationship, we see relationships between all nursing staff and other quality measures such as hospitalizations. By the way, we also have looked at a threshold for when

hospitalizations long stay residents don't get any better. And we do not see a cap or a threshold on some more recent analysis. But to answer your question, the strongest relationship does appear to be between RNs. But there still is a relationship with all their staff.

Co-Chair Roberts: Liz, I think you have your hand raised.

Member Goodman: Yeah, I was just curious in the workgroup discussion or for the measure creators, we're in a terrible nursing shortage cause not insignificantly by COVID. And it feels a little bit like we're setting the nursing homes up to fail here. And I don't disagree with every discussion we've just had about more up to a point is better.

That's not the question. It definitely -- the studies are consistent. My question is really, is it achievable at this juncture?

Mr. Shulman: Yeah, totally hear you on that. And I think again we're not establishing what is achievable, and this isn't necessarily about cut points or a threshold. This is the measuring of it. And everyone is in the same bucket or boat based on how they are performing relative to each other. The establishing of a threshold is not what's in scope for this -- I think for this -- purpose of this meeting.

Member Goodman: Yeah, and I don't mean to be disruptive. But everybody is not in the same boat. If you're in a nursing home in rural Idaho, you're in a very different boat than a more populated area with a deeper pull of available nurses. So I understand that it's relative to one another. But I don't think all nursing homes are similarly situated.

Mr. Shulman: Yeah, I was probably using too broad of a term. I guess what I would say, and this has come up in previous discussions. It's when would we want to know that. When would we want and be able to see that there are nursing homes, say, in

rural areas that are struggling more than others or nursing homes with other characteristics that are associated with higher or lower levels of staff? So that's what this measure does. It gives us the ability to see those differences.

Co-Chair Roberts: So I think -- I understand. I know two people have questions. But I just want to follow up on this because I think that what I'm having a hard time with is still understanding what the intent of the measure is and how it will be used. Can you clarify that, Evan?

Mr. Shulman: Sure. And I'll also ask my CMS colleagues to jump in here on the value-based purchasing side. But this is for inclusion of a staffing measure into the value-based purchasing program. How this measure is eventually used to determine payment or not is not being -- is not in scope for this discussion.

This discussion is, is this a valid way to measure staffing in nursing homes? And is measuring staffing important? And we believe the answer to that is (audio interference).

CMS colleagues, if there's anything you'd add, please chime in.

Dr. Schreiber: This is Michelle. We completely agree. It is really, we think, important to be looking at the staffing ratios within nursing homes, in particular, nursing staffing but really staffing ratios in nursing homes because it's a patient safety issue. And we feel that it should be included in public reporting and in the programs.

How this gets scored within the VBP, as Evan pointed out, is something that has yet to be determined. And we would introduce that into rule writing. But we do think that nursing home staffing -- and somebody, by the way, needs to go on mute, thank you -- that nursing home staffing is actually an important issue for nursing homes. Alan, I don't know if you want to comment either, Dr. Levitt. But

Evan, agree with what you said.

Dr. Levitt: No, this is Alan Levitt and I concur. Again, we were given -- there are certain measure topics or domains by statute that are suggested or recommended to be part of this program. And in addition, we believe that staffing is one of those domains and components that can be included.

Co-Chair Roberts: Parul, I think you've had your hand raised.

Member Mistry: Yes, thank you. While staffing is a concern for nursing homes, is the intent of this measure to compare how the staffing is in relation to the MDS assessments that most of the nursing facilities use to see how much care a resident would require?

Mr. Shulman: I may need you to reframe your question. But I'll try to provide some insight. The staffing measure is risk adjusted using the MDS assessments. So we do base the measures based on the level of acuity in the facility. But I apologize if I'm misunderstanding your question. Could you maybe ask a different way?

Member Mistry: Sure, sure. So I know you mentioned that more is better. But then are you looking at -- so if most of the facilities run short on staffing. So if they are, say, plus 1.5 hours or -1.5 hours, is that taken into consideration? Is there a certain threshold that if they drop below that, it's still within the acceptable range?

Mr. Shulman: This is not a -- this doesn't measure, if you're asking, acceptable staffing. This measures -- just measures staffing in general and the level of staff that each nursing home is providing, including relative to the acuity of the residents that they have. There's no determination in the measurement itself of whether it is acceptable or not. It is just the level that it's at. Does that help?

Member Mistry: Thank you.

Mr. Shulman: Okay.

Co-Chair Roberts: So yes, I know you've had your hand raised for a while. David Gifford?

Member Gifford: Oh, yeah. Thank you. So I think it's really important to point out that this is not -- this measure is currently publicly reported by CMS. It's currently used in a Five-Star. So consumers, media, everyone has this information.

You can figure out what's going on in Iowa or anywhere or Idaho on this measure. This is not adding it into the SNF VBP program. The SNF VBP program currently ranks providers on measures. So it assumes a linear relationship.

And then based on your ranking is how your payment adjustment is made. The statute that's set up for the VBP program talks about healthcare outcomes. This is not an outcome measure.

I don't think it -- by not supporting this measure, it doesn't mean that this -- this measure is already out there. It's being used. I think clearly there is a relationship between staffing and quality. I'm not going to sort of contest that.

I think the data as Evan has pointed out, it's superior for nursing. But that's just a quibbling issue. The question is really, is this appropriate for the VBP program?

We do know how it's going to be used because we're going to be ranked on the measure and then you're payment is going to be adjusted. The other issue as far as the availability of staffing, you have an issue that about two-thirds of all nursing get their revenue from Medicaid which MedPAC shows underpays. And the relationship with staffing level, one of the strongest predictors is the percentage of Medicaid residents in your facility.

This is the result of a two percent cut to your Medicare Part A payment. To raise your staffing

level in many places, the cost of that will far exceed the two percent cut. So what this will do is inadvertently just result in cutting nursing homes further rather than actually improving the care out there.

It's not clear how this -- how, in our opinion, CMS adding this measure in the VBP program furthers the initiative in that it really creates a financial incentive to not increase staffing because to achieve the staffing, you actually have to invest more money than you would in the law. So it's really a cut masquerading as a quality improvement effort. And then there is data that has been show in states that have acquired some of these levels that since LPNs are cheaper, you actually have the effect of driving up LPN levels than RN levels.

So that research has been done by some investigators at Brown and elsewhere. And so we're concerned this will have a paradoxical effect of driving RN nursing down right when we know that RN nursing is probably the most important thing. So our view is that this should not be used and ready for rulemaking because it doesn't fit in the program. Certainly, it fits well in the QRP program and it fits well in the Five-Star program but not in a payment program.

Mr. Shulman: Yeah, I think the other is -- look, I think that some of those things are not conclusive, David. I think to suggest that this would automatically -- that this would automatically cut payments more than is available is not grounded because we don't know enough about finances. We do know some other things that it's not necessarily uniquely or exclusively tied to the percent Medicaid.

There are other unique factors where we know facilities that invest more in their staffing have been able to staff higher. There's other relationships that we see, we see, like, as I'm sure you know, for profit facilities are staffed lower than not for profit facilities. We see other relationships that it's not

uniquely tied to Medicaid.

I think the ability to say that we believe staffing is a key part of value-based purchasing because of its strong link to quality is well within the scope of a value-based purchasing program. And it's not that the program is completely slashed. Just remember it's two percent. It's not like it's slashing rates dramatically. But in terms of adding it to a value-based program and what we would expect to pay for, we think this is exactly what additional funds should be going for in staffing.

Co-Chair Roberts: David Baker?

Member Baker: He already addressed my issue. My biggest concern in the equity issue. So Evan just touched on that. Thanks.

Co-Chair Roberts: Katie?

Member Boston-Leary: Yeah, I think a lot of what I was going to say has already been said. And I appreciate David Gifford's comments because he captured a lot more eloquently what I was going to say on this. And from our experience at the ANA, we know that the behavior dynamics also important here as it relates to acute care and skilled nursing facilities or long-term care.

There's a line -- invisible line but very clear line where most RNs work in hospitals, LPNs work in long-term care. So there is a challenge that a lot of long-term care facilities have with recruiting RNs. The other things that the measurement are hours, and hours can come in a number of different ways.

And what we're also finding particularly in long-term care and right now in acute care because of the scarcity of these resources is overtime. So you will get the hours and, yes, you'll get the coverage. But the quality is poor because people working well above and beyond what they should be working. And there's a lot of data that indicates that after a certain amount of hours, that does impact patient

safety.

Lastly, I'll also mention that -- and it's coming to me now. It's leaving me. But I just want to -- oh, the timing of this with -- not just with RNs and recruitment of RNs being a major challenge right now which is making the news.

What we constantly hear from our constituents is that long-term care is not making the news. During COVID and all of the accolades that were given to acute care, long-term care was forgotten, the donations and everything. And they have not recovered from the initial surge.

They are still struggling, not just with RNs but LPNs and also CNAs. So I just want to reemphasize the point that David made about the timing of this where the stick is bigger than the carrot. And it's not necessarily going to result in the outcomes that we want because we do know right now, particularly in organizations that have to provide care where they do have the hours.

And the hours will indicate that people are working. But because people are working well beyond what they should be working and overtime, additional hours of quality care, the quality of care is suffering. So I just want to make sure that the intent -- to emphasize the intent of this is not necessarily fitting what the outcome will be with this measure because the hours could get long.

And the last thing I'll also mention is there are not a lot of systems that are very nimble to measure acuity. Acuity is measured maybe once or twice a day in most organizations. And we deal with humans, so some of that may be very low level in the morning may be highly acute in the afternoon or late morning.

And a lot of systems don't capture that until well later on in the day. So even though, yes, acuity is probably factored in there, part of the challenge that we've always found in these settings is that

there are not enough nimble systems to account for acuity when it's actually happening. So that's all I have to add. Thank you.

Mr. Shulman: Hi, this is Evan Shulman again. Thanks for those comments. And I'll count on a couple of them. On the overtime and the acuity, I think those are bundled into our analyses and what's been out there for a long time.

And if those were factors, then I don't think we would see the same strength of association between staffing and outcomes. In other words, if overtime was such a problem, then we would not see that facilities with large numbers of hours, we would see their quality decline. We don't see that.

On the -- the other thing I'll just mention which was kind of an overarching comment on long-term care being forgotten, I, for one, you'll never find someone who's a bigger proponent of raising awareness on long-term care nursing homes. I will say that it does feel like there has been a lot of attention to long-term care as someone who's been in the middle of a lot of criticism of it. So there has been a lot of attention to long-term care.

In addition, there's been billions of dollars in federal funds. I think it's over 20 billion that's gone to long-term care facilities. So I think to say there hasn't been any support to them wouldn't be painting the full picture. So I just want to make sure that we are bringing everything to the forefront here. Thank you.

Co-Chair Roberts: Clarke, did you have a comment?

Member Ross: Yeah, since the previous comments are pretty skeptical, I wanted to show some support for the CMS initiative and give my reference point. If staffing -- inadequate staffing was not a problem before COVID then I would feel differently. But trying to blame the COVID and the existing, it does make everything worse.

But this is a problem that's chronic, and my perspective is twofold. I worked on OBRA '87, on PASRR when I worked for the State Mental Health Directors Association and in a lot of nursing homes during the several years implementing PASRR. And then my mother at the age of 92 died in 2006 in a very good nursing home that was struggling with staffing problems, a nonprofit nursing home, still struggling with staffing problems.

So I know when we get into management -- financial management and human resource management within facilities, it's really tough. But the large issue is, how do we improve the quality in nursing homes? And how do people looking for nursing homes, the crisis of trying to find a nursing home, the people that go through that really stress produced.

And how do we improve quality and let people know about quality? And staffing is an important issue and for the reasons that Evan and others have argued. I just want the committee to know at least one of the consumer reps is supportive of the intent and effort at this. Thank you.

Member Binder: I would echo what Clarke said too. This is a really important issue for consumers. And all of the incentives, current payment incentives in the market right now are overwhelming against extra staffing.

The incentives are not there right now to improve staffing for patients. And we know. I mean, the literature is good. But also the just common sense is also good, having more nurses or more LPNs in a nursing facility would make it safer.

I think that's just a general feeling anyway among patients. But the good thing, the literature supports that. So I would say that this is an incremental approach to at least changing somewhat the payment incentive to make it more of a positive decision for an administrator of a nursing home to staff up. And it's really important.

And I don't know the issue with overtime that Katie was talking about. What I've heard about nursing homes is kind of the opposite where they don't want to pay health benefits. So they hire people for 20 hours a week or something.

And so they end up with a lot of different people coming in and out of nursing homes and that's contributed to some of the issues with COVID because there's just so many people coming and out. So there's been a real effort because that's where the incentives are to try to reduce the staffing investment that nursing homes make. So I think that this is a one-two percent piece. It's a small piece perhaps, but it's in the right direction.

Co-Chair Roberts: So let's go ahead and move forward with voting on the workgroup recommendation and go from there. Susanne, can you pull that up?

Dr. Pickering: While she's pulling that up. So now we're moving to vote on MUC2021-137, Total nursing hours per resident day. And this is to support or not to support the workgroup recommendation of conditional support for rulemaking pending NQF endorsement. Susanne?

Ms. Young: Voting is now open for MUC2021-137, Total nursing hours per resident day for the SNF VBP program. Do you vote to support the workgroup recommendation of the committee recommendation as conditional support for rulemaking?

Co-Chair Roberts: Looks like we have 20 votes.

Ms. Young: Voting is now closed for MUC2021-137, 13 committee members voted yes, 7 committee members voted no, or 65 percent. Our Coordinating Committee recommends the MUC2021-137 conditional support for rulemaking.

(Simultaneous speaking.)

Dr. Pickering: All right. So great, thank you, Misty. And thank you, everyone, for that discussion. Just to remind everyone, so the other measures we'll keep the MAP workgroup recommendations from PAC/LTC because there was not objection to doing so. The only one that did have an objection was what we just discussed, MUC2021-137.

And that still maintained the workgroup recommendation of conditional support for rulemaking due to that vote. So that concludes that portion of the agenda. I'm going to turn it over to Tricia to see if you'd like to proceed with the next steps or the other items of the agenda. Tricia, are you there?

Ms. Elliott: Yes, I am, Matt. Thank you. So Chip and Misty, I would like to propose at 4:15 we're supposed to move to the social determinants of health measures.

I would like to proceed on that path, and we're circle back to the clinician and take a similar approach with the consent agenda on the clinician measures after we get through the cross cutting measures of MUC-134, 136. So it means you're still up, Misty. You don't get a break yet.

Co-Chair Roberts: Some of you have really given me the difficult part of the agenda.

Ms. Elliott: Yeah, and the way we've reordered things, we have you on the hot seat for a little while long. So thank you for that.

Co-Chair Roberts: That's okay. I can handle it.

Ms. Elliott: Excellent, excellent. So thank you for being able to take the liberties to just kind of readjust the timing of the agenda. So just to clarify for everyone, we are moving into a section of the agenda that is listed at 4:15 p.m. It's now 4:10 p.m., so we're starting this section a couple minutes early.

But this is the cross-setting measures, the social drivers of health measures. Technically, there's four measures. It's two measures that are in two programs each, so hence, the count of four. So if we could move ahead to the next topic.

So very quickly, I just wanted to provide a description of the two measures that are under consideration. So the first one is MUC2021-136. And this measure is Screening for Social Drivers of Health. And this is a screening measure that addresses social determinants of health and healthcare equity.

This measure is consistent with CMS' Meaningful Measures 2.0 priority areas and the priorities of the MIPS program as well as the hospital program. So this particular measure, the 136, is considered in the clinician and in the hospital programs. So then if we could go to -- sorry, I'm juggling all my papers around since we're doing things slightly different order.

Can we go to 136, Becky? Is that the next slide? I know we were trying to move some slides around. If not, I just want to introduce Measure 136 which is -- sorry, I'm mixing you up, aren't I, Becky. Let me backtrack one second. Okay.

MUC2021-136 Screening for Social Drivers of Health

So the two measures that we're going to discuss during this time period are 134 and 136. What's on the screen right now is MUC2021-136 which is Screening for Social Drivers of Health. So my apologies for any confusion.

So this measure description is percent of beneficiaries 18 years and older screened for foot insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. The numerator, just to give some context, is

the number of beneficiaries 18 and older screened for foot insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence. Denominator, number of beneficiaries 18 and older in practice or in the population.

MUC2021-134 Screen Positive Rate for Social Drivers of Health

The programs that this measure applies to is the MIPS program and the hospital IQR. We could go to 134, Becky. And I'll add clarification to that one since I was referencing that one incorrectly. Okay. Measure 134 is the Screen Positive Rate for Social Drivers of Health. And this measure is the percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs or interpersonal safety.

The numerator is the number of beneficiaries 18 and older that screen positive for those items, food insecurity, housing instability, transportation needs, utility assistance, or interpersonal violence. And at this point after this introduction of the measures, once again 136 and 134 are both in the clinician and hospital programs. So at this point, we would like to open things up for public comment on these two measures.

Dr. Valenti: Hello. If you'll accept comments --

Co-Chair Roberts: Real quickly, Joseph. Before, I just want to reiterate for the public because we do expect a lot of comments, make sure that we limit our comments to two minutes so that we can get through all of the comments. Thank you. Go ahead, Joseph.

Dr. Valenti: Thank you. My name is Dr. Joseph Valenti. I'm in private practice in Denton, Texas. I'm on the Board of both The Physicians Foundation and the Texas Medical Association, and I work in an area where I accept Medicaid and Medicare and a lot of

low pay and indigent patients.

And anecdotally just today I had a patient who's been putting off a hysterectomy for almost ten years because she can't afford her housing and food bills. So she can't help pay for any co-pays in surgery. Came in with a hemoglobin of 7.6, a uterus that's ten times normal size.

And now she needs an open procedures which this could've been done before. Hadn't really been able to get her in. But this is the kind of patient we're seeing all the time. And if we're not screening for what's going on with them outside of their true medical problems, we're never going to get to the bottom of why they can't access care.

And this is just making care more expensive. So as a clinician and as a Board of Trustee member for both the Texas Medical Association and The Physicians Foundation and someone who sees Medicare and Medicaid patients every day, you really, really need this measure because it's happening to our patients more often than they know. But they're not really not happy to tell us about it. They're a little bit ashamed frankly.

And we need to be able to screen for it and get reimbursed for screening for it. We can address these needs and get on to the care. So obviously speaking, very much in favor of these measures as both a Board member and a practicing clinician. Thank you very much.

Co-Chair Roberts: Thanks, Joseph. Allison Bryant?

Dr. Bryant: Hi, good afternoon. My name is Allison Bryant. I'm the Senior Medical Director for Health Equity for the Mass General Brigham Health System which is over a million primary care patients across the northeast.

So I would just say those of us who are striving as we just heard to delivery equitable healthcare really are aiming. And we understand that the value of

taking care of our patients sort of extends to the reality of their lives beyond the four walls of our healthcare institutions. So time and time again, we've seen how critically important unmet social needs like food and security and housing instability have escalated and really been so dynamic during the COVID crisis.

But unfortunately, we know that the federal government and our current quality frame works don't capture and code for these socially mediated barriers to -- and sometimes enablers of optimal health outcomes. So within our health system alongside other healthcare delivery systems, we have committed to screening for and addressing health-related social needs. And as committed as we are to this work, we know that we're doing that without the benefit of any SDOH measures and any federal payment models.

Within our system, we are screening annually for our medicate ACO members in the context of primary care. Under our United Against Racism campaign, we scaled up these efforts payer blind in 23 communities that are of highest need. And we have a fantastic and expert workforce of community health workers, digital access coordinators who help to assist our patients in meeting their needs. But we are expanding this work in sort of inpatient spaces as well, and we know that this program sort of relies on a robust need for screening, not just for food insecurity but nutritional access more broadly.

We have also really begun to screen to digital access to things like devices with working cameras, internet at home at the time of hospital discharge, informed care planning in an environmental that's increasingly reliant on technology. And so while we are applauding a preliminary recommendation at the clinician and Hospital Workgroups, we consider it really important to note that both of the SDOH measures that are being considered really are critical to make visible the impact of these issues in the lives of our patients.

Given disproportionate impact of SDOH on people from historically marginalized communities, we consider this equity agenda to be very clear. We must recognize providers and institutions for screening patients as well as reporting the screen positive rate to really elucidate racial and ethnic disparities in social determinants that in turn fuel disparities in outcomes. So in our health system, we are measuring equity. Both our measures in equity --

(Simultaneous speaking.)

Co-Chair Roberts: Allison, I hate to cut you off. I'm actually timing people. If you can just wrap it up, and I'm going to move on to Sylvia.

Dr. Bryant: Absolutely. So I just think that we really need to remove the stigma about reporting positive screens because if we don't measure it, we absolutely cannot improve it. So I thank you for your time.

Co-Chair Roberts: Thanks, Allison. Sylvia?

Ms. Trujillo: Yes, thank you. Hopefully, you can hear me. I'm assuming you can hear. Hi.

Co-Chair Roberts: Yes, we can hear you.

Ms. Trujillo: I'm Sylvia Trujillo. I'm a Senior Director of Policy at OCHIN. We're a national nonprofit health innovation and research network founded 20 years ago. Our members include over 1,000 locally controlled community-based healthcare sites, 21,000 providers in 45 states serving nearly 6 million patients. We have 137 federally qualified house centers, localites, rural health centers, as well as critical access hospitals.

Notably for today's discussion, we have collected -- our members have collected over one million social risk screenings with more than 30,000 screenings added every month. We facilitate quality measure reporting for our members through technical

workflow and clinical support for a wide range of quality measures including MIPS, UDS, and state and payer specific quality measures. We have significant technical experience and on the ground implementation experience with SDOH screening, data collection, and navigation.

We have 40 researchers who specialize in health disparities research with some of the nation's preeminent subject matter experts in SDOH. They include investigators and members of the SIREN Network Research Advisory Committee as well as a coauthor of the groundbreaking 2019 National Academies report on integrating social care in healthcare settings. We also have technical experts that have played a central role in the development of SDOH domains and data element standards through the HL7 Gravity Project.

RCO has served on the ONC Federal Health IT Advisory Committee and strongly support the adoption of the SDOH domains and elements in Version 2 of the US Common Data Initiative. We're also undertaking accelerated technical testing of the USCDI SDOH adopted data elements and domains taking a cross-sector interoperability to support closed loop digital referrals. The five core domains in the proposed risk measures under discussion today align with the USCDI Version 2 domains as well as Z codes. For that reason, we offer our conditional support for both MUC-136 for both MIPS and for the hospital inpatient quality reporting program as well as MUC-134, Screen Positive for both --

(Simultaneous speaking.)

Ms. Trujillo: -- MIPS and IQR.

(Simultaneous speaking.)

Co-Chair Roberts: Thank you, Sylvia. We're going to go ahead and move on. It sounds like we received your conditional support.

Ms. Trujillo: If I may just comment. We were not given a time limitation in advance. And just to promote improved public comment and solicitation, we'd recommend improved advanced notice of both meetings as well as limitations. And we appreciate this opportunity. Thank you.

Co-Chair Roberts: We will note that for future meetings. Thanks, Sylvia. And so let's move on to, I think, Maureen Bisognano.

(No audible response.)

Co-Chair Roberts: Okay. Mandy C.?

Dr. Cohen: Hi, good afternoon. This is Mandy Cohen. Can you hear me?

Co-Chair Roberts: Yes, we can hear you.

Dr. Cohen: So as of two weeks ago, I recently stepped down North Carolina's Secretary of the Department of Health and Human Services and also the Operating Officer in Chief at CMS. And so I know the measure development process well. And in North Carolina, we have worked for the last five years while I was Secretary thinking about how do we both measure and tackle some of these hard issues.

So I applaud all the work that's gone to this point. I want to just say right up front that I endorse both of these measures. But I want to make sure you talk about it from two perspectives.

One, as a physician myself who did not do all the things I needed to for a patient and frankly wasted healthcare resources by ignoring some of these social determinate factors. But also as a healthcare leader in the public sector, we committed to doing this kind of measurement at scale in North Carolina. It was really important the moment you are sitting in right now.

And I want to encourage the folks who are thinking

this is going to be hard. I will say one commitment is there. All kinds of stakeholders in North Carolina mobilize around it, payers, health systems, clinicians, our medical society, community-based organizations.

So what we are doing in North Carolina was screening for social determinants at scale, requiring all Medicaid MCOs (audio interference) for social determinants. And so this can be done at scale. (Audio interference). You're doing it, but also to publicly report it. That sunshine is really important, that transparency, the only way we're going to get better at this. Thank you.

Co-Chair Roberts: Thanks, Mandy. Kathleen C.?

Dr. Conroy: Hi, my name is Kathleen Conroy. I am the clinical chief at Boston Children's Hospital Primary Care. And I'm speaking today as an individual clinician in support of these measures and bringing deep experience in implementing the type of screening for social determinants of health in my own practice, and I want to speak to Massachusetts experience briefly.

So we serve 23,000 children in my practice. And we've informally and universally screening for these same measures or the same domains for over a decade. And like many, many pediatricians and many non-pediatricians across the country, we've adopted this practice because of the overwhelming evidence that screening is both acceptable to families and of course helps facilitate connections to needed social resources with the intended health benefit.

Just like screening for depression and anxiety, screening and addressing social determinants of health has just become a standard part of our clinical program. But more recently in 2018, the Massachusetts Medicaid program introduced two quality measures through its current 1115 waiver that are nearly identical to the ones that we're talking about today. And so for my practice who is

already screening, what really changed for us was the need to examine the percent of our patients across the population who are screening positive for various needs and this forced us to do different work.

It forced us to work on our data differently and helped us to look at the associations between needs and other clinical and demographic factors and how needs were changing over time in our population. And then this in turn helped us to facilitate the creation of new community partnerships and new responses to these needs. It also helped us uncover disparities because we were looking at these issues across the population. So for this reason, I would argue that we need 134 and 136 together.

And then just for those who are worried that this is at the tip, that we are not ready for this, I want to remind you that this is happening daily in thousands of healthcare settings across the country. It's happening in many states as Mandy was alluding to at scale already. And I think what this committee has the opportunity to do is to put a stake in the ground that everyone must do this and also require people to look at their populations at a whole and be able to understand where they have the greatest needs and thereby build programs that are going to help the most patients. Thanks very much for your time.

Co-Chair Roberts: Thanks, Kathleen. Patrick Conway?

Dr. Conway: This is Patrick. Hopefully, you can hear me okay. So a couple key points. One, just as a policy maker, I was Chief Medical Officer at CMS for almost seven years, was Director of CMI for five-plus. As was said, I think if I was there, I would put both measures into practice. I think it'll drive change.

Two, on health equity that was mentioned, I think it's a major -- as we know, it's a major issue in health equity. And now is the time to implement

and address the health equity issues. Three, as a payer serving with Mandy and others when I was in North Carolina, we saw when you put these into programs -- and you have to screen plus measure the positivity rate.

Quite honestly, just doing one without the other is not useful. So you need to do both and put them both into programs. I think it'll shed light on the subject to drive the change we want.

Four, you know the evidence on the impact of health outcomes overall and that it's much larger than many of the other things we put into public programs. And then five, now I lead a lot of care delivery businesses. This is part of our work.

It's what we do. It's how we address these issues at scale across population. So I think for our nation's health system, we should put both measures into practice and publicly report.

Also a practicing physician, I deal with these. I still practice. I see them when I work on weekends with children as others mentioned. So I think critical that these go into place.

Co-Chair Roberts: Thanks, Patrick. Dr. Price?

Dr. Price: Thank you. I'm Gary Price. I'm the President of The Physicians Foundation and a practicing surgeon for the last 35 years. I've spoken extensively on behalf of the foundation, the major developer.

I very much appreciate the previous comments and would like to amplify them with my personal perspective briefly. I've done many trips to developing countries, especially to very remote areas to do volunteer surgery. My very first trip, I was given 48 hours notice and quite frankly was very concerned that I couldn't duplicate the technology there that would enable my team to do a great job.

It turned out that was our very smallest problem. We could overcome technological barriers quite easily. Our real problem was somehow ignoring the incredible depth of the need in the area we were working for all sorts of healthcare services as well as economic and social changes.

We had to blind ourselves to that to work effectively and get somewhere between 30 and 60 children's faces and hands reconstructed on the trip. With each succeeding trip, it was still a problem. There was always at least one member of our team who really, really couldn't shut their eyes to it and it renders them ineffective on a focal mission.

In many ways in our society, we've chosen to do the same thing here. Those of us who work at the bedside in healthcare have had to because we can't get our jobs done and tackle these major issues. And it's just become more comfortable for all of us not to try to.

We now have hard evidence published in peer reviewed journals and the national experience with a pandemic that doesn't allow us to ignore that anymore. This group doesn't have to turn a blind eye. It's their job and our job to address these issues.

I've heard a lot about fear of unintended consequences. My fear is that we don't seize this moment to begin to change things for the better, for all the good that we could be doing by frankly admitting that these are having a tremendous impact on our health costs and outcomes, and beginning to get metrics so that we can address positive change. To decouple reporting from actually obtaining the measures, serving them would be a very high tech way to put our blinders back on and yet convince ourselves that somehow we have done something.

I can't imagine and certainly the healthcare community would never stand for either a hospital or a physician to be punished for a lower score on

social drivers of health as far as the nature of their patient population. On the other hand, we now know from good hard evidence that our physicians are daily punished because their MIPS scores and their reimbursements are lower if they have a higher demand as far as social drivers is concerned on their patient population. I hope that all of the information we've submitted and the technical support we're willing to give today will be helpful, and I really appreciate your time and also keeping your time schedule to a fashion that the people who are testifying could be available. Thank you.

Co-Chair Roberts: Thanks, Dr. Price. Maureen Bisognano, I think you are now able to unmute.

Ms. Bisognano: Thank you so much. I'm Maureen Bisognano. I'm the President Emerita for the Institute for Healthcare Improvement. And I am calling in today to strongly recommend the passage of these.

We're at a unique moment, I think, at a time in our country where we now see clearly the gaps in health from one part of the country to the other and particularly the influence of those gaps on equity. Throughout the decades that IHI has been working on quality improvement, we've learned a lot of lessons about measurement. And the first one is that I think in order to improve, we've got to move beyond individual projects and really think about scale which means we need to see the data.

At IHI, we believe that you need to build the will for change, share ideas, and then use quality improvement science. And I remember back decades ago when we began our work in safety and quality that there was a lot of concern about sharing metrics. But what we found is that though perhaps they weren't perfect at first, getting that data out there built the will for change.

It allowed people to see the gaps that they were having in front of them and also to reach out to share ideas across systems that don't happen

otherwise. If we don't work on building real ideas and execution, I don't think we'll get to see the decreases in inequities across our system. And I think finally it's time for us to take this step forward.

It's our obligation to begin to measure and to improve over time. I know that together, especially given the realities of COVID, that there's never been a more important moment for us to take this opportunity. And I strongly recommend that the Coordinating Committee recommend all four measures. Thank you for your time.

Co-Chair Roberts: Thanks, Maureen. Do we have any other comments? Yes, we've got Ron Wyatt.

Dr. Wyatt: Yeah, hi, and thanks for giving me the time, Misty. So I'm going to go in a bit of a different direction on this. Just to tell you, I'm a guy that grew up on the side of the road in rural Alabama. And I'll say that I grew up in the belly of the beast of inequity, the beast that motivated me to go to medical school to help people.

I would say for every clinician on this call if you ask why did you go into medicine, it's to help people. These measures are to help people. Where I grew up, Harper's called a place that healthcare won't go, and it's because of the inequity.

I currently now lead five equity collaboratives across the country. The weakness in all of them is trying to come together with a set of measures that can be used to change people's lives. Changing people's lives means that we begin to put an end to the harm and the suffering and the premature death that results from disparities and longstanding inequity.

So here now we have this opportunity. And to echo what Maureen was just saying, we have an opportunity right now to do the heart work, not the hard work, heart work to change the world. The work that NQF does with these measures is

changing the ground that you stand on first so that we can change the world.

That's the opportunity. That is the chance that we have that we must seize at this moment in time that we can now have measurable data that we can act on as Maureen talked about. They won't be perfect.

But when we look at the test data that's been done psychometrically, we know that we have an opportunity. Inside of that is almost 90 percent of the people that says, we need help. So it goes back to why we're here in the first place.

So if I echo the words of Dr. Conway, Cohen, and Conroy, we're at a point where we need to put people and communities first. We need to commit to them. We need to commit to putting in place I will call forcing functions, that we don't regress, that we move forward.

And this is ironic that we're in the week of the MLK holiday. One of the things that MLK said was, if we can't fly, we need to run. If we can't run, walk. If we can't walk, crawl. We need to move this forward with urgency as I think as Patrick Conway talked about, with commitment as someone else talked about, with a renewed motivation to truly help people that need our help.

This is an opportunity for all of us to change the world. And I'm not just asking, I'm begging that we start here to change the world. NQF and these measures aren't going to stand alone.

There are so many other things that need to be done. But I assure you and I think Dr. Conroy said this that we're at the point of using force. So these measures I see as forcing functions and to ask people to commit to this work.

And lastly then that we have hope. These measures will give a lot of people hope. And from days at IHI, Maureen is my hero. We know hope is not a plan. Soon is not a time. Some is not a number. So I ask

you with urgency to help people that have suffered for far too long. Thank you.

Co-Chair Roberts: Ron, you're so compelling, I forgot my clock. Let's move on to Karen Smith.

Dr. Smith: Thank you. I'm Karen Smith, Raeford, North Carolina family physician. Rarely do we find men who willingly engage in hard, solid thanking. There is an almost universal quest for easy answers and half baked solutions.

Nothing pains some people more than having to thank. And those are words that was expressed by the Reverend Martin Luther King, Jr. But he also expressed shallow understanding from people of good will is more frustrating that absolute understanding from people of ill will.

We now have an opportunity to actually get good understanding and people who are already working on those factors of SDOH. Now currently we know the debate is taking place for civil rights and voting rights by another entity in our country. But in healthcare, we have the opportunity to have impact on SDOH from out side of the house.

It is our opportunity to now quantify this information which we can actually use to not come up with half baked solutions but good solutions that are going to make a difference in the lives of individuals that we care for. As a physician, if I have someone presenting to me, I go through the SOP format. If I suspect that it's a cancer, I'm going to get the subjective the objective by doing an assessment and plan.

But we're dealing with SDOH. And unfortunately, it remains very much undifferentiated because we have no data to know what it is that we're dealing with. And we don't want to come up with a plan that is not going to solve the problem. And this is one way in which all care can make a difference in SDOH. While our colleagues continue to debate on civil rights, let us engage and make a difference in

human rights. I wholly support all four measures.

Co-Chair Roberts: Thanks, Karen. I think we have William Lawrence.

Dr. Lawrence: Good afternoon. Hopefully you can hear me. William Lawrence, North Carolina Chief Medical Officer at Carolina Complete Health. But speaking really from professional experience as a general pediatrician, I echo many of the points already made by my colleagues and for brevity will not repeat most of those.

But we do really strongly recommend the adoption of both measures, the use of those measures in tandem which is going to be of most relevance and effectiveness and see it as a critical part of the framework for equality going forward. One point I will amplify that Dr. Price made is while it's understandable that some entities may perceive things negatively or inappropriately burdened by sharing this type of data publicly, especially considering those entities are dealing with circumstances that are not really under their control. The reality is that many physicians and other healthcare entities serving in underserved areas have had to be compared against their more ideally situated colleagues with the same quality measures for years despite providing excellent care for those individuals who did the bear more of these recognized but often not addressed barriers to optimal outcomes.

So I experienced that personally in my practices, both in Winston-Salem, North Carolina and in the heart of Washington, D.C. And I often felt that it led to an unfair distribution of resources. So therefore, I believe that there is opportunity in identifying these needs and recognizing clinical entities that serve them best. So I strongly believe the implementation of these measures can increase our capacity for systems to recognize the needs, to foster improvement and innovated supports, and to more efficiently use available resources.

Screening without sharing the results for action portends a risk that some might turn a blind eye and that others might choose to just move to more favorable settings. Allowing a true and transparent assessment of the population served, the resources given, and the actions that may be undertaken gives us a more global and reliable opportunity to truly shed light on and reverse the impacts of social inequities of deprived communities and even of systemic racism. So appreciate the opportunity to share and support.

Co-Chair Roberts: Thanks, William. Stephanie Franklin?

Ms. Franklin: Thank you. I'm Stephanie Franklin. I'm the Associate Director of social determinants of health, insights, and business intelligence at Humana. Humana is a large national healthcare company, including a Medicare Advantage contractor.

I'm here to express Humana's support for the adoption of both of the measures for both the screening and the screen positive measures in both programs. We've long been committed to addressing the health-related social needs of our members and the communities we serve. This includes screening our members and beneficiaries for their health related social needs and taking steps to address those.

We also make this data publicly available. And last year, we actually conducted over six and a half million screenings. This is really -- understanding that the prevalence of social needs and talking about it publicly, making it public, has really impacted how Human has invested as a company and the benefits and services we provide and has allowed us to make impactful partnerships for collective impact for the patients in the communities that we are serving.

So speaking to the screen positive rate in particular, we do think this is very important, not only to

reveal disparities but more important to help us identify areas for investment and communities and to be able to measure the progress we're making toward achieving equity. So I will echo everyone's comments here to not allow the perfect be the enemy of the good to move forward with both of these measures. Thank you for the time.

Co-Chair Roberts: Thanks, Stephanie. Richard Thomason?

Mr. Thomason: Hi, thank you. I'm Richard Thomason, Policy Director for Blue Shield of California Foundation, which supports lasting and equitable solutions to make California the healthiest state and end domestic violence. But we can't do this work alone.

We need federal leadership, and you all have an opportunity today to make a significant stride forward in federal leadership on addressing health equity. We applaud the leadership of the MAP Clinician Workgroup in supporting both 134 and 136 and the Hospital Workgroup and likewise supporting Measure 136. And we encourage the Coordinating Committee to endorse those decisions. We're troubled, though, by the Hospital Workgroup's vote on 134, do not support with potential for mitigation.

We know that the workgroup expressed concern that the positive rate may be challenging for consumers to interpret when publicly reported. Through the lens of a commitment to equity and from our own deep work in community, we find is remarkable that the workgroup determined that consumers would be unable to exercise their own judgment in interpreting important data about the degree to which their friends and neighbors are impacted and affected by social drivers of health. Hospital reporting of the screen positive rate will be important to patients for a number of reasons, including providing transparency, enabling the targeting of hospital and community investments

based on the social needs shown by the data, signifying the hospital's understanding of the social drivers of health among its patient population, and four, providing data for targeting quality improvement activities, including highlighting and addressing disparities and the social drivers of health for patients.

So for these reasons, it's crucial from an equity perspective to move forward, not only the screening measure but also the measure that recognizes how systems were reporting this screen positive rate to reward screening. But not reporting of the screen positive rate would mask these disparities and risk exacerbating inequity. So we strongly encourage the Coordinating Committee to recommend both measures for both MIPS and the IQR. Thank you.

Co-Chair Roberts: Thanks, Richard. I do not see any other public comments, either in the chat or hands raised.

Ms. Elliott: Misty, this is Tricia. I agree. Just maybe one last call if there's anybody we missed navigating through chat, let us know. But we got through all the hands raised.

Co-Chair Roberts: And appreciate everyone's patience with us. Recognize we might've had to cut some people off and there were some additional comments in the chat. And we do appreciate that.

Ms. Elliott: Okay. I think we can move to the next slide then, Misty, if you're --

Co-Chair Roberts: Yeah.

Ms. Elliott: -- comfortable.

Co-Chair Roberts: I know we can vote on these. Are we going to do the consent agenda on these two -- or this one for these two programs? Or do we need to vote on them individually?

Ms. Elliott: I think we'll do our regular agenda. So

we'll go to clarifying questions next because I've already introduced the measures.

Co-Chair Roberts: Okay. Any clarifying questions on these measures?

Member Goodman: Misty, I'm sorry. Clarifying questions on all four or just on MIPS?

Co-Chair Roberts: At this point, I think let's, I guess, focus on MIPS. Tricia?

Ms. Elliott: So just to comment here, the way we've structured it is on this slide you'll see MUC2021-136 which is the screening for social drivers of health. And that appears both in MIPS and Hospital IQR. Maybe to keep things clear, we'll go in order and we'll start with MIPS, Misty, and then we'll vote and then we'll move to the next one, just so we can make sure we capture all the comments appropriately. So we'll start with MIPS comments on 136.

Co-Chair Roberts: Any clarifying questions for this one?

Member Tufte: This is Janice. Hi, I had my hand up. I guess you can't see it. Anyway, I only have one concern. I think it's absolutely wonderful and having lived and utilized these resources in recent decades, I really see the importance of this.

And having social determinants of health at the head of the work that I do, I really am excited to see this. I'm concerned a little bit that telehealth or internet access wasn't called out. And I'm just hoping that the developers will be able to add it into the utilities at some point.

So I have been able to do that where I live, like -- my internet can actually been claimed as a utility on my taxes. So I just want to add that because of telehealth and it's so widely used. One person had mentioned regarding handheld devices, but a lot of people do not have those. Thank you.

Co-Chair Roberts: Thanks, Janice. Heidi?

Member Bossley: I have a question. It's more around conditions for the measure. So I don't know if this is -- sorry, I've lost track of when that's the time to ask for it or not.

Co-Chair Roberts: I think it's now.

Member Bossley: Okay. All right. So I think one thing that the AMA has been trying to look at is to what degree when these measures do get deployed in MIPS. And I think this would also apply to IQR. What resources are available in understanding, for example, what survey tools are available that map to these five drivers that are included?

And kind of building on what Janice said, it's not clear to me what utilities are actually included in the specifications. So I think as this goes out into programs, if it does, understanding what tools are there and do one-to-one mapping, for example, to each of the drivers. What resources and potential reimbursements could be available for practices and hospitals as they deploy these because I think again it comes -- it just gets harder if you don't have the details that are needed.

And we don't quite see that in these measures. And so if there could be some conditions on that. And I think the last thing was raised for 134, a positive screen. And I don't think it made it into the conditions but would also apply here is around data standards.

It does align with USCDI. I don't think it yet aligns with gravity. And I think that work is absolutely critical. And so having a condition around alignment with data standards would also help move this. But again, I can drop the conditions in the chat if it's helpful.

Co-Chair Roberts: Yes, that would be helpful. And Tricia, I do have a clarifying question real quickly. Is the conditional support NQF endorsement?

Ms. Elliott: Yes.

Co-Chair Roberts: Okay. Amir, you've been awfully quite today.

Ms. Elliott: Actually, Misty, let me -- before -- Amir, sorry to cut you off. So the MAP offer conditional support for rulemaking pending testing of the measure's reliability and validity and NQF endorsement. So I just wanted to add that clarification that they did call out the reliability and validity specifically.

Co-Chair Roberts: Okay. Thank you. Go ahead, Amir. You're on mute.

Member Qaseem: Can you hear me? Sorry, the mute was not coming off for some reason.

Co-Chair Roberts: I can hear you now.

Member Qaseem: All right. So I mean, first of all, okay, I want to start off by congratulating the measure developers. And I think this is such an important topic area. I am so glad that we are taking on the social determinants of health.

And I absolutely agree. All the comments that were made during the initial conversation from the physicians especially because me being a physician, I think this is really important. I have a couple of clarification questions because I'm not following it, and I want to make sure I have the measures right. The first one is the Measure 134. The numerator states that the number of beneficiaries who screen positive.

Ms. Elliott: Actually, Amir, we're going to talk 136 first, and then we're going to 134.

(Simultaneous speaking.)

Co-Chair Roberts: Sure. So let's just do 136. So I think I'll ask about that because that also threw me off a little bit.

Ms. Elliott: Okay.

Member Qaseem: So I am looking at all the specs and the details and the reliability and validity testing. That's all about the instrument. Am I missing? Where is the reliability and validity data for the performance measure because we're here to talk about the performance measure, not the instrument? So absolutely agree.

(Simultaneous speaking.)

Member Qaseem: I applaud that that instrument is wonderful. And it's like essentially saying the PHQ-9 is a wonderful valid instrument, right? But that does not necessarily automatically translates into a performance measure based on that instrument is a reliable and valid instrument. I'm curious if the measure developer can tell me where is that information. I don't see it.

Co-Chair Roberts: And real quickly, Tricia, wasn't that the condition support is to have the testing and reliability --

Ms. Elliott: Correct.

Co-Chair Roberts: -- with the NQF endorsement? Okay.

Member Qaseem: All right. So I understand it correctly, so the clinician subgroup is saying since this measure has not even been tested or operationalized, so we don't even know the information that's going to come from this measure is going to lead to any changes and improvement in health outcomes or improving processes or whatever, right? Is that what they were saying?

Ms. Elliott: Yes. Matt, can you help to clarify here because some of this came out of the hospital program as well?

Dr. Pickering: Right. There's recognition that the instrument itself or some of the instruments that

have been cited in the measure submission information have been psychometrically tested for reliability and validity. However, given those instruments are within a performance measure framework, that still needs to be tested for reliability and validity based on NQF criteria. So that would be within the pending NQF's endorsement would be the reliability and validity testing of the measure itself in which the instruments have been cited for use within the measure.

Member Qaseem: So my suggestion, Matt, is going to be is if we're going to go forward with upholding the workgroup's recommendation, I really think we need to bring this forward. I'm going back to just having pending NQF endorsement is burying the fundamental issue that we are talking about and we don't have the reliability, validity, or the testing data. And MAP would like to see the testing data, right?

So I'd like to stress that part. And I think this issue, if I remember correctly, came up with the Health Equity Group. And unfortunately, the Health Equity Group ended up saying that the measure is wonderful, but this is beyond their scope.

And that's why this measure passed through Health Equity Group that they actually raised this issue of the testing big time as well. And it continues to go through the process without getting the answer. So I'm curious actually if the measure developer is there. Why haven't they tested such a great measure? I mean, I'd love to have this measure. But what happened? Why hasn't it been tested?

Mr. Perla: Hi, Amir. Thank you. I'm Rocco Perla with The Health Initiative. We're the technical advisor to the measure developer. And I will say I really appreciate your question, especially as a psychometrician.

I think us folks appreciate for any instrument-based measure, validity of the tool is absolutely essential in addition to the output, the response format, and

the scale. Obviously, in this case, we're dealing with a binary variable, the presence or absence of a particular SDOH. And they really need to be understood collectively.

There has actually been extensive testing as you noted and I think as the NQF folks and others have around the measures, both looking at reliable. So when folks are asking this question and multiple raters are asking it, how well do they agree? The Cohen's kappa statistics has been fairly solid, typically over 0.6. And those are the adjusted Cohen kappa statistics, as well as evidence of concurrent and predictive validity.

So for example, if you are an individual who's low income, do you tend to screen positive or negative when asked these questions? How well does the two actually predict the measures. And some of those studies have things like variables that should not correlate like the presence of a flu shot in order to try to assess construct validity.

There is more work that needs to be done on the measures. You are absolutely right. And that testing needs to be done in collaboration with the screen tool.

You can't validate an instrument-based measure with just the tool or the measure. They have to be done collectively, and there is work being done on that. There have been a number of seminal studies that have looked at those findings. They are cited in the MUC submission report as well as some of the other item level analysis because the other thing we want to make sure is that we can look at the item in the domains, food, housing, transportation.

But you also need to look at the overall tool performance. And again being able to quantify that degree of agreement and validity is absolutely essential. It's an active field right now and more work needs to be done.

Dr. Pickering: And Amir, I appreciate your -- the

interest in also just wanting to see the testing information for using for this measure specifically. Once it goes through NQF endorsements, all of that information is publicly disclosed. The testing information, what the developer submitted as far as their testing of the measure.

And so that is obviously assessed by our standing committee. And then also that decision to endorse or not endorse is then also disclosed ultimately after the standing committee makes their deliberations. Is that something that still would be acceptable?

It is publicly available for members of the MAP to consider once it goes through a standing committee. So kind of keeping it under this condition of pending NQF endorsement, that would include the testing of the measures. But is there something more specific that you would like to --

Member Qaseem: No, that's fine.

Mr. Shulman: -- see outside of what we normally --

Member Qaseem: Yeah, I mean, I think that will be good. But if it's we're discussing under MIPS umbrella, right? For any physician program, it's important for us to be able to see the testing data.

So I understand the whole entire process. I just want to make sure it does not get buried. Michelle was there or she may not be there. The CMS team is listening to what I'm saying, and hopefully they hear us out.

Whether it goes in written comments or verbally, we need to see the performance measures data. And I certainly appreciate what you're talking about, Rocco, in terms of, of course instruments first needs to be reliable. But then to the friendship, the care I may be giving versus David Baker, I think you need to have the testing data as well.

Mr. Perla: Agree.

Co-Chair Roberts: David Baker?

Member Baker: Thanks. So I wanted to start off by just thanking everybody who gave public comments. It's just really powerful. My question is we've been looking at the joint commission at some of the different screening tools for these social determinants. And they're quite different.

And so my first question is, is there any specified tool for this measure? And the second on the backside if you're looking at actually reporting is there any specifications about how that information should be reported. There are a few comments in the chat and in the public comment as well about how to actually capture that data in a reliable way.

Co-Chair Roberts: I think that's a question for the measure developer.

Mr. Perla: Great, thanks, Misty. I can take that, and it's a really important question. Thank you for asking it. So as the measure developer submitted the measure, there is no standard or mandated screening tool at this point in time.

The focus is on creating a standard around the measure and not the tool to minimize barriers to data collection or reporting. Of course, any approach or tool used to collect the data would have to mirror the five specific domain questions in the measure in order to be valid submissions. Extensive public comment that's been provided through the process makes it pretty clear that providers desire to have that flexibility in the specific SDOH screening tool that they use or may be using.

So if a standard tool were mandated and it wasn't one that they were using, then they would be really sort of -- a burden would be placed on them. CMS may at some point choose to move towards an approved list of screening tools in the future. I think this gets to a little bit of what Amir is talking about as we begin to develop a more psychometric data environment, we can make those determinations.

But the primary focus right now was on allowing flexibility relative to the tool. There is no standard mandated tool just to make that absolutely clear to be used in practice in order to satisfy the measure. The only criteria is that whatever tool that's used reflects the questions that are part of the five domains.

(Simultaneous speaking.)

Ms. Onie: I would just -- this is --

Member Baker: How about reporting the screening? Is there any specific requirements about how that's done?

Mr. Perla: No, there isn't. And as was identified in the NQF preliminary analysis, there are a number of modalities that could be used, electronic means, patient reported outcomes, paper forms, any mechanism that is currently being used right now by a system, again, that reflects the five domains at the point of care would be allowed. There are no restrictions and certainly nothing that CMS would imposed based on what was submitted by the measure developer.

Co-Chair Roberts: Julie?

Member Sonier: Thanks. So I will echo sort of all of the excitement and feeling personally excited by all of the enthusiasm that I've heard for these measures. I just want to make a couple of comments. One is that we talked about making expectation for reporting.

And in the IQR program, that's right. But in the MIPS program, it's one of 200-some measures that would be optional. And so my comment, I guess, would be more for CMS that perhaps should be considered on of those foundational measures that goes into the MIPS value pathways which would create an expectation that everyone report on that.

But that said, it's a process measure. And it's going

to tap out very quickly. And so we need to understand that, and I think we also need -- and one of the things that means I think is that we need to be prepared to move rather quickly beyond just kind of, like, creating this expectation that people do screening.

There is one question that I have or maybe it's concern or something that we haven't talked about yet that is perhaps an unintended impact which is about patient burden. So if everyone all of a sudden is doing this screening, if you think about it from being a patient perspective, wondering, like, why is everyone suddenly asking me all these questions. Can't they talk to each other and share this information?

So kind of a plea for more effective and meaningful ways of sharing this information or figuring out, like, who has the responsibility to do this so that we don't created this burden for patients as well as the frustration that they have. Perhaps that no one is talking to each other. Why do I have to answer these same questions over and over?

Co-Chair Roberts: Thanks. Mary Barton?

Member Bossley: I think Mary had to step off for another meeting.

(Simultaneous speaking.)

Co-Chair Roberts: Oh, okay.

Ms. Elliott: So Chip Kahn and then Leah Binder are on the hand raised list, Misty.

Co-Chair Roberts: Go ahead, Chip.

Co-Chair Kahn: Yeah, thanks. And thanks for all the speakers and clearly enthusiasm about a very important move forward. What's CMS' schedule on this, because it sounds like the instructions and the -- that it's somewhat of a work in progress.

I mean, would this for MIPS be in the reg and start

2023 -- January '23? Or -- and I guess I could ask the same question for the hospital side which would be a little bit different in terms of the timing. But what's the -- what are we agreeing to here in terms of the timeline?

Dr. Schreiber: This is Michelle. If this were to go into rule writing, this is 2023. If it were to be proposed, it would start data collection in 2023. This is 2022, data collection 2023, reporting 2024. And that's the earliest time frame, Chip.

Co-Chair Kahn: Okay. So that's only a possibility. It may not be ready for that, I guess. Because frankly --

(Simultaneous speaking.)

Dr. Schreiber: That is absolutely correct. I gave you the earliest possible time frame.

Co-Chair Kahn: Yeah, okay. Because knowing -- I mean, this is a complex thing. And it almost has to be ready for prime time many months before January 1 for you to actually put it into the process. So you're almost pregnant by April or so anyway on that, whether you're or not you're going to do it the following the year, right?

Dr. Schreiber: That is generally correct. So I gave you the earliest possible timeline.

Co-Chair Kahn: Okay. That was my question. It just seems -- I mean, it needs to be done. I just wonder particularly for MIPS how fast it's going to be done considering the kind of questions that Amir was asking.

Member Qaseem: Yes, and Chip, that's such a great question you asked. I don't know if Rocco is still there. I don't see him on screen. I'm curious. What is their timeline? When will they have the data that we just talked about? Is Rocco there? Misty, I can't see him.

Mr. Perla: Yes, I'm here, Amir. Sorry. I can see me. I don't know if you can see me. I will say that a lot of the particularly post-Accountable Health Committees pilot, there has been incredible research activity around the validation and validity and reliability studies and obviously the process of developing that evidence-based is moving now. And so we anticipate there will be additional research, both on the private side but even on the public side relative to subsequent evaluations that'll be coming out through AHC within the next year and are really excited to see that degree of scientific rigor being brought to the questions that you asked.

Co-Chair Roberts: Leah?

Member Binder: I did have -- I have a question for clarification. I'm sorry if I missed this in the discussion. But my understanding is when we looked at validity and reliability, that was testing the -- or I was thinking that was testing the instrument.

The measure itself, that was the next step was to test the measure. But there is no instrument, right? There's not actually -- this isn't calling for any one instrument that can be used for this. Is that correct?

So what exactly is being tested for both validity and reliability so far, one thing? And also is there any requirement in the measure of how these questions are asked? Like, in other words, are they asked -- who asks them because that really does matter?

In particular some of the research on domestic violence, if it's the clinician asking, the results are very, very different than if it's just a question you answer in a waiting room. So anyway, I just wondered those two things. But I'm really trying to understand how the validity is tested on an instrument when there's no required instrument on this. Or how does that work?

Mr. Perla: I can take that, Misty, if that's being directed to the measure developer.

Co-Chair Roberts: Yeah, Rocco.

Mr. Perla: Thank, Leah. It is a great question. So one of the things that I think is important to point out is that these measures are derived directly from the Accountable Health Communities pilot. So the measures were taken from that program which that program has been up and running for five years across 644 clinical sites, 21 states, and screen over a million beneficiaries.

And so the validity studies that we presented, for example, have specifically focused on the AHC tool, model, and approach, even down to the level of face validity where CMS brought together a technical expert panel who reviewed the merits and practical implications of the screening and reporting for the five domains and identified those. So if people are wondering where the domains came from, that's where they came from. And as we were talking about with Amir, the AHC screening tool has been used -- the AHC screening tool used to generate the data that has informed the measures that had been used for five years do demonstrate evidence of reliability and validity.

Of course, there is no final once and for all for reliability and validity. So in terms of being able to justify the measure on scientific merits alone, the measure developer stayed very closely to the AHC tool to demonstrate that in practice these tools could be used in a highly reliable, consistent, and valid way. Your question I think is a great one is, as other tools are allowed and are being used, they do have and share some crossover validity. So the studies that had been done with the AHC instrument looked at other tools like the your current life situation tool.

There was another study that looked at the WE CARE instrument. For those of you that are familiar with PRAPARE and other tools, the reliability and validity evidence and data there is really growing by leaps and bounds. So as far as the measure

submission process goes, the measure developer stayed very closely to AHC. And in fact, one of the studies that is cited directly looked at the AHC psychometrics relative to other instruments just to understand the degree of generalizability that might be afforded the use of that instrument in the measure.

Member Binder: Can I just ask a follow-up? If you have two different -- and you've looked at, let's say, crossover and AHC, if you look at those two as part of the same measure, then are they comparable? Is it acceptable to compare the results or the -- well, this is a process measure on screening, I guess.

Mr. Perla: The early evidence on this suggests that is actually the case. So there is evidence of reliability. So reliability implies we are comparing multiple instruments and that there's reliability across it. That's also from validity.

And so at this point, the evidence suggests that that is possible. And as I mentioned and Amir was talking about the other studies that are being done for some of these other instruments are also beginning to demonstrate a fair significant degree of consistency relative to the psychometrics. It's not perfect by any stretch.

So there is some degree of consensus that these screening questions which have been asked way before AHC. For those of you that have been doing this work for a long time, you know that through USDA and other mechanisms, many of the items are actually derived from already valid students on these items. So it's just a real opportunity right now to really get a better handle on this and to understand this more broadly across a number of different instruments as they're being used widely across the programs.

Member Binder: Thanks.

Co-Chair Roberts: Libby?

Member Hoy: Hi, everybody. I'm Libby Hoy, founder and CEO of PFCC Partners. We're a patient and family driven organization with about 850 current patient family partners from across the country. And I just first of all want to thank the public commenters, incredible insights, incredible experience, and knowledge that you shared with us. I very much appreciate that.

I just had a couple of questions, one going back to the comment and concern for burden to the patient and family caregiver responding. Did you have any feedback from -- you had considerable -- as I saw it, a considerable amount of engagement of your patient and family partners. Did you have any comments back from that group related to burden?

Dr. Price: Was that question intended for the developer?

Member Hoy: Yes.

Mr. Perla: Sorry, Libby. It's a great question. Thank you, Dr. Price, for jogging me here. So -- and this -- the factors that you're talking about are relative to sort of engaging patients and families. There's a significant amount of evidence that has been provided through the MUC submission.

So there's lots and lots of studies. I will say that many of those studies are capturing the data, both qualitatively and quantitatively. I would point to two that we thought were exceptionally well done in the bolus of research studies that were shared to reinforce this idea that patients and families have been brought to the table. There was a 2020 study published in the Journal of General Internal Medicine that found that 85 percent of the patients were in favor of health systems asking about social needs and 88 percent were in favor of getting help to address them.

And there was a physician foundation patient survey in 2019. This was a survey of over 2,000 patients of which 77 percent agreed hospitals, clinics, and

doctors should look beyond their patients' medical needs to see if causes such as food issues, transportation issues, and housing concerns are interfering with health issues. Again, those are representative samples. But the measure developer as you heard in some of the opening comments have been very focused on understanding the impact on patients' families and their caregivers, understanding that they're kind of in this dynamic together.

Member Hoy: Thank you. That certainly is supported by the conversations that we have across our community on a weekly basis, especially over the last two years. And so I really appreciate that.

I also wanted to pull out another concern that I read in the documents, and that was about this concern for screening without accessibility to resources. And I took that really sort of personally. Years ago when my sons were diagnosed with mitochondrial dysfunction, I was screened for maternal depression and was found to be suicidal and then told to walk out of the room with no resources and no anything.

So that hits me really deeply. And yet I'm also really feeling very much that if we don't ask these questions, we are not going to know what resources are needed. So I fear that too. I fear that, and that's a realistic concern that I have and our community has.

But I don't know how else we get started. And so I guess on behalf of this large patient and family community, there's so many things that I've heard and read that make me feel that this is indeed the time to move this forward and these may not be perfect -- aren't perfect. And it's going to require us to keep a close eye on how they get rolled out.

But the reality is -- and I talk to people every day across the country. The reality is if we don't start asking these questions, if we don't standardize these screenings so that there isn't stigma around responding to them, people are going to continue to

die. And I think that COVID highlighted the disparities of care, the influence social determinants have on our health and our outcomes.

I don't see how we can meet any of the other quality improvement goals that NQF is endorsing without engaging the patient and the families' circumstance. You just can't dissect. So in the words of the late great Maya Angelou, she said, when you know, you do better.

We know better. We have to do better. The only way for us to be at clarity is to start screening. The only way to redistribute financial resources and other resources into the community is to understand what the needs of those communities.

So I guess I just really wanted to share the perspective of our community. It's been a hard two years for people around the country. It's been a hard two years for all of you. I know that. But now it feels like the moment. So I would implore my fellow MAP Committee members to push all four forward.

Co-Chair Roberts: Appreciate that. For the sake of time, it does seem that there is kind of a consensus, a lot of support for these measures. I know we have a few other hands raised, but we do have a lot more to get through. So I might ask that we only have a discussion if there is something new that might be brought up. So does anybody have anything new that might change a viewpoint?

Member Sonier: Misty, I do have a question about the measure that is about the screen positive. So whether that is a pay for reporting, like, pay for making that information transparent or is it actually, like, the payment varies depending on the percentage of the provider's population that screened positive?

Ms. Elliott: And Misty, it's Tricia. I'm sorry. And Julie, thank you for your question. That's the next measure. So if we could just --

(Simultaneous speaking.)

Member Sonier: I thought that the motion was to move forward on four. So that's why I jumped in with a question.

Ms. Elliott: Okay, okay.

Co-Chair Roberts: So with that, can we move forward? Should we do the consent agenda where we just ask for any objections to moving forward with the workgroup recommendations for Measure 136 for both MIPS and hospital IQR?

(No audible response.)

Co-Chair Roberts: Okay. Seeing no objections, we will accept the workgroup recommendations.

Ms. Elliott: Okay. So we'll advance the slides to the next measure which is the MUC2021-134 which is Screen Positive Rate for Social Drivers of Health. We did a quick overview. During -- I'll describe the Clinician Workgroup quickly. And then actually we can go to lead discussants. For the MIPS program, there is conditional support for rulemaking. And in the Hospital IQR Program, this particular measure had do not support with potential for mitigation.

Co-Chair Roberts: Tricia, I'm sorry. I'm confused. We are going to go to lead discussants, or are we just going to present the summary of the workgroup findings and comments?

Ms. Elliott: We can do that if you wish. We can do the workgroup. So on the clinician side after -- the agenda was originally set up to discuss 134 first and then go to 136. But then the group decided to discuss the order that we presented here today.

So after the group had voted on 136, the MIPS -- the Clinician Workgroup came back to this 134 measure and voted to recommend conditional support for rulemaking pending NQF endorsement. So as noted, this measure assesses the percentage

of patients who screen positive for health-related social needs. It'll be the first MIPS to specifically address these.

The MAP Clinician Workgroup noted that this measure is to document screen rates for social drivers of health as an important first step in all of that. Some of the comments and themes that came forward, there's many questions regarding the use of the standardized tool and the use of the different questions for different providers. The MAP further stated measures are reported on an annual basis.

And then -- let's see. There's clarification from the measure developer on the domains created were made to closely align with the measures from the Accountable Health Communities pilot. So a lot of the discussion has been captured in those statements as well as what've been covered with a prior measure. Matt, do you have any other additional comments to speak to on the hospital IQR? And then we could go to --

(Simultaneous speaking.)

Ms. Elliott: -- clarifying and discussion. Chip, did you have a comment?

Co-Chair Kahn: We need to hear that.

Ms. Elliott: Okay, yeah.

Dr. Pickering: Yeah, so I think what was summarized is somewhat reflective of what the Hospital IQR Programs are, just going through my notes here. So the MAP provides the do not support for the -- or the do not support with a potential for mitigation here. The mitigation here is contingent upon NQF endorsement to resolve reliability and validity concerns.

And there should be updates to the measure which link the positive screens to actionable interventions conducted by the accountable entity. So even though the hospital worker did recognize the

importance of this measure and obviously reporting out the results, there were a lot of discussion on what providers should do with those results. A lot of the unintended consequences that have been mentioned previously related to resources and not being able to connect patients to certain resources to address those social unmet needs, this led to the MAP to vote down the preliminary analysis which originally was conditional support for rulemaking.

They then proceeded to move to do not support rulemaking with the potential for mitigation. And that mitigation is to link those report outs of social needs, the positive rates, to some sort of actionable intervention. So that is a material change of the measure. And that's why they went to do not support for potential for mitigation.

Co-Chair Roberts: That's helpful, Matt. Chip, I see you have your hand raised.

Co-Chair Kahn: Yeah, I guess I'm really -- I hate to bring up these issues. But I'm looking at Michelle's comments and I think it's very important here whereas the other ones are just asking -- making sure you're asking the questions if I understand the other. Here I guess if you have more sort of negative findings in a sense, then you get a more positive score.

Is that correct? So that in a sense the more people with social -- negative social determinants, the higher the score. Am I misreading that? Or is that what comes out here?

Dr. Schreiber: It's Michelle. Let me try and answer. So what the measure -- and Rocco can correct me. What the measure will do is it will show what is the percent positivity.

In other words, what percentage of patients -- I'm going to call them vulnerable. So they screen positive for any one of these five social determinants. So what percentage of your patients really have vulnerability needs?

As I said at the outside, CMS does not have any intention of either paying for or implying that one hospital or provider is better or worse because they have a higher or a lower percentage of vulnerable patients. And so as we're thinking through these measures, we are thinking about if we were to propose them, how we would craft not so much the pay for reporting because that is basically reporting, but in pay for performance so that we would not penalize somebody who had a higher vulnerability population. As a matter of fact, over time, I suspect the opposite would be true.

Co-Chair Kahn: See what worries me here is that there are findings. I mean, there was a report the other day I think it was in JAMA, was it a letter, that showed that some hospitals that treat lower vulnerability populations actually had much worse quality scores. So what worries me here is where this drives you because on the one hand if you're treating more vulnerable patients so you have a higher score, that's a great thing.

On the other hand, one doesn't show that you're necessarily the best place for them or that you're going to be able to do all those things for them that need to be done. So I guess I'll vote this. I'm not going to -- but I think there are a lot of questions here that need to be very careful about.

And I guess on the MIPS side, it depends on whether you make this a foundational thing or whether it's just one -- I mean, who's going to choose it necessarily? People may self-select in terms of -- if I understand the MIPS program unless you make it foundational. So I think this is all very important. I'm all for it. But I think this is really going to take a lot of thinking as to how to appropriately use the information.

Dr. Schreiber: Your point is well taken. Thank you.

Co-Chair Roberts: Yeah, sorry. I'm going to -- I guess I'm not for sure. You did clarify, Michelle, in the chat and I appreciate that, that the MIPS is pay

for performance and the IQR is pay for reporting. So how exactly do you -- is there a threshold for this, for the pay for performance? I guess I'm trying to figure out because there is no outcome tied to this.

Dr. Schreiber: All of the programs, Misty, are basically one hospital compared to another hospital. So they're all comparative programs, same is true in MIPS. They're comparative programs.

So for example, going back to the other one, the percentage of patients screened, okay, the idea outcome of that would be 100 percent of your patients are screened, right? And so those hospitals who score very high are going to look better in public reporting. And those clinicians who score very high will do very well.

I think the concern that we are hearing is this, what does the percent positive rate mean? So if you have a percent positive rate that is -- and I'm making these numbers up obviously -- that's 75 percent. Seventy-five percent of your patient population shows social determinants vulnerability.

What does that mean? Does that mean you're better? Does that mean you're worse? And the answer is no. It means those are the needs of your population, right?

So again, we are looking at how then might that be incorporated into a program. So could we score it, for example, that you reported the data, yes, no, making the results public. But really the metric is that you have collected the data.

I'm hypothesizing because right now this is a general writing. This is still how CMS implements measures. The question on the table is, is this a measure that should move forward?

But I appreciate the concerns. I definitely do. And again, I just want to reiterate it is not in any way, shape, or form CMS' intent to penalize a provider or a hospital who has a more vulnerable population.

Co-Chair Roberts: Thanks for that. David Baker?

Member Baker: In an ideal world, we should be paying providers more if they're screening a higher proportion of patients and if they have a higher proportion who screen positive. It takes resources to do the screening. And obviously, it takes resources if people have social needs to get them the resources they need to help them.

So the challenge I think that we're in right now is we're starting off with measures rather than starting off with system redesign. And we're trying to use the measures to drive those changes. So it's hard because it doesn't fit neatly into the usual way that we're thinking about measures.

But I am sure you can be creative. I see you nodding your head and we're on the same page. But that's ideal. And that's -- when we're talking about recording and reporting this, that's one of the reasons why it's so important.

I think we should be measuring the screen positive rate by that it's ideally recorded in some way that is actually going to be able to query how many of those people got referrals, right? And you can use it for a whole variety of things. So these are intimately related to be able to have these.

Ideally, you'd have the screen rate, you'd have the screen positive rate, and you'd have the proportion of patients that said yes, I want referral to resources. You capture all of that and you uses those together to drive additional payments for practices with greater social needs who are actually meeting those needs.

Co-Chair Roberts: David Gifford?

Member Gifford: So building off of Dave Baker's comments -- and Michelle, I really appreciate your -- sort of letting us -- you're revealing the conundrum you're in with this measure. I guess the question that we're asked to do is, is this measure

ready for rulemaking in MIPS or the IQR program? And what I've heard you say is you don't know whether high or low on this measure what it means for either inclusion in the IQR program or inclusion in the MIPS program.

And you said that the MIPS program is about measures are used for payment. Now if it was that some measures, it's going to increase payment, then I can see -- as Chip said earlier on, it makes sense to include this measure. And given Dave Baker's comments, if you have higher on the measure versus -- and not punishing anyone. But if you're not sure how it goes, it sounds like you want to use it for a risk adjustment purpose and neither of these programs are about designing for risk adjustment purpose.

So I'm really torn with how to vote on -- I mean, it's clear how to vote on the previous measure. This one, I'm really torn with how to deal with the measure and to David's point, the issue. So is it really ready for even rulemaking for us to review on it because it's not clear what rule it even fits in or how you think about redesigning these programs to include that.

So I'm sort of inclined to say I don't support this for rulemaking at the time with a very strong recommendation I think you need to pursue it in some way. But it just sounds like it's just not quite ready for the rulemaking on that angle. And I feel uncomfortable saying, yes, it's ready for rulemaking given the ambiguities that are here.

And not to confuse that with -- the public comments were compelling. I think everyone agrees that frankly we could do more improving the health of the country by targeting on this and addressing this. So that's not the issue here. It's really again how it fits in the existing rules and what you have available.

(Simultaneous speaking.)

Member Gifford: Maybe you'll clarify and sway me one way or the other on the vote here.

Dr. Schreiber: So just to be clear, we're not using this as risk adjustment. What I'm saying is that CMS would look at how to -- would use this measure but look at how to score it within a program. So you can score a measure a certain way.

It can count for points. It can count high or low. So I think that's up to how a measure would be used within a program. What I'm hearing is that there are -- that people have thoughts about how it should be used or could be used in a program.

Co-Chair Roberts: Heidi, did you have additional clarifying questions?

Member Bossley: Have we moved beyond questions? I just have a couple comments because again I want to stress these measures are so important as we all know. And I think the goal is to make these as good as possible so we are successful in implementing these.

And so if I had seen this measure come forward similar to other measures that we see in MIPS that look for screening, use an tool that works for you, and then we pair it with a plan of action and you've done something, I think I personally would have less discomfort moving these measures forward, using different tools, not knowing if we can map and then known that in MIPS it will be benchmarked. So I think that's why I found the conditions that the Hospital Workgroup put on the measures -- this measure specifically appealing, especially if they haven't fully tested the measure yet. There is an opportunity, I think, for them to think this through and maybe wait on a positive screen because we don't know what this means and move forward with something that looks at the action component which is, I think, partly what we all want to get to.

And also, Michelle, to say AMA has talked to you about other ways to benchmark MIPS. I think they'd

be more than happy to talk to you how a measure like this could also work.

Dr. Schreiber: Yes, I'm sure, Heidi. Thank you.

Member Bossley: Because it's an ongoing struggle, right? So if there are other opportunities, they are more than happy to work with you on it.

Co-Chair Roberts: Parul?

Member Mistry: Yeah, just one comment. I feel that personally it takes a lot of courage for somebody to say I need help with food or I need help with housing. And if we don't have a positive rate with an action, it's just going to cause them to lose trust in the healthcare system. And they may not want to report it again if they leave their physician's office without any positive experience. So that's my concern about not putting any actions tied to it.

Member Peden: I have a question.

Co-Chair Roberts: Carol?

Member Peden: Yeah, I mean, a comment really and a further question to Michelle. Just I mean I go back to some of the comments we heard that without data, we can't drive improvement. And I think that's absolutely central to what we're talking about here. And it sounds to me like CMS' goal here is to get more data about where the needs are in regards to the hospital question. And can you just clarify that again, please, Michelle?

Dr. Schreiber: That's certainly a true statement, Carol. We hope that hospitals, organizations, clinicians, I mean, I will broaden this to the entire healthcare ecosystem. We hope that everybody will start screening for social determinants because of their importance.

And the positivity rate is important to understand what the needs really are. So you are correct. We do need data. We have to start somewhere.

Over time, we have to tie that data to performance -- to payment. But this is kind of a stepwise approach to social determinants. But this is a start.

Co-Chair Roberts: Emma?

Member Hoo: Thanks. Speaking from a purchaser perspective, I feel that if we're going to be looking at screening rates but not asking for the positives, we're burying our heads in the sand. I mean, I think we need to understand the data and to look at the magnitude, have information for comparison and geographic exploration in order to build the capacity to have the systems that provide the actions and the referrals and the resources to be responsive to the community needs.

Absent knowing what the positive rates are, what good does the screening rate really accomplish? So having this disconnect about not supporting the reporting of the screening rates just seems to me delaying the possibility of crystalizing some of the changes that we all conceptionally know need to be made in delivery. So not having this as part of this reporting process seems like a step in the wrong direction.

Co-Chair Roberts: Leah?

Member Binder: I agree with Emma. I would just add one piece of this which is I guess it's really a question for Michelle too. Would you see this as an opportunity -- a factor that could be used to stratify other quality data? Because we talked about in that earlier health equity measure, for instance, how it's important for health systems to stratify their data. So there's many uses for this in the long run. But we first got to start collecting it and really analyzing it.

Dr. Schreiber: Yes, Leah. I would agree with you. As we talk about stratifying data, many of us have had these conversations, maybe are doing it. How do we stratify data? Is it race? Is it ethnicity? Is it dual eligibility?

Is it -- there are many factors. Screening positive for these social determinants could absolutely be a factor in stratification. But you can't do it if you don't have the data.

Member Binder: Right.

Co-Chair Roberts: Margareta?

Member Brandt: Hi, yes. Margareta Brandt with Covered California. I wanted to echo many of the things Emma said. I think we just -- if we don't have this data, many purchasers are not going to know kind of how to redistribute resources and how to adjust payment, things like that in the future. And I think I'm a little bit concerned that we would support the prior measure without supporting both of these measures for MIPS and IQR and reporting that screen positive for both programs.

Just I think it's really important to know how many screen positives so we can know how to address the issues and how to move forward. And I think with the piece about action, I think that maybe is the potential future iteration of this measure or of another measure. But I don't think it should hold up this measure because this measure provides us data whereas we could have potentially another measure or a future iteration of this measure to tie to action.

And I will just note that many purchasers are already moving on the path of implementing and requiring social needs screening, social determinants of health screening. So this is kind of not new for many health plans or potentially providers. And it would be great to have more alignment about the measures that we're using.

Co-Chair Roberts: David Baker, any new information to ask or share?

Member Baker: Just a comment on what people have been saying. I think this is -- these measures are really a good start to get us moving forward. But if we're talking about adjusting payments or any

of these other things, we're going to have to have standardized questions.

Better be thinking about that pretty soon because you remember right now people can choose whatever instrument that they want to use. That's what we heard. But from what I'm hearing -- and I agree. This is something that could be used for adjusting payments. It could be something that is used to adjust performance measures, a whole variety of things. But you can't do any of those things if people are just choosing whatever measure.

Co-Chair Roberts: Amir, anything new?

Member Qaseem: Oh, God. I mean, my brain is tired and fried by 6:00 o'clock. But is there anything new? I mean, Michelle, I hear you and I hear the measure developer. Guys, this is so important.

But I'm struggling, I think, what David said. That's the bottom line. We have to think about we are talking today about MIPS and IQR program. Let's go back what's the fundamental question.

And I'm struggling if we are there yet, just gathering this information, Michelle. And we're going to ask patients to get all this information and then we're not going to do anything about it. I don't know.

I mean, do we need to gather this data? Perhaps, but I don't think not under MIPS, Michelle. It's not there yet, and I haven't heard any convincing argument.

And so Misty, going back to anything new, I am struggling with the workgroup conditional support right now. I feel like that needs to be the same as IQR. But I think that's what we're going to vote on. I lost track on what we're doing anymore, but just to bring that up.

Co-Chair Roberts: Thanks. And I am going to give

the last comment to Chip.

Co-Chair Kahn: Okay. I hate to be a spoiler. But when we look at the -- getting to David's point, when we look at the S-10 on the cost report which is supposedly accounting, we see across hospitals without having standardization, tremendous differences in terms of what's charity care, what's uncompensated care. And that plays actually right to this, that if you don't have an assurance of a common creation of the information, frankly, I love what everybody is saying, but it's garbage in, garbage out.

So we really need to be very careful here. This isn't accounting data, but at least those are numbers. Here we're dealing with data that's much more difficult to deal with.

And we will get very rapidly once it's available to the issue of how it should affect payment. And so I think we have to be very, very careful. That's my two cents.

Member Baker: Can I just clarify? Sorry for interrupting, but people are saying that I was arguing against something. My feeling is that organizations need to go forward. They need to set up these programs for doing the screening. They need to be able to record it in a systematic way.

Co-Chair Kahn: I agree with that. That's what I'm saying.

Member Baker: Yeah. But I'm saying we're talking two steps down the way. And the current measures are not going to get us where we need to. They're not going to really provide something auditable to know that patients actually got the referral. They're not going to be standardized for risk adjustment for payment.

So this is kind of the approach that we like to take with the joint commission. Get structures in place, right, and then build on them. But we're going to --

we should start the building now because there's a lot of really ambitious plans. And there's going to need to be standardization. That's all I'm saying. I'm in favor of the measures.

Co-Chair Roberts: Lastly, if -- let's see. Is there anything else, the measure developer?

Dr. Pickering: Yeah, Misty, there was a -- sorry, there was a question from NCQA and maybe the measure developer to respond because I think there was some -- also some discussion on screening without action required. But the question from NCQA here was, why is this measure being considered as two separate measures as opposed to a single measure with two indicators, as interpreting a positivity rate without looking side by side with the screening rate could lead to a significant misinterpretation. So I'm not sure if that is something the developer would like to respond to.

Mr. Perla: I can take that. Also maybe circling back on the other question around the tool use that there is some evidence that's been submitted to, I think, support the conversation. We'll just say the reason that the measures have been submitted in tandem is that's exactly how they were implemented.

And so I think to David's point around building off of progress, the AHC model has been up and running for five years. So there's that foundation. But to answer NCQA's point, the screening measure and the screening rate were implemented together in the program. And so we focused on how the measures were implemented.

The other point that's really important is that the minute you separate these two measures, you immediately enter a slippery slope when it comes to the psychometric data. It is not possible to validate a tool where you're just looking at the screen but not the output of the screen. And that was the whole conversation we had earlier on.

So the rationale for coupling the measures and

introducing them together is that's how they were tested. That's how they've been validated in the research literature. And that is how they've been implemented. So I'll stop there for that point.

Member Binder: Rocco, there's questions coming up in the chat that I think it'd be good if you could use it which is this issue that we talked about earlier about how do you know if you're using different screening tools that they're comparable when you're looking at those five elements.

Mr. Perla: Right. And I think that was part of the conversation we had earlier --

Member Binder: Right.

Mr. Perla: -- to your question was there is evidence to suggest that many of these tools that have been in practice for some time, whether it's AHC, PRAPARE, the Your Current Life Situation, that there is evidence that they demonstrate and produce consistent findings. Is it perfect? Absolutely not. Could it be better? It will and it should be.

And so I think a little bit to David and even Chip's comments around what are we building here, how do we begin to sort of collect that data so that we can improve these over time. It is going to be very difficult to improve anything over time if the measures aren't introduced. I think I've heard a commitment from CMS to really sort of work through some of the more nitty gritty specifications in terms of how this stuff gets integrated into different programs. But without collecting that data, we will not be moving forward. We'll be kind of standing still.

Co-Chair Roberts: Okay. So I am going to suggest that we move forward with a vote. And because I am honestly -- I feel like there are a lot of mixed thoughts here. I am going to -- I do see that there is some wording changes that have been suggested.

But I might suggest that we go ahead and move

forward with voting on the workgroup recommendation because I frankly can't tell how we're going to vote. So specifically for MIPS for 134, the screen positive rates, vote on the workgroup recommendation of conditional support for rulemaking. And if we can clarify that conditional support because I do think that there were a few elements to that.

Member Qaseem: Misty, can we add David G.'s suggestion, the text as a condition? Or we're not allowed to do that?

(Simultaneous speaking.)

Co-Chair Roberts: That's a good question. Go ahead.

Member Gifford: I was going to say since I was suggesting some language, I want to retract that. I want to go back to Leah's point about we start with accepting the workgroup recommendation, vote from there. I also think that the minutes and notes and conversation from this are always captured by the staff.

And the CMS staff, not just Michelle, her whole team has been very respectful in sitting throughout this lengthy meeting and listening to this conversation and hearing us. And I think we need to take Michelle on her word of how they're looking at considering it. So I think we should start out with the voting of this.

And if we feel after voting on that we need to go back and add any additional language, fine. But I don't feel there's a need, at least for the MIPS side of it where it's conditional support for rulemaking. We may want to think differently about the voting on the IQR program given the conversation we've had. So I would not say we need to wordsmith additional comments at this time.

Co-Chair Roberts: Okay. So Tricia or Matt, can you clarify the conditional support, though? I do (audio

interference) understand that.

Ms. Elliott: Sure, Misty. On the MIPS side, the conditional support from rulemaking pending testing of the measures reliability, validity, and NQF endorsement.

Co-Chair Roberts: So --

Ms. Elliott: And this is what came from the workgroup. So --

Co-Chair Roberts: Okay.

Ms. Elliott: -- that was the condition.

Co-Chair Roberts: Okay. So just to clarify because my brain is foggy now, there is a suggestion from David, additional conditions. We do recognize that CMS will take into consideration the discussion. I don't know if that has to be included as a condition for the voting or if we just vote since it's not going to change the vote.

Ms. Elliott: Yeah, I think David verbally withdrew those comments for consideration.

Co-Chair Roberts: Okay.

Ms. Elliott: So it stands with NQF endorsement with the validity and reliability testing. Am I correct, David Gifford? Yeah? Okay.

Member Qaseem: And Misty --

Co-Chair Roberts: Thank you.

Member Qaseem: -- the only thing is there was a rich discussion on there needs to be a link. It's not just about capturing the data, right? And we're not even communicating that in any way. I mean, ultimately, that's just what I guess. But that's a missing link still.

Co-Chair Roberts: So let's vote on the workgroup recommendation of conditional support for

rulemaking, specifically for MIPS for Measure 134, Screen Positive Rate.

Ms. Elliott: Susanne, can you pull up the vote? Thank you.

Ms. Young: Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the MIPS program. Do you vote to support the workgroup recommendation as a committee recommendation of conditional support for rulemaking?

Co-Chair Roberts: Looks like we have 19 results. I think we can close it out.

Ms. Young: The vote is now closed for MUC2021-134, 17 committee members voted yes and 2 committee members voted no. The Coordinating Committee upholds the recommendation of conditional support for rulemaking with 89 percent yes.

Co-Chair Roberts: And for the next one, same measure, 134, Screen Positive Rate for the IQR program. The workgroup recommendation was do not support with potential for mitigation. And Tricia, can you clarify that potential for mitigation?

Ms. Elliott: Yes. Matt, can you speak to that on the hospital side? Thank you.

Dr. Pickering: Right. So the mitigation here was -- it was contingent upon NQF endorsement to resolve any reliability and validity concerns with the measure. But also that the measure should be updated to have a link to a positive screen to some sort of actionable intervention conducted by the accountable entity. So it's NQF endorsement but also that the positive screen is linked to some sort of actionable intervention that can be conducted by the accountable entity.

Co-Chair Roberts: Thank you. Can we move forward with voting on this one?

Ms. Young: Voting is now open for --

Member Gifford: Can I -- sorry. Can I raise my hand? I have a question.

Dr. Pickering: Yeah, David Gifford, you had a question?

Member Gifford: I just want to clarify. So one is if we vote not to support this, then we have a discussion about what we would support. And I guess I'm raising the question as, why do we vote not to support this for IQRP but we did vote to support for MIPS? How does that -- what's the difference between why we would support the recommendations differently coming forward from the workgroup?

Member Binder: I think because MIPS is used for payment and this is used for reporting.

Member Gifford: Right. But --

(Simultaneous speaking.)

Member Gifford: -- if we vote for MIPS for payment, we just voted okay with --

(Simultaneous speaking.)

Co-Chair Kahn: No, but it's voluntary.

Member Gifford: -- endorsement.

Co-Chair Kahn: It's still -- unless they make it foundational, it's still voluntary, right? You don't --

Member Binder: Right, right.

Co-Chair Kahn: So the hospitals will be required to report this. And that's why they were concerned.

Member Gifford: Okay.

Co-Chair Kahn: And they also wanted to make sure as to how it was going to be used.

Member Gifford: Got it. That's a helpful distinction, Chip. Thank you. I couldn't wrap my head around why they were different. Okay. That's very helpful.

Co-Chair Roberts: Heidi, did you have another comment?

Member Bossley: I just -- I don't know where this vote is going to go. But say that the do not support for potential for mitigation stays for IQR. We're sending mixed messages to CMS and the developer which is, to me, a concern.

So I feel like there's always the potential for any measure that's in IQR to eventually move into VBP or anything else. So when I look at this, I am looking at it assuming it could move forward in the future for payment purposes. And so that's again why I feel like this measure is not yet ready for prime time.

The issues with standardization across the tools and understanding what a positive screen, using PRAPARE versus AHC or anything, means. In practical use, using measure testing the way we typically see come through MAP, we don't have that yet. And to me, do not support for potential mitigation lets us see it, have another chance to look at it before it goes into a program, MIPS or IQR. So to me, this is the right recommendation because we don't know yet the full story with the measure.

Co-Chair Roberts: Leah?

Member Binder: I think we have to get started. It's not different for hospitals. It's difficult. The nature of social determinants of health is that there is no one solution. We're never going to be able to say to physicians, here's how you solve the problem. Let's uncover it.

I'll go back to domestic violence. I did a lot of research on that. And physicians don't like to ask because they don't like it because then they get the

answer and they don't know what to do. What they have to do is connect the resource, et cetera. It's really hard. It's not easy. But it's critical. And that's the direction that we need to go.

If these screen tools are being used, and we ought to look at the results. And those results ought to be something that's available. I think anyone would know that in reading this IQR, for instance, that it's not necessarily going to reflect badly on a hospital if they have a high score. But it is going to be a really important piece of data to use, understanding there are other quality measures and looking at them and stratifying them and really understanding on a different level how a hospital is dealing with the actual patients they see.

Co-Chair Roberts: Thanks. I do think we should move forward with voting on the workgroup recommendation of do not support with potential for mitigation.

Co-Chair Kahn: Let's see what happens.

Dr. Pickering: All right. We'll move forward to the vote.

Ms. Young: The voting --

(Simultaneous speaking.)

Ms. Young: -- is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the Hospital IQR Program. Do you vote to support the workgroup recommendation as the committee recommendation of do not support with potential for mitigation?

Co-Chair Roberts: Okay. I think we have enough votes in.

Ms. Young: The voting is now closed for MUC2021-134, Screen Positive Rate for Social Drivers of Health for Hospital IQR Program, 10 committee

members voted yes and 9 committee members voted no. The Coordinating Committee did not support the staff's recommendation of do not support with potential for mitigation 53 percent yes.

Co-Chair Roberts: So with that, I think the next step is to -- well, I guess there's two options. I guess we can move forward with the lead discussants and maybe ask to bring forth any additional information that has not been shared and then also potentially have a recommendation.

Co-Chair Kahn: Or we could have no recommendation. I think that's an alternative because I think that there's no new information from discussion. But there is the point that Heidi made that, I mean, frankly as important as this is, it's a pig in a poke until we see a lot more. So we could just go with that vote which is that we didn't come up with anything.

Member Baker: I didn't think that was an option, Chip, by the rules.

(Simultaneous speaking.)

Co-Chair Kahn: Do we have to have a recommendation on everything?

(Simultaneous speaking.)

Co-Chair Roberts: -- Tricia?

Ms. Elliott: Correct. So --

(Simultaneous speaking.)

Ms. Elliott: -- go ahead, Matt.

Dr. Pickering: Go ahead, Tricia. Oh, okay. So I was going to say that's correct. We need to provide a recommendation for these measures.

If this Coordinating Committee cannot come to consensus on a decision category, as a reminder, the workgroup decision will stand. So that

workgroup decision again was the do not support with the potential for mitigation. So if there's no consensus that the Coordinating Committee can gain on any of the decision categories, the workgroup decision or recommendation will stand.

Co-Chair Kahn: Well, then it depends on how you -- so let's say we do conditional support for ruling. If the ten people hold or even a large proportion of them hold, you're not going to get to 60 percent. And then I guess the ten is default.

Member Baker: I don't think we know how the vote is going to go, Chip. People could've voted no for different reasons.

Co-Chair Kahn: Okay. Then I guess we should -- I assume the only thing to put up as an alternative is conditional support because you're not going to do not support, so --

Member Baker: Right.

Member Walters: I would like to get this going and make a motion for the same thing, conditional support with the conditions we mentioned earlier. Let's vote on that.

Co-Chair Kahn: Let's see what the vote is.

Co-Chair Roberts: So Chip, you second that?

Co-Chair Kahn: Yes, second.

Co-Chair Roberts: Okay.

Dr. Pickering: Okay.

Co-Chair Roberts: Let's vote.

Dr. Pickering: So just to clarify, that conditional support, the condition is NQF endorsement which would consider the reliability testing of the performance measure.

Member Walters: Absolutely.

Dr. Pickering: So there was a motion for that and then second from Chip. We can go to the vote.

Ms. Young: Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the Hospital IQR Program. Do you vote conditional support for rulemaking?

(Pause.)

Ms. Young: Voting is now closed for MUC2021-134, 15 committee members voted yes and 4 committee members voted no. The Coordinating Committee votes to -- for conditional support for rulemaking with 79 percent.

Co-Chair Kahn: Okay. So let's move quickly then to the physician -- the clinical -- the clinician part.

Ms. Elliott: Yes. Chip, there's been a request from the Committee for a quick five-minute probably bio break.

Co-Chair Kahn: Okay.

Ms. Elliott: We'll move quickly then. We'll keep that to five minutes, so 6:12. And we will move to the Clinician Workgroup with a consent agenda. There's 11 measures to review.

Co-Chair Kahn: Okay.

(Whereupon, the above-entitled matter went off the record at 6:08 p.m. and resumed at 6:14 p.m.)

Co-Chair Kahn: Okay, let's get started everybody. So take it away, Tricia.

Ms. Elliott: Okay. So, clinician programs is the last group that Measures will be discussing today. Next slide, please.

I want to open it up for public comment on the clinician programs, if there's any open comment before we start discussing the measures.

(No response.)

Ms. Elliott: Okay. I don't see any hands being raised, and I do not see anything in the comment. Chip, are you okay if I proceed?

Co-Chair Kahn: Ready to go.

Ms. Elliott: Okay. So, for the pre-rule recommendations for the clinician program, this slide shares the programs that the measures are included in.

Today we have measures in Medicare Part C and D ratings and the Merit-Based Incentive Payment Systems. Next slide, please.

The Clinician Workgroup meeting themes, there was a few themes that came out of the Clinician Workgroup. One was alignment of the Shared Savings Program with the APM Performance Pathway.

So the MAP Clinician Workgroup expressed concern for unintended consequences by reporting on all payer data in SSP, particularly for FQHCs or those that care for a disproportionately disadvantaged population.

The workgroup also noted that the social driver measures would fit well within the SSP, so we have already discussed the social driver measures, so just for the record, we don't have to circle back on those.

Feedback on the measurement approach, the workgroup expressed the desire to evaluate measure performance across programs and the rates of performance across programs at the clinician level versus the ACO level are of particular interest. Next slide, please.

So, we will do a consent agenda. There are 11 measures within the clinician program. I'm going to walk through ten of the measures and include those

on a consent agenda.

The one measure we'll pull out is MUC2021-063, which did receive a do not support, but all of the other measures received support or conditional support.

Pre-Rulemaking Recommendations for Clinician Programs

MUC2021-053 Concurrent use of Opioids and Benzodiazepines (COB)

I'll start with Measure 053. The MAP supported this measure for rulemaking, and it is the concurrent use of opioids and benzodiazepines.

This NQF-endorsed measure addresses the prevention and treatment of chronic disease, high-priority care, which are of concern with CMS.

The measure has been updated since its initial endorsement in 2028, and has no competing measures that address both the same focus and same target range.

And just to clarify, this measure is the percentage of Medicare Part D beneficiaries ages 18 or older, with concurrent use of prescription opioids and benzodiazepines during the measurement period.

The next measure, we did receive public comments on those, and it was split between support and do not support.

Much of the support spoke to that there is a measurement gap and low burden, and do not support spoke to some unintended consequences of discontinuing meds and substantial risk for patients who need medications.

MUC2021-056 Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

The next measure is MUC2021-056, Polypharmacy,

Use of Multiple Anticholinergic --sorry about that -- Medications in Older Adults, the Poly-ACH measure.

The MAP offered conditional support for rulemaking, pending NQF endorsement.

This measure addresses polypharmacy of ACH active medications in older adults, and the effective communication and coordination of care and effective treatment of chronic diseases, a high priority for Part D measure consideration.

The MAP Clinician Workgroup encouraged CMS to monitor potential negative unintended consequences due to the denominator definition raised by the commenters.

Concerns were raised regarding prescribed versus over-the-counter medications and some concerns for the unintended consequences during the workgroup discussion.

The public comments came in. We had about six public comments.

The majority were in support of the measure, and spoke to some negative potential consequences of implementing the measure, but believe elderly potential for unintended consequences to patient care must be continuously monitored.

MUC2021-066 Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

The third measure on this page is 066, and this one is Polypharmacy, Use of Multiple Central Nervous System, or CNS-Active Medications in Older Adults.

The MAP workgroup members started the discussion with questions regarding exclusion criteria, however the MAP offered conditional support for rulemaking pending NQF endorsement.

This measure addresses the polypharmacy of the CNS-active medications in older adults and effective

communication.

The MAP Clinician Workgroup encouraged CNS to monitor potential negative unintended consequences due to the denominator definition raised.

So concerns regarding the data capture of medication use in nursing homes, as well as distinction between short stay versus long stay.

But this particular program of course is in the MIPS program -- or I'm sorry, the Part C and D ratings program.

Okay, so next slide. Does that shift to MIPS? Okay, can we go back one slide?

Chip, I'm thinking we could pause here because these are the measures that are under Medicare Part C and D ratings program.

Do we want to do consent agenda on these measures within this program, and then we can move into MIPS?

Co-Chair Kahn: Sure, if there's no objection.

Ms. Elliott: Okay.

Co-Chair Kahn: Any objection?

(No audible response.)

Co-Chair Kahn: Okay, so is that done, then?

Ms. Elliott: These three measures would be done, unless there's clarifying questions or --

Co-Chair Kahn: Yeah.

Member Goodman: Yeah, so Chip, I don't -- yeah, I don't have any clarifying questions, but I just think it's important to say, you know, we are among the public commenters, we are concerned about potential negative effects for people who actually need these medications and some of the

specifications of the second two.

I'm not going to go deeply into it at 6:22, but just felt like it was important to say it.

Co-Chair Kahn: Okay. Well hopefully CNS will be sensitive to that.

Member Goodman: And do we --

(Simultaneous speaking.)

Member Mistry: Yeah, this is Parul and I would agree with that comment.

I just feel that while there were exceptions noted in the denominator, it does not completely capture all the possible clinical scenarios that would be able to meet that exception criteria.

Ms. Elliott: Okay. And there's a few hands raised. David Gifford?

Member Gifford: Yeah, I had a question for the measure developer, if they're still hanging around.

There were a number of comments that I was reading, that the way the measure's structured -- and I didn't quite understand it --it sounds like the numerator and denominator are very similar in that as you get better on this measure, your denominator shrinks, which has the unintended effect of potentially making you look a lot worse.

Have they looked at that phenomenon? Is that a theory? Is the number so big that that's just more theoretical?

What actually happens on that, because that was the one thing that I couldn't understand how the measure's constructed with that.

Mr. Shirley: Yeah. Hey everyone, this is Ben Shirley with Pharmacy Quality Alliance, the developer.

We've got three measures up there. Can we clarify

just the third?

Member Gifford: It's a comment on all three measures.

The denominator is person years, who has received two or more of these bad drugs, or these drugs, and the numerator is anyone who's received two or more of these prescriptions in the target period.

So it looks like, you know, one is person years, and then whether they received two or more, and so as you get fewer people who have two or more, the denominator shrinks, and you have a smaller denominator, you're going to have a potentially higher percentage with a number in there.

At least that was my understanding of the public comments that came in on the measure.

Mr. Shirley: Yeah, so I certainly appreciate that question. I'm going to make it concrete in the context of that first measure, the COB, just so we're sure that we're speaking the same language here.

But really, so the purpose for creating this denominator, which is individuals who have exposure to opioids, is to create a target population, right?

This is a measure where we want to have an eligible population that's at-risk for this harm, which is concurrent use.

So basically this is going to allow plans to have a much more targeted approach towards intervening and, you know, tracking these patients.

This is a pretty common construction of measures for medication use in Part D. It's a denominator that's used in several other opioid measures.

Currently used in the Part D displays, it's NQF-endorsed, and is used in Medicaid, this measure, as well.

So the phenomenon that you're talking about, it is basically theoretical to use the word that you mentioned. It has not been borne out in some of these other current implementations.

Essentially what would depend -- it's about the ratio of people you're de-prescribing and how many of them would be in the numerator, anyway.

If you assumed that all the people you were de-prescribing weren't in the numerator, then it would affect it one way, but if they are in the numerator, it affects it another way.

It's sort of more theoretical than it is an actual practical operational concern. Is that helpful?

Member Gifford: Yeah. Thank you, yeah. I mean, it'd have to be a really small population, and mostly plans are --(Simultaneous speaking.)

Mr. Shirley: This is a health problem --

Member Gifford: I wanted to verify that, so thank you, Ben.

Mr. Shirley: Great.

Co-Chair Kahn: Did David have a --

Member Baker: Just a quick comment. I agree there are these always concerns about people who actually need these medications, but -- and you can't adequately exclude them from the denominator, but it tends to be a very small group, and it really doesn't affect the performance and the measures or comparisons of groups.

We've seen that and written about that, so valid concerns, but I don't think it should affect our view of them.

Co-Chair Kahn: Okay, Janice?

Member Tufte: I was on an innovative Innovative Accelerator project measurement set development

in 215. I think this MUC-053 -- is it the same one? Is that true, Ben? Is Ben on there?

Because if that's the case, it's been on for quite a bit. I mean, it's been used in the state level in the Innovative Accelerator project.

And one reason it is is because there's high rates of, you know, overdose. There's a much higher rate of overdoses within those two.

Thank you. Ben didn't answer, I don't know where he went, but.

Mr. Shirley: Oh, I'm still here. I'm actually not exactly sure what specific program you used.

I know it is used in a variety of state-level Medicaid programs, so it's entirely possible.

Member Tufte: It would be the same, I'm sure. I actually was the one that initiated it in that program, but it was innovated with the Accelerator project, SUD, yeah, we found out PQA did it.

So anyway, it's a very important measure. I just want to say, you know, I'm very involved with homelessness and other issues, and it's very important to be aware of this, so thank you.

Co-Chair Kahn: Okay, are there any other questions or points to be made?

(No audible response.)

Co-Chair Kahn: Well, Tricia, I think we can -- I mean, can we pass this without objection, the package, or does anyone want to have a vote? I mean, a formal vote.

Member Sonier: We might want to have a formal vote just to confirm that we have enough people.

Co-Chair Kahn: Okay. Well let's have a formal vote, then, on the three as a package. Can we go ahead and do that?

Ms. Elliott: Yeah, we're just checking on that Chip, but we don't necessarily have a vote set up for all three.

Co-Chair Kahn: Well, if we do vote on one, and we understand that it's a package, we did that before.

Ms. Elliott: Okay.

Co-Chair Kahn: Then you could just vote on the top one, 053, but everybody needs to understand we're really voting on 053, 056, and 066.

Ms. Elliott: Then carry those votes over. Okay. So Susanne, if you can pull up MUC2021-053?

Ms. Young: Voting is now open for MUC2021-053, Concurrent use of Opioids and Benzodiazepines.

Co-Chair Kahn: Oh I got it, okay. Great. You all are doing really well.

Ms. Young: For the Part C and D Star Ratings program.

Co-Chair Kahn: We got to 17.

Ms. Elliott: Seventeen.

Co-Chair Kahn: And I assume from the discussion that we can probably close it and look at our responses because we got to roll here. And we got more than 60 percent.

Okay, what's up next?

Ms. Elliott: Can you read the results, Susanne?

Co-Chair Kahn: Oh.

Ms. Elliott: We just have to read the results out loud.

Ms. Young: Yeah. Can you hear me?

Ms. Elliott: Yes.

Ms. Young: Yeah. Fourteen committee members responded yes, and three committee members responded no for a total of 82 percent.

Co-Chair Kahn: Okay, good consensus.

Ms. Elliott: And we'll carry those over to the other two measures as a consent agenda. That was kind of a package deal. Okay.

Co-Chair Kahn: Okay.

Ms. Elliott: Ready for the next group? We have MIPS.

Co-Chair Kahn: Yeah, let's go.

MUC2021-125 Psoriasis, Improvement in Patient-Reported Itch Severity

Ms. Elliott: Okay. Measure MUC2021-125 Psoriasis, Improvement in Patient-Reported Itch Severity, the MAP offering conditional support for rulemaking pending NQF endorsement.

This measure under consideration is a patient-reported outcome for a psoriasis symptom, complementing an existing measure in a set of psoriasis disease activity.

This measure would be outcome measure in the MIPS dermatology set and as a patient-reported outcome. It's consistent with CMS's Meaningful Measures Initiative.

All right, catching up on my notes here. There is two public comments in support of the measure.

MUC2021-135 Dermatitis Improvement in Patient-Reported Itch Severity

Next one, 135. MUC2021-135 Dermatitis, Improvement in Patient-Reported Itch Severity. The MAP offered conditional support for rulemaking pending NQF endorsement.

This measure under consideration is also a patient-reported outcome for a Dermatitis symptom.

This measure would be an outcome measure in the MIPS dermatology set as well, and as a patient-reported outcome, it's consistent with CMS's Meaningful Measures Initiative.

The MAP Clinician Workgroup was encouraged to see another PRO proposed in this program.

The advisory groups found no concerns with the measure regarding relative priority or utility data collection, measure calculation, or unintended consequences.

MUC2021-063 Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)

Measure 063, care -- hold on one second -- 063. That is the one that we'll pull out separately.

Do you want me to introduce it now, and then we'll introduce discussion later? Skip that one for now?

Co-Chair Kahn: Nope. Let's roll through everything that we're going to read, we're going to do together, and then we'll come back to that.

Ms. Elliott: Okay. So we'll come back to that one, so we'll go to the next slide, 107.

MUC2021-107 Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

So MUC2021-107, this is Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure.

The MAP offered conditional support for rulemaking pending NQF endorsement.

This patient-reported outcome measure addresses the quality priority of patient-centered care in the CMS Meaningful Measures Framework, the use of the joint specific patient-reported outcome measure, instruments, incorporate shared decision-making and orthopedic surgery, and with a potential to improve patient health outcomes.

There is some discussion regarding the ability of this measure to be properly and fully reported on within the time frame provided, 300 to 425 days.

The measure developer clarified the 310 to 425 day follow-up is a recommendation based on significant stakeholder input, and addressed that concern.

Due to dropoff in data collection from the pre-op window, expectation is that a shift in the post-op window would in fact enhance post-op data collection, and increase response with both pre and post-op data.

Those topics were discussed during the meeting. And we did receive seven public comments on this measure.

And some were concerned with the data collection burden, increased implementation burden, and produced scores that may be confusing to end users.

Most spoke to the data collection burden because of the surveys. Okay.

MUC2021-090 Kidney Health Evaluation

Next measure is the MUC2021-090 Kidney Health Evaluation. The MAP offered conditional support for rulemaking pending NQF endorsement.

This measure focuses on nephrology and the critical condition of diabetes, both identified as gaps within the MIPS program and considered priority areas for future measures.

This measure will also replace and improve upon the

existing HEDIS medical attention for nephrology measure.

Some of the discussion commented that this measure's already been accepted by HEDIS and is being considered in the Core Quality Measure Collaboration, CQMC, to be added to the PCMH ACO set, and is already being used by health plans.

And there was expressed support of the measure, and yep. Okay. So that's that one. And there were 11 comments on this particular measure. Most public comment was in support of the measure.

MUC2021-127 Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Measure MUC2021-127, Adult Kidney Disease, Angiotensin Converting Enzyme, ACE, Inhibitor or Angiotensin Receptor Blocker, ARB, Therapy.

The MAP supported this measure for rulemaking.

The measure concentrates on nephrology and the critical condition of diabetes, both identified as gaps within the MIPS program, and considered priority areas for future measurements.

The workgroup members commented on an observation from the Health Equity Advisory Group in relation to burden on providers to report the measure, specifically the chart detail needed to understand exclusions.

However, the measure developer clarified that measure elements could be collected electronically and would not require an extensive chart review by the provider.

This particular measure received four comments, two of the four comments were I support of the measure. Okay. One twenty seven.

Co-Chair Kahn: Is that the last -- oh wait, the last one.

(Simultaneous speaking.)

Ms. Elliott: Yeah, I think we have two more.

Co-Chair Kahn: Yeah.

Ms. Elliott: On the next slide.

Co-Chair Kahn: One hundred and five and 058.

MUC2021-105 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Ms. Elliott: Yep. Okay. So 105. So MUC2021-105, Mismatch Repair or Microsatellite Instability Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma.

The MAP offered conditional support for rulemaking pending NQF endorsement, and specifically the review of the upcoming review of the guidelines.

The measure addresses the priority area of pathology for patients with Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma.

This process measure addresses gaps in biomarker testing for specific cancer types, leading to a potential increase in personalized care.

There was questions regarding the ability of different providers to broadly report on this measure.

The measure developer provided clarification and that the measure -- there's three options to participate in reporting this.

One is direct feed into the laboratory system, a pole mechanism in which they run a report, extract the data into an Excel spreadsheet, and upload it into a registry, and third, manual data entry.

This could be a broad quality measure for more than just MIPS, but for right now, it's applicable to MIPS, and a MAP member mentioned the potential for this measure to lead to an overuse of testing our resources, but the measure developer clarified that specific types of cancer outlined in guidelines would prevent overuse and cited the 2016 guidelines for colorectal cancer, and the new iteration being developed.

That measure had 17 comments all in support of the measure.

MUC2021-058 Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors

The last measure, 2021-058, Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors.

The MAP offered conditional support for rulemaking pending NQF endorsement. This newly developed measure addresses the Meaningful Measures areas of patient safety.

If included, this measure would be the only quality measure in MIPS addressing gastrointestinal adverse effects from the use of immune checkpoint inhibitors as part of cancer treatment.

The measure developer provided clarification to some questions for measure for the medical oncologists where they would be assessing for any adverse event affects prior to the next administration of the immunotherapeutic drug.

As part of the routine assessment of patients in the oncology visit, they would be assessing the frequency of diarrhea as a side effect that would typically be documented in clinical or progress notes.

And there were eight comments, and I believe all

comments were in support of the measure.

Co-Chair Kahn: Okay. So we'll take up the one measure after we've considered these, right?

Ms. Elliott: Correct.

Co-Chair Kahn: Okay. So is there any discussion of any of these measures, or questions?

(No audible response.)

Co-Chair Kahn: Okay, hearing none, can we just assume then -- is there any objection to en bloc consideration?

Do we have to have a vote, or do we think we have a quorum so we can continue to the one that's controversial? Trish?

Ms. Elliott: I believe we have maintained quorum since the last vote, so if there's no objections we could move forward as a consent agenda with every -- agreement with the workgroup's recommendations.

(Simultaneous speaking.)

Co-Chair Kahn: Okay. Let's take up the last measure.

Ms. Elliott: Okay. Let me just find that in my notes. Sorry, I had to skip around here. Three. It's number six.

Okay. Are we on the right slide here? We need Measure MUC2021-063.

Co-Chair Kahn: Yep.

Ms. Elliott: Okay. This is Care Goal Achievement Following a Total Hip Arthroplasty or Total Knee Arthroplasty.

The MAP did not support this measure for rulemaking. This measure aligns with the goals of the CMS Meaningful Measures 2.0 to prioritize

outcomes in patient-reported measures.

However, the measure did not pass the NQF SMP for sufficient reliability and validity of the measure specifications.

During the MAP workgroup discussion, there was a question regarding efforts in place to continue to develop the measure and to build out more volume in terms of reporting and testing.

The measure developer clarified that the measure was tested in a real-use case scenario using Epic and six clinician groups, who observed that three clinician groups met the benchmark, and data collection is still ongoing across all six sites.

Both the developer and MAP workgroup members raised a question regarding the NQF recommendations on do not support and that was discussed.

The failure of the measure not passing the NQF SMP for sufficient reliability and validity of the measure specifications was the compelling factor for did not support this measure for rulemaking.

Co-Chair Kahn: Are there any questions? Let me look.

Dr. Rozenblum: This is Ronen Rozenblum, the measure developer.

Co-Chair Kahn: Yes?

Dr. Rozenblum: From the Brigham. Can --

Co-Chair Kahn: Go ahead, go ahead.

Dr. Rozenblum: Okay, so first, thank you the committee for considering our measure and for the late time. Really appreciate that. Just to say a couple of things.

So the new PRO-PM, as mentioned, Care Goal Achievement Following a Total Hip or Total Knee, is

designed to promote patient-centered care and enable care that is personalized and aligned with patient goals.

We believe that our measure enabled clinician groups to identify patient goals and expectations for their surgery and incorporate information into their conversation with patients, which allows decision-making and management of unrealistic expectations, all of which has the potential to enhance patient experience, improve clinical outcome, and increase health self-sufficiency, which is the PROMs and PRO-PM, as you all know, is a priority of CMS.

One item that we would like clarification on is the designation of do not support for rulemaking of our measure by the working group committee.

When we reviewed the preliminary analysis that you have, we saw that we met the evaluation criteria for Assessment 1 to 5, but not Assessment 6, which address the reliability and validity issues, which we acknowledge.

Assessment 7 is not applicable because we are not first-time submission, specifically the preliminary analysis highlights that our measure made the following assessments.

Addressed the criteria for quality of care is evidence-based, address performance gap aligned with other measures and can be feasibly reported. This was mentioned in the preliminary analysis.

Based on the decision categories in the assessment criteria we met, it would be helpful to get the rationale for how we fell into do not support rulemaking and not conditional support for rulemaking or do not support for rulemaking with potential for mitigation.

So basically, as we read the algorithm, we think that we should fall there. So based on the assessment of criteria and the importance of this

measure, specifically with, you know, with the importance of the measure, we ask the committee to consider our designation do not support for rulemaking and be assigning into conditional support or potential for mitigation decision category.

It's important to state that the main reason for the committee, the working group committee to decide what they decided is based on the small sample size that affected the reliability and validity.

We are continuing to collect data. Our measure is implemented in Epic in six hospital and department systems in Boston, so we have the opportunity to get to the numbers that we need.

So basically we ask with the importance of the measure to promote patient-centered care, and the fact that we believe that we shouldn't be, you know, do not support.

We ask the committee to consider condition of support or potential for a mitigation decision category. Thank you.

Co-Chair Kahn: What is the NQF staff -- in terms of, I guess, potential endorsement, where do you stand considering what we know?

Ms. Elliott: The measure developer has responded to the questions and provided additional information here.

You know, it can be considered by the coordinating committee here. We would have to do the yes, no on whether or not to support it, and then revote on the new designation.

Co-Chair Kahn: Okay. Heidi, I'm going to start with you and then go to David.

Member Bossley: Sure. And this, actually I have a few concerns because this tool -- and maybe the developer can help with this to understand if it is a do not support, or with the potential for mitigation -

- it appears the tool was developed.

I'm not sure what languages it's available in, who, what populations have been used to test the measure.

You were unable to risk adjust, I think, and actually said that you thought that you didn't need to include social risk factors such as health literacy, which is a concern to me, and also does not line up with measure 107 that does include health literacy in the risk model.

It's also a PRO-PM. And testing in one metro area, to me, for a measure like this, it's important -- I don't disagree with the topic, they're the measures we want to get to, I'm just concerned of rolling out something like this in MIPS without more data to support it, especially given what you found and were unable to do with the data you have.

Totally understand why. So I think it would be helpful to understand what are the plans to go beyond Boston, for example?

What are the plans to begin to look at social risk factors in those things? That would help me decide whether I would be comfortable putting some mitigations on this and potentially changing the recommendation.

Dr. Rozenblum: So I appreciate the response. So first, we were supported by CMS, so we developed this throughout the last three years via a comprehensive process of the measure development.

We did a very thorough and comprehensive, you know, mixed approach of quantitative and qualitative.

We did a lot of focus group and interviews with patients, and providers and payers, that supported, you know, the measure

So we tested in a real environment, that Tricia mentioned, which we see that as a strength.

So basically, we incorporate our measuring to Epic, and it's been used in six hospitals across the system.

Yes, it's all in Boston area. We've more than 70, you know, physicians. The focus groups and interview included a lot of people from diverse populations. It was very important.

It's all documented in the document, so when we're saying that the patients, providers, and payers received that, it's -- included diverse population, it was very important to us to get the different opinion.

They all supported the measure.

When it's coming to risk adjustment, you know, and basically, you know, health equity, we feel based on the literature, based on talking with experts, and mainly with patients and providers, that basically by enhancing patient-centered care, enable more shared decision-making and conversation with different population, we actually improving health equality because now not -- you know, with some specific population, you know, surgeon are not having the discussion about their goals and expectations.

Regarding the risk adjustment that you mention, it's a very good point, you know, we did thorough work about -- we looked at the other measure, we talked with experts in the field, and based on our qualitative and quantitative, we risk adjusted for age, gender, and BMI. Okay?

So it's all risk adjusted for this component. We made the decision not to risk adjust for other, like, race and ethnicity based on two things.

First, that's what we heard from people, but in our testing, we didn't see any differences, you know,

between them in terms of their statistical results.

Yes, it will be helpful, so what is our current state?

Because our measure is actually incorporated into a real environment, we continue to collect data, so our sample size is increasing and there's good signs that basically that we're going to show statistical significant, which goes back to the concerns of the committee, the SMP committee.

We have plans to extend, you know, the testing to other environment because we're aware of the, you know, population in this area, and we really feel that this measure is very important, is in the core of patient center care.

So thank you for the clarification.

Co-Chair Kahn: David?

Member Gifford: Yeah, I think it's interesting that, you know, we have some measures come before us that there's no data at all or no one's really done any testing, and we support it for rulemaking with NQF endorsement or some other process.

We have other measures that come before us where we actually have enough data to suggest reliability and validity's a problem on there.

Here we have a measure where the measure developers try to do everything, provided a lot of information, but clearly has had too small of a sample size.

I feel like they're almost getting penalized for having too small of a sample size. They're trying to give us all the data we want.

We also have a measure here that we as a group at NQF has said repeatedly, we need more patient voice and patients' involvement in the decision-making, and we have a really clear measure that moves in that direction.

We also have a bunch of surgeons in the public comment supporting the measure going forward with this.

I mean, I agree, you know, back to my earlier comments, I think measures that come forward that don't have an urgent need, a time limitation, or something else, I'm not sure whether we should be supporting them for rulemaking with NQF endorsement alone, but, you know, that's a discussion for future meetings, not at 7:00 at night.

I would agree with the measure developer's point that this falls into do not support with mitigation.

This is a measure I think we clearly want to send a signal to CMS so they continue to test and develop, but without the reliability and validity, it's hard to say it's ready for rulemaking.

So I think it got in the wrong category of do not support for rulemaking. It should be do not support rulemaking with mitigation recommendations -- would be my recommendation for how we vote on this measure.

Dr. Rozenblum: So --

Co-Chair Kahn: Well, Ronen, it's me. If we're moving that direction, I think we --well, do you have anything else to say, because we really need to bring this to a close.

(Simultaneous speaking.)

Dr. Rozenblum: No, I just want to say that even -- and we don't have time to talk about it -- even in terms of reliability and validity with mixed outcomes -- and I thank David for this comment, and it's important even to promote, you know, measure like us that we are tested, you know, prospectively to get the pair of data sets, and we are not based on registry. That it's easier, you know?

Co-Chair Kahn: Okay. So let's do this, I guess. We

need to vote on do not support for rulemaking.

If we don't get to 60 percent, then I would suggest we go with David's suggestion and then vote on do not support for rulemaking with mitigation, and see what happens. Is that acceptable to everybody?

Ms. Elliott: We had one more hand --

Dr. Pickering: Hey Chip, that sounds -- yeah? Go ahead.

Co-Chair Kahn: I think we had --

Ms. Elliott: Sorry, Matt. We have had one more hand raised. Emma Hoo. Just wanted to make sure we --

Co-Chair Kahn: Oh I'm sorry. I didn't see that. I didn't. I'm sorry.

Ms. Elliott: Yeah, no problem. Yeah, sometimes the scrolling is funny. Emma, did you still have a comment you wanted to make?

Member Hoo: Yeah, I do want to just echo what David just said in terms of surgeon support for this measure, and that it does focus on that patient-centered component that we have been trying to advocate for, as well as, you know, moving the market around advancing shared decision-making that, you know, has broad effects both for outcomes and patient experience.

And I would concur, you know, also that, you know, based on some of the earlier processes today, you know, having the conditions of additional data that support further reliability and validity, testing, you know, seems to make sense.

Co-Chair Kahn: Okay, thank you, Emma. Okay, anybody else, Trish, you see that needs to make comment?

(No audible response.)

Co-Chair Kahn: Okay, so let's go ahead. We're going to vote on this.

And then if it doesn't get to 60 percent affirmative, then we would come back and I'd suggest we'll need a motion, or I'll make a motion to vote on do not support for rulemaking with mitigation. Okay, so let's vote.

Ms. Young: Voting is now open for MUC2021-063, Care Goal Achievement Following a THA or TKA for the MIPS program.

Do you vote to support the workgroup recommendation as the committee recommendation of do not support for rulemaking?

Member Baker: Yeah, I lost my connection to the voting, so I'm not sure what you want to do.

Co-Chair Kahn: If you go back to the email --

Member Baker: Yeah, I know to do, I'm just saying --

Co-Chair Kahn: You ought to be able to reconnect.

Member Baker: Yes, I can reconnect, but I'm just saying, I won't be able to do it in the next three seconds. So.

Co-Chair Kahn: I'll wait. I think we have to because we need to get the --

Co-Chair Roberts: Can he send it to you, Tricia?

Ms. Elliott: Yes. Dr. Baker, it's Tricia.

You can send it to me privately in the chat, and we have one other person with internet issues that will be sending a vote that way, as well.

Co-Chair Kahn: Oh good, so we're at 15, so.

Member Ross: This is Clarke Ross. I lost my connection. Maybe it's a system issue, so I'm just going to email to the quality host in the chat.

Ms. Elliott: Okay.

(Simultaneous speaking.)

Co-Chair Kahn: Great, so we have 17 then, if you all will email your votes.

Ms. Elliott: Just give us a second behind the scenes to aggregate the results.

Member Tufte: Since we're waiting, I just want to say I thought these were important, and I was the main discussant on the 63, and I just see these as really large quality of life, the itching ones, and this as well, so thank you.

Co-Chair Kahn: Thank you. So Trish, you can integrate those other two votes into the system here, or --

Ms. Elliott: Yep, we're working on that. Give us one second.

Member Tufte: Ronen, who are you working with?

Dr. Rozenblum: Sorry?

Member Tufte: Who do you work with?

Dr. Rozenblum: In our group?

Member Tufte: Yeah.

Dr. Rozenblum: David Bates, and other. Are you familiar with?

Member Tufte: For CMS, for who?

Dr. Rozenblum: Oh, for the CMS. I'm not working for the CMS.

Member Tufte: Yeah, I guess I meant --

(Simultaneous speaking.)

Dr. Rozenblum: CMS.

Member Tufte: So do you have an organization?

Dr. Rozenblum: Yeah, so we are the Brigham and Women's Hospital in Harvard Medical School.

Member Tufte: Oh, I got it.

Dr. Rozenblum: This is my affiliation. And we got this grant from the CMS to develop this measure.

Member Tufte: Got it. I just forgot who it was. Thank you.

Dr. Rozenblum: No, that's totally fine.

Ms. Elliott: Okay. We have the results. So Susanne, are you comfortable sharing the -- because we have the 15 on the side, and then two others.

Ms. Young: Okay, voting is open for MUC2021-063. Six committee members voted yes, and 11 committee members voted no for 35 percent.

Co-Chair Kahn: Okay, so I'll make a motion then that we have -- how do we word it --do not support for rulemaking with mitigation. Does anyone second?

Co-Chair Roberts: Second.

Participant: Second.

Co-Chair Roberts: This is Misty.

Co-Chair Kahn: Okay, do we need a discussion or can we go ahead and vote?

Member Bossley: Can we walk through what the mitigations are? I think I'm not clear on that.

Co-Chair Kahn: Okay. Trish, what do you want the mitigations to be?

Member Bossley: I can suggest some if it would help for me to do it. I don't know, unless you have a --

Ms. Elliott: There -- yeah, if you can propose them, Heidi -- I think you articulated them earlier -- that'd

be great.

Member Bossley: Yeah. So I think succinctly that the measure be more broadly implemented and tested, the survey, and the measure itself.

I would like to see it personally -- unless others disagree -- tested beyond one metro area, particularly because of the potential equity issues and rural health issues.

And then from there would be the liability and validity.

But I think it does come down to -- as David and everyone else said -- having a larger sample size and more broadly representative across the U.S. There may be more, but that's kind of my thinking.

Co-Chair Kahn: Okay. Is that enough? Does everybody agree to that as a --

(No audible response.)

Co-Chair Kahn: Okay.

Member Hoo: I --

Co-Chair Kahn: Yeah. Who?

Member Hoo: This is Emma. If I could weigh-in?

Co-Chair Kahn: Sure.

Member Hoo: You know, while I understand, you know, based on the equity discussion today, you know, we want to assure that diverse populations are represented, but, you know, I think historically, you know, we have relied on the methods committee and the, you know, formal validation processes, and I'm not sure if selectively imposing a geographic requirement on one particular measure makes sense, you know, given that it's not typically been standardly applied, you know, across the book, and so I would just raise that, that, you know, if the survey instruments have been validated

in multiple languages, and that the population responding to the surveys, you know, are representative, that, you know, it be under the same requirements that, you know, follow the normal process of the methods review and the committee review.

Co-Chair Kahn: Heidi, will you buy that?

Member Bossley: I guess so, yeah. It all comes down to the data, right, and if they can demonstrate, like you're saying, Emma, the differences, I think that's fine.

And when it comes to resources that are required for these types of measures and practices, I'd like to know that a smaller practice, for example, will be able to do this just as much as one that is within a larger health system.

So those are the types of things that I would like to see, if they can do that with what they have.

I don't know that I have a problem with it, but I'd just like to know that that's addressed.

Co-Chair Kahn: Ronen?

Dr. Rozenblum: May I say something, or --

Co-Chair Kahn: Sure, go ahead, because we're trying to wrap up.

Dr. Rozenblum: Well, I'm just saying regarding the small assessment interview with the providers, they didn't see any issues implemented that across small clinic and large clinic.

We did also cognitive testing -- and it's all reported, obviously -- it took the patients to fill out the survey like two to three minutes, so it's eight questions, pre and post, and they can fill out electronic, you know, in the clinic, or at home, so for all these reason and more, we don't see a lot of concern implement it in small clinics versus big clinics.

Co-Chair Kahn: Okay. Dan, are you still --

Member Culica: Yeah, it's more of a technical question. I was still wondering if we still have the quorum right now?

Co-Chair Kahn: I'm sorry, I couldn't hear you. He still --

Ms. Elliott: He's asking about the quorum.

(Simultaneous speaking.)

Member Culica: I was asking about the quorum.

Ms. Elliott: Yeah. We are at 16 right now. We had one other person drop, so.

Co-Chair Kahn: Yeah, we really need to vote. So, Liz, can you be quick?

Member Goodman: Super quick. My question is, can the condition be that goes back to the Methods Committee who comes up with a method that they're comfortable with?

You know, just fundamentally, after the equity discussion, the idea that you would create a measure that we don't know is broadly applicable across populations and practice types, makes me a little anxious, but, you know, I'm not a methodologist, so I don't know.

I don't know if sending it -- you know, having it go through the Methods Committee is a valid condition to require, is my question.

Co-Chair Kahn: Do we view that the same way or something in MIPS since this is optional, right? Practices could choose to do this.

I agree, that would be an important concern if every practice needed to do this. But I --

(Simultaneous speaking.)

Member Bossley: I think we don't know, David,

unless Michelle or someone can say that.

I don't think we know because there are the foundational population health measures where something like this could apply technically.

We've seen them propose it for heart failure, for example. So that's why --

Co-Chair Kahn: Well, can we have some language in there that's reasonable in terms of what we're asking for on this?

(Simultaneous speaking.)

Dr. Rozenblum: Based on my knowledge, it's --

(Simultaneous speaking.)

Ms. Gomez: Hi, this is Lisa Marie with CMS. I just want to note that some of the measures that we have are optional.

So, clinicians can choose which measures they report on. And we don't necessarily prescribe which measures to report on.

It's a little bit different, but in traditional MIPS, folks get to choose what measures they report on, so there's not a specific mandate for a measure requirement in terms of you have to report this.

If that was your question?

Member Bossley: I don't want to take any additional time, Lisa, but for measures that require risk adjustment, it either has to be through a registry or it's a population health foundational measure.

So understanding that, I think, Chip, we could probably come up with some language, even if NQF staff worked to make sure that this is reliable and valid and representative.

I think that captures the intent, at least from my viewpoint, and maybe --

(Simultaneous speaking.)

Member Hoo: But these measures also would go through the rural and health equity committees, as well.

Member Bossley: Exactly.

Co-Chair Kahn: Okay.

Member Bossley: Right. Exactly.

Co-Chair Kahn: So, with that, Trish, do you have enough?

Ms. Elliott: It's marginal. We might be below 16. Do you want to try, Chip?

Co-Chair Kahn: Yeah, let's go ahead, let's try.

Ms. Elliott: So we'll bring up the --

Co-Chair Kahn: Yeah, so the --

Ms. Elliott: Do not support with mitigation.

Co-Chair Kahn: With mitigation. Actually, we need a second. Can I look at Heidi? So, why don't you give me a second? Okay.

Member Bossley: Second.

Co-Chair Kahn: So let's vote. Hopefully we --

Member Gifford: Second. Second, third, fourth, fifth.

Co-Chair Kahn: Well, we need 16 at this stage.

Ms. Young: The vote is now open for MUC2021-063, Care Goal Achievement Following a THA or TKA, for the MIPS program.

Co-Chair Kahn: Okay. Did any of you need to telegraph it in to Trish?

Ms. Elliott: Yes, we did.

Member Baker: I'm from Chicago. Do I get to vote

twice?

Co-Chair Kahn: Ah, come on, let's get to 16.

Member Baker: I already voted.

Co-Chair Kahn: One more. Yay. We got --

Ms. Elliott: Yay. All right.

Co-Chair Kahn: Okay.

Ms. Elliott: Because we had folks tell us their votes before they had to drop off, so.

Co-Chair Kahn: Oh, thank you. Thanks to everybody. Okay, I think we're now completed that, and --

Ms. Elliott: Yep. We just have to read the results, Chip. Hold on one second.

Dr. Pickering: Yeah, read it off.

Ms. Young: Sixteen committee members voted yes, zero committee members voted no for MUC2021-063 in the MIPS program for do not support with potential for mitigation.

Public Comment

Co-Chair Kahn: Okay. And I think we have to have the opportunity for public comment. So we open up for public comment. Does anyone have any public comment?

(No audible response.)

Co-Chair Kahn: I'll give it five. One, two, three, four, five.

(No audible response.)

Co-Chair Kahn: I hear no public comment. And so now, do I turn it back over to Becky? Is that right?

Ms. Elliott: Correct.

Ms. Payne: That's correct, Chip. Thank you. And I'll make this very quick, so just a few next steps for everyone.

The summary transcript and recording for this meeting will be posted to the coordinating committee project page, so you're welcome to revisit that at that time.

The final recommendations from the MAP group will be presented to the U.S. Department of Health and Human Services by February 1, and we also just want to highlight for everyone that we will be having our 2022 MAP coordinating committee strategic meeting this year during February, so that will be on February 23.

And please let us know if you don't already have the calendar invitation for that, and we will be using this strategic meeting to discuss both processes for the typical MUC cycle and to revisit the MSR cycle that will be coming up this spring.

So Chip and Misty, I will turn it to both of you for any closing remarks you'd like to make.

Co-Chair Kahn: And I'll turn it to Misty, if she wants so say anything.

Co-Chair Roberts: My closing remark is thank you, thank you, thank you. That's about all I got in me right now.

Co-Chair Kahn: Yeah, I think I'm sorry of with you, so thanks everybody. It's been a marathon but we completed it.

Not in three hours, but it's been a marathon, and thank you very much for sticking with us.

So Becky, do you finish out, and then we're done?

Ms. Payne: Tricia, I'll just check back with you. Is there anything else you'd like to add to close the

day out?

Ms. Elliott: No, I just want to thank everybody for hanging in there, getting us to this final vote, and being so flexible and willing to adjust to accommodate, you know, very robust topics, very important measures, and thank you.

Thank you to everyone participating here, to our CMS colleagues, the measure developers, the whole NQF team.

We couldn't have done it without the team of people behind the scenes here, so thank you all so much and have a wonderful evening. Thank you.

Co-Chair Kahn: Yeah, thanks. Thanks everybody.

(Whereupon, the above-entitled matter went off the record at 7:09 p.m.)