NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP (MAP) COORDINATING COMMITTEE

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MONDAY
JANUARY 25, 2021

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

PRESENT:

CHARLES "CHIP" KAHN III, MPH, Federation of American Hospitals; Co-Chair
MISTY ROBERTS, MSN, Humana; 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
KATIE BOSTON-LEARY, PhD, RN, MBA, MHA, American Nurses Association
SCOTT FERGUSON, MD, American Medical Association
ANDREA GELZER, MD, MS, AmeriHealth Caritas
DAVID GIFFORD, MD, MPH, American Health Care Association (AHCA)
ELIZABETH GOODMAN, JD, MSW, DrPH, America's Health Insurance Plans (AHIP)
EMMA HOO, Pacific Business Group on Health
ARIF KAMAL, MD, MBA, American Academy of Hospice and Palliative Medicine
KACIE KLEJA, HCA Healthcare
WENDY MARINKOVICH, RN, MPH, Blue Cross Blue Shield Association
AMIR QASEEM, MD, PhD, MHA, American College of Physicians

JULIE SONIER, MPA, Network for Regional Healthcare Improvement

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING):

HAROLD PINCUS, MD
JEFF SCHIFF, MD, MBA
JANICE TUFTE
RONALD WALTERS, MD, MBA

FEDERAL GOVERNMENT LIAISONS (NON-VOTING):

MIA DeSOTO, PhD, MHA, Agency for Healthcare Research and Quality (AHRQ)
DAVID HUNT, MD, Office of the National Coordinator for Health Information, ONC
MICHELLE SCHREIBER, MD, CMS
DANIEL BUDNITZ, MD, MAPH, Centers for Disease Control and Prevention (CDC)

NQF STAFF:

CHRIS QUERAM, Interim President and CEO
CHRIS DAWSON, Manager
MICHAEL HAYNIE, Senior Managing Director
AMY MOYER, Director, Quality Measurement
UDARA PERERA, Senior Manager
MATTHEW PICKERING, PharmD, Senior Director, Quality Measurement
SAM STOLPE, PharmD, Senior Director
SHERRI WINSPER, Senior Vice President, Quality Measurement

ALSO PRESENT:

JOEL ANDRESS, PhD, CMS
NIRMAL CHORADIA, MD, Acumen
AKIN DEMEHIN, MAP Hospital Workgroup Co-Chair
ELIZABETH DRYE, MD, Yale University
REBECCA ETZ, PhD, Virginia Commonwealth University
ROB FIELDS, MD, MHA, MAP Clinician Workgroup Co-Chair
LEE FLEISHER, MD, Chief Medical Officer and Director of the Center for Clinical Standards and Quality (CCSQ), CMS
AARON GARMAN, MD
DANIEL GREEN, MD, CMS
KELLY KYANKO, MD, New York University
GERRI LAMB, PhD, RN, FAAN, MAP PAC/LTC Workgroup Co-Chair
ALAN LEVITT, MD, CMS
COLLEEN McKIERNAN, MSPH, The Lewin Group
SEAN MORRISON, MD, MAP Hospital Workgroup Co-Chair
IRA MOSCOVICE, PhD
KARTHIK MURUGIAH, MD, Yale University
SRI NAGAVARAPU, Acumen
DIANE PADDEN, PhD, CRNP, FAANP, MAP Clinician Workgroup Co-Chair

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

10:00 a.m.

DR. STOLPE: Welcome, everyone, to the National Qualify Forum Measure Application Partnership Coordinating Committee, virtual review meeting for the 2021-2021 cycle.

I am Sam Stople, I'm a senior director here at NQF. And it's very much my pleasure to be facilitating this meeting today.

Before we get started, just a couple of housekeeping reminders. We invite you to please mute your computer or phone line when you're not speaking.

And also, if you are going to be on video, which we would invite all of you to do, we would please ask you to ensure that your name is correctly displayed. We have, on the slides here, some instructions.

Just to right click your picture and click rename, if you would like to edit how your name appears.

We are especially excited to be

hosting this meeting. Normally, of course, we do it in-person, but times being what they are, we have moved to this virtual platform. So, to keep our engagement as high as possible, especially during our measured discussions, when you're speaking, we would encourage you to please turn on your video.

If you would like to switch how your display is, you can right click on view in the upper right corner and select speaker or gallery.

We would also encourage the members of the Coordinating Committee to please use the raise hand feature whenever you would like to make a point or raise a question. To do this you simply click on participants icon at the bottom of your screen. And at the bottom of the list of participants you will see a button that says, raise hand.

We have a chat feature which we'd invite you to use as well. If you have any technical difficulties or questions for the NQF Staff, you can communicate directly with NQF

hosts or with IT support.

For this meeting, of course, we're using the Zoom platform for presentations and discussion. But we'll be using the Poll Everywhere app for voting.

So, Coordinating Committee Members, you should have that at the top of your inbox. Our team as sent it out to you, but it's also included inside of your calendar invitation. As are all of the materials for this material.

Next slide please. Let me hand it over to our Interim President and CEO, Chris Queram, and our Senior Vice President, Sherri Winsper, to please state some hellos and opening remarks.

MR. QUERAM: Great, thank you very much, Sam. Good morning, everyone.

Let me begin by thanking you for taking time from your schedules to participate in this important meeting. I have had the pleasure of being in the seat that many of you are occupying.

In fact, I have worked alongside many of you as a former member of the Coordinating Committee, so I know the amount of time and effort that goes into preparing for the meeting. And I want to be sure to thank you for that.

My name is Chris Queram. It's my pleasure to serve as the Interim CEO of the National Quality Forum.

Prior to joining NQF, a few weeks ago I was the president and CEO of the Wisconsin Collaborative for Healthcare Quality, a state-wide quality measurement and improvement organization in the State of Wisconsin.

And in that capacity we had extensive content with NQF. And as I noted, served as a member of the Coordinating Committee representing the network for regional healthcare improvement.

I'd like to thank all of the workgroup members, as well as our federal liaisons for the commitment to the MAP. This has been an unprecedented review cycle.

All of the work that you will be

considering today was prepared for you by the four workgroups that have met over the last two weeks. And we appreciate everybody's flexibility in accommodating the change to the normal review cycle. And the move to this virtual platform.

For those of you who are experienced with the measure application partnership, this is the tenth year that the National Quality Forum has convened with MAP. And during this period of time the MAP has reviewed over 1,000 measures since the first convening back in 2011.

I'd like to give a special thank you to our colleagues from CMS for their continued confidence in NQF as the steward of this important meeting process. We look forward to a very productive day.

And with that, let me just turn the podium over, briefly, to my colleague Sherri Winsper for her introductory comments. Sherri?

MS. WINSPER: Thank you, Chris. Good morning, everybody. Happy Monday and happy,

we're just so excited to finally get to our conclusion of this great conversation today and look forward to a great conversation.

I'm Sherri Winsper, the Senior Vice President for Quality Measurement at NQF. I just joined last June, so I think I'm on month seven. So getting close to not being able to say I'm new anymore. But definitely enjoining work, beginning to work with many of you over the last six months, and will continue to do so.

This is certainly, as Chris alluded to, we've made some changes with the timing this year, obviously. And the format may be a little bit different, but our purpose really does remain the same.

And your purpose as the MAP Coordinating Committee, which is to provide CMS with some very valuable feedback around the lens of consumers and providers, stakeholder groups and health plan groups. And really to inform that rulemaking process for CMS and their quality and performance programs.

We're certainly, no one is unaware that we are convening in the midst of the national healthcare crisis. Our nation's resources have certainly been very, very stretched as we face the challenges that COVID has presented us.

So we know that all of you are sacrificing quite a bit of the time. Especially those of you that are actually some of our front line workers, so we appreciate your time for this important work today.

And now with two, and maybe a third, I've been reading more about the Johnson & Johnson vaccine recently, but maybe a third vaccine on the market. We look to a future where we can respectfully overcome this crisis.

MAP will discuss the roll that measurements and accountability should play related to COVID vaccinations today, among other critical measurement issues.

Thank you to our CMS colleagues and partners. Dr. Michelle Schreiber and Kim and the rest of the team, for really partnering with us

and setting the right tone of taking your feedback and listening. We really appreciate that.

And here also, just to provide support to the deliberations, but most of all, they're here to listen.

I want to say I could not, not say a grand thank you to all of the NQF Staff. Sam and Michael and the team, you guys have made this happen at a Hercules timing or fast timing this year, so we really appreciate, or I really appreciate, your time as well.

And to the Coordinating Committee for all of your time in preparing. We know it takes of reading and a lot of studying. And probably less time than you normally would have had, so we appreciate that.

So thank you so much. And I'll turn it back to you, Sam, I believe.

DR. STOLPE: Very good. And I'm just going to send it directly to our two terrific co-chairs, Misty Roberts and Chip Kahn. Please go

ahead and introduce yourselves to the Committee and provide some opening remarks.

CO-CHAIR KAHN: Okay. Thank you, Sam. And thanks, Chris and Sherri and everyone at CMS.

I think a lot of preparation went in to this meeting today. Both on the Staff side, the CMS side. And clearly, and most importantly, on the volunteer side with those of you on the coordinating committee or others that took part in the workgroups and are here today helping us.

This is an independent, volunteer effort in terms of all us that sit on these committees. And it's an important contribution. And I just want to express my appreciation. And obviously everyone else is appreciative of your time.

It's so important to get your perspective in terms of putting together our recommendations today.

A couple of other things. I think we have probably a smaller list. As Chris

mentioned, this is the tenth time we've done this.

And as a Member, or as a Co-chair, I believe I've been at every single session that we've had. And I can remember when we went on for days. Here, we only have a day, it's a rather compact. But fortunately I think we have a list that we can get through without too much trouble.

I'm sure what will always, what always seems to happen is, we'll hit one or two sort of rocky discussions. And those seem to take an inordinate amount of time.

And then everything sort of speeds up and we get finished on time, which I'm confident we will.

Before I pass the baton to Misty, two other things. One, I think possibly during the CMS part of our discussions this may come up. And at the end of our meeting, we will have a discussion of the new statutory language regarding removal of measures.

I would like to see us develop some

kind of recommendation from the Coordinating Committee to NQF and CMS, if that's the will of the Coordinating Committee, that we can play a role in reviewing measures to determine whether some are worthy of keeping and others should be removed. And we'll have a discussion about that later in the meeting.

Finally, I just want to make sure, Sam, because actually, I'm not prepared for this, we need to make sure everyone has the voting app. Because as I looked around, I couldn't find it in my calendar. So we need to make sure everybody has got the voting app because we want to make sure we have everybody voting.

So with that, I pass the baton off to Misty.

DR. STOLPE: Misty, if I could just jump in for one second.

CO-CHAIR ROBERTS: Sure.

DR. STOLPE: It should be at the top of your inbox, Chip. And everyone else.

CO-CHAIR KAHN: Okay.

DR. STOLPE: We resent it this morning about --

CO-CHAIR KAHN: Okay.

DR. STOLPE: -- start, the meeting start as though --

CO-CHAIR KAHN: Okay, great. Thank you.

DR. STOLPE: Misty.

CO-CHAIR ROBERTS: All right, thanks. Thanks, Chip and Sam. So, for those of you who do not know me, I am Misty Roberts, Associate Vice President of Clinical Quality at Humana.

And this is actually my first year as co-chair. I think some of you all had the opportunity to meet me last year when we did meet in person, so I just ask that you might bear with me as we possibly could fumble through some of these logistics. Especially with this being a virtual meeting.

I do wish that we were able to meet in person, but we are fortunate that we do have some of the technology and capability to make

this happen regardless.

If 2020 has taught us anything, it really is about being flexible and adaptable. I think Chris kind of alluded to that. And also being patient.

So we certainly appreciate your patience today as we get through this long day virtually. I know that it is going to be long. We do know that this is very important part of the rulemaking process, so please try to stay engaged throughout the day.

And I also have to say that I'm pretty impressed with the fact that we have went through a 1,000 measures in the past ten years. That's pretty impressive.

That's about 100 measures per year. So, excited that we're able to keep up this good work and look forward to the discussion today.

And now I think I'll hand it over to Chuck. Chuck, do you want to review the objectives of the meeting?

CO-CHAIR KAHN: Yes. Let me get

myself full screen here. So are we going to put up, this is the agenda. Do you put up the objectives?

DR. STOLPE: I think we just have them in your notes.

CO-CHAIR KAHN: Oh, okay. So, obviously today we want to finalize the recommendations to the CMS on measures for use in federal programs for the clinician hospital and post-acute long-term care settings, consider strategic issues that span all of the MAP workgroups, and discuss potential improvements to the pre-rulemaking process.

Obviously our emphasis today, and the bulk of our discussions, will be around the measures that have been recommended to us. Or the measure recommendations that have been recommended to us by the workgroups.

So with that, I guess I'm, it's my turn now to turn it back over to Sherri to conduct the DOIs and the roll call.

MS. HAYNIE: Actually, speaking of

flexibility, this is Michael, I'll be taking us through the disclosures of interest today.

CO-CHAIR KAHN: Okay.

MS. HAYNIE: Thank you, Joe. So, before we start, just another housekeeping item.

As a reminder, NQF is a nonpartisan organization. So out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendos or humor relating to, for example, race, gender, politics or topics that otherwise might be considered inappropriate during the meetings.

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

So as Chip mentioned, we'll be combining our disclosures with out introductions. We'll divide the disclosures interests into two parts because we have two types of MAP members. Organizational members and subject matter experts.

I'll start with our organizational members. So, organizational members represent the interest of a particular organization. We expect you to come to this 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.

So we'll go around our virtual table here, beginning with the organizational members only please. I'll call on anyone in the meeting who is an organizational member.

So when I call your organization's name, please unmute your line, state your name, your roll of your organization and anything you wish to disclosure. If you did not identify any conflicts of interest after stating your name and title, please just say I have nothing to disclose.

And if you do have trouble getting off of mute, you can use that raise hand feature and the Staff will help chat you out of it.

All right. So let's go ahead. American Academy of Hospice and Palliative Medicine.

MEMBER KAMAL: Good morning. I'm Arif Kamal, Board Member at AAHPM. And I have no conflicts of interest.

MS. HAYNIE: Excellent. Thank you. AmeriHealth Caritas.

MEMBER GELZER: Good morning. Andrea Gelzer, Chief Medical Officer, SVP Medical Affairs. I have nothing to disclose.

MS. HAYNIE: Thank you. American College of Physicians. All right, we'll come back there.

American Health Care Association.

MEMBER GIFFORD: David Gifford. I'm the Chief Medical Officer, represent nursing homes, assisted living, and iSNFs.

And I have my retirement 401(k)

account, which invests in some healthcare entities, which I don't know what they may influence that.

And my wife is commissioner of Medicaid and Public Health in Connecticut. And would be involved in using it.

And we also are measure stewards on a number of NQF measures that are coming before the Committee today.

MS. HAYNIE: Thank you. American Medical Association.

MEMBER FERGUSON: I'm Scott Ferguson, Board of Trustees, Member at the American Medical Association. I have nothing to disclose.

MS. HAYNIE: Thank you. American Nurses Association.

MEMBER BOSTON-LEARY: Good morning. Dr. Katie Boston-Leary, Director of Nursing Programs and Nursing Practice and Work Environment at the American Nurses Association. And I have nothing to disclose.

MS. HAYNIE: Thank you. America's

Health Insurance Plans.

MEMBER GOODMAN: Good morning. I'm Liz Goodman. I'm the Executive Vice President of Government Affairs and Innovation at AHIP. And I have nothing to disclose.

MS. HAYNIE: Thank you. Blue Cross Blue Shield Association.

MEMBER MARINKOVICH: Hi, I'm Wendy Marinkovich. I'm the Executive Director for Provider Measurement Programs. And I have nothing to disclose.

MS. HAYNIE: Thank you. HCA Healthcare.

MEMBER KLEJA: Hi, Kacie Kleja. AVP of analytics and reporting at HCA Healthcare. I do own more than $10,000 in stocks for HCA Healthcare. And that is my only disclosure.

MS. HAYNIE: Thank you. The Joint Commission.

MEMBER BAKER: Good morning. I am David Baker. I am Executive Vice President for Healthcare Quality Evaluation at the Joint

Commission. And no disclosures.

MS. HAYNIE: Thank you. The Leapfrog Group.

MEMBER BINDER: Good morning. I'm Leah Binder, I'm president and CEO of the Leapfrog Group. We represent employers and purchasers to health benefits advocating Quality and Safety Healthcare. And I have nothing to disclose.

MS. HAYNIE: Thank you. National Business Group on Health. All right, we'll come back there.

National Committee for Quality Assurance. NCQA? Anyone? All right, we'll come back there.

National Patient Advocate Foundation. All right. Network for Regional Health Care Improvements.

MEMBER SONIER: Good morning. I'm Julie Sonier, representing the Network for Regional Health Care Improvements. It's a member organization of regional collaboratives.

And I serve as the CEO of Minnesota Community Management, which is a ENRI member. I have nothing to disclose.

MS. HAYNIE: Thank you. Pacific Business Group on Health.

MEMBER HOO: Good morning. This is Emma Hoo. I'm a Director of the Pacific Business Group on Health. A nonprofit coalition at-large, private and public purchasers. And I have nothing to disclose.

MS. HAYNIE: Thank you. Patient and Family-Centered Care Partners.

All right, so my team has notified me that the American College of Physicians has notified us they are running late, so we will have Amir disclose when he gets here.

Let's just run back through a couple of these others in case there was an issue getting off of mute. National Business Group on Health. Anyone?

National Committee for Quality Assurance?

National Patient Advocate Foundation? All right, so with that, thank you for these disclosure. We will go ahead and move to the next slide.

So now we're going to --

CO-CHAIR ROBERTS: Do Chip and I also need to disclose?

MS. HAYNIE: Yes, ma'am. Getting there in a second. Thank you, Misty.

CO-CHAIR ROBERTS: Okay.

MS. HAYNIE: So, we'll move on to our disclosures with our subject matter experts, which is both of our Co-chairs. 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're 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 it's relevant to the workgroup's work.

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 formally interested in your disclosure of activities where you were paid. You may indeed have participated as volunteer on a committee where the work is relevant to measures reviewed by MAP. We are looking for you to disclose these types of volunteer activities as well.

Finally, just because you disclose does not mean you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name, what organization you are with and if you have anything to disclose. I'll call your name so that you can disclose. Misty, would you like to kick us off?

CO-CHAIR ROBERTS: Sure. Misty

Roberts, Associate Vice President of Clinical Quality at Humana. And I do have more than $10,000 in stock for Humana. And that's it.

MS. HAYNIE: Thank you. Chip.

CO-CHAIR KAHN: Chip Kahn. President and CEO of the Federation of American Hospitals. And I may, in some fund, have health holdings, but I am not aware of them and sure I probably am confident that a few that are as large as $10,000, if I even have them.

MS. HAYNIE: Thank you, Chip. Harold Pincus. Jeff Schiff.

MEMBER PINCUS: Hi, this is Harold. Sorry, I was on mute. So, I am professor and Vice Chair of Psychiatry at Columbia University. And also the New York Psychiatric Institute, which is, part of the New York State Office of Mental Health.

I'm also an adjunct senior scientist at the Rand Corporation. I have no investments in anything above $10,000, but I am on advisory committees for Vine Health Plan, AbleTo Cerebral,

the National Counsel of Community Behavioral Health, and also the NCQA Behavioral Health Measurement Advisory Panel.

MS. HAYNIE: Thank you. Jeff Schiff, just in case you were also having trouble getting off mute? Janice Tufte.

MEMBER TUFTE: Hi. Thank you for having me here today. Can you hear me?

MS. HAYNIE: Yes.

MEMBER TUFTE: Okay. And I, what I have to disclose is, I was involved with MACRA, the physician cost measure and patient relationship codes, which we have a few of those episode cost measures we're looking at.

And so, as a patient or public member, I did serve on that committee. I wasn't paid, but I did provide input.

And then also, the Patient and Family Center Care Group, who also is serving on this committee. Had put out a survey, so I provided input onto some of the measures that we're looking at. Thank you.

MS. HAYNIE: Thank you. Ronald Walters.

MEMBER WALTERS: Hi, I'm Ron Walters. I am a Medical Oncologist and Physician Administrator, University of Texas, MD Anderson Cancer Center, where I have been for 40 years.

I have no grants, conflicts. No speaking that conflicts with this at all.

I am the Chair of the Board of NCCN, which is a grouping of the cancer centers. That has no relevance to the measures today that will be discussed.

And I'm on the Board of Texas Medical Foundation QIN-QIO, which is a QIN-QIO, which also has no relevance to the discussion today of any of the measures. So I have nothing to disclose, other than those issues.

MS. HAYNIE: Thank you. So now we'll shift over. And I'd like to invite our federal government liaisons, who are non-voting members, to introduce themselves. Can I have the liaison from AHRQ?

MEMBER DESOTO: Hi. Good morning. My name is Mia DeSoto and I lead the ARRQ Quality and Behavioral Program. And I have nothing to disclose.

MS. HAYNIE: Thank you. Our liaison from the CDC. Our liaison from CMS.

DR. SCHREIBER: Good morning. Michelle Schreiber from CMS. And nothing to disclose.

MS. HAYNIE: Thank you. And our liaison from ONC. All right, thank you all for being with us --

MS. WINSPER: Michael?

MS. HAYNIE: Yes.

MS. WINSPER: Michael, this is Sherri. I think Dr. Schiff is here now and raising his hand.

MEMBER SCHIFF: Great. Can you hear me?

MS. WINSPER: Hi, Dr. Schiff.

MEMBER SCHIFF: Am I unmuted? Can you hear me?

MS. HAYNIE: We can hear you.

MS. WINSPER: Yes we can hear.

MEMBER SCHIFF: Okay, thank you. I'm Jeff Schiff. I am a former Medicaid Medical Director for the State of Minnesota, and now a senior scholar at Academy Health.

I work on the quality rating systems as a consultant for Mathematica. And depending on the day, I do own a portion of Moderna stock. Thank you.

MS. HAYNIE: Thank you. All right. So, I'd like to remind you all that if you believe you might have a conflict of interest at any time during the meeting, as more data is shared, please go ahead and speak up.

You may do so in real-time in the meeting. You can message or share. It will go to NQF Staff. Or you can directly message the NQF Staff. They're labeled as such in the meeting.

If you believe that a fellow committee member may have a conflict of interest or is

behaving in a bias matter, you may point that out during the meeting, approach the chair or go directly to the NQF Staff.

So, does anyone have any questions or anything you'd like to ask based upon the disclosures made today?

All right, thank you very much. I will turn it back over to Sam, I believe.

CO-CHAIR KAHN: I think it's over to me, isn't it?

MS. HAYNIE: Oh, my apologies.

CO-CHAIR KAHN: So, we'll have to be watching everyone's behavior. It's a little bit more difficult in this meeting than usual, but I'm sure everybody in the, in our group is very used to Zoom.

So, it's now my role to just highlight our role of the Coordinating Committee. NQF Staff and the MAP workgroup co-chairs will outline the measures and the programs evaluated by the workgroups. Including the top strategic issues that emerged from this years pre-

rulemaking meetings.

I want to emphasize that the workgroups include experts in the relevant fields, in care settings, as well as those who have real-world experience in those settings and should express a strong preference.

Hopefully the Coordinating Committee will not only take into account, but I hope we'll have a strong preference for the recommendations, from the real-world groups, because they really drill down. And obviously brought expertise.

So with that, let me pass the baton back to Sam to introduce the NQF Staff, which I think is going to be on Slide 7.

DR. STOLPE: Thanks very much, Chip. Of course, you have my name first.

But we have a series of folks who have supported this meeting, and will continue to support the meeting, as we're moving through today's agenda.

We have Katie Berryman, who is the project manager. Udara Perera, who is one of our

senior managers.

Chris Dawson is a manager on the project. Becky Payne, as the senior analyst. And Michael Haynie, our senior managing director.

Go to the next slide. Now it's very much my pleasure to introduce our CMS colleagues. We have both Dr. Lee Fleisher and Dr. Michelle Schreiber, who are with us today.

Lee serves as both the CMO, as well as the Director for the Center for Clinical Standards and Quality.

And Dr. Schreiber serves as the Deputy Director of Quality and Value for CCSQ. I'll hand it over to the two of you for opening remarks.

DR. FLEISHER: Great. Thank you so much. And thank you, Chris and Sherri, for your leadership during this time of transition at NQF.

Having been treasurer of NQF on July 4th and being recused from being involved with NQF on July 5th, when I took this new position. I'm quite familiar with the organization.

And sat in the seats, although not on the Coordinating Committee, Chip and Misty, but on the hospital workgroup. And I'm very appreciative of everyone who is here today.

I frequently say that you're only as smart as the people you bring into the room. The people who give you that peripheral vision and add to how you think about things.

And we at CMS are extremely privileged and happy that we can get your view on your measures.

You talked about rocky discussions. And I sort of laugh because I remember leading some of those rocky discussions. Either at the CSAC or the MAP in the past. And we relish those in that they really bring clear insight to us.

Chip talked about removal of measures. Having been one of the 14 people in the room when we created the SCIP measures. Probably 15, 16 years ago.

I think that's a very important point. And your insights, as one of our data points in

how we think about these measures, is always valued.

As we all know, not only is NQF going through a time of transition, but certainly the leadership of the country, and therefore our leadership is going to transition, we are still waiting for the naming of our new administrator and the confirmation of the leaders of the HHS. And Michelle will be presenting the priorities from our perspective, Meaningful Measures 2.0.

We continue to think that's very important and we look forward to getting endorsements of that. But we know, as Michelle had always planned, but certainly with the new executive orders, the importance of equity is, I think it was Executive Order 2, that the President had signed, will become extremely important.

We also know that virtually all of us believe in eCQMs. Whether or not, how we will be transitioning into speed will be something that we'll be getting guidance on.

And we recognize that for this MAP, one of the major reasons for the limited number is really part of the previous administrators goals with regard to measures.

But we certainly, and Michelle and I both strongly believe in getting to outcomes, particularly patient reported outcomes. And we'll hear that today. But again, we value your insights.

And lastly, as I talk to individuals who have been in the field a long time, and really have had the privilege of working with Carolyn Clancy in various roles throughout my career, the idea of alignment. And I know it's been important in the past.

I know CSAC frequently wrestles with the issue, or did wrestle with the issue, of making sure in an given space that we really had measures that were aligned. That one of the insights I gained in the last six months is, for example, for federal programs.

If we need to compare the quality of

care of somebody at the VA to the quality of care of somebody going to one of Chip's hospitals or any hospital in the country, that that alignment around the specifications and the outcomes to say, if you particularly need mental healthcare, cardiovascular care, can we be able to look at the various different hospitals and delivery systems.

Not only hospitals but groups, community settings. How can we assure that they really are aligned by having alignment in the way we measure them.

So with that, I again thank you for your hard work today. Hope that you do have some rocky discussions and give us good input on these measures so that we can take back and noodle upon as we move them forward to the new administration. And thank you for your service.

And with that, I'll turn it over to Michelle.

DR. SCHREIBER: Thanks, Lee. And good morning to everybody. This is my third MAP

now from CMS's point of view and I'm very excited to be here.

On behalf of CMS, to each of you, Happy New Year. It's still January so I think we can still fairly say that.

So, to the Coordinating Committee, thank you so much for your time and your efforts. We really look forward to your opinions today.

And I'm going to spend a little bit of time basically outline, sort of walking through CMS's quality action plan. What we're thinking of measurements going forward.

And share with you, actually, a couple of newer slides that we have put together to, kind of hot of presses, to get your feedback and opinions on those.

Thank you to our Co-Chairs, Chip and Misty. I know you will keep this meeting running along and on time. And I promise that my section will be done at 11:15 this morning, even though we started a bit late.

So all of you and all of the

organizations that you represent, this clearly has been a year of tumult. The crisis, the pandemic has affected everybody.

But we'd really like to say a specific thank you to you, your organizations and the people who work in the organizations, for the COVID response. Because the front line providers, and all of you working on this, you are really the true heroes to healthcare. And so, we extend absolutely a deep thanks and appreciation to all of you.

The NQF Staff, CMS would like to formally welcome Chris Queram as the new interim CEO. We've had wonderful conversations with him so far.

And, Sherri, I'm afraid we don't feel like your new anymore.

(Laughter.)

DR. SCHREIBER: But thank you to you and the NQF Staff. You guys have been wonderful and flexible partners.

As you all know, these meetings are

usually in December, so we've been working with incredible time constraints. Thank you.

We have a number of CMS Staff on the call today. We are here to assist you and to answer questions as best we can.

We also have a number of our contractors who can also provide their expertise. But we are here really to answer questions and to provide any clarifications. To our federal partners who are on the call today, thank you for joining.

Now, as Chip and Lee and NQF have already pointed out, the role of the MAP is to have an independent consensus base group who can provide recommendations and comments back to CMS about the measures that we use in our various value-based incentives. The payment programs and public reporting programs.

And we really look forward to everybody's input. But we also value that that this is a totally independent body and the decisions that you make are entirely up to you.

So, again, we are here today to provide clarification to any questions that you may have.

We've had several good meetings so far. The rural committee, the post-acute committee, the hospital committee and the clinician committee, all compacted into a very short time frame. But we have their recommendations for you today. They've brought significant expertise. And we did have some, lots of interesting conversations that will be shared today.

The Committee does make recommendations, but I've said this every year. Just as a reminder, the final say of what does go into rule writing is a government decision. But that doesn't mean we don't absolutely value the recommendations that are made by the MAP. And year-over-year we always learn something. We always change our rule writing as a direct result of what comes from these committees. So it's extremely important. And we value your expertise and your feedback.

As Chip pointed out, as part of the recent Consolidated Appropriations Act, there is language in there around the 1890A section, which is NQF funding the consensus-based entity talking about the recommendations for removal of measures too. So, Chip, I think that conversation is going to come at the end of today, but we wanted to recognize that we are very supportive of that as well. And look forward to the next steps around that.

I also wanted to note that today we're going to introduce some COVID vaccine measures, that we recognize did not get support either by NQF in their initial recommendations or by the committees. And we understand why. Because we could not bring you the specifications that you are all used to and the testing that you are all used to. Because, frankly, it doesn't exist at the moment.

But we wanted to make sure that the MAP committees had insight into the measures that we are hoping to bring forward around COVID

vaccinations. And we understand the spirit of not having supported these is not because anybody doesn't support vaccination but it's because we really can't bring to you exact, the exact specifications.

So with that, I'm going to turn to the CMS quality action plan. And I'm probably going to go pretty quickly so that we will have some time for discussion at the end. Because we really value your insights as to our thoughts and actions going forward. Sam, if I can have the next slide please. And this really is just a disclaimer that says, this isn't regulatory, this isn't what's going in the Staff chute, but this is really our interpretation of where we would like to go in the future with quality measures.

Next. You know, I think all of us can agree with the vision for measures. NQF, certainly all of you have been thinking of this for a long time. And then it's to use impactful quality measures to improve outcomes and to deliver value. We do that by empowering patients

to make informed care decisions. And there has been, obviously a lot of focus, rightfully so, on reducing burden to clinicians. And this gets to measure alignment and what we can do to reduce the burden of measures.

Because there has been a lot of discussion, and you know this from the past year, about what is the role of quality measures. Are there too many, are there too few. HHS, as you know, had convened a group of individuals who weighed in on the HHS quality roadmap. Which recommended measure reduction, measure governance and changes in data. And so, there is a lot of conversation across what we'll call the quality measurement ecosystem about, where should we be going with the measures moving forward. So this is CMS's view of our priorities for measurement.

Next slide. So the goals of the CMS quality action plan are four. Actually, Sam, can you just show me the next slide. Okay. Then go back. Thanks. The reason that I just did this

is, as I told you, we have a couple of slides hot of the press so that you can see we've been taking feedback from external stakeholders. We've had these conversations at the other MAP meetings that we've talked about. And we've actually started to make some changes that I wanted to share with you today to get your opinions.

So the goals really are using the meaningful measures framework, which is morphing into, from Meaningful Measures 1 and Meaningful Measures 2. A little bit more streamlined. To streamline and simplify quality measurement. And a lot of that has to do with alignment. Then take those measures and leverage those measures to drive value and outcome improvement. To decrease the burden of measurement and to make measurers more efficient by transitioning all measures to digital. That also allows us to use, and leverage, advance data analytics. Which, frankly, may make measures look different in the future.

And then to empower patients to make

the best healthcare choices, one, by making our information more user friendly and consumable, but also to ensure that we are always hearing the voice of the patient, the care giver, the consumer. In patient reported outcomes measures wherein measures that we would say are very patient-centric. Such as shared decision making.

We had talked about equity. And we run equity in all of our actions. But we heard loud and clear, to call it out specifically, so that on the next slide you can see that we did specifically call out and add equity to the leverage quality measures to promote equity and closed gaps in care. And we think that this is a great step forward in making sure that we are clearly calling it out. That it's not just cross cutting, because sometimes as you have cross cutting measures you lose the focus of a specific gap.

Next slide. Most of you are familiar with Meaningful Measures 1.0, but we have six

different domains. We had a number of focus areas. But we've had great successful with Meaningful Measures 1.0. And we'll show you our diagram for Meaningful Measures 2.0 in just a moment. And on the next slide, I am going kind of quickly. We've had some real significant accomplishments in the last couple of years with Meaningful Measures 1.0.

It has helped us really set our priorities for measures that go forward in our programs, measures that go on the MUC list measures that are considered for going into the programs after lining up within the important topics of the Meaningful Measures. And we have used this actually to also identify gaps. As well as identify measures for retirement.

So, Chip, when we talk about removing measures, we have been using this framework. And as a matter of fact, over the past couple of years we've had a 15 percent reduction in the number of measures that we use in the CMS fee-for-service programs. From 534 to 460. No, it's not the

several thousand that people sometimes reference, but we continue to reduce the number of measures. We also continue to shift the types of measures from process measures to more outcome measures. But we recognize there is an important role for some process measures. And frankly, some structural measures also.

But we are moving more towards outcome measures. And we have decreased the percentage of process measure prominently increased, certainly by 25 percent the number of outcome measures. And finally, this streamlining has had a projected savings of millions of dollars and millions of burden hours.

Next slide. So our diagram for Meaningful Measures 2.0 is actually quite simplified. With the true north, the arrow, the house being the patient, we have seven different domains. And the foundation of the voice of the foundation.

But next slide please. We have, through the feedback that we had from both the

MAP committees and from external stakeholder conversations, we've actually morphed that a little bit towards building value-based care as the goal, build a true north, being the patient and the patient family. We have explicitly added equity to the meaningful measures framework. We have changed the patient's safety to safety. I'll be curious what you all think of that. Because there was a lot of conversation, is it healthcare safety, is it patient safety.

There's a whole body of knowledge around that, but it's more than just patient safety, it's workforce safety. And issues of resiliency even come into this. So we morph that to safety. Chronic conditions. Seamless care coordination. That had been seamless communication of care, but we changed that to seamless care coordination, which will also embrace communication.

Equity we spoke of already. Affordability and efficiency, wellness and prevention. And we added behavioral health, that

hadn't been in the original meaningful measures, with the recognition of how important behavioral health is.

And this is all built on the foundation of ensuring that we have the consumer and caregiver voice. There was a lot of discussion around visitation voices, consumer voices and caregiver. And so we landed on the consumer and caregiver voice based on the feedback.

And the goals of meaningful measures, we really kind of outlined these. And I'll show them on the next few slides. Utilizing only quality measures of highest value and impact, aligning them across all of our programs. Across our federal partners. And frankly, across all payers, as much as possible.

Prioritizing outcomes and patient reported outcome measures, transforming to fully digital. Yes, 2025 is not a typo. And there is a lot of conversation on whether or not that time frame is realistic or aspirational, but 80

percent of our measures we would consider digital today on the MUC -- on today's MUC list. And implementing the measures that reflect social and economic determinants.

So let me just pause for a moment. Sam, if you can open up the conversation. And it would be very helpful if people would like to comment on, do you like the changes that we've made about calling out equity, about some of the other changes that we have made to the specific CMS action. Thanks, Sam.

DR. STOLPE: Thanks, Dr. Schreiber. I'll now open it up to the working, excuse me, to the coordinating committee for comments. I did want to give a recognition to CMS for a quick turnaround. Many of the things that are different in this slide are direct recommendations from the workgroups that just convened two weeks ago. So kudos to you.

And we'll now open it up to the coordinating committee for any comments on Dr. Schreiber's presentation thus far.

CO-CHAIR KAHN: Do you want me to share this?

DR. STOLPE: You're welcome to, Chip, if you wish to.

CO-CHAIR KAHN: Okay. And I'll take the privilege as the Chair and just ask a couple of questions. I appreciate everything that you went over, Michelle. And you mentioned the aggressive timing on the eCQMs.

And I just wanted to make sure that in your -- this is sort of a question, sort of a statement, sort of in your process of going through this, that I presume but I'd like you to give us some sense of it, that when you go to eCQM it isn't just an IT project, it really affects workflow and is a different aspect, I mean different kind of measure. And I think that's really important in validation.

I mean, ultimately we want real time because you want real-time information. That's what's really useful to people. And we won't get there without this.

But what's your thinking about that in terms of this evolution? Beside measures that are already there with claims.

DR. SCHREIBER: No, Chip, you're absolutely right. And in the next few slides, when we dive a little bit more deeply into the goals, I can speak to it again.

But first of all, digital measures. We are viewing it broadly. Okay. So we're starting with a broad definition of what a digital measure is.

And it's not just an eCQM, an Electronic Clinical Quality Measure, which traditionally is from an electronic medical record. But it's also measures that are claims, measures that are also -- that have other digital information.

And for example, measures in the future may include information from downloadable devices from patients. And so we take a fairly broad view really of what is a digital measure.

You know, Chip, I've implemented lots

of electronic medical records in my day. And I understand completely that this is not an IT project. Certainly not an exclusive IT project.

This has to do with what is clinical workflow and how you embed getting the right data into clinical workflow and actually create that flow of clinical workflow to getting the data that you need that is easily embedded there, to rapid feedback reports, to clinical decision support so that you can have this ongoing learning system. And that's what the goal is here.

But taking a broad view of what a digital measure is I think will allow us to get there quickly. We are working on a roadmap actually for digital measures, which really will lay this out over time. A lot of it is based on using FHIR and FHIR APIs, so that measures -- so that data actually is easier to transmit. And certainly to share.

This rests on interoperability as well. So this has many tentacles. We've been

working closely, not only across CMS but with the provider community. I know NCQA is moving some of their measures to digital as well.

We're working with ONC, with the USCDI for standardization of data elements. So it has many tentacles, Chip, and we fully are aware, that this is not just an IT project.

CO-CHAIR KAHN: Okay, great. Let me open my participants. Do we have any hands?

MS. PERERA: We do. First we have David Baker.

CO-CHAIR KAHN: David.

MEMBER BAKER: So Michelle, I just wanted to say that I support this change from patient safety to safety.

DR. SCHREIBER: Thank you.

MEMBER BAKER: As we've seen during COVID, the patient safety and staff safety are really intimately related. The staff don't have adequate PPE. They get infected. They have to take time off, then you have less staff to take care of patients and worse outcomes.

Similar issues for the burnout issue and workplace violence as well. So I really support this.

DR. SCHREIBER: Thanks, David.

MS. PERERA: Next we have Elizabeth Goodman.

MEMBER GOODMAN: Sorry, I'm trying to get off mute. Michelle, this looks terrific. And I, you know, we are deeply grateful for the focus on alignment. And totally agree with calling out equity.

The one thing that I would just phrase is there are some measures on today's list that the payers have concern that while the data may be electronically available to CMS, it would not be electronically available to payers.

And so as we focus on alignment and we move to electronic measures, we just need to make sure that it is universally electronically available.

DR. SCHREIBER: Yes.

MS. PERERA: Janice Tufte.

MEMBER TUFTE: Yes, thank you. I was on a few of the calls so I am very glad to see that what had been discussed was incorporated where equity, I don't think had been called out before, and safety regarding safety overall.

And I just wanted to add that, regarding the social determinants of health, I know that some of the measures that we're looking at today were not, are not adjusted for social risk factors. And the truth, it can really make a big difference in -- when we're dealing with chronic conditions.

So that should perhaps be a subset or something of the chronic conditions. How we're actually going to do that and look at social risk factors. It's going to be only exasperated at the end of COVID, as well as it is right now. Thank you.

DR. SCHREIBER: Yes, thank you. Sam, maybe one more comment. Sam or Chip, one more comment because I want to get to some other slides and another couple sets.

CO-CHAIR KAHN: Okay. I guess somebody else has control of the hands. I mean Harold Pincus, I see your hand. So --

DR. STOLPE: Let me just add one thing there, Chip.

CO-CHAIR KAHN: Okay.

DR. STOLPE: You have all the comments for CMS and you'd like to put them in the chat. All of the chat comments will be compiled by staff at the end.

CO-CHAIR KAHN: Okay. Good.

MEMBER PINCUS: This is Harold. I appreciate the updates in terms of the 2.0. And especially including behavioral health.

But I want to get a sense of what that means to actually include behavioral health as a subcategory, because I notice that there are no behavioral health measures among those that we're discussing today.

DR. SCHREIBER: There aren't among those that are being discussed today. I think, in large part, we put it there in recognition of

how important. It's not just behavioral health but it's obviously mental health and substance abuse would go into that.

And it reminds us to make sure that we always are thinking of them in bringing them forward. So we think it's an important topic to recognize. I don't think we have enough measures there, Harold.

MEMBER PINCUS: Yes. And I think the agenda for today sort of demonstrates that.

DR. SCHREIBER: Okay. How about if we move forward to the next slide so that we can get a --

CO-CHAIR KAHN: Okay.

(Simultaneous speaking.)

DR. SCHREIBER: -- deeper dive into a bit more of what we mean.

The first one was using Meaningful Measures to streamline and align. Alignment is actually very important here because as we pointed out, certainly amongst our federal partners, we work very closely with the VA and

the DoD now, making sure that we're comparing apple-to-apples.

That patients who receive care anywhere, these measures are standardized and aligned. And we recognize that perhaps that hasn't always been the case, even to the definition of what hypertension is. And the definition of what diabetes out of control is. We need to ensure that we're aligning there.

So we're using our measurement framework to not only reduce burdens but align measures, as I said we're working really across many entities to do that.

This also has called out some gaps to prioritize some high targeted areas, such as SES measures, internal mortality, kidney care. And frankly, as Harold pointed out, the behavioral health, opioids and the substance abuse.

Aligning our measures to quality improvement activities, we've already spoken of them increasing the proportion of outcome measures.

And I want to recognize the important work of the quality measures collaborative with AHIP, CMS and NQF, where we're trying to align measures across all payers that have actually chosen ambulatory measure sets in-between eight and ten for areas now that hopefully we can all align to.

Next. Leveraging our measures then for CMS through our valued-based programs. That's how we use these to become publicly transparent so that consumers and everyone can see performance and link this to payment or incentives and penalties as well.

Many of you have seen the transformation in MIPS that we're moving forward to smaller sets of measures, really related, interrelated measures, that focus on a specific category, such as improving prevention or improving chronic disease management, or improvement hip and knee surgery.

We've had a wonderful experience actually working closely with many of the

speciality societies to make programs that are -- and measures that are really more meaningful to clinicians.

So we continue to modernize many of our programs. You've seen that we've updated the Stars Program, we've updated, and now through legislation, will have an expanded SNF value-based purchasing program so that it's not just one measure but there are ten. So we continue to modernize our programs.

We also intend to provide confidential feedback reports on measure performance specifically stratified by dual eligibles. And I will have a proposal at the end about stratifying in other ways, to ensure that we're closing the gaps in equity.

Next slide. We spoke, I think already, a lot about digital measures and the transformation and the move to digital measures.

CMS actually has been a pioneer in using FHIR and FHIR APIs. We will be scanning up the ability to receive all quality measure

information in FHIR, through FHIR APIs.

This will also allow us the ability to accelerate and expand filing performance reports. Though we talked about, this is not simple. But we are doing it with a lot of collaboration with not only measure developers but with ONC in working towards interoperability.

We think the most exciting thing though is that this would not only in the long run reduce burden, although we recognize the short-term work, but in the long run reduce burden. But improving interoperability would allow the various other payers to have access to this information.

So to your point before, thank you. And it also allows us to leverage advanced machine learning, neural networks. Whatever you want to call it, but will help us innovate and create new concepts and quality measures.

Next slide. We spoke of patient reported outcomes. So we have a commitment to increase by 50 percent our patient reported

outcomes. We recognize they're not so easy to use because they sometimes require another application; they sometimes require calling people 30, 60, 90 days out.

And so you have to get to a point to where these are easier to use. But nonetheless it's absolutely essential to hear the voice of the patient, and to make sure that we have more patient-center measures.

And next slide. Finally we did speak of equity, confidential feedback reports. We have some plans to be leveraging our programs to help close the gaps, to ensure equity by ensuring that we're developing measures. Maybe for social economic status.

But we are partnering with the Office of Minority Health. They have a health equity score that we're looking to use as well. So we are looking to really have a robust response to equity. To highlight it, to call it out and then to start closing the gaps through measurement.

Next slide. Okay, let me pause there.

And we have a couple of moments for comments on this somewhat deeper dive, very rapid, on specifically the action steps for the CMS quality plan.

And then I wanted to spend the last few minutes talking about another way of looking at equity. So Sam, Chip, maybe a couple of comments.

CO-CHAIR KAHN: Okay. Any hands up? For the moment I'm looking down the hands. I don't see any.

MS. PERERA: None that I see as well.

CO-CHAIR KAHN: Okay.

MS. PERERA: Amir. Actually Amir Qaseem just raised his hand.

CO-CHAIR KAHN: Okay.

MEMBER QASEEM: Hi, Michelle. Good morning.

DR. SCHREIBER: Hi, there. Good morning. Happy New Year.

MEMBER QASEEM: Happy New Year. It's a wonderful presentation. First of all I think

it's really nice to see the changes that are being made at CMS and it's exciting. This is steps in the right direction.

I feel like it's more of a comment. I think you will agree that I think just even if you take the example of patient reported outcome measures, right, that the issue with that is that you are trying to achieve go more in the direction of outcome measures, but you also want to address let's say social determinants of health, right.

The problem over there is that science is still trying to catch up, Michelle. You know it, I know it, and everyone who is in performance measures, expert or here, knows.

My worry over there is that since science is not still there yet and if it's not done right you can actually end up doing more harm than benefit.

So in terms of goals I think you're heading in the right direction, but once you start changing this into accountability measures or something along those lines, I think you

need -- I just raise a cautionary flag over there.

And I can add more to it, now just one more example. I know we are moving more towards outcome measures and we are moving away from structure and process measures, but remember that you can't just lag that behind.

If I put my physician hat on, I need to have time to sit down with my patient to be able to address some of these patient reported outcome measures that are -- you can't just ask for it and hope that the structure will take care of this itself, right.

So I worry that there are a couple of -- These two are just examples of the goals I think, so you are heading in the right direction and that's what we should do.

But we are not addressing some of the fundamental issues that if we don't do that we're not going to be able to move the needle, and I think you are aware of it, CMS is aware of it, but we haven't been able to address it.

DR. SCHREIBER: You know you are

absolutely right. The devil clearly is in the details of all of this and is in the operationalization of all of this as well.

We have some fairly detailed ways to operationalize this, but it will take time and it will take -- that's why actually I am so excited to talk about this with the MAP groups.

It will take this kind of partnership to make sure that we are not introducing unintended consequences, to make sure that we are moving in this direction though, because clearly kind of the quality ecosystem of the country isn't really happy with where things are now from measurement, but we think these are the important principles in moving forward, and it will be up really to all of us to be talking about when we retire what do we bring forward, what's in the pipeline, and how do we get there?

So I am looking forward to it as a partnership, but directionally we wanted to make sure that the Committee knew that this is where CMS is thinking and to ensure that we are

capturing kind of the right direction.

CO-CHAIR KAHN: I guess David, David Baker.

MEMBER BAKER: Just a comment on the PROM performance measures. I think the measures are good, but as you said the big challenge is implementation and the low response rate.

We work with the American Joint Replacement Registry and the American Spine Registry and still the proportion of patients who have a pre and post is very low. So I think we are really going to need to think outside the box, including something like financial incentives for organizations so that they have the resources to try and collect this.

You talked about some of the technology to help solve this. It's not just in the electronic health record, but these are smartphone data collection and other things.

And even how do we incentivize patients to complete these because regardless of statistical adjustments, I just don't believe any

comparison between organizations that have 25 percent reporting rates.

DR. SCHREIBER: All very good comments, and I am trying to look at the chat, but I apologize that I can't get to everything.

MEMBER BAKER: Yes.

DR. SCHREIBER: So I am looking forward to seeing everybody's comments. I want to spend, because we only have a few minutes left, I want to introduce this other -- this next concept.

We had some interesting discussions at the various MAP meetings around this. As we look at equity -- can I have the next slide, Sam? We can see that to be quite honest with you we don't have great data, okay.

So when it comes time to differentiating in sensitivity and specificity between patients who are black and white, it's not terrible but the sensitivity specifically for African Americans isn't what we would want it to be.

And when we start looking at ethnicity, Hispanic, Asian-Pacific, American Indian, it's terrible. And so how can we actually even provide confidential feedback reports to organizations when the underlying data really isn't very good?

Part of the challenge for CMS is that the collection of this data at enrollment with Social Security stopped a number of years ago when the funding for that stopped.

Now we know that organizations have some of that data. Many organizations are actually collecting this in detail. They don't send that; we don't have it.

So I guess one question is should we be asking to ensure that organizations are collecting the data and that they themselves are stratifying their information and discussing it internally?

But if CMS, for example, wanted to provide confidential feedback reports back we can do duals, but we're not going to be particularly

good with anything more granular.

Next slide please. So many of you know that there are several of the statistical models, one is by RAND, one is by RTI, and I think that there is others.

So there are statistical models for indirect estimation. And the question on the table is how people would feel about CMS using some of these indirect models to estimate race, ethnicity, and language and to be able to provide confidential feedback on that.

Then you can see the science here is that the numbers, the correlation, is actually pretty darn good and certainly better than what we have with directly collected data.

But there is something that sometimes doesn't sit right in saying we're going to impute whether or not you are a Latino patient because maybe you married somebody with a last name that sounds, you know, more ethnic.

And so the question to the group is how do you feel about this because these models

are used widely in organizations across the United States.

But my question is how would folks feel for CMS to be using indirect estimates to provide confidential, this would not be publicly reported, this would not be used in pavement, but starting to provide confidential feedback reports to organizations or providers about their performance so that they can at least develop a greater awareness of it.

So I will open that up for discussion. I know we only have a few minutes, but Chip, I'll turn it to you and Sam for some conversation here.

CO-CHAIR KAHN: Yes. I guess the issue is how the information is going to be used. It has to be done with great care. I mean if it's simply part of a feedback loop, that's one thing.

The trouble is that once it is in the agency, then the question is: does it become part of some regulatory power not just simply a feedback loop to help facilities improve, because

as you say it's still based on estimates and, you know, that approach. Are there other comments? Do I see any hands?

MEMBER SONIER: This is Julie Sonier.

CO-CHAIR KAHN: Julie.

MEMBER SONIER: I've got sort of an observation. Well there is a lot I could say on the topic. I think as long as it's being used for stratification instead of risk adjustment, so like you don't want to adjust in a way, for example, the effects --

(Simultaneous speaking.)

DR. SCHREIBER: Right.

MEMBER SONIER: What I wanted to share is that, you know, I've recently had the opportunity to be part of some community conversations about disparities with groups of people that experience greater levels of disparities.

One of the things we talk to them about is, for example, the possibility of using like area-level data from American community

surveys to kind of help with analysis.

I was surprised by the degree of lack of trust that was expressed in those sorts of data sources. And so my only input at this point is to be cautious about it.

So if people -- First of all because of less likelihood of responding to those types of surveys for people from certain communities, especially if they are afraid that something bad could happen to them immigration wise if they do, as well as even in the EHRs they told us some of the data may not be accurate because of the same types of fears that people experience when they get healthcare perhaps not providing accurate information, so a big challenge.

I would say that trust is going to be huge. It's going to take quite awhile to kind of work through, but the community representatives should be involved in that.

DR. SCHREIBER: Thank you.

CO-CHAIR KAHN: Any other questions, comments?

MS. PERERA: We have Janice Tufte.

CO-CHAIR KAHN: Okay.

MEMBER TUFTE: Hi. This is Janice Tufte again. I just wanted to mention that I agree it should be stratified.

And in regards to the last comment, on one of the previous calls, I believe it was the clinicians workgroup, it was mentioned about community data and I agree with like the extra four digit zip code because it will tell what is available in the community.

There is wide variation within zip codes. I live in one of those zip codes that has a 17 to 20 year, you know, variance as far as mortality rates, but you'll also have an understanding with the four, the extra four zip code, what is available to the community.

But I also live in Seattle and we have a very large Alaska, you know, American Indian/Alaskan Native presence, and they really are moving forward in what they would like to see done and do have a presence currently at the

National Academy of Medicine and elsewhere.

So the API is where we see a big, a huge disparity where I live, and so it's hard to bring it all together, but if you stratify by it it will bring opportunities so it doesn't push certain populations out or leverage other ones.

CO-CHAIR KAHN: Okay.

DR. SCHREIBER: Chip, I think maybe just one more comment. I want to be mindful of everyone's time.

CO-CHAIR KAHN: Yes. I don't see any other hands, so why don't you proceed?

DR. SCHREIBER: Okay. Well I think -- was that my last slide I think, Sam?

(No audible response.)

DR. SCHREIBER: Now this just talks about indirect estimation pro and con. As I was looking at the chat I saw a number of comments about being very, very careful about this.

That's really one of the reasons that I brought it to the group today because there is, you know, a lot of concern about doing this.

Obviously the best method is to ensure that we have direct collection of this data, but since we don't at the moment, and you can imagine that will take awhile to get that machinery going, we wanted to be able to provide at least some feedback back, and we will take your comments and your concerns back and continue to discuss this at CMS.

So thank you all for your input. Again, I will just re-echo what Sam said, if you put your comments in chat, we'll have an opportunity to look at them there or feel free to reach out to me or to anyone at CMS and provide your comments.

We really look forward to the ongoing partnership. So thank you all very much. And to NQF, Chip, Misty, Sam. I turn it back to you guys.

CO-CHAIR KAHN: Thank you. Thank you, Michelle. That was really very helpful. I know we have a number of comments from some of the earlier questions in the box which will be

passed on to Michelle and catalogued.

So now let me ask Udara to review the pre-rulemaking process, including the decision categories and the voting procedure. And I think our slides are two later, so we are at 27 I think rather than 25.

MS. PERERA: Thank you so much, Chip. We'll now take a look at an overview of the approach to decision making and walk through the preliminary analysis algorithm for measures that are under consideration.

We'll also review the voting decision categories as well as the voting process and the charge of the rural health workgroup.

Next slide please. So our NQF staff conducts a preliminary analysis of each measure under consideration.

The goal of the preliminary analysis is for the NQF staff to flesh out each measure under consideration in detail and to create a succinct profile of each measure by giving a brief rundown of the measures and a preliminary

look at how it compares to the evaluation criteria.

The intention is to help facilitate MAP workgroup discussion and to serve as a starting point for MAP discussions. In order to conduct the preliminary analysis, the NQF staff uses an algorithm, which we'll look at in the next few slides. This algorithm was developed from the MAP Measure Selection Criteria to evaluate each measure in light of MAP's previous guidance.

This algorithm was also approved by the MAP Coordinating Committee and it is an important aspect of our overall process.

Next slide please. We have seven key components of the preliminary analysis algorithm that we'll go through today.

The first assessment is if the measure addresses a critical quality objective that is not adequately addressed by the measures in the program set.

And in terms of outcome if we say yes

the measure does meet this definition or criteria then the review continues, but if we say no then the measure receives a do not support for recommendation decision.

And MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

The second assessment is if the measure is evidence-based and it's either strongly linked to the outcomes or it is itself an outcome measure.

For process or structural measures we are looking to see if the measure has a strong scientific evidence-base to demonstrate that when the measure is implemented it can lead to the desired outcomes.

And for an outcome measure we are looking to see if the measure has a scientific evidence-base and has a rationale for how the outcome is influenced by healthcare processes or structures. Similar to the outcome for the

previous assessment, if we say yes then the review continues, but if we say no then the measure will receive a do not support recommendation.

And MAP may provide a rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

The next assessment component is if the measure addresses a quality challenge. So if we say yes, then the same as the other measures, the review continues, but if not then we do not support the measure for implementation.

But again, MAP may provide a rationale for that decision to not support or make suggestions on how to improve the measure.

Next slide please. For the next couple of assessment criteria the algorithm changes a little bit in the sense that we need to pass those first three assessment criteria first.

The fourth criteria is that the measure contributes to efficient use of

measurement resources and/or supports the alignment of measurement across programs.

If the answer is yes then the review continues. However, if the answer is no, then the highest rating can be do not support with potential for mitigation.

So if the Committee does arrive at this decision category, then the Committee would outline precisely what the measure developer should do to improve the measure overall for future support.

The next criterion is if the measure can be feasibly reported. The outcome is similar to the previous criteria, if yes then the review continues, if no, the highest rating is do not support with potential for mitigation.

And again, MAP may provide how to potentially mitigate the measure along with any sorts of rationale for how we arrived at that decision.

Next slide please. Our next preliminary analysis algorithm assessment point

is that the measure is applicable to and appropriately specified for the program's intended care settings, levels of analysis, and populations.

So this generally means that the measure is NQF endorsed, or the measure is fully developed and specifications are provided, and the measure testing has demonstrated both reliability and validity for the level of analysis, program, or setting for which it is being considered.

So if the outcome is yes then the measure can be supported or conditionally supported. If it is no, then the highest rating can be conditional support.

MAP in that instance dictates what those conditions are and suggests how the measure can be improved.

And the last criterion is if the measure is in current use, then there haven't been any negative unintended consequences to patients and that burdens don't outweigh the

benefits.

The outcome of this is that if there is no negative unintended consequences or implementation issues then the measure can be supported or conditionally supported.

However, if there are implementation issues, then the highest rating should be conditional support. And MAP can elect to provide a rationale on that point and how they think those challenges could be overcome, or anything else that the measure developer should consider.

Next slide please. Next we'll talk about the MAP voting decision categories. Next slide. So there are four decision categories as you can see in the first column.

Those are support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, and do not support for rulemaking.

The first category, support for rulemaking, means that MAP supports the

implementation and MAP has not identified any conditions that need to be met prior to implementation.

So linking it back to our evaluation criteria, what this means is that the measure is fully developed and tested for the setting in which it is going to be applied.

That means that the measure meets the first six assessment criteria that we saw on the previous slides. And if the measure is in current use, then it needs to meet the last assessment criteria, which was about the unintended consequences and burden.

The second decision category is conditional support for rulemaking. And this means that overall MAP supports implementation of the measure as it is specified; however, MAP has identified certain conditions or other modifications that would ideally be addressed prior to implementation.

And this designation within this category assumes that one of the assessments

between Assessments 4 to 7 has not been met, and ideally those modifications would be made before the measure is proposed for use.

The next decision category is do not support for rulemaking with potential for mitigation. And for this category MAP does not support implementation of the measure as it is specified, but MAP agrees with the importance of the measure and has suggested material changes to the measure specifications.

For this category the measure meets the first three evaluation criteria, but the measure can't be supported as it is currently specified and a designation of that category assumes at least one of the assessments from Assessments 4 through 7 were not met.

The last category is do not support for rulemaking. It means that MAP does not support the measure, and this is when the measure under consideration doesn't meet at least one or more of the first three measure evaluation categories.

Next slide please. Next we'll talk about the voting process that we conduct on MAP. Next slide. So one of our key principles is that of quorum.

This is ubiquitous across the National Quality Forum, and we require a certain percentage of the workgroup to be present. For MAP, quorum is defined as 66 percent of the voting members present virtually for the meeting to commence.

And since we are convening completely virtually this year, we need to have 66 percent of the Committee present in order for us to be able to take on any vote.

So once we establish that quorum is present, that process involves simply taking a roll call or an attendance. So at any given time we can determine if quorum is established at the beginning of the meeting, but if we feel that we have lost quorum we can do a check before we actually conduct a vote.

So if we don't establish quorum, we'll

vote via an electronic ballet after the meeting. So we will present a recording of the proceedings and then ask MAP members to vote once we have conducted our business without actually conducting the votes during the meeting.

MAP has also established a consensus threshold, and that is greater than or equal to 60 percent of voting participants must vote positively and a minimum of 60 percent of the quorum figure voting positively.

So one thing that I do want to point out is that if for any reason you were conflicted on a measure, we invite you to recuse yourself and any abstentions do not count in the denominator, and as I mentioned before, every measure under consideration receives a decision category.

Next slide please. Our NQF staff provides an overview of the process for establishing consensus through voting at the start of each review meeting.

After additional introductory

presentations from staff, the chairs will give context to each programmatic discussion, and then voting will begin.

Each measure that is under consideration will have been subject to a preliminary staff analysis that is based on a decision algorithm that was approved by the Coordinating Committee as I mentioned before.

The preliminary analysis shows the results, for example support, do not support, or conditional support, and provides rationale to support how that conclusion was reached.

Next slide please. So here is the step-wise process by which we will conduct voting. First, our NQF staff will review the workgroup decision for each measure under consideration.

Next, our co-chairs will ask for clarifying questions or concerns from the Committee, and the co-chairs will compile all Committee questions and expressed concerns.

The measure developers will respond to

clarifying questions and concerns related to specifications on the measure and NQF staff will respond to clarifying questions and concerns on the workgroup decision.

For Step 3 we vote on acceptance of the workgroup decision. So after clarifications have been resolved the co-chair will open up the vote on accepting the workgroup decision.

The vote will be framed as a simple yes or no vote to accept the result, and if greater than or equal to 60 percent of the Committee members vote to accept the workgroup recommendation, then the workgroup recommendation will become the MAP recommendation.

If less than 60 percent of the Committee votes to accept the workgroup decision, then we open up the discussion for a full review of the measure.

Next slide please. Step 4. This is the penultimate step, and that is discussion and voting on the measure under consideration.

First, the lead discussant will review and present their findings.

Coordinating Committee members that are assigned as lead discussants for the measure will be asked to respond to the workgroup decision, and lead discussants should state their own point of view whether or not it is in agreement with the preliminary analysis recommendation or the divergent opinion.

Then the co-chairs will open for discussion among the Coordinating Committee and other Committee members should participate in the discussion to make their opinions known.

However, we just ask that we refrain from repeating points that have already been presented in the interest of time.

After the discussion is concluded, the co-chairs will open up a vote on the measure under consideration. So NQF staff will summarize major themes from the Committee's discussion, and co-chairs will determine which decision category will be put to a vote first based on where they

think consensus was emerging from the discussion.

Now if the co-chairs do not feel that there was a clear consensus position, then they will start at the top.

The Committee will take a vote on each potential decision category one by one, and the first vote will be on support and then conditional support and then do not support with the potential for mitigation, and then finally do not support.

Next slide please. And now our last step, tallying the votes. If a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the votes the motion will pass and the measure receives that decision category.

But if no decision category achieves greater than 60 percent to overturn the workgroup decision, then the workgroup decision will stand. And those are the five steps of our voting procedure.

I wanted to now take some time and see

whether we have any questions on the voting procedure, the decision categories, or the preliminary analysis algorithm. Are there any questions from the group?

DR. STOLPE: So Udara and I will now take any questions that you have. I just wanted to make one note, too. So for our lead discussants and discussants, part of our step-wise process is that you will be able to give your full evaluation of the measure once we open up for discussion.

This does not preclude you from asking questions or expressing concerns during the initial gathering of questions and concerns before the vote. So I just wanted to make sure that is clear.

Any questions from our Coordinating Committee members?

(No audible response.)

DR. STOLPE: Okay. Well hearing none, let's go to our next slide. Well actually, this is where we are going to pause for a break.

CO-CHAIR KAHN: Okay.

DR. STOLPE: So we're going to take a 10 minute break before we jump into our next section.

CO-CHAIR KAHN: Let me say this is a real 10 minutes, so we really will come back precisely --

DR. STOLPE: You know what, I'm jumping the gun here, Chip. Udara has a couple more slides. I am so sorry.

CO-CHAIR KAHN: Oh, okay.

DR. STOLPE: Udara, why don't you go ahead and wrap this up, and then we'll take a break?

MS. PERERA: Sure. Thanks, Sam. So just a few more slides before a break. We are now going to give a brief overview of the rule of the MAP rural healthcare workgroup in the pre-rulemaking process.

Next slide. Thanks. So the MAP rural health workgroup's charge is to provide a rural perspective on the measures under

consideration to the other MAP workgroups and the committees to help address priority rural health issues, such as the challenge of low case volumes.

Next slide please. The rural health workgroup reviews some measures under consideration and provides input to all three of the setting-specific workgroups.

With the release of the MUC list, we sent out the preliminary analyses for the measures for your review. The rural health workgroup also received these preliminary analyses, and they were able to provide us with input on the relative priority or utility of MUC measures in terms of access, cost, or quality issues that are encountered by rural residents.

They also provided information on data collection and/or reporting challenges from rural providers, as well as any methodological problems of calculating performance measures for small rural facilities.

They also provided us with information

about any potential unintended consequences of inclusion within specific programs as well as gap areas in measurement that are relevant to both rural residents as well as rural providers for specific programs.

Next slide please. The rural health workgroup feedback for setting-specific meetings was provided to the workgroups for their consideration during the discussion and voting on the measures under consideration.

A qualitative summary of the discussion that the rural health workgroup had for each measure as well as the quantitative result of the rural health workgroup voting results are included in the measure preliminary analyses.

We have also had a rural health liaison at each of the three setting-specific workgroup meetings in order to summarize the discussions as well. Are there any questions on the rural health workgroup charge?

DR. STOLPE: All right, well hearing

none, let's take our true 10 minute break. We'll be returning at 11:45 Eastern to start into our hospital workgroup discussions.

CO-CHAIR KAHN: And I'm starting the timer now.

DR. STOLPE: All right. Thanks, Chip. See you soon, everybody.

(Whereupon, the above-entitled matter went off the record at 11:34 a.m. and resumed at 11:44 a.m.)

CO-CHAIR KAHN: Next we will have our public comment. I know I got some questions about the public comment.

Before we proceed to public comment let me provide a few guidelines. First, this public comment is on the hospital programs, so those recommendations obviously from the workgroups have been made public. So please only address the hospital programs. Second, because of time limitations, please limit your comments to no more than two minutes. And third, make any comments on the measures or opportunities to

improve the current hospital measures set at this time. Public comment from those who raised their hand on the platform will be taken first. All lines are open so people participating on the phone can comment.

So let's go ahead and start with the public comment. Do we have any public comments?

(No audible response.)

CO-CHAIR KAHN: I'll give it another minute.

(No audible response.)

CO-CHAIR KAHN: Not hearing any, Sam, should we proceed then?

DR. STOLPE: Yes, let's go ahead and move forward, Chip.

CO-CHAIR KAHN: Okay. And then do I give it now to Matt? Is that right?

DR. STOLPE: That's correct.

CO-CHAIR KAHN: Okay.

DR. STOLPE: So, Dr. Pickering?

DR. PICKERING: Okay. Thank you. Thank you all very much. And it's a pleasure to

speak with you all today to walk through the pre-rulemaking recommendations for the hospital program. And as you can see on slide 49 there are 13 measures that came through for consideration with the Hospital Workgroup.

Seven of these measures are going to be discussed later on, which are the COVID-19 measures. And so what I'll be talking about during this first session is the other six non-COVID measures that came through for the Hospital Workgroup in their recommendations based on those measures.

Before I proceed though I just want to check in to see if either of our co-chairs, Akin or Sean, are on the call.

Akin, are you there?

MR. DEMEHIN: I sure am, Matt.

DR. PICKERING: Great. Thank you. And then I believe Sean had a conflict. He was going to try to attend if he could.

But, Sean Morrison, are you on the line?

(No audible response.)

DR. PICKERING: Okay. No worries. Well, thank you, Akin, for joining.

And again thank you all very much for this morning and your time in reviewing these measures coming out of the Hospital Workgroup.

So again, 13 measures. The six we'll talk about during this morning's session are non-COVID-19 measures.

If we'd go to the next slide, please? So there were a series of themes that came through this cycle with the Hospital Workgroup, the first being the transition of services for the inpatient setting to the outpatient setting. This is really some of the feedback we also received on some of the measures through the Rural Workgroup as well in that during some of the gap discussions the workgroup members encouraged CMS to be mindful of the relevance of some of the measures in the inpatient setting due to some of the transition and shifts that are occurring of services provided in the inpatient

setting to the outpatient setting.

And so just being mindful of some of the applicability of the measure as more of these services are offered specifically related to the minimum case volume to calculate these measures as there were some concerns and discussion raised -- some of which we'll talk about in a little bit --- with some of the measures related to this issue. So that was one key theme to point out.

The second feedback or piece of recommendations for CMS really was around measuring cultural obstacles for quality improvement. And this was suggesting CMS identify opportunities to really measuring these cultural obstacles of organizations that are trying to do quality improvement efforts and really further promoting a commitment to doing quality improvement and cultural knowledge sharing around quality improvement as well. So really trying to create measures around this.

The last really key theme here was around the burden of measure collection and

reporting, and we've heard this previously around the importance of trying to reduce measure burden and a lot of the efforts that CMS is moving forward with. And the workgroup largely is supporting that and underscores the importance of this, even for the measures that are coming through this cycle, really recognizing that the electronic types of measures or EHR-based types of measures are important to help move towards moving -- improving measurement burden and moving away from that type of reporting burden.

And there was also some concerns raised around some of the data collection for surveys and patient-reported outcomes as well, which we'll touch on. But those were the key themes that came through with the workgroup.

If we go to the next slide we can get into the next measure, the first measure we'll talk about.

CO-CHAIR KAHN: So let me set this up for you, Matt.

So there are three steps here, just so

the Coordinating Committee will know: First, we're going to review the measure. Matt and the co-chairs will review the measures -- each measure.

Then we'll open it up for clarifying questions. And I want to stress that these are technical questions, clarifying questions. If we get into -- we'll get into -- if there are issues with the recommendation, which is the next part, then we can -- we will get into those -- that discussion later. So keep this sort of at a technical level so -- to make sure that you understand the implications of the measure, but you don't need -- we're going to try to restrict it to that at this point.

Then step 3 would be to vote on acceptance of the workgroup measures. After the clarifying questions we'll open up for a vote on the workgroup decision. The vote will be framed as yes or no to accept the result. If it doesn't -- if we don't accept the result, then we'll have another opportunity for the lead

discussants and an open discussion. This will be most efficient if we're really careful.

So with that I think I hand it back to Matt and to the Hospital co-chairs to review the decisions on each measure. Thank you.

DR. STOLPE: Thank you. Before we continue, I just wanted to note that Amir Qaseem has joined us.

Amir, would you mind providing us with a -- just a brief introduction and your disclosures of interest, please?

(No audible response.)

DR. STOLPE: Amir, are you still on?

(No audible response.)

DR. STOLPE: He may have dropped off. Let's go forward then, Matt.

CO-CHAIR KAHN: Okay.

DR. PICKERING: Okay. Great. So the first measure is for the End-Stage Renal Disease Quality Incentive Program, or ESRD QIP. And it's MUC-0039, which is the Standardized Hospitalization Ratio for Dialysis Facilities.

And this measure is defined as the ratio of number of hospitals -- hospital admissions that occur for Medicare ESRD dialysis patients treated at a particular facility to the number of hospitalizations that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities.

The measure can be calculated as a ratio but also can be expressed as a rate. And for the workgroup -- the workgroup supported this measure for rulemaking. This is an NQF-endorsed measure. It's NQF No. 1463 and it's used currently in the ESRD QIP program.

The measure seeks to improve patient outcomes by measuring hospitalization ratios among dialysis facilities. And the reason it is coming back before the MAP is because of updates to the measure, namely the risk-adjustment model which includes prevalent comorbidity adjustments and the addition of Medicare Advantage patients and Medicare Advantage indicator in the model,

and also the updates to the parameterization of existing adjustment factors and the reevaluation of certain interactions within the model. And there's an indicator for a patient's time spent in the skilled nursing facility.

These updates and the testing, et cetera, for this measure were reviewed this past cycle for spring 2020 by NQF Standing Committee for the all-cause admissions and readmissions portfolio and ultimately recommended for a continued endorsement.

The workgroup recognized that hospitalization rates vary across dialysis facilities even after adjusting for patient characteristics, and also observed that this measure seeks to promote communication between dialysis facilities and other care settings to improve care transitions. And so the workgroup supported the continued endorsement -- or continued use of the measure within the ESRD QIP program.

You can see that we did receive a

number of comments largely supporting for inclusion. There was a comment raising concern around reliability, specifically the decline in reliability calculations or statistics from prior years.

And the absence of results really stratified by facility size was another -- was a comment related to reliability, as well as some concerns with validity, namely the C-statistic, which looks at the appropriateness of the model fit of the risk adjustment model.

And also some concerns related to whether the increase -- increasing the Medicare Advantage patients receiving dialysis and their geographic variation are appropriately accounted for and really recommending that CMS perform a sensitivity analysis of performance with and without Medicare Advantage patients and making those results publicly available. But largely there was also just the support for inclusion within the program received from the public comments.

Akin, I'll pause here to see if you have any additional comments to add related to that summary.

MR. DEMEHIN: Matt, I don't. That was a very complete summary of the workgroup's conversation as well as sort of the public comments we received.

DR. PICKERING: Okay, Chip, we --

CO-CHAIR KAHN: Are there questions? Are there any questions from the Coordinating Committee, technical questions or other questions?

(No audible response.)

CO-CHAIR KAHN: Okay. If I don't hear any, then, Sam, is it possible for us to proceed to a vote on this then? Is that the next --

DR. STOLPE: Yes, that's possible. But before we do let's allow Mary Barton from NCQA to say hello and to offer any disclosures.

MEMBER BARTON: Good morning. This is Mary Barton, Vice President of Performance

Measurement, NCQA. My employer uses a lot of measures to evaluate health plan quality, and that's my expertise and also I guess potential interest. Thank you.

CO-CHAIR KAHN: Thanks, Mary.

Now that we've done that, we --- should we go in and vote on this measure, if there are no more questions -- as there are no questions?

DR. STOLPE: All right. Very good. Let's open it up for a vote.

CO-CHAIR KAHN: Okay.

MR. DAWSON: Okay. Becky, I'm getting a message that I can't share while you're sharing. Can you clear the PowerPoint off the screen for a moment?

(Pause.)

MR. DAWSON: Thank you.

CO-CHAIR ROBERTS: Just a quick -- does this automatically pop up and --

(Simultaneous speaking.)

CO-CHAIR KAHN: Yes, that -- I have

nothing. It still says Northeast, Southeast, Midwest.

CO-CHAIR ROBERTS: Yes.

CO-CHAIR KAHN: Oh, there it goes.

CO-CHAIR ROBERTS: Oh, there we go.

CO-CHAIR KAHN: Great. Thank you.

MR. DAWSON: Okay. Thank you. So voting is now open for MUC20-0039, Standardized Hospitalization Ratio for Dialysis Facilities for the ESRD QIP. Do you vote to support the workgroup recommendation -- support the rulemaking as the Coordinating Committee recommendation, yes or no?

(Voting.)

CO-CHAIR KAHN: Okay. What's the -- what's our quorum total?

MR. DAWSON: I believe we need a minimum of 12 votes for quorum.

CO-CHAIR KAHN: Okay. Looks like we've got 12.

MEMBER BINDER: I'm not able to log into the voting part.

MEMBER GOODMAN: Yes, I'm having an issue with it as well, so.

CO-CHAIR KAHN: Can -- I see 13. Can staff provide any help, Sam, to --

MEMBER BINDER: I'm in now, actually. I'm okay.

CO-CHAIR KAHN: Okay.

DR. STOLPE: If you're not able to get into the voting platform, we can help you before the next vote.

CO-CHAIR KAHN: Well, I think we have 16.

DR. STOLPE: That's about where we need to land. So --

CO-CHAIR KAHN: Okay.

DR. STOLPE: Wait. Just want to confirm with the Coordinating Committee, if -- is there anyone who isn't able to access the voting platform at this point?

CO-CHAIR KAHN: Okay. What's the yes/no on the 16?

DR. STOLPE: Go ahead and close it?

CO-CHAIR KAHN: Yes. Yes, let's go ahead. Well, it looks like --

DR. STOLPE: Voting is closed.

CO-CHAIR KAHN: Yes, we have no issue on this --

DR. STOLPE: Sorry, Chip.

CO-CHAIR KAHN: I'm sorry. I said I -- it looks like we have no issue on the 60 percent, so we should -- we can proceed to the next measure, I think, Sam, in that unless we --

DR. STOLPE: Then let's go to the next one, please.

CO-CHAIR KAHN: Oh, wait. I think Katie Boston has her hand raised. Does she -- do you have something to ask?

MEMBER BOSTON-LEARY: No, I was just -- you asked whether anyone has any challenges and I do, so that's why I raised my hand.

CO-CHAIR KAHN: Okay.

MEMBER BOSTON-LEARY: I'll put it back down.

DR. STOLPE: Katie, did we miss your vote?

MEMBER BOSTON-LEARY: Yes.

DR. STOLPE: Would you like to send your vote via chat in the next vote if you're not able to get the platform working?

MEMBER BOSTON-LEARY: Yes.

CO-CHAIR KAHN: Okay. Great. Sorry, Katie.

Okay. So now let's go to the next one.

And, Matt, you're going to lead us through that?

DR. PICKERING: Certainly. Thank you. Thank you, Chip.

So the next program, which is the Hospital Outpatient Quality Reporting Program or Hospital OQR, has two measures come through for consideration, so we'll talk about the first one listed here, which was MUC-0004, the Appropriate Treatment for ST-Segment Elevation Myocardial Infarction, or STEMI, Patients in the Emergency

Department.

So this measure is the percentage of emergency department patients with a STEMI who received appropriate treatment. The measure will be calculated or is calculated using electronic health record data and is intended for use at the facility level.

The workgroup offered a conditional support for rulemaking pending NQF endorsement for this measure. The workgroup recognized that this measure addresses the meaningful measure areas in Hospital OQR Program priorities of effective prevention and treatments and promotion of effective communication in coordination with care.

This is an eCQM, or electronic clinical quality measure, and it is a combination of two existing chart-extracted measures in the Hospital OQR Program set, one being the Fibrinolytic Therapy Received Within 30 Minutes of Emergency Department Arrival, and the other being the Median Time to Transfer for Acute

Coronary Intervention. And it also includes a third option, which is to transfer patients to a percutaneous coronary intervention-capable facility, or PCI facility.

The workgroup recognized that the inclusion of this eCQM could really reduce data collection and burden from previous chart-based measures for collection. There was also some discussion around whether or not those other two chart-based measures would be potentially removed from the program. And then CMS added some clarity that these measures would be used in parallel and that introducing these electronic quality measures and programs has the intent of reducing burden but also to further de-duplicate measures over time.

The workgroup further recognized the importance of this measure and that the addition of this EHR-based quality measure can really improve adherence to fibrinolytic therapy in accordance with clinical practice guidelines and also recommended that NQF endorsement -- the NQF

endorsement process should evaluate the EHR feasibility, reliability and validity testing conducted by the developer.

As far as the comments that were received, there was strong support for the adoption of this measure and the importance that eCQMs really will reduce burden of data collection for the Hospital OQR Program.

Akin, do you have anything else to add on top of that?

MR. DEMEHIN: You know, on 0004 there was a good robust conversation from the group about the need to make sure that the measures function across different EHR platforms and definitely a strong sentiment around the notion of de-duplication. It's in keeping with the theme that you mentioned earlier, Matt, about really a desire to make sure that we are streamlining measures to the maximum extent we can and being attentive to the issues of measurement burden for hospitals. But otherwise I think you nailed it.

CO-CHAIR KAHN: Okay. Are we going to -- any other comments from the discussants or the -- Matt, or are you ready to go to questions?

DR. PICKERING: No, I think we can go to questions.

CO-CHAIR KAHN: Any questions from the committee?

DR. STOLPE: David Baker has his hand raised.

CO-CHAIR KAHN: Okay.

MEMBER BAKER: I had one question: First, Akin, I want to say I hope that you're actually in Sedona.

(Laughter.)

MEMBER BAKER: It's snowing here in Chicago, so if you are, I'm really jealous.

So my question was -- it's just a really interesting measure because there are three different ways you can satisfy the numerator: the fibrinolytic therapy, PCI and transfer within these specified time periods.

So the question is whether those are

all equally difficult. And this comes up with the issue of if you're comparing hospitals on this, some hospitals provide 24/7 PCI and others are providing thrombolytic therapy, and it may actually be easier to comply with the thrombolytic therapy.

So I'm just wondering if there's big variations in hospitals in the type of services, the way they're treating this, could that lead to kind of spurious differences if you're comparing hospitals with different treatment modalities? I think about this as like the Olympic diving. What's the degree of difficulty and can you actually compare? So I'm just wondering if that was discussed.

DR. PICKERING: No, that --

CO-CHAIR KAHN: Matt?

DR. PICKERING: --- specific --- yes, thanks, Chip.

So that specifically was not discussed by the workgroup, but that's a great comment that you raised. And I know that we -- I think we do

have developers on the line if there is anything that they would like to add in relation to that comment, but that specifically was not discussed by the workgroup.

DR. SCHREIBER: Yes, so, Matt -- hey, this is Michelle. We didn't discuss it at the last meeting. David, you're absolutely right.

You know, generally hospitals tend to gravitate towards those who don't have capability for this transfer, those who don't have capability for full-service PCI do thrombolytic. So I think it's less of that because they really just don't have the capability usually for one of those three things. But Yale is the developer for this and I know that they're on the call.

So I don't know if you guys have specifically looked at that, but I see it really -- you know, hospitals kind of self-select about which one generally fits for them.

MEMBER BAKER: Definitely.

CO-CHAIR KAHN: Does Yale have any comment?

DR. DRYE: Karthik, are you on? He's our interventional cardiologist. I don't think so, so I'm going to jump in. It's Elizabeth Drye.

Thanks, Michelle.

We -- that did not come -- it's interesting. So I -- we talked in the prior meeting about potential unintended consequences. I think that's what you might be implying, that maybe people would shift if something is -- if one treatment modality might be easier to meet. I'm not sure if that's what you're implying, but that concern was not raised by experts in the -- in our expert panel.

And there's strong endorsement of this measure by -- if you look at the comments in the MAP materials for AHA, American Heart Association or American Stroke Association, and also SCAI, the interventional angiography society.

So I think it's always prudent to monitor for those kinds of shifts, but that risk of affecting practice patterns that I think as

Michelle was saying are pretty pre-set at these providers is not likely, if that's what you're saying.

MEMBER BAKER: No, that actually wasn't what I was saying because they are set, but if you have a hospital that provides PCI 24/7, it may be more difficult -- particularly during the evening hours -- to meet that than another hospital that's doing exclusively thrombolytic therapy -- or almost exclusively -- because they don't have 24/7 PCI capabilities.

So I'm not saying that I don't support this. I'm just saying this is something going forward that you probably should think about because as you start comparing hospitals it may be an apples to orange comparison.

DR. DRYE: Yes, I --

MEMBER BAKER: Now that is to some degree they try and take into account that by the time threshold for doing these, right?

DR. DRYE: Yes, exactly. I think you're -- yeah, you're making a really good

point. I mean, I think the starting presumption is that it is an apples to -- to some degree it's got to be an apples to orange measure because hospitals that are rural and transferring patients and don't have PCI capability are just super different.

But what we were aiming for and I think is -- specialists in the field are comfortable with is the three -- the time targets set for each of those modalities. But I agree, it's not going to be the same -- complying with this and hitting these targets isn't going to be from the outset the same level of difficulty across providers. This is for -- this measure is being proposed for hospital outpatient quality reporting, which is a pay-for-reporting, not pay-for-performance program. So you're not paid on your score, but --

MEMBER BAKER: Yes.

DR. DRYE: -- yes, the score would be publicly reported.

MEMBER BAKER: Thanks.

CO-CHAIR KAHN: Okay. I think Katie has a question.

MEMBER BOSTON-LEARY: Yes, I think Mr. Baker eloquently made the point that I was going to make, and I love -- I would not even have thought about connecting it to the --- in this way.

It's definitely -- and I guess this is where I need clarification on whether this is a process measure versus an outcome measure because the time, time sensitivity is a major piece of this and regardless of what treatment modalities are taken on at the end I guess it does impact what treatment modalities are taken to the patient.

But the early identification of this patient having that ST-segment elevation, and some of that even moving to the field with EMS and that early identification, how that impacts the treatment and reduces any chance -- the likelihood of the patient getting deficits, I think -- I don't have much clarity on this measure

because there are so many components to it.

But -- and I just want to make sure that the actual standard here is really not just about the selection of the treatment modality. It's the early identification of the patient being an ST-segment elevation, which is a key factor in this piece, even before you get to the interventional measures that happens procedurally for PCI and all the other things that happen on the surgical side.

DR. MURUGIAH: Hi, this is Karthik. I'm an interventionalist and part of this -- the Yale group working on this measure. And that's an excellent point. And moving forward I think in terms of therapies for STEMI, thrombolytics and PCI both have -- are sort of like mainstays depending on the situation. And hospitals have sort of moved in and changed their processes in a way that a lot of hospitals are able to achieve these times, but most of the future benefit for STEMI is going to come from early identification, be it in the field or in the hospital.

So each of the three components of this measure -- which is thrombolytics, transfer or PCI -- all of them require an early and prompt identification of STEMI. So I think it affects this measure across all the three components, so that is definitely a big piece within it.

But what happens outside the hospital in terms of early identification by EMS, that is obviously not a component of this measure because again the challenge is incorporating EMS performance and hospital performance in one unified thing. But that is -- definitely is a direction for the future.

MEMBER BOSTON-LEARY: Yes, and one last thing I'll add is there is a segment of practitioners that have not fully embraced thrombolytics as well, so some of these patients fall out. So just want to put that on your radar as well. Thank you.

DR. MURUGIAH: Thank you. Thank you for the comment.

CO-CHAIR KAHN: Okay. Any more

questions?

(No audible response.)

CO-CHAIR KAHN: I don't see any. So I think if there are no more questions -- we have a recommendation of conditional support for this. We can go to a vote, right, Sam?

DR. STOLPE: We can, but let's just remind everyone what the conditions are and it was received under NQF endorsement.

CO-CHAIR KAHN: Okay. Matt?

DR. PICKERING: So for MUC-0004, the condition here was that it would receive NQF endorsement, so -- and the workgroup offered conditional support for rulemaking pending NQF endorsement.

CO-CHAIR KAHN: Okay. So we go to the voting machine?

MR. DAWSON: Yes, sir. So voting is now open for MUC20-0004, Appropriate Treatment for ST-Segment Elevation Myocardial Infarction Patients in the Emergency Department for the Hospital OQR Program. Do you vote to support the

workgroup recommendation of conditional support for rulemaking, yes or no?

(Voting.)

CO-CHAIR KAHN: Okay. If I see it, we have 18 results, so we're getting there. Let me count. One, two, three -- I think.

MR. DAWSON: Should I go ahead and close the vote?

CO-CHAIR KAHN: Yes, I think we're ready, Sam.

MR. DAWSON: Okay. So voting is closed. The results are 18 yes and 0 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0004, Appropriate Treatment for ST-Segment Elevation Myocardial Infarction Patients in the Emergency Department for the Hospital OQR Program.

CO-CHAIR KAHN: Great. So let's go to the next measure. We need to get our screen back up. Good.

DR. PICKERING: Thank you. So the next measure within this program is MUC-0005.

It's the Breast Screening Recall Rate measure. And this measure calculates the percentage of beneficiaries with mammogram or digital breast tomosynthesis, or DBT, screening studies that are followed by diagnostic mammography, DBT, ultrasound, or magnetic resonance imaging of the breast in an outpatient or office setting with 45 days.

The workgroup offered conditional support for rulemaking pending NQF endorsement of the measure and they recognized that this measure does address Hospital Outpatient Quality Reporting Program high priority areas of making care safer, making care more affordable and that CMS hospital programs currently do not include measures of breast screening recall rates.

The workgroup observed that this claims-based measure identifies recall rates from breast screenings at the facility level and considered whether the evidence submitted by the developer includes a clear target recall rate for the accountable entity and for patients using the

measure to evaluate provider performance since high or low recall rates could represent an opportunity for improvement.

The developer clarified the interpretation of the range, which the developer submitted for this measure that there was a target of 5 to 12 percent. So the developer provided some interpretation of this range, whether that -- below the range could be missing cancer whereas above the range leads to calling back too many people, so increasing the resource of the measure -- of the services. Therefore, this came forward to really ensure that the abnormal screenings receive appropriate follow up while avoiding over-diagnosing and causing undue anxiety and testing for patients.

The workgroup further considered that this measure is not based on a specific clinical guideline, but is supported by expert panel consensus and is supported in the -- from the literature. There was also discussion regarding whether there should be a stand-alone metric for

this measure or should be used within a composite. In this discussion the developer had mentioned that there is some need for a suite of measures in this area and that this measure is really the first step to improve the quality of care for women.

Ultimately the workgroup recommended this measure with conditional support for NQF endorsement.

For the comments received there was some concern due to the performance range of that 5 to 12 percent recall rate being consensus, really not evidence-driven. And that does -- the measure alone is limited and provides a limited assessment of a facility's ability to appropriately screen for breast cancer. Again, thinking about this measure alone is not the best to really get at appropriate screening. There may be some other measures that could be used with this measure.

The proposed 45-day window as well for this measure was too short; that was another

comment received, as well as the recall rates really being varied by population, and also -- there's also varied screening modality as well. There was agreements with the workgroup recommendation in that the NQF endorsement process will evaluate the appropriateness of this measure's basis on clinical consensus recall rates rather than specific clinical guidelines in addition to reviewing reliability and validity of the measure, so the scientific acceptability.

I'll turn it over to our co-chairs.

I believe Sean Morrison has also joined, so, Akin and Sean, any additional comments related to that summary from the workgroup?

MR. DEMEHIN: So, Matt, I think you summarized the conversation very well.

If you look at the voting results, this was the measure that I think was actually the closest of any of the measures that we recommended. I think it was really sort of a question of weighing the value -- the potential

value of a measure like this with some of the underlying questions around evidence.

And I think it was the sentiment of the workgroup that that evidence evaluation would probably be best accomplished through an NQF endorsement review. And hopefully the conversation we have sort of gave some guideposts to the endorsement committees for issues that really do need to be evaluated carefully. And we would lean quite heavily on the endorsement process for this.

Sean, I don't know if there's anything I may have missed in that.

DR. MORRISON: Not at all. You got everything. The two of you got it all.

CO-CHAIR KAHN: Anything else? Any other questions from the -- or are there questions, technical questions or otherwise from the -- our membership?

(No audible response.)

CO-CHAIR KAHN: I'm not seeing any. Going once.

MEMBER GIFFORD: Chip?

CO-CHAIR KAHN: Yes?

MEMBER GIFFORD: It's Giff. Dave Gifford.

CO-CHAIR KAHN: David. Yes?

MEMBER GIFFORD: I was assigned the lead discussant for this and I think it was very nicely summarized on everything there. I was struck by the fact that it was -- as Akin was saying -- the lowest voted measure of the 13 measures out there. I think a lot of times we are talking about needing to get NQF endorsement, but the measures are pretty well-defined here. I was really struck by the fact that this target range is based on statistical analysis and really doesn't have a good clinical other than expert opinion issues.

And while a majority of the public comments or committee comments were in support, a few were against, but a lot of them were very similar to what was summarized there. I might suggest that we go beyond just the condition of

getting NQF endorsement because we are talking about losing in rulemaking that we might want to think about guidance to CMS on this being included as part of a composite or aggregate measures, not solely, because that doesn't breed consistent discussion in the comments that I was reading through, and that it -- that there be really consideration before rulemaking about looking at this NQF endorsement, particularly as target range since it's not a clinically-based target range.

CO-CHAIR KAHN: So --

MEMBER GIFFORD: I think there's a lot of concern about the unintended consequences on either side.

And then lastly, the inclusion of social determinants and whether it's appropriate to include them in this or not because of the difficulty in recall rates from that group. But I do think -- I felt really uncomfortable as I read through all of this personally on this measure. In a lot of these other measures, you

know, I'd like NQF endorsement. It makes sense and everything else. But this was one that I just felt a little uncomfortable with.

And I think it was captured in the comments, so I don't know how to capture that comment to CMS that of all the measures that sort of come through that they're thinking about rulemaking, this doesn't seem like it's a measure that has to go in rulemaking. It's not mandated by statute. This specific measure, it's a movement in the right direction. I think no one's questioning the merits and the topic. There's a need for the measure. But it just -- I did not feel comfortable about it being ready for rulemaking. But I'm okay with it, but I think I'd like something stronger in the wording from this committee to CMS about that.

CO-CHAIR KAHN: Okay. Let me -- I think this brings up an issue on how we'll deal with it, but Leah Binder I think had a comment. And then let's come -- and I'll make a comment when she finishes.

MEMBER BINDER: I actually want to commend CMS for putting this forward. I'll be honest, I personally experienced a false problem on a mammogram when I was in my 40s and it was extremely distressing. So this is really a quality measure of some interest to women. And we know with mammography that this problem is really significant. We've had a lot of back and forth among experts about what's the right age because of these false positives, or whatever you call them when things appear to be a problem when they aren't for recall rates.

So I know that this is of great interest. It's extremely important. And one of the impacts that I know from other friends who've been through this is that you don't want to go back. I mean, I think it actually discourages preventive screening when there are higher levels of recall that are not warranted by the actual findings on the mammogram.

So I do think this is a critically important issue. It's very important to women.

It's something we are grappling with particularly around the issue of breast screening. So I would strongly encourage that. I do think that endorsement is a good plan, but I strongly encourage that we support it.

CO-CHAIR KAHN: Let me ask Sam a question before we proceed.

So Dave really put a lot more guardrails around the conditional approval. Do we have to vote this recommendation which is tied to endorsement down and then come back in the next go-round to make a recommendation if the group wants to accommodate Dave's suggestions, or can we do that here in some way procedurally?

DR. STOLPE: Thanks, Chip. Our procedure as we've outlined it is to first vote down the conditions that the previous workgroup has proffered, but if we vote that down, then we can regroup and suggest additional things to include inside of the conditions. But it's the co-chairs' purview to determine where our starting point for the next series of votes would

be.

CO-CHAIR KAHN: Okay. So why don't we have a vote on this? I guess my recommendation would be then, if it's acceptable to the committee, is that we have a vote on this to follow the procedure that Sam said. If there's a preponderance of people who agree with Dave, then it will be voted down. And then since all I'm hearing about is conditional comments because, I'm just going to extrapolate from Leah's comments, there probably is a lot of interest in this going forward in some form, then we could come back to conditional as our option and we could then let Dave again go through his suggestions and see whether that's where we end up. Is that acceptable, Sam?

DR. STOLPE: Yes, that makes sense to me. Chip, I also wanted to recognize that Scott Ferguson has his hand raised.

CO-CHAIR KAHN: Oh, I'm sorry. I didn't see that.

Scott, will you make -- you have a

comment?

MEMBER FERGUSON: Yes. This is what I do for a living is mammography. And so I can sympathize with the women that are recalled and nothing is found, but I can tell you that a lot of it depends on has the patient had previous breast surgery? Have they had implants? Do they -- have they had a mastectomy? There's a lot of findings that you're unsure of that you want to clear up.

And I notice that only 40 percent of the facilities that they have in there was within the range that's projected and I think that we really need some good data on what the range should be because it is quite difficult if you're rating in an institution that's done a lot of surgery, you're going to have a lot of call-backs because you're going to have post-surgical women, you're going to have breast reduction women, and they are more difficult to interpret and need further evaluation.

So I think with some conditions and

guardrails -- I obviously want to see mammography included in any of the measures because I think it's vitally important, but I'd like to see some good numbers on what an appropriate recall rate is.

CO-CHAIR KAHN: Okay. I don't see any other hands raised. Why don't we go to a vote? And then if the vote is negative, then we'll go to the conditional option. So why doesn't everybody -- let's go to the vote, Matt.

DR. PICKERING: Okay. So I'll just chime in again. So we're voting now on MUC-0005, Breast Screening Recall Rates and this is for the -- to uphold the workgroup recommendation of conditional support for rulemaking, and this condition would be pending NQF endorsement of the measure.

CO-CHAIR KAHN: Okay. So --

MR. DAWSON: Thank you, Matt.

MEMBER GIFFORD: Just to clarify, voting no means --

CO-CHAIR KAHN: That we'll then proceed

to the next step.

MEMBER GIFFORD: We'll proceed to the next step, which is to add additional conditions, not to go to not --

CO-CHAIR KAHN: Right.

MEMBER GIFFORD: -- endorsing it?

CO-CHAIR KAHN: Right, right.

MEMBER GIFFORD: Correct. Okay. I just want to make sure it's clear.

CO-CHAIR KAHN: It's optional to us to choose the category we want to go to for the next vote.

MR. DAWSON: Okay. Thank you, Chip. So voting is now open for MUC20-0005, Breast Screening Recall Rates for the Hospital OQR Program.

CO-CHAIR KAHN: Yes.

MR. DAWSON: Do you vote to support the workgroup recommendation of conditional support for rulemaking of the Coordinating Committee recommendation, yes or no?

(Voting.)

CO-CHAIR KAHN: Okay. We have 19. I think that's probably the high water mark. So what's the outcome of the -- okay. So we now will then proceed to a discussion I believe, Sam, of the conditions that we would apply, right?

MR. DAWSON: So --

CO-CHAIR KAHN: So, Dave, why don't you take the -- I'm sorry.

MR. DAWSON: Sorry, Chip. If I can interrupt for just a moment --

CO-CHAIR KAHN: Sure.

MR. DAWSON: -- and just read this off for the sake of those that may be on the phone and can't see the screen and also --

CO-CHAIR KAHN: Okay.

MR. DAWSON: -- for any transcript.

CO-CHAIR KAHN: Sure.

MR. DAWSON: So voting is closed. The results are 6 yes and 13 no. The Coordinating Committee did not support the workgroup's recommendation of conditional support for rulemaking for MUC20-0005, Breast

Screening Recall Rates for Hospital OQR Program. Thank you.

CO-CHAIR KAHN: Okay. So we'll now proceed to this same category and have a discussion of conditions we would apply beyond endorsement that we would then consider for a vote.

And, Dave, why don't you --

MEMBER GIFFORD: So I would recommend that we support this for rulemaking with the condition of NQF endorsement plus it being considered as part of a broader suite of measures and/or a composite measure and that it incorporates -- it looks at whether social determinants should be incorporated into the measure.

And then lastly, to -- which is part of the NQF endorsement, would be looking at the target range for this measure, whether it's supported -- whether the evidence supports that range. But I -- and I would agree with Leah's comment that this issue of breast mammography

screening and the wide variation and accuracy of it and the turnaround times really is a significant thing that needs to be addressed. So I don't want also that condition to hold that back. And I think CMS is on the call so they can hear our discussion on that, but that -- those three things would be the added conditions I would add onto it.

CO-CHAIR KAHN: Okay. Is there discussion of the proposition on the floor?

I'm looking at my -- I don't see any hands up. Jeff?

MEMBER SCHIFF: I just wanted to ask -- and maybe this is part of that same condition. It seems like there's a -- for the most part we've been talking about an over-recall is a problem, but I'm also concerned about why we have both tails of this and whether there -- it would be adequate to have an over-recall measure without anything on the other side. The under-recall seems like a whole separate quality issue and I think we conflate them by having a range

that -- 5 to 12 percent versus just saying above a certain range and thereby -- of quality.

DR. SCHREIBER: It's Michelle. I'd just comment on --

CO-CHAIR KAHN: Yes.

DR. SCHREIBER: -- the key things that -- I think both ranges is important, that over- recall and under-recall actually are both extremely important. And so that's why we have both ranges on there because I think it's equally, if not perhaps more of a safety event to under-recall women who need to be kept -- who need to have additional studies.

I am curious. I know Yale is on the phone. This is Yale and Lewin who have both stewarded this.

Do you guys have any comments on the additional conditions, if you have any further scientific evidence that you want to bring forward?

MS. McKIERNAN: Hi, Michelle. This is Colleen McKiernan from Lewin. I can jump in.

So over-recall and under-recall are both important based on the way the measure is currently specified to prevent missing cases of cancer for under-recall and recalling too many women for over-recall.

The original version of the measure -- so there was a measure called OP9 that was in the Hospital OQR Program and that did not have a lower bound. So we just said cases near zero could reflect missing cases of cancer and the upper bound was 14. So we have created more tight guardrails of the 5 to 12 range based upon the article that we cite in our evidence base as well as consensus that we've reached with our expert panel, individuals from ACR and (audio interference) publicly. So we gathered quite a bit of input from a breadth of stakeholders.

CO-CHAIR KAHN: Okay. Other comments from the technical -- okay. I have Julie, Misty and Leah.

So, Julie?

MEMBER SONIER: Sure. My question

really is a little bit of a procedural one. I mean, the proposed additional conditions that we're added -- adding seem to me like a lot. And so do we need -- I mean, is there an option to say we support the idea but we would want to consider this measure in combination with the other ones, for example, that we're suggesting be developed? So it's kind of a -- is it sort of like a come back later recommendation or is it a yes now without really knowing how it would fit into a broader package and how the social determinants would be addressed?

DR. STOLPE: Let me just comment on that briefly. There isn't a return to MAP option, unfortunately. It's at CMS' discretion if they would like to have MAP weigh in on the measure, but we just proffer the best advice that we can given where the measure is.

CO-CHAIR KAHN: And we could go to turning it down with -- and then ask for mitigation, but I had a sense -- the reason I proposed going with the way I did was I have a

sense that there's a lot of support on the body for conditional approval, and that's why I guess I was proposing to start with conditional, knowing as Sam pointed out that we are limited by this just being a recommendation. But it would be a clear signal that goes beyond just endorsement. That was the reason I proposed the approach I did.

CO-CHAIR ROBERTS: Yes, Chip, I also had some of the same concerns and questions as Julie had just because it did seem like a lot of other conditions to support the measure. And could that change the measure, especially if we're talking about this being a suite or a composite measure. That seems like a completely separate measure to me. So I do have some concerns about all the other conditions that have been brought up.

CO-CHAIR KAHN: Okay. I think -- let me just get one more. Scott has a comment. Did I --

MEMBER FERGUSON: Yes, I just -- I'd

like to say that under NQSA every mammography facility has to report their positive outcomes, their negative outcomes. The FDA compiles this information. It's readily available. I have to do a score card. I read this many, I missed this many, I had this many right, I recalled this many. So the information is out there at the FDA. And as far as not recalling enough, sure, that's a good number to say, yes, you didn't bring this person back and they developed cancer. Well, we are currently reporting that to the FDA, just to let you know.

CO-CHAIR KAHN: Leah, do you have a comment?

MEMBER BINDER: Yes, I'm interested in the FDA comment actually, if that was made public. And that would be great. I would just sort of -- just want to say that the process for endorsement of measures is quite thorough and would address I think many of the issues that have already come up. And it's perplexing why we would want to just pile on some additional

requirements when I think the process for endorsement is a good one and I think fully adequate for a measure of this importance.

CO-CHAIR KAHN: Okay. So let me remind us of the bidding and then I'll go back to Dave. So I was suggesting support with conditional. And then maybe Dave when he speaks in a moment can redefine his alternatives. And there is one which is do not support with potential for mitigation, but I sensed that -- I didn't go there because I sensed there was so much support for the measure on the body.

So if we stick with this conditional, at least for this vote, Dave, considering the comments do you want to modify the conditions at all before we would go forward with a vote?

MEMBER GIFFORD: Yes. No, and I think it's a really good point that Leah and others are making that if the social determinants, certainly the validity piece, is part of the NQF endorsement process, we shouldn't add that on a condition. That's redundant. We

are saying it needs to go through the NQF endorsement, but I don't believe whether it's part of a suite of measures or issues is part of that endorsement process.

And I think to underscore what Leah just said, I mean, FDA's got data and other data out there. This is the first of what should be many other important measures. I mean, the accuracy of the reporting and the variation is equally, if not almost more important than this recall measure. And so I would really encourage that they make this as part of that broader issue. I think that would be sort of the condition that's here.

And that is not part of a -- we look at the individual measures when we endorse things for NQF. We're not looking at the broader issue. We do provide guidance. This is -- the MAP body is more about rulemaking and where it fits in with broader rulemaking.

So that would be -- so I would modify my initial recommendation to really being just

about that because I do believe, and the staff can confirm, that the other components I said were all part of the NQF endorsement process. And then we should not be adding specific conditions within the NQF endorsement. I would agree that that's redundant and not fair.

CO-CHAIR KAHN: Okay. So, Dave, could you -- so for the record here then, because I want to -- so what do you want the conditions to be, if you just repeat it one more time, that we would add to endorsement, which is already the one that was recommended by the workgroup?

DR. PICKERING: So maybe, Chip -- I'm sorry.

CO-CHAIR KAHN: Yes.

DR. PICKERING: This is Matt from --

CO-CHAIR KAHN: Right.

DR. PICKERING: -- NQF just to sort of chime in to maybe help with the conversation because --

CO-CHAIR KAHN: Okay.

DR. PICKERING: -- this is -- you're

correct as far as some of the evaluations that would occur with our standing committees for the consensus and endorsement process. Some of these issues would come through. One is if it's an outcome measure, which this measure is slated as an outcome measure, a consideration of socioeconomic status or sociodemographic variables or social determinants would need to be somewhat assessed conceptually and statistically by the measure developer. So that's the part of the validity component with risk adjustment.

CO-CHAIR KAHN: Yes.

DR. PICKERING: The other aspect around range and evidence to support the range would also need to be considered within the consensus development process. So those are the conditions that maybe through the NQF endorsement, as I've been hearing from this Coordinating Committee, and some of which have been discussed in the Hospital Workgroup related to the range of why they wanted to do pending NQF endorsement, knowing that these issues would also

be discussed with our standing committees.

CO-CHAIR KAHN: Yes.

DR. PICKERING: So the evidence is to support the range. And then from what I'm hearing with the social determinants, this is for -- outcome measures are considered within our validity assessment with our standing committees.

CO-CHAIR KAHN: Yes. Okay.

DR. PICKERING: Sorry to interrupt.

CO-CHAIR ROBERTS: One component that would not be addressed would be incorporating it into a suite of measures instead of just a stand-alone measure.

CO-CHAIR KAHN: Yes.

DR. PICKERING: That's correct.

CO-CHAIR KAHN: And --

MEMBER GIFFORD: So, Chip, I put the wording in the chat where -- what I would suggest to revise.

CO-CHAIR KAHN: Okay. I think David Baker has a comment. And then after that I would say let's look at Dave's language in the chat and

go forward and have a vote on that, because we -- I think we've gone through this, and we also need to keep moving.

But, David Baker?

MEMBER BAKER: I just have concerns about saying that this needs to be incorporated into a suite of measures. From what I've heard that suite of measures, those other measures don't necessarily exist. So our question is should we put this measure on hold potentially for several years while those are being developed so that you can have a suite? So that might be a good long-term goal, but I don't think that that's what we should be using as a criteria for voting on this measure today.

CO-CHAIR KAHN: Okay. Well, Dave, do you have any comments on that?

MEMBER GIFFORD: I'd like to hear Leah's comments first.

CO-CHAIR KAHN: Leah?

MEMBER BINDER: So I want to agree with David, just say that I think this measure is --

I've said it's very important to a lot of women and I don't think we should delay it for the purpose of incorporating it into a larger suite of measures, though certainly a large suite of measures would be really great to have in the long run.

MEMBER GIFFORD: So, Chip, let me make a revision --

CO-CHAIR KAHN: Okay.

MEMBER GIFFORD: -- to move this along. The minutes and discussion of this are reflected and passed onto CMS. I think these issues will get to CMS, and that's fine. So I would recommend that this be endorsed with the condition of NQF endorsement, period.

CO-CHAIR KAHN: Okay.

MEMBER GIFFORD: And that's the original one we just voted down. We had this discussion and went forward. I think it was a healthy discussion. I appreciate it all, but I would go back to that because I mean it's -- otherwise the way it's going to go, the way I'd

vote it is we're going to vote down what we just said and then we're going to go back to the other voting because -- so I would just go back to the original voting.

CO-CHAIR KAHN: So, let's keep it really simple and let's again have a vote on the recommendation that was on the table from the workgroup.

So can we do a vote, Sam?

DR. STOLPE: Chris, go ahead and open the vote when you're ready.

MR. DAWSON: Okay. Voting is now open for MUC20-0005, Breast Screening Recall Rates for the Hospital OQR Program. Do you vote conditional support, yes or no?

DR. STOLPE: And just a reminder, the conditional support is NQF endorsement, which we determined captures both the SDOH concern as well as the evidence and that the broader suites of measures for composite consideration will be incorporated into the notes for this discussion but not included as part of conditions.

CO-CHAIR KAHN: Okay.

(Voting.)

CO-CHAIR KAHN: Great. And --

MR. DAWSON: I think we had 19 votes last time that we voted.

CO-CHAIR KAHN: Nineteen. Yes, okay. So let's get a tally and see where we are.

MR. DAWSON: Voting is closed. The results are 17 yes and 2 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0005, Breast Screening Recall Rates for the Hospital OQR Program.

CO-CHAIR KAHN: Okay. So we just passed on that one and now we go to Hospital Inpatient Quality Reporting Program Measures. And I'm going to suggest that we plow forward and get these finished, if that's okay with everybody. Any objection?

Okay. So, Matt, will you take that?

DR. PICKERING: Sure. Thanks. Thanks, Chip.

So two measures for this program, the

Hospital Inpatient Quality Reporting Program. The first measure which we'll discuss is MUC-0003, which is the Hospital-Level, Risk Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty, or THA/TKA.

The measure will estimate hospital-level risk standardized improvement rate for patient-reported outcomes following elective primary THA or TKA for Medicare fee-for-service patients 65 years of age or older. Substantial clinical benefit improvement will be measured by the change in score on the joint-specific patient-reported outcome measure instruments measuring hip or knee pain and functioning from the pre-operative assessment, which is data collected 90 to 0 days before surgery to the post-operative assessment, which are data collected 270 to 365 days following surgery.

The workgroup supported this measure for rulemaking. This measure is a patient-reported outcome-based performance measure, or

PRO-PM. And the workgroup recognized that this measure addresses the high-priority area of functional outcomes for the Hospital IQR Program, and the program currently does not include a measure that assesses patient-reported outcomes among THA or TKA patients at the hospital level.

The workgroup also expressed some concern regarding data collection and reporting for this measure and the developer did mention that they have worked to mitigate the burden by reducing the number of questions on this patient-reported outcome instrument to try to mitigate that burden of collection, but also patient fatigue.

There is also an effort to create a strategic implementation plan to inform CMS' strategy to minimize burden in data collection and reporting for this measure. And the workgroup observed that patient-reported outcomes among THA and TKA patients really do vary across hospitals suggesting opportunities to improve in quality of care and that this measure

seeks to improve the patient outcomes following elective primary THA or TKA by providing information to patients, physicians and hospitals about the risk standardized patient-reported outcomes such as pain and functional status.

As far as the comments that were received, there -- this was -- the summary of the comments really were support about adding this measure to the program. There was some concern in some of the comments regarding the burden of data collection, which the workgroup also had discussed, and the survey fatigue with patients and further evaluation of this measure's interaction with the impact on the CAHPS measure is needed. That was one comment that came through.

Another comment raised some concern with the shift in the THA and TKA procedures to the outpatient setting, and that shift may impact the minimum case volume or the minimum case number necessary to calculate the measure. This was also something that came through in the

workgroup conversations as we noted in the key themes earlier in the slide presentation.

I'll turn it to our co-chairs. Akin or Sean, any additional comments?

MR. DEMEHIN: That was a good summary, Matt. I'll add one small nuance around the issue of data collection burden and coordination with other surveys. I think one of the things that was on the minds of a few people, actually a number of people at the workgroup, was the extent to which fielding multiple surveys leads to non-response. Non-responses and how you deal with that as you implement the measure I think is something that CMS is going to need to consider as they move forward. But otherwise, I think you captured it well.

DR. MORRISON: And I concur.

CO-CHAIR KAHN: Okay. So this -- anything else, Matt, or are we -- and this measure received full --

DR. PICKERING: This measure received full support for rulemaking.

CO-CHAIR KAHN: Full support? Is there -- are there any technical questions from the -- from our group?

I think we can move to vote then if -- let me get my --

MR. DAWSON: Okay. Voting is now open for MUC20-0003, Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty for the Hospital IQR Program. Do you vote to support the workgroup recommendation of support for rulemaking, yes or no?

(Voting.)

CO-CHAIR KAHN: Okay. I think with 19 -- 18 or 19 we're going to be there.

Okay. Let's get the -- what's the outcome?

MR. DAWSON: So voting is closed. The results are 17 yes and 1 no. The Coordinating Committee supports for rulemaking MUC20-0003, Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective

Primary Total Hip and/or Total Knee Arthroplasty for the Hospital IQR Program.

CO-CHAIR KAHN: Great. So let's move on to Global Malnutrition Composite Score. I think that's our next one, right?

DR. PICKERING: Yes, it is. So next measure in this program is MUC-0032, Global Malnutrition Composite Score. This is a composite measure consisting of four component measures of optimal malnutrition care which focuses on adults 65 years of age and older admitted to the inpatient service who receive care appropriate to their level of malnutrition risk and/or malnutrition diagnosis if identified.

Appropriate care for inpatients includes malnutrition risk screening, nutrition assessment for that at -- for those at risk and proper malnutrition severity indicated along with a corresponding nutrition care plan that recommends treatment approach.

The workgroup offered conditional support for this measure for rulemaking pending

NQF endorsement and recognized that this measure addresses a clinical topic area not currently addressed in the program. Further, the measure may be considered to address the high-priority meaningful measure area of promoting effective communication and care coordination through the EHR data source and the electronic quality -- electronic clinical quality measure.

The workgroup also recognized that this measure was voted on and passed the Scientific Methods Panel in October of 2020 and will be evaluated for endorsement for the first time as part of the fall 2020 cycle.

The workgroup did seek some clarification on the structure of the specific care plan with the patient and the developer did comment that the care plan is really structured as part of the standards of care from the Academy of Nutrition and Dietetics and includes making specific recommendations based on the needs of the patient, including education and counseling needs and referrals to outside support entities.

There was also some discussion regarding whether CMS intends to change the reporting structure for the Hospital IQR as currently hospitals really can select a list of eCQMs available to them. CMS did confirm that hospitals will continue to have the choice and that CMS intends to publicly report eCQM data.

The workgroup also discussed that the components of this composite had previously come to the MAP, and the developer confirmed that the component measures were brought to the MAP several years ago, back in 2017, or for the 2017 pre-rulemaking, which at that time the workgroup did recommend that this measure be a composite, and thus this measure coming back around as a composite.

The workgroup observed that this measure encourages the identification and treatment of malnutrition hospital admission and that it is a prevalent clinical issue, but encouraged CMS to consider using this measure in the ambulatory care setting as there is an

opportunity for a broader impact.

As far as the comments received on this measure, largely there were several comments in support of this measure recognizing the importance of this clinical condition and the high prevalence of malnutrition among hospitalized patients. Comments also highlighted the improvement in subsequent patient care and outcomes and reduction in those outcomes such as high-resource utilization that can result in malnutrition and supplementing that with adequate diagnosis and a care plan for malnutrition.

Sean or Akin, any additional comments to add?

DR. MORRISON: Not from me. Akin, I don't know if you had --

MR. DEMEHIN: I don't think so, but I will say that this measure generated a lot of really rich conversation. I think the comments around considering this measure or a related measure for the outpatient setting I think

reflected a feeling among some in the group that the inpatient setting may not necessarily be the best place to focus efforts on measuring malnutrition. But I think that on balance the group felt like this was a measure that should move forward but should get NQF endorsement, especially so that some of the issues around evidence could be scrutinized a little more carefully.

But otherwise, great summary, Matt.

DR. PICKERING: So, Chip, nothing further to add. I think you might be on mute, Chip.

CO-CHAIR KAHN: Any technical questions for Matt and the team from the workgroup? I don't see any hands raised. Okay. Then I think we can go to a vote then.

Matt, if you could just explain the vote?

CO-CHAIR ROBERTS: Real quickly, is Matt going to review the conditions?

CO-CHAIR KAHN: Well, the -- that's

what I'm saying, he'll review the conditions.

DR. PICKERING: Sure. And Chris, I'll turn it to you. I think you'll review the conditions on this.

MR. DAWSON: Matt, I don't have the conditions on it.

DR. PICKERING: Oh, I'm sorry. So, yes, the condition here -- so the workgroup offered conditional support for rulemaking pending NQF endorsement for the measure.

CO-CHAIR KAHN: Yes, it was very simple. Okay. Any other questions? Then I think we should go to a vote.

MR. DAWSON: Okay. Voting is now open for MUC20-0032, Global Malnutrition Composite Score for the Hospital IQR Program. Do you vote to support the workgroup recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

(Voting.)

CO-CHAIR KAHN: We got 15. Let's see. We've been going to 19. Let's see if we

get 19.

DR. STOLPE: I think we lost one --

(Simultaneous speaking.)

CO-CHAIR KAHN: Okay. Then let's tally the vote then. Let's see the vote count then. Okay.

MR. DAWSON: Voting is closed. The results are 18 yes and 0 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0032, Global Malnutrition Composite Score for the Hospital IQR Program.

CO-CHAIR KAHN: Terrific.

Okay. Now we're going to go to Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals or Critical Access Hospitals Measures. And this is, if I'm looking at my sheet right, this is our final one in the Hospital Group.

So let's go ahead, Matt and team.

DR. PICKERING: Great. Thanks, Chip.

And so this is a single measure for this program, the Medicare and Medicaid Promoting

Interoperability Programs for Eligible Hospitals or Critical Access Hospitals. And again, it is also MUC-0032, the Global Malnutrition Composite Score.

The workgroup conversations were very similar with this measure within this program as was with the last program, the Hospital IQR, and the discussion points were also very similar related to this. And overall the workgroup did offer conditional support for rulemaking pending NQF endorsement, again recognizing that this measure has gone through the Scientific Methods Panel and has passed and is under review by the fall 2020 cycle, by the NQF standing committees.

And they sought some clarification on structure of the measure as well as a specific care plan, which we discussed previously with the Hospital IQR. And they also had some discussion related to the components of the measure coming back through to the MAP Hospital Workgroup on this measure as it previously had come through back in 2017.

So there was very similar types of conversations related to this measure within this program recognizing that it is the same measure being submitted to two different programs.

But, Akin or Sean, I don't know if you have anything else to add.

The comments as well are also similar related to this measure within this program where there was strong support for the measure highlighting the importance of this clinical condition as well as the improvement in patient outcomes related to appropriate diagnosis and care planning for malnutrition.

Akin or Sean, any additional comments you wanted to mention with this measure for this program?

CO-CHAIR KAHN: Other comments?

DR. MORRISON: Sorry. No.

CO-CHAIR KAHN: Are there questions from the Coordinating Committee, technical questions? Going once? Going twice?

Let's go back then since there are no

questions. It's fairly straightforward. Matt, why don't you repeat what we're voting on and let's vote?

DR. PICKERING: Sure. So we're now voting on MUC-0032, Global Malnutrition Composite Score. This is for the Medicare and Medicaid Promoting Interoperability Programs for Eligible Hospitals or Critical Access Hospitals. And we're voting on -- to uphold the workgroup recommendation of conditional support for rulemaking pending NQF endorsement of this measure.

DR. STOLPE: And Chip, did you want to invoke the option to carry the vote from the previous measure?

CO-CHAIR KAHN: To carry the vote? I'm sorry?

DR. STOLPE: Yes, so for measures that are exactly the same or we're just applying them to a different program we have the option to carry the vote. And that just means if there's no objections from the Committee and there's --

(Simultaneous speaking.)

CO-CHAIR KAHN: So -- okay. So, yes. So we'll -- we only would have one vote then on this then. So are there any objections to having one vote on this? Is that -- that would be a proper question. I don't hear any objections, so let's go ahead, Sam.

DR. STOLPE: Well, let's pause to wait and see if there are no objections.

CO-CHAIR KAHN: I don't hear any objections.

DR. STOLPE: Okay. I don't either.

CO-CHAIR KAHN: I already started my lunch, but others may be wanting to get to it. Okay.

MEMBER GIFFORD: Dave Gifford, I have no objections.

CO-CHAIR KAHN: Yes.

MEMBER GIFFORD: My question is -- as I said in my earlier conflicts of interest, my wife runs Medicaid in a state. This is a Medicaid measure. Do I -- do you -- do people

feel I need to recuse myself from voting on this measure? That's all.

DR. STOLPE: We wouldn't consider that a conflict, David, no.

CO-CHAIR KAHN: No.

MEMBER GIFFORD: Thank you. I just wanted to clarify that.

DR. STOLPE: Thank you.

CO-CHAIR KAHN: Okay. So this is an all-encompassing vote in terms of this measure, all its aspects. I mean, it's the different -- so let's go ahead with the vote then.

DR. STOLPE: So, Chip, are we voting or did you want to use the carry the vote option?

CO-CHAIR KAHN: I'm sorry. I misunderstood. When you said carry --

DR. STOLPE: So it means we would keep the vote from the previous vote as -- and apply it to this measure as well.

MEMBER WALTERS: We don't have to vote again.

CO-CHAIR KAHN: Oh, I misunderstood.

Okay. I misunderstood. If that -- if there are no objections we'll go forward with that then, yes. We can do that.

DR. STOLPE: So any objections to carrying the vote?

That sounds like none to me, Chip.

CO-CHAIR KAHN: Okay. So let's -- so now we're at a point where we have finished the hospital and it's lunch, but we're also behind. And so I would suggest 15 minutes. Is that acceptable to everybody as a break and then people could eat when they come back? Sam?

DR. STOLPE: Yes, why don't we suggest that? That sounds like a good compromise. We can continue our -- a working lunch once we get back. So 15 minutes for everybody to grab some food and get started. And then let's keep rolling with the discussion to keep us on track.

CO-CHAIR KAHN: Okay. Great. And then I think I hand the baton off to Misty. She takes charge at the end of the 15 minutes.

DR. STOLPE: That sounds terrific.

So let's convene at 1:20 then.

CO-CHAIR KAHN: Yes.

DR. HUNT: So eating on screen is acceptable?

CO-CHAIR KAHN: Well, I've already been doing it, so yes.

(Laughter.)

DR. STOLPE: If you want to go off camera while you're chewing, no one will be offended by that.

CO-CHAIR KAHN: Yes.

DR. HUNT: Thank you.

CO-CHAIR KAHN: Okay. Great.

DR. STOLPE: We'll reconvene at 1:20.

CO-CHAIR KAHN: Thanks, everybody. See you at 1:20.

(Whereupon, the above-entitled matter went off the record at 1:05 p.m. and resumed at 1:20 p.m.)

CO-CHAIR ROBERTS: So I think next up on the agenda is the clinician programs. And with that, we will open it up for public comments.

Is there any public comments?

DR. STOLPE: Looks like we have a hand raised.

CO-CHAIR ROBERTS: I can't tell the name. S. Pogones?

MS. POGONES: Yes. Hi, this is Sandy Pogones calling on behalf of the American Academy of Family Physicians. And I would like to make a statement on three of the measures. The first is Measure 0042, the person-centered primary care measure.

Measures of primary care should focus on the unique features that are most responsible for better outcomes and lower costs and under reasonable control of the primary care physicians. These elements include such things as first contact, access to care, comprehensiveness, coordination, patient and caregiver engagement, continuity in care management. Primary care is a lot more complex than many people understand.

Three out of four of the complaints

that present are self-limited, and 40 percent of new symptoms do not lend themselves to any current coding system. So capturing data in billing and EHR systems is very difficult. But research has shown that having a strong primary care force in a healthcare system reduces costs and improves quality and population health.

And there are certain features of primary care that are responsible for that. And that is what this person-centered primary care measure looks at, those unique features that add value to primary care. If you see or look at clinicians or practices or organizations that are concerned mostly with volume, that run patients through a revolving door, they get patients in and out as quickly as they can in order to increase their income and volume or increase referral to specialists, these types of practices will score lower on this measure.

And that's exactly what should happen because this type of approach to primary care offers less value than a primary care service

that offers the elements that are really responsible for better health and overall better outcomes, which is measured by this particular measure. So the AAFP highly supports the patient-centered primary care measure as a great improvement over existing measures for primary care.

We'd also like to express our opposition to the composite measure for preventive care and wellness. SCMS presented earlier its intention is to move towards smaller measure sets, fewer measures under the MVP program. But when you combine seven existing measures into one and then count the measure as one which is what is being done in this composite measure, that is not accomplishing the goal of fewer measures.

It's simply disguising a laundry list of measures into one measure. It will add burden. It will not decrease burden. You also lose the ability to focus on the measure where performance is falling short because the result

is just an overall average of seven measures. So you really can't tell which measure is falling short and which measures you're doing well on.

I'd also like to make a brief comment on the Measure 0040, Intervention for Prediabetes. The AAFP is opposed to this measure as it lacks evidence for improvement of outcomes, relies solely on the expert opinion of the American Diabetes Association. The measure has no upper limit, conflicts with the AAFP and the United States Preventive Services Task Force recommendation which both recommends screening for abnormal blood glucose as part of a cardiovascular assessment in adults aged 40 to 70 who are overweight or obese. So one of the measures of this conflicts with that recommendation.

The measure also presents a large potential for harm due to overtreatment with medication for prediabetes. Also, prediabetes is a risk factor. We're all pre-something.

This measure is prescribing exactly

what should be done for all patients with abnormal blood glucose. But there are many other options that are available that are much more patient-centered. I'll rest my comments on here, although I do have a few more. Thank you.

CO-CHAIR ROBERTS: Thanks, Sandy. We appreciate your comments. I do want to make a few reminders on the comments. If you could please limit your comments to two minutes, ensure that we're only focusing on the clinician level measures at this time, and then make any comments on MUCs or opportunities to improve. Do we have any other public comments?

(No audible response.)

CO-CHAIR ROBERTS: Okay. If not, then I will hand it over to Sam next. I think Sam, you're going to give an overview of the workgroup summary and key themes.

DR. STOLPE: Yep, thanks very much. So let me just first pivot to our two workgroup co-chairs that whom I'd like to both introduce and make sure they're on the line. Do we have

Diane Padden and Rob Fields?

(No audible response.)

DR. STOLPE: Okay. Well hearing neither, I may be riding solo on this one. I was hoping that Dr. Fields and Dr. Padden would be able to join, but perhaps they were not able to.

DR. PADDEN: I'm sorry. I was muted. I'm here, Sam. This is Diane.

DR. STOLPE: Thanks, Diane. Okay, wonderful. Well just as a preview here, you'll note that we have a total of 11 measures that were considered by the workgroup. Oh, and I just saw a note from Rob. He says his audio seems to be having some trouble, so --

MR. DAWSON: Sam, you're on mute.

DR. STOLPE: So we had a total of 10 measures that we considered from MIPS and one measure that we considered for the Shared Savings Program. Next slide. So we had two key themes that emerged from our discussions. The first related to the cost measures.

The clinician workgroup expressed a

series of concerns for each of these related to stinting of care, and suggested that perhaps sometimes doing the best thing clinically for a patient may result in higher episode-based cost but result in long-term global saving cost measures. So just encourage CMS to be especially cautious in how they roll out cost measures to make sure that there isn't stinting of care, or that some of the up front savings that you may be gleaning aren't reflective of long-term costs or vice versa, that some of the up front costs themselves might have some long-term benefits but might not be reflected during the measuring period.

The workgroup is also concerned about clear connections associated with upstream interventions that result in downstream cost savings, and have this baked into a series of recommendations that they proffered as part of mitigation points. The next thing was around balancing PRO-PMs within programs, which is the theme that was discussed to some extent earlier

in our discussions with CMS this morning. So the clinician workgroup also noted this importance of capturing the voice of the patient but that there may be additional burdens associated with having too many PRO-PMs and highlighted the potential of losing patients along the way, so to speak, if you have PRO-PMs that you may be responsible for across the program and how that might have consequences for patient response rates. Go to the next slide please.

Okay. So now we're going to jump into our mixed measures beginning with the cost measures. So currently MIPS has 20 cost measures, 18 episode-based cost measures, and 2 population-based cost measures. And CMS is required by statute to develop episode-based cost measures. And there's 5 new measures that are proposed to be included in them and support the MIPS Value Pathway, MVP. Go to the next slide, please. Sorry, am I supposed to be handing this over to CMS at this point?

DR. SCHREIBER: Yes.

DR. STOLPE: Okay. So apologies, CMS. I'm actually covering your material.

DR. SCHREIBER: You're doing such a good job, Sam. It's okay.

DR. STOLPE: Thanks, Dr. Schreiber.

DR. SCHREIBER: So as Sam pointed out, we are statutorily obligated to have cost measures in the MIPS program that cover the majority of providers. And we have two population-based, that's the MSPB, and the total per capita cost. And we have been bringing to this committee a series of cost measures that are episode-based costs that have over time had lots of comments about attribution. Is this appropriate attribution?

And we've tried really very hard to make sure that the cost that is captured is actually referable to the care for that episode. So it excludes other things that aren't part of that episode and to that clinician who is actually providing care for the patient. Next slide. So the measurement framework focuses

specifically on capturing the clinician role here.

They're constructed using the same framework that you've seen before, and some are procedural based which I think are sometimes a little easier perhaps to understand, who did the procedure and who was responsible for the follow-up care and the pre-op care seems to be a concept that is -- I don't want to say easier to understand. But the cost of attribution to that clinician seems a bit more straightforward than who is attributable for the cost of care of a chronic condition such as a couple that we're bringing forward today, the care, the cost of diabetes care, and the cost of asthma. But they share a same framework.

The attribution for something like a chronic disease as in diabetes, it begins with seeing the patient. So a provider gets attributed cost first when they've had two visits to identify the start of that clinician-patient relationship. And then that episode generally

continues at least for the reporting year, but it can go through multiple visits over an 18-month period.

And the cost is measured for at least that year to reflect the ongoing nature of a chronic condition in care coordination. These measures, they're tailored to capture care that, as I said, is specific to the management of diabetes or asthma. So if somebody comes in from a car accident, those costs aren't, for example, included.

If somebody is seen for diabetic education, if they're seen for an admission for ketoacidosis, those obviously would contribute to an episode of diabetes care. And I've also stratified the patient cohort into smaller groups, which really include only those clinically-related costs as we talked about and account for risk factors that are specific to that indicia. Next slide.

Okay. Let me just pause there and introduce some of the Acumen group who has really

put a lot of work into developing cost measures. Nirmal or others, if you guys want to clarify anything that I said, introduce yourselves so that the committee knows that we are here to answer your questions. But we just wanted to set the framework around the cost measures because there was certainly spirited conversation around them.

MR. NAGAVARAPU: Okay. Thanks very much, Michelle. This is Sri Nagavarapu from Acumen from the measure development team. Can you all hear me okay?

DR. SCHREIBER: Yes.

MR. NAGAVARAPU: Great. So I'll just give a very quick overview. I know we're constrained on time. I'll speak a little bit to the evidence that we submitted a memo to the MAP on the workgroup's concerns.

Real quickly, the purpose of cost measures as defined by NQF is to assess resource use, to be effective and to capture costs related to a clinician's care decisions and account for

factors outside of their influence. The measures are required by statute and are essential for MIPS and MVP as Michelle noted. And the goal of MIPS is to reward clinicians for value for care.

It does this by having categories for quality and cost measures so that they can balance each other. Each of these types of measures explicitly assess different aspects of care. So they are not intended to move in lockstep with each other.

Right now, there are over 200 quality measures and only 20 cost measures. The majority of clinicians for the chronic conditions and sepsis measures today are currently being assessed by global cost measures, MSPB and TPCC. The episode-based measures assess condition-specific costs as Michelle noted, complementing MSPB and TPCC which capture total patient costs for inpatient and primary care.

Both types of care have a role to play in measuring performance. And our testing submitted in the memo that you all have shows

that providers who tend to do well on condition-specific care also tend to have lower total patient cost. This directly addresses the MAP's second concern, that caring for a condition with out-of-pocket costs while lowering total patient costs. The evidence does not support that concern.

The five measures today were developed with extensive stakeholder engagement. We began by convening over 160 clinicians who identified the importance to MIPS to assessing these costs. These clinical experts and the literature supported that these measures are areas where clinicians can make care decisions that reduce the likelihood of high cost down the road, for example, improved care coordination.

The measures don't attempt to dictate how clinicians practice. That would be beyond their scope. But rather, they aim to fairly capture the costs related to that practice within a defined episode and provide this information to clinicians. This clarifies the MAP's third

concern about downstream costs.

Once stakeholders identify the need for the cost measures, we work closely with 85 clinicians affiliated with 73 specialty societies to think through each aspect of the specifications and make iterative adjustments based on empirical data of an 18-month process. We also conduct a national field testing and produced over 214,000 reports for all attributed clinicians to review and provide feedback. While development has now wrapped up, measures will continue to be monitored through regular maintenance to make any updates.

Slide 63 summarized some features of the measures. We just want to quickly talk about the MAP workgroup's concerns around the relationship between cost and quality. We shared a short memo, as I said, that contains relevant testing results and highlights key points in the interpretation of such correlations of cost and quality.

Cost and quality measures each

evaluate different aspects of care. So it's important to think about what the direction and strengths are actually showing. The workgroup had been concerned about care stinting, their first concern that Sam noted.

The way this would be reflected in a cost quality correlation is in a strong inverse or negative relationship, that is where there's good performance on cost but poor quality performance. We did not see any evidence supporting this concern in our testing across the measures as the memo shows. What we do see is weak correlations which indicates that there is variation in cost at any given level of quality.

Crucially, that implies lower cost can be achieved without negatively impacting quality. We're happy to answer any other questions you have about the testing or the memo or provide more details about the measure specifications. Thanks.

DR. STOLPE: Perhaps at this point, Misty, it'd be good to allow for general

questions from the Coordinating Committee related to the presentation and to Sri's explanation.

CO-CHAIR ROBERTS: Yeah, and thanks to Sri and Michelle for that overview. Looks like Harold has his hand raised.

MEMBER PINCUS: Yeah, so are out-of-pocket costs included in the cost measures?

CO-CHAIR ROBERTS: Who would be the best to answer to that, Sri?

DR. SCHREIBER: That would be Sri. And I don't think so because I don't know that we can capture the patient's out-of-pocket expenses. Sri, I'll leave that to you.

MR. NAGAVARAPU: Sure. So the cost measures are based on standardized allowed amounts. Allowed amounts are the amount that a Medicare provider is entitled to be paid for a given service. So that could include the rate that comes from co-insurance, for instance. And standardized means that it's standardized to remove any variation due to geography or policy adjustments in order to ensure fair comparisons

across providers.

MEMBER PINCUS: One of the reasons I'm wondering about it, it comes up with a couple of the examples, is that there are certain circumstances where specifically if you've had a particular procedure where wealthier patients can get private nursing, which might reduce the likelihood of subsequent hospitalizations or other complications. And it sort of gives almost a reverse social determinants kind of effect. I was just wondering how people have thought about those issues and how to deal with it.

MR. NAGAVARAPU: Thanks for the question. We have several approaches to deal with exactly that concern. Beneficiaries with a primary payer other than Medicare are excluded from these measures to try and speak to concerns about interactions with private insurance. We've also done significant testing on these sorts of issues in order to see whether we see differences across different types of status in terms of risk or social risk factors.

CO-CHAIR ROBERTS: Thanks, Sri. Leah, did you have a question?

(No audible response.)

CO-CHAIR ROBERTS: Oh, we didn't catch that. Sounds like it was answered? Okay. Are there any other questions on the MIPS cost measures?

(No audible response.)

CO-CHAIR ROBERTS: Okay. If no other questions, then we will go ahead and get into the individual measures. And I'll hand this over -- actually the first one is Asthma-COPD Episode-Based Cost Measure. And I'll hand this over to Sam and the workgroup co-chairs to give information on the workgroup recommendation.

DR. STOLPE: Very good. Let me just do a quick sound check for Rob. Rob Fields, are you --

DR. FIELDS: Can you hear me?

DR. STOLPE: Yeah, sounds great. All right. Thanks, Rob.

DR. FIELDS: All right.

DR. STOLPE: Okay. So we'll start with MUC20-0015. And we'll have five measures total that we're going to walk through on the episode-based cost measures beginning with the Asthma-Chronic Obstructive Pulmonary Disease Episode-Based Cost Measure.

So the brief measure description on this, the Asthma-COPD Episode-Based Cost Measure evaluates a clinician or clinician group's risk adjusted cost of Medicare for patients who receive medical care to manage asthma or COPD. The measure score is a weighted average of risk-adjusted cost for each episode attributed to the clinician where each episode is weighted by the number of assigned days during the episode.

Now this quality measure includes services that are clinically related and under the reasonable influence of the attributed clinician. And services are assigned during the episode, which is a portion of the overall time period of a clinician group's managing of a patient who has COPD. And this includes Medicare

Part A and B beneficiaries during the performance period who are eligible for the measure.

Now the workgroup did not go with the -- excuse me, the staff recommendation of conditional support. Rather they went for a different outcome. That was do not support with potential for mitigation. Mitigation is contingent on further evaluation on the impact of actionability, demonstrating the connection between upstream medical interventions and downstream costs as well as --

(Audio interference.)

DR. STOLPE: It was those two things. It specifically evaluates on all of those impacts. MAP noted attention in expenses associated with good care that may result in reductions in overall cost of care but --

(Audio interference.)

DR. STOLPE: MAP encouraged CMS to balance the cost measures with appropriate quality measures, and to demonstrate the connection between them. They further noted the

cost measures associated with upstream preventions that result in lower downstream costs and expressed concerns that's not the case for the measure and it may impact its overall actionability.

We also expressed concerns associated with the reliability and validity of the measure and the episode-based cost in general, noting the previous Acumen measures have been brought forward to NQF for endorsement consideration and have had mixed reviews from the NQF Scientific Methods Panel. But the developer has noted that they perform and prepared validity tests looking at known group analyses to ensure that expected high cost episodes were reflected in higher cost scores as well as correlation analyses. We received a number of public comments on these measures. We have 12 in total, and I'll just briefly summarize those.

We had both expressions of support for the measure as well as some concerns that were raised. The primary concerns were associated

with one including physical therapy, therapists in the measure, that there's clarity of episodes start and stop. Note that many patients may be incorrectly diagnosed with asthma by non-specialists as well as some concerns related to risk adjustment by disease severity and social determinants of health.

There's also a note to request additional testing and to delay implementation until that's been -- excuse me, it's the last thing conducted. There was one comment that was used across the board that I won't mention every time. But just a concern related to inability of physician groups to replicate episode-based measure data, that all scores are retrospective, and there is no actionable data to help providers improve in real time.

Claims data should be provided on an ongoing basis to correct for this. This is a summary of the measure and the measure comments. Let me just pivot to our two co-chairs for any supplementary remarks.

DR. FIELDS: I don't know that I have any specific comments to add, Sam. I think you summarized it well. I mean I think a lot of -- as you mentioned, a lot of the concerns that you just described were -- many of these were similar across many of the cost measures. So I won't belabor that point either. But they were consistent across the board.

MEMBER FERGUSON: Yeah, this is Scott Ferguson. There were -- we do not support with the potential for mitigation. I'd to put that out there. But we'd like to some additional conditions such as ensuring the minimal reliability rate is 0.7 or higher.

Part D prescription drugs should be removed. And I was glad to see the quality information provided -- the quality of care and cost information provided. And I think that ought to be the standard with any of these cost measures, that we should be furnishing that information.

DR. STOLPE: Diane, did you have

anything that you wanted to supplement to Rob's remarks?

(No audible response.)

DR. STOLPE: Diane, you may be on mute.

DR. PADDEN: Double muted. No, I don't have anything else. Thank you.

DR. STOLPE: All right. Very good. Back to you, Misty.

CO-CHAIR ROBERTS: Thank you for that. So with that, I'll open it up to the Coordinating Committee for any questions or concerns. Looks like Janice has her hand raised. Janice?

MEMBER TUFTE: Hi, thank you for this. I'm a minor discussant on the colon-rectal-diabetes cost measure. But I went through all the comments and I found them very interesting. And I just had a couple comments.

One is there was more than one individual that discussed the social risk factors, right, that they're not -- it's not

taking into account that. And in particular with diabetes and even asthma, right, this is a big -- is important in those areas. And regarding the surgery, I guess -- this is in the weeds. But the enhanced recovery after surgery I think is really important just to take note of. Thank you.

CO-CHAIR ROBERTS: Thanks, Janice. Looks like we have Amir next.

MEMBER QASEEM: Hi, everyone. First of all, I think a good discussion. Misty, sorry. I think we're discussing this asthma measure, right? So I'm just going to stick to asthma measure for now.

I think it's the step in the right direction, but I struggle with it. Just from the basis, I think CMS did a good job describing the evidence. I like that you guys looked into whether some of these interventions are primarily influenced of the clinician.

So you guys know me. I dive deep into the studies. So I can tell you that one thing

that I would have benefitted was to get a feel for the quantity, quality, and consistency of data supporting that claim because once I started looking at those studies individually, perhaps it may not be as directly supporting the claim that it is under influence of physicians or not. So that's one thing.

So then I started looking at individual clinicians on a group level. So group level, you can see that 40 episode case minimum reaches a reliability of 0.74. I can start breathing a little better once it's past 70.

But there is a major variation if you look at 20, 30, 40 at an individual clinician level. It's going to be difficult to differentiate between physicians, right? That's the bottom line. And my gut estimate looking at those numbers right now is perhaps you will need at least 50 to 60 episode case minimum to get the reliability of 70 or get past that.

So the bottom line is going to be if you can't differentiate between the physicians,

what's the benefit of using this measure? And I think that is something to strive towards. I'm happy to hear if anyone has any response to that, but if you can't differentiate between the physicians, you shouldn't be using the measure.

DR. SCHREIBER: So Amir, this is Michelle and I'll just comment for a moment. We recognize that there's probably going to be a tradeoff between the number of cases that has to be attributed to a clinician in order to get a reasonable reliability. On the other hand, there's a balance of making sure that the measure is applicable to enough clinicians to make it worthwhile. So if we start excluding everybody until they have 50, 60, 70 cases attributed to them, I think that that makes it less usable. So somewhere in the middle there, I think there has to be a balance.

MR. NAGAVARAPU: And this is Sri Nagavarapu from the measure developer. I can speak to Janice Tufte's comment about social risk factors. I should note both the asthma-COPD

measure and the diabetes measure do adjust for dual eligible status in the risk adjustment because in testing, we saw that there was an impact of this status on provider scores.

And so we do risk adjust for dual eligible status in those measures. Regarding reliability, the reliability of the measures that an episode case minimum of 20 for asthma-COPD is 0.643 for TIN. It hits 0.7 at 30.

There were questions about TIN/NPI. There's only 6 percent of clinicians in MIPS that participate in TIN/NPI. But we realize it's still important to look at. The reliability there is 0.57 at a case min of 20, 0.63 at 30. And then by the time you get to 50, it's at 0.7.

And there's still a substantial -- so the reliability is quite high for the asthma-COPD measure. And I should note that a large number of NQF endorsed measures have reliabilities of 0.5 or below that, including ones that recently passed the patient safety measure. So we definitely appreciate that concern and feel

comforted by the results of the testing that we've seen there.

MEMBER QASEEM: So Misty, can I just respond to that? So Sri, I hear you, what you're say, right, that reliability is high. But using the term high is a very relative term, right? High compared to what?

So when we have had this discussion -- this issue is something we have discussed in the past. By the way, I support clinicians workgroup's recommendation on this. So strongly support what they have come up with. But when you're talking about high, we have had this conversation with NQF and even -- I think it was MAP or maybe it was -- anyways roughly speaking, we need to go to 0.7, right?

That's the minimum threshold that we have talked about. So if you're going to use that threshold because you have to have a threshold because otherwise you can argue that 20 is higher than 10, right? But that's not good enough. You're not going to go that route.

So if we believe that 70 is a good enough differential -- and I hear you, Michelle, what you're saying. I'm not disagreeing with what you're saying, that we need to -- is it good enough. But good enough for what?

Do you think that any of us would like to be held accountable using certain levels that we know are not even close to perfect, right? If you use the reliability, it's a hit or miss at that point. So it comes down to what are you planning to use that measure for.

If it is going to be used for clinicians can use it for quality improvement purposes internally, that's a whole different concept. But if you're talking about you're going to use it for accountability, for payment programs, or for reporting purposes, that's where the problem -- it becomes problematic. And that's why I'm supporting clinicians workgroup.

MR. NAGAVARAPU: Yes, and thanks for that. Yeah, in terms of high, I do think that everyone has separate standards with this. And

so I'm sort of going by previous NQF endorsed measures. And we definitely appreciate the types of standards that you're thinking about. And at various case minima, it is possible to get reliability for this measure of 0.65 and higher than 0.7, depending on the case minimum that CMS decides to choose in rulemaking.

CO-CHAIR ROBERTS: And before we go to vote, are there any other questions or concerns? Okay. So I will ask Sam to reiterate the workgroup's recommendation. It was do not support with potential for mitigation. Any additional information you want to add, Sam?

DR. STOLPE: Thanks, Misty. So the recommendation from the workgroup, as you mentioned, was do not support with potential for mitigation. And the mitigation points were twofold. First, receive an NQF endorsement which the workgroup emphasized that this reliability concern will be resolved in the course of the endorsement conversation. And the other mitigation point is contingent upon further

evaluation of impact points for actionability that demonstrate the connection between upstream medical interventions and downstream costs.

CO-CHAIR ROBERTS: Thanks, Sam. So with that, we will open it up to vote on the workgroup recommendation. Again, we're voting to support their recommendation which is do not support with potential for mitigation.

MR. DAWSON: Thank you, Misty. Voting is now open for MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease Episode-Based Cost Measure for MIPS. Do you vote to support the workgroup recommendation of do not support with the potential for mitigation as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Okay. It looks like we've got about 17 votes now. We were having 19, weren't we?

MR. DAWSON: Yeah, 19 was the highest that we had at one point.

CO-CHAIR ROBERTS: Okay. Oh, someone changed. Okay. Are we ready to close? We're

at 17.

MR. DAWSON: Okay. I'm going --

(Simultaneous speaking.)

DR. STOLPE: -- voting. Let's just --

CO-CHAIR ROBERTS: Oh, what was that?

DR. STOLPE: I just wanted to check if there was anybody who's having trouble voting. But we did have some people who had to mention they need to step away for a bit --

MEMBER GELZNER: This is Andrea Gelzner. I lost the voting link, so yeah.

CO-CHAIR ROBERTS: Can she send her vote through to you all?

DR. STOLPE: Yeah, you can --

CO-CHAIR ROBERTS: What's the best way to handle that?

DR. STOLPE: Andrea, you can send your vote to me via chat if you would like.

CO-CHAIR ROBERTS: And then can someone help her get reconnected?

MS. PERERA: I will send you a link

via email in just a moment.

CO-CHAIR ROBERTS: Okay. So what are our results?

DR. STOLPE: You can go ahead and close it, Chris.

MR. DAWSON: So voting is closed. The results are 16 yes and 1 no. The Coordinating Committee -- sorry, do not support with potential for mitigation, MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease Episode-Based Cost Measure for MIPS.

DR. STOLPE: So just as a note, this is actually off by one vote. So it should be 17 votes for yes and 1 vote for no.

CO-CHAIR ROBERTS: All right. Great. So we'll go to the next measure which is the Colon and Rectal Resection Episode-Based Cost Measure. Sam, do you want to give a summary of the workgroup recommendation?

DR. STOLPE: Thanks so much, Misty. So MUC20-0016, the Colon and Rectal Resection Episode-Based Cost Measure evaluates the

clinician or clinician group's risk-adjusted cost to Medicare for patients who receive colon or rectal resections for either benign or malignant indications. And the measure score is the clinician's average risk-adjusted cost for the episode group across all attributed episodes.

This is an inpatient procedural measure which includes services that are clinically related and under the reasonable influence of the attributed clinician. During the 15 days prior to the clinical event that opens or triggers the episode through 90 days afterward. Medicare beneficiaries enrolled in Parts A and B during the performance period are eligible for the measure.

Now the workgroup's recommendation for this is conditional support contingent upon NQF endorsement. So they had a number of questions related to the risk-adjustment approach that the measure developer highlighted that dual eligible patients are not included, and that other risks in the model include left ventricular

assist device, major bowel surgery, discharged against medical advice, transfers within three days, et cetera. So a number of different risks that are included in the risk adjustment, and they further clarified that 90 percent of attributed clinicians were general and colorectal surgeons.

As you'll note from this slide, there were a total of 11 public comments received which I'll just briefly summarize. The main comments associated with this were in support, although there were some that called for clarity on attribution language as well as some reflections on the overall reliability thresholds. There was also some suggestions that the measures aren't actionable because the development with the measures were flawed -- suggested they were flawed and that Acumen presented framework that all clinical subcommittees were required to follow -- to develop the cost measures.

That's the summary of the discussion and the comments that we received. Let me pivot

to our workgroup co-chairs to see if they have any supplementary remarks. Rob and Diane?

DR. FIELDS: I think the only thing that I'll comment on is that I see the recommendation for the group is a little different than some of the other cost measures in terms of support or conditional support. But I think that was also based on trying to differentiate procedural-based episodes of care measures like this compared to chronic condition-based measures which are a little bit harder to wrangle. I won't resurface all the discussion we just had.

But there's more precedent, I think, for defining both attribution episode and the costs associated within the measure. So those have, I think, more inherent comfort with something like this based on previous performance of other similar measures. And then known that there was another measure like this one that existed. So I think it was why the change.

DR. STOLPE: Thanks, Rob.

DR. PADDEN: Nothing further to add. Thank you. You both covered it.

DR. STOLPE: Thanks, Diane. Misty, back to you.

CO-CHAIR ROBERTS: Great. Thanks for that. I'll open it up to the Coordinating Committee for any questions or concerns. Looks like Julie has her hand raised.

MEMBER SONIER: I do. So this is one of the ones that I looked at closely to prepare as a lead discussant. One of the additional comments that I had was that this concern that was just raised about reliability seems to be particularly applicable to this measure. So reliability is really quite low.

But in combination with that, one of the things about this measure is that there's a really tight range of cost. So it's really like plus or minus 10 percent in cost between the 10th and 90th percentiles, which just raised for me the question about sort of whether it's worth kind of the scare resources for measurements to

invest in this measure. And then separately, kind of the question about it's kind of the flip side of that question about the chronic disease where you want to connect the -- it's not clear how connected the quality is to the cost.

Here there's some really clear ideas about what could influence cost that is also quality. So using minimal invasive surgical techniques and reducing infection, which really just raised the question for me about why aren't we just measuring those things directly. So whether a cost measure is really the right way to get at the problem that we're trying to solve here.

CO-CHAIR ROBERTS: Thanks, Julie. It looks like Janice has a question as well.

MEMBER TUFTE: Hi, it's a comment. But I was just curious why we -- the trigger is 15 days before and not 30 because this also includes like diverticulitis and other colon resection. The diabetes, I believe -- oh, no. It was melanoma has a 30-day before. And I just

thought that 30 days might be more appropriate and then the after could stay the say. But that's my comment.

MEMBER QASEEM: So Misty, not a comment over here. I'm just struggling. Just if Rob or Diane, can you just tell me why did you go with this recommendation for this measure, because it's not really different from the other one. Yours is conditional support or whatever you guys call it for this one, right? Yeah.

CO-CHAIR ROBERTS: Real quickly, before we get set, Amir, I want to know if anyone is able to address Janice's question around the 15 days versus the 30 days. I'd definitely like to hear the rationale for that.

DR. CHORADIA: Sure. So my name is Nirmal Choradia. I'm a clinician with Acumen. So the reason for 15 days versus 30 days as the group deciding this, we went out to the community and got a basically group of people -- group of clinicians that focused on colon and rectal resection. They talked about this in detail.

And specifically, their thought in only focusing on 15 days was they were going to focus on capturing specifically the things that were under the influence of the surgeon.

So their idea being that if they send a patient off to a cardiologist and then that cardiologist recommends X, Y, and Z testing, they don't necessarily want the physician who is -- or the surgeon who's going to be held responsible for this episode to get that testing way downstream. They're only focusing on specifically the testing related to their -- well with their ability to control for colon and rectal resection. And that's why they focus -- they thought that 15 days was more appropriate.

The other thing I just wanted to quickly go back and address is -- well actually two things, first, the scarce resources for management. So it is understandable that there is only a 10 percent difference between the 10th and 90th percentile. But you also have to take into account that already for all of these

episodes, there is a large part of that that is a large basically lower level cost that's already built in.

And you can think about that as the cost for the colon and rectal resection. We're talking about looking at the 10th and 90th percentile at 22,000 and 28,000. But you're talking about a basically baseline cost of 17,000. I don't remember the exact number off the top of my head. But that's not including anything like post-acute care or anything of that nature. So we're really looking at the cost beyond a fixed cost for the hospital stay and the surgery.

And then last thing, so in response to the actionability issue, people are basically looking at -- so we understand and like just giving a general score for how you did on a colon and rectal resection, it's hard to see what you can do to decrease that score without like really digging in or really looking back at every single episode of yours. And even then, it's pretty

difficult. And so because of that, at least in the reports that we sent out for field testing, we broke it down into I believe 10 categories, where costs occurred, where they were higher than the national average, where they were lower than the national average, where they did better, where they did worse.

And then the idea behind that is they can look at these reports. They can understand. We're doing great with colon and rectal resection, but we send way too many people to post-acute care or so on and so forth. So I'll stop there and hand it back.

MEMBER TUFTE: This is Janice. I just wanted to add that the reason on the 30 days is because I know I'm not alone on this where somebody has had a colonoscopy and they realize there's a tumor. And a surgeon prefers to have it tagged or tattooed. Anyway, it might not fall into -- I don't know when the actual -- there's other things that might have to be done that the surgeon wants. And I just think it could be 30

days. That's all.

CO-CHAIR ROBERTS: Thanks, Janice. I do want to get back to Amir. I think your question was really around understanding why this one was conditional support pending NQF recommendation versus the other ones that do not support with potential mitigation. Was that your question?

MEMBER QASEEM: Yeah, I mean I was just curious what the clinicians group thing was.

DR. FIELDS: I can try to start and Sam or Diane want to fill in. I think that's what I was trying to address in my opening comments is why this one was different. And I think there was another procedural-based measure that also got similar endorsement. And I think it has a lot to do with -- and actually the comment was in terms of trying to really encourage changes around the non-acute part of the episode.

We know just from bundled payments and other programs that there's a significant amount

of variation in particular in the pre- and post-acute part of an episode. We've seen that in the bundles program, for instance. And so I think there was a sense of, hey, we have experience with measures like this that are surgical episodes that have a discrete beginning and end and have significant impactable costs and improvements in quality in particular after the event itself.

So I think that was a big part of it. The clear definition of the episode, clear attribution, clear inclusion of specific costs that would be included in an episode which is a little -- which is actually significantly less true with things like diabetes, asthma, or other chronic conditions. But there's not a clear start and stop. Attribution gets a little bit messy because you have multiple providers involved, things of that nature which makes those measures a little more difficult to execute on and impact, but defer to Sam and Diane if you remember differently.

DR. STOLPE: That was my recollection, Rob. Thank you.

CO-CHAIR ROBERTS: That makes sense. I think Scott, you had some comments in the chat and your hand raised.

MEMBER FERGUSON: Yes, I wanted to agree with Julie about reliability, and I put that in the chat. And I'll probably put it on several of these. I think the reliability should be 0.7 or higher on all of these. In this particular instance, the difference between the highest and the lowest cost is really small. And it'd be hard to know how we will distinguish the differences across positions and groups with -- below a difference between the highest and lowest cost measure.

CO-CHAIR ROBERTS: Does the measure developer want to respond to that?

DR. CHORADIA: Sure. So just really quickly, keep in mind that there is a very high fixed cost for doing a colon and rectal resection. So the variation that you're seeing

is the variation in the post-acute care and honestly an extended hospitalization, things of that nature. So while it is -- while you're seeing a variation of 10 percent of the total cost, you're actually seeing a variation of 25, maybe 30 percent, maybe even more of the non-fixed cost of the episode.

MR. NAGAVARAPU: And one clarification on Scott's comment. Part D prescription drug costs are not included in this procedural measure, in the colon and rectal resection measure.

MEMBER FERGUSON: Great. Thank you.

CO-CHAIR ROBERTS: Ron, did you have a question? Okay. Any additional questions or comments before we open it up for a vote?

MEMBER FERGUSON: My comment goes back to what Amir was saying about why is this one different. Why do we -- conditional support versus do not support with the potential for mitigation. And I would -- personally I want to err on do not support with the potential for

mitigation. So that's what I'll be doing.

CO-CHAIR ROBERTS: So I think if I can summarize, I think the primary reason has to do with the fact that this is a procedural-based measure versus -- with more of a clear start and end attribution than the other measures. Did I summarize that right?

MEMBER FERGUSON: That's correct.

CO-CHAIR ROBERTS: Yeah. Okay. Sam, do you want to summarize the workgroup recommendation before we vote?

DR. STOLPE: I'd be delighted. So this is conditional support for rulemaking pending NQF endorsement. Chris, do you want to open up our voting?

MR. DAWSON: Yep. Okay. Voting is now open for MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure for MIPS. Do you vote to support the workgroup's recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Okay. Did we get Andrea working?

DR. STOLPE: That looks like a yes.

CO-CHAIR ROBERTS: Okay, great. Okay. So I think we're at 18.

MR. DAWSON: Okay. So voting is now closed. The results are 13 yes and 5 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0016 -- sorry, Colon and Rectal Resection Episode-Based Cost Measure for MIPS.

CO-CHAIR ROBERTS: Okay, great. So we'll move on to the next measure.

DR. STOLPE: Very good. Thank you very much. So our next measure that we'll be looking at is MUC20-0017. And this is the Diabetes Episode-Based Cost Measure which evaluates a clinician or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage either type 1 or type 2 diabetes.

The measure score is the weighted

average of risk-adjusted cost for each episode attributed to the clinician or clinician group, where each episode is weighted by the number of assigned days during the episode. This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician or clinician group. The services are assigned during the diabetes episode, which is a portion of the overall time period of the responsibility for managing a patient's diabetes.

Medicare beneficiaries enrolled in Parts A and B during the performance period are eligible for the measure. Now comparable to the other chronic condition-based, episode-based cost measure, the workgroup did not support the measure for rulemaking with potential for mitigation. Mitigation is once again contingent on further evaluation on impact points for accountability, demonstrating the connection between upstream medical interventions and downstream costs. Of course, this is also

contingent upon NQF endorsement.

Now the workgroup --- I once again noted that there's quite a bit of attention to the -- excuse me, expenses associated with good care that may result in reduction in overall cost to care but raised the condition-specific care costs. So this is much to Rob's previous point that the nature of chronic conditions is different than the procedural-based, episode-based cost measures in the mind of many of the workgroup members. And given that's the case, the MAP workgroup -- the clinician workgroup noted that upstream preventions should result in downstream costs and expressed concern that this might not always be reflected accurately in the measure, impacting its overall actionability.

I'll note that this measure received 13 total public comments, and I'll just summarize those briefly before turning it over to Rob and Diane. So for this measure, the main points were, once again, to include physical therapists. There was some strong support for the measure and

they urged the episode include cost of management and complications resulting from diabetes, including chronic wounds. There was a mention of risk-adjusted standardized costs, and that should be reflected in the numerator.

There were a number of comments that mentioned this, achieving a reliability of 0.7. This was discussed by the Workgroup, and they felt that this would be captured through NQF endorsement. There was a concern expressed associated with social determinants of health, ensuring transparent attribution, and a number of comments related to NQF endorsement. Let me pivot to Rob and Diane to see if they have any supplementary remarks.

DR. FIELDS: Nothing from me, Sam. Nothing to add.

DR. PADDEN: I'll just add one comment which has to do with the costs up front in terms of the care and then hopefully have better outcomes. I thought there was a lot of discussion within the MAP for both of these

chronic disease measures about the importance of ensuring that the quality measures are working in tandem with our cost measures. We had quite a bit of discussion about that, that they're not to replace one or the other but rather they should be complementing one another.

CO-CHAIR ROBERTS: Thanks, Diane. I'll open it up to the Coordinating Committee for any questions or concerns. Looks like Leah has her hand raised.

MEMBER BINDER: Yes, I had a question. There was a comment from a public comment earlier, from I think it was the family physicians group about -- something about the American Diabetes Association and the standard was focused on their standard. I think that's what she was saying. So I wondered if anyone -- any of the developers could comment on that, what that issues was. I was unfamiliar with that issue.

DR. SCHREIBER: Leah, it's Michelle. That was specifically an issue that they had that

the American Academy of Family Physicians had with a prediabetes measures. So I'm --

(Simultaneous speaking.)

DR. SCHREIBER: -- it a different measure.

MEMBER BINDER: Okay, sorry. Thank you.

CO-CHAIR ROBERTS: Thanks for that clarification, Michelle. I thought it was this measure as well. Looks like Ron has his hand raised.

MEMBER WALTERS: Yeah, I was going to bring this up during the last. But I just wanted to see how that discussion turned out. And perhaps -- because I've been on that fence between conditional support and do not support with potential for mitigation.

And what drives one, one direction and what drives another one that direction? We'll see how that plays out over the next two measures too. But I guess if the good that's coming out of this session is we're giving, as was just

summarized, guidance to CMS that the shorter term episodes are easier to go through the process than the longer term episodes that might require more work.

As you said, there's a lot of discussion and feedback about pairing it, I use that term in quotes, with quality measures. And I think that does have to be done in a way. But as was stated very earlier on, cost measures measure cost. Quality measures measure quality. And you do have to put the two hand in hand but not necessarily in the same measure. It gets very hard to do that.

So I think as the day has gone on, I think we're getting some crystallization. I would've felt completely comfortable with all five of these being conditional support with the condition being endorsement because I trust the process. But I'm also fine with do not support for potential mitigation because we've developed advice in the process.

DR. SCHREIBER: So hey, this is

Michelle again. Can I just comment to Ron? So thank you because we think exactly. So a cost measure is a cost measure. A quality measure is a quality measure. And I don't know that combining them into one measure is what we think would work best.

But one of the strategies of moving forward with the MIPS Value Pathway as we're transitioning the MIPS is to have both in the same program. So for example, if there is a MIPS Value Pathway on diabetes, you have certain quality indicators of diabetic care. You have diabetics out of control, whether or not they've been screening exams, some of the outcome measures that we may have, and an episode-based cost measure around diabetic care. And so the goal ultimately is to have exactly that.

CO-CHAIR ROBERTS: Thanks, Michelle. Amir, you have a question?

MEMBER QASEEM: No, not a question. It's more, Misty, I support Clinicians Workgroup recommendation. We hear, Michelle, the same

issue, right? I think that at the clinician group level, I'm seeing better data than an individual clinician level.

And the same concern with the asthma measure applies over here as well. I don't think the information is going to be -- I will have confidence than not that that information can be used reliably to improve the quality of care provided in my practice. So that's something to keep it in mind.

And as far as -- I heard, Sam, you talking about NQF process. I think that's an issue that comes up, and it has come up in every MAP meeting that over the past years that we have to put these measures through MAP -- through NQF endorsement process. Another thing, at least some of these measures do end up getting used by CMS regardless of NQF's endorsement or not, right, although they strive to get NQF endorsement. So we want to make sure that we provide feedback that Michelle and her team can take back and make sure that we have concerns

regardless of NQF endorsement or not.

DR. STOLPE: I agree with you, Amir. And it's just the difference between what's a mitigation point and what's captured in the discussion. So if we're lumping them under mitigation points, that gets kind of captured inside of the NQF endorsement criteria. At least that's what was proffered by the Workgroup.

CO-CHAIR ROBERTS: Amir, that was a good point. I am curious, Michelle. You may not have it off the top of your head. But do you know how many of the measures are endorsed versus not endorsed in federal programs or the percentage?

DR. SCHREIBER: Sorry. I was on mute. So we actually had a table of this that we brought to the committee last time about how many that were recommended for endorsement that actually went through endorsement. Sam, I don't know if you have that data. It's generally -- I don't know. It's not all but it's many. We try very hard to have measures that are endorsed by

NQF to use in the programs. But I can't tell you it's 100 percent. Sam, I just don't remember those data, if you have them or not.

DR. STOLPE: I don't have that off the top of my head. But that has been shared with the Coordinating Committee.

CO-CHAIR ROBERTS: Yeah, I do remember that from the last meeting last year.

MEMBER QASEEM: So Misty, can I make a request to you over here? So it would be very helpful for MAP Coordinating Committee meeting that one standing agenda item needs to be what we reviewed last year and of which how many got incorporated and what was our recommendation versus not an NQF endorsement. This request, I think it's going to be very helpful for us as well as MAP Coordinating Committee members that what is the value or how much value added. What is it? What are we doing here, right?

And I think it's going to help us a lot to know that, yes, there is value. Here are the comments that NQF have been made to CMS and

they incorporated it or if they didn't. Something along those lines, it's a pretty simple request. And it has come up repeatedly, guys, over the past --

(Simultaneous speaking.)

DR. STOLPE: We presented that during our orientation. So we had a 15-minute session at the onset of our meeting where we reviewed that. And it's our plan to do that moving forward.

DR. SCHREIBER: Yeah, so we have -- as Sam pointed out, we have made that available and we plan to continue to make it available.

CO-CHAIR ROBERTS: Thank you.

MEMBER HOO: Hi, this is Emma Hoo. If I could weigh in for a moment. One of my overall concerns about the cost measures is that there tends to be a bias towards the procedurally-based services that in some ways are easier to design relative to the trigger points and to definition of the episode.

And with both commercial Medicare

population, diabetes is a huge cost. And there's also huge variation in performance that allowing for the desire to look at the correlation of the cost data with quality measures and also the borderline reliability scores for this measure. I guess to some of the earlier comments, I would've preferred seeing this as conditional support with opportunity to address some of the issues as opposed to do not support because I feel like there's the need to advance chronic care measures and to improve the opportunity for testing them.

CO-CHAIR ROBERTS: Thanks, Emma. Are there any other last comments before proceeding to vote?

MR. NAGAVARAPU: Just one quick note that several of the commenters brought up the question of a correlation with quality measures. And we're fortunately able to put that together for the two-page memo that we sent to the Coordinating Committee. And so just to summarize for the diabetes measure, we looked at the

correlation with several MIPS measures, the A1C measure, medical attention for necropathy, one about diabetes, foot and ankle care, and then all-cause hospital readmissions.

And we do not see any evidence for the concern expressed by the Workgroup about care stinting. So all the correlations are positive, some weak, some stronger. But in general then, they all show that there's opportunities to lower costs for a given level of quality which is really the focus of this chronic condition measure.

CO-CHAIR ROBERTS: Thanks for that information, Sri. It's helpful. Okay. I'll hand it over to Sam for last-minute comments on the Workgroup recommendation.

DR. STOLPE: Just a reminder that this was -- that the do not support with potential for mitigation and the mitigation points received NQF endorsement as well as what was mentioned previously for the other measure that mitigations contingent on further evaluation of impact points for actionability.

CO-CHAIR ROBERTS: Do you want to bring up the vote?

DR. STOLPE: Thanks, Misty.

MR. DAWSON: Voting is now open for MUC20-0017: Diabetes Episode-Based Cost Measure for MIPS. Do you vote to support the Workgroup recommendation of do not support with potential for mitigation as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Looks like we have 18 votes -- 19, 19 now.

MR. DAWSON: All right. I'll go ahead and close it. Voting is closed. The results are 15 yes and 4 no. The Coordinating Committee does not support for rulemaking with potential for mitigation, MUC20-0017: Diabetes Episode-Based Cost Measure for MIPS.

CO-CHAIR ROBERTS: Okay. Now we'll go to the Melanoma Resection Episode-Based Cost Measure, MC20-0018. Sam, you want to give a brief overview of the recommendation?

DR. STOLPE: Sorry about that. Okay.

So thank you very much. The Melanoma Resection Episode-Based Cost Measure is evaluating clinician or clinician group's risk-adjusted cost to Medicare for patients that undergo an excision procedure to remove the cutaneous melanoma.

The measures for clinicians average risk-adjusted cost for the episode group across all episodes attributed to a clinician or a clinician group. This is a procedural measure that includes services that are clinically related and under the reasonable influence of the attributed clinician or group during the 30 days prior to the clinical event that opens or triggers the episode through 90 days after. And once again, as with previous measures, this Medicare includes Medicare Parts A and B beneficiaries.

So this measure was, excuse me, conditionally recommended by the Clinician Workgroup contingent on NQF endorsement. As with previous measures, there was a lot of discussion around what the nature of the procedure was. And

MAP questioned the impact of the depth of a given melanoma may have on cost, especially with sentinel lymph node biopsies.

And the developer noted the risk adjustment associated with assessment of disease severity was included. Reconstruction is also noted to be included in the risk adjustment. There were some attribution concerns which the developer addressed by noting the cost generally align with the clinicians who are performing the procedures. They further noted that Part D costs are not included in this measure unlike some of the other cost measures brought from that cycle.

As you'll note, there are a total of eight public comments that were received, and I'll just briefly summarize those. So there was a concern expressed of the lack of quality context to the measure and suggested that clinicians should not be accountable for cost. This was noted by the -- associated with Parts C and D. But this was noted by the developer to not be included.

There were calls for transparency and attribution as well as NQF endorsement. Also some expressions of support that were included. And let me pivot back to Rob and Diane for any supplements.

CHAIR FLORES: Nothing to add from me, Sam.

DR. STOLPE: Thank you.

MR. FOX: Nothing for me.

DR. STOLPE: Misty, back to you.

CO-CHAIR ROBERTS: Okay. We'll open it up to the Coordinating Committee for questions.

(No audible response.)

CO-CHAIR ROBERTS: Let's see. I am not seeing any hands raised. So with that, Sam, if you want to summarize the recommendation again and we'll move to vote.

DR. STOLPE: All right. Very good. So this was, once again, a melanoma resection measure, condition support for rulemaking, and an NQF endorsement. Chris, would you like to open

it up?

MR. DAWSON: Voting is now open for MUC20-0018: Melanoma Resection Episode-Based Cost Measure for MIPS. Do you vote to support the Workgroup recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Okay. It looks like we've got 18 votes -- 19. We want to close it out?

MR. DAWSON: Voting is closed. The results are 16 yes and 3 no. The Coordinating Committee conditionally supports for rulemaking, MUC20-0018: Melanoma Resection Episode-Based Cost Measure for MIPS.

CO-CHAIR ROBERTS: Okay. We'll move to 0019: Sepsis Episode-Based Cost Measure. Sam?

DR. STOLPE: Excellent. Thank you, Misty. Okay. So this is the last of our cost measures. So MUC20-0019, it's the Sepsis Episode-Based Cost Measure which evaluates clinician or clinician group's risk-adjusted cost

to Medicare for patients who received inpatient medical treatment for sepsis.

The measure score is the clinician or clinician group's average risk-adjusted cost for the episode group across all attributed episodes. This acute inpatient medical condition measure includes services that are clinically related and under the reasonable influence of the attributed clinician's role in managing care during each episode from the clinical event that opens or triggers the episode through 45 days after. As the previous measures, this includes Medicare Parts A and B beneficiaries during the performance period.

Now a couple of notes related to the discussion. Here MAP noted the exclusion of hospice patients that present with sepsis as well as noting that if a patient goes to hospice during the sepsis episode, all hospice costs are excluded. And additionally, any patient who dies during the sepsis episode is also excluded.

MAP also noted that this measure is

diagnosis-related group, DRG-based, and that miscoding is a concern due to issues associated with overdiagnosis to reflect lower cost. And this is a big concern associated with the measure. There might be some gaming involved. The developer noted that there are risk-adjustment variables to assess the level of sickness to the patient.

But MAP was especially concerned that the data available to CMS may not be sufficient for them to be able to mitigate a gaming issue. So MAP did not support the measure with potential for mitigation with the mitigation points being, once again, NQF endorsement as well as an analysis of the potential for gaming associated with overdiagnosis of sepsis and further evaluation of the correlation with clinical quality measures.

As you'll note here, we received a total of nine comments. And I'll just briefly summarize those. There were some strong support. Also, once again, physical therapists commented

they would like to be included. There were also some concerns related to reliability expressed as with previous measures and with risk adjustment, transparency, attribution, and the receipt of NQF endorsement. Let me pivot to Rob and Diane for any supplementary comments.

DR. FIELDS: I will only just further clarify that a big focus and discussion was really less about I feel like the measure itself. It was the diagnosis of sepsis and the DRG. The problematic nature of the DRG as Sam pointed, there was a lot of discussion about that. And so that definition is not clear and certainly being utilized in different ways by different systems. And then it makes it problematic as a measure as a result. So that was really the focus of the discussion.

DR. PADDEN: That would be my comment as well to say. Thanks.

DR. STOLPE: All right. Misty, back to you.

CO-CHAIR ROBERTS: I'll open it up to

the Coordinating Committee for questions or concerns.

(No audible response.)

CO-CHAIR ROBERTS: I guess everyone has got their fill of cost measures. Got all the comments out in the beginning. Oh, there's David.

MEMBER BAKER: I'm just doing this to keep you happy, Misty. I agree with all of the concerns about the challenges of defining which patients have sepsis and whether some places are doing aggressive clinical decision support tools that are extremely sensitive. So they may be including people who have very early sepsis. And it's really not comparable. So again, I'm just piling on. I agree with the Workgroup's concerns.

CO-CHAIR ROBERTS: Thank you.

DR. CHORADIA: Can I respond to the miscoding concern --

CO-CHAIR ROBERTS: Yeah, go ahead.

DR. CHORADIA: -- just really

quickly? Yeah, sure. So miscoding in sepsis is ever present. And the committee clinicians who helped us in creating this measure, they were well aware of this and they put in safeguards to account for sepsis over-coding. Some of this includes putting in variables to identify organ dysfunction as a separate risk-adjustment variable and also other things to -- putting in other variables to account for episodes that they don't think are actually sepsis which would actually decrease the expected cost.

And so additionally after the MAP suggested we -- well, because of the MAP's suggestion and because of this obvious over-coding of sepsis and obvious concern, we took a look at basically all of the providers that were -- that got this episode and looked at percentages of basically how many -- or basically, like, are they coding a majority of sepsis, are they not coding a majority of sepsis, and look at that in relation to how they did on the episode.

And what we found was actually that there is no specific relation, whether you're coding a ton of sepsis, whether you're not coding a ton of sepsis. There's no relation to how you do on the episode score which actually suggests that this measure does a very good job of accounting for that, accounting for those people that are accurately coding sepsis as only a small proportion of -- or as a small proportion of the patients they get versus those that are just throwing sepsis on every single patient that they see.

CO-CHAIR ROBERTS: Thanks, Nirmal. Any other questions?

(No audible response.)

CO-CHAIR ROBERTS: Okay. Sam, you want to summarize before voting?

DR. STOLPE: Thanks very much. So once again, the recommendation is do not support with potential for mitigation. And those mitigation points were receive an NQF endorsement and analysis related to the over-diagnosis of

sepsis or potential for gaming, and further evaluation of the correlation with clinical quality measures. Do you want to open it up for voting, please, Chris?

MR. DAWSON: Voting is now open for MUC20-0019: Sepsis Episode-Based Cost Measure for MIPS. Do you vote to support the Workgroup recommendation of do not support with potential for mitigation as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Okay. Looks like we have 18 votes. Do you want to close it out?

MR. DAWSON: Yes. So voting is closed. The results are 18 yes and zero no. The Coordinating Committee does not support for rulemaking potential for mitigation, MUC20-0019: Sepsis Episode-Based Cost Measure for MIPS.

CO-CHAIR ROBERTS: Okay, great. So now we'll get into the MIPS program quality measures. And we are going to shift this around a little bit, if you'll advance to the next slide. I think we're going to start with actually 0042.

Is that right, Sam?

DR. STOLPE: Yes, that's correct. We're going to be listening our measure developer at 3:00 p.m. So Rebecca Etz, are you on the line?

DR. ETZ: I am indeed. Thank you. And thank you for the adjustment. I appreciate it.

` Thanks, Dr. Etz. Appreciate having you here. So I'll just go forward by summarizing the measure here. So this is the Person-Centered Primary Care Measure. It's a Patient Reported Outcome Performance Measure, PRO-PM, which uses a level point patient reported item survey to assess the broad scope for primary care.

Now in the brief measure description, developer noticed that unlike other primary care measures, the PCPCM measures the high value aspects of primary care based on a patient's relationship with a provider or practice. Patients identify the PCPCM as meaningful and able to communicate the quality of their care to

their clinicians and/or care team. The items within the PCPCM prong are based on extensive stakeholder engagement and comprehensive reviews of the literature.

The Workgroup recommendation for this measure is conditional support for rulemaking with support condition being a receipt of NQF endorsement. I just wanted to make sure that the committee is aware that this measure has been submitted to NQF and will be reviewed by the primary care and chronic illness committee has passed the SMP review and -- excuse me, our Scientific Methods Panel in case I wasn't clear -- and is going to be discussed in early February by the primary care committee. Just a couple of things that were expressed by the Workgroup.

Well, first, there's some concerns related to case mix adjustment. And the practices may vary substantially according patient age, health status, and tenure with the index practice. And MAP also noted that chronic care populations rather than full primary care

may be more appropriate.

The Workgroup also suggested that the provider may not, quote, need to stand up for the patient, end quote, or to coordinate care across multiple providers for instances where healthy patients just require quick checkups. This was noted by the developer to be -- still result in similar scoring despite the tenure of a patient within a practice. MAP also expressed concerns associated with ensuring health equity and culture responsiveness. And those might be included as items.

The developer noted that despite the fact that some items may not be as meaningful to all vocations, there's still good reliability demonstrated in the measure of the data element and the score level. The developer further noted that there are no differences in the measure testing according to race, ethnicity, gender as well as no differences based on educational attainment. We received a total of five comments on the measure which I'll just briefly summarize.

So some -- there are some expressions of support as just a general encouragement, the use of PRO-PMs inside of MIPS, especially those that are low burden to patients.

It was noted by the developer that this survey is especially quick for patients to fill out. It usually takes, like, less than two minutes. There was one opposing comment that cited a need for case-mix adjustment and also noted that it's possible that PCPCM scores which include items that implicitly assume a need for care for multiple places and a long enough relationship to have been through a lot together. And let me just pivot over to our two co-chairs for any supplementary comments.

DR. FIELDS: Just a quick comment that I think there was a fair amount of discussion in the group on questions regarding appropriateness and the variety of cultures and testing the variety cultures outcomes, socioeconomic groups, racial and ethnic groups, et cetera, all that were, I think, pretty very thoroughly addressed

by Dr. Etz. And so if I recall, our vote was pretty strong in support of this one. But yeah, no other comments other it was a good discussion and well developed, I thought.

DR. PADDEN: No additional comments.

DR. STOLPE: Misty, back to you.

CO-CHAIR ROBERTS: I'll open it up to the Coordinating Committee for questions. Looks like David has a question.

MEMBER BAKER: Yeah, I'll just start off by saying I think this is a really intriguing measure. I hadn't seen it before, and it's got a lot of really positive things. My only question was how this compares with the CAHPS for MIPS clinician measure and whether this is really filling a gap.

DR. ETZ: So yeah, I'm happy to answer that, David. Thank you for the question. We are currently fielding this measure alongside CAHPS to provide primary evidence for that. However, in the materials that we submitted, we provide a table that shows what kinds of things

CAHPS asks about versus what kinds of things this measure asks about.

There's one question in which there's overlap. But largely, CAHPS is asking about communication coordination and has one or two questions about clinician themselves. This measure actually addresses all of the areas of primary care identified through 40 years of literature and hundreds of stakeholders as being significant. So it includes a comprehensiveness. It includes community.

It includes access, coordination, behavior health goals, all sorts of things. With regard to CAHPS as well, although we are just starting to field it alongside CAHPS in the U.S., we have fielded it for two years in Toronto alongside a patient experience survey which is their equivalent of CAHPS. And they are currently thinking about replacing their survey with this measure in part because it is such a lower burden on the patients by tens of questions.

CO-CHAIR ROBERTS: Thanks, Rebecca. Are there any other questions?

MEMBER QASEEM: Yeah, guys. Really good. This is -- I got excited. It's in this PRO-PM world, I don't see much activity happening. So nice work, CMS and the family physician board people. I think this is a step in the right direction. I was digging through some of the information over here which I can't find. So what I was able to find is that the instrument behind this performance measure is reliable. Please correct me if I'm not reading it right. So the instrument being used is reliable. I haven't been able to find the information on the reliability of the performance measure based on that instrument. So that's my first question.

Second thing is it's not really a question. It's more of a comment. Sixteen physicians, okay. You guys can convince me, twist my arm to go with that result. But sure, I think that also raised a little bit of a red

flag for me. And the second one is that if I get these results based on an instrument that we don't even know, does it lead to actions that are going to change the quality of care being provided? So those are essentially the two over here I'm struggling with.

DR. ETZ: Sure. I'm happy to answer those. So I'll go backwards forwards. And you let me know, Amir, if I miss anything. Does it relate to actionable things? Absolutely. And we've connected it to about 50 different approved quality improvement activities available on the CMS website.

We also have a list of activities by item that's available on our website so that people can know what to do. I also -- since I get this question often and I mean it in the most respectful way, I also wonder why we need to specify if your patients don't answer well the question, does my doctor know my health goals, do we have to tell the doctors, okay, so now what you should do is pay attention to the health goals

and then reassess and see if you've done any better at that, right? So these questions -- the items in the survey have wonderful face validity to them.

And they actually provide more actionable information than clinicians feel most -- than primary care clinicians feel that most quality measures do. Yes, our application for endorsement only included 16 clinicians. It did show a fairly large sizeable difference among those 16 clinicians. It was over 1.0 which shows that it has ability even in a small group to see big differences. You would expect that difference to be a smaller number in a small group. So this is an indication that it does show great variability.

We are currently fielding it among hundreds of clinicians for our follow-up maintenance submission. We'll be able to give you more information on that. So far, it looks to be performing very strongly. For the question about cultural appropriateness, I appreciate that

Rob brought up that this was discussed and well supported. But I did want to also share that the measure has been validated in 28 languages and 35 different country settings. And the article providing evidence of that, it was recently accepted to the Annals of Family Medicine. So it will soon be out for public consumption.

CO-CHAIR ROBERTS: Great.

DR. ETZ: Did I miss anything, Amir?

MEMBER QASEEM: Just a follow-up? So just so I understand. What you're saying is the reliability scores on a clinician level for the performance measure, not for the instrument?

DR. ETZ: Correct, correct. And we provided -- I think it was a split correlation as well as ICCs to show that. In all cases, the measure performed relatively high. So I also heard the conversation you were having before about having a threshold of 0.7 as being really important. Our measure actually typically performs at 0.8 and 0.9.

MEMBER QASEEM: All right. No,

that's very helpful. And again, I don't have that detail. I was digging through that because the simplest example that comes to my mind is the PHQ-9 in depression, right? PHQ-9 is wonderful. It's the difference between PHQ-9 between one patient to the other. A physician might have done a phenomenal job making a huger, bigger difference. But their PHQ still might be worse. Worse is another physician is not doing as good of a job, right? There's so many --

DR. ETZ: Yes.

MEMBER QASEEM: -- instruments that come to my mind. A1C used that as an example. A1C is all about the organ. It's not an instrument like that, but it's an easier example for folks to understand.

DR. ETZ: Sure.

(Simultaneous speaking.)

DR. ETZ: So we have some preliminary evidence that suggests that we will be able to respond even more robustly to that with our next submission. But we feel -- on validating, we

feel that this measure alongside two other validated instruments, one that was about patient self-management and one that was about cost and utilization. We did that among thousands of patients.

And in both cases, we found that the measure positively correlated with cost and utilization as well as with self-management. So what that means is among thousands of patients, we found if they scored well, if they provided a high score on the PCPCM, they were less likely to use services and they were more likely to feel confident about their own self-management. That suggests that this has a real connection to outcomes that are significant to clinicians and health systems.

MEMBER PINCUS: It could also be due to an association with certain personality characteristics as well.

DR. ETZ: It certainly can. We did answer that in a comment that we received about common method bias. We investigated it. And

even though there's published literature showing that common method bias doesn't necessarily mean the measure is not reliable or valid. In testing this measure, we found that even with a common method bias consideration, it was still reliable among patients and clinicians.

MEMBER PINCUS: Just to confirm, how is the data collected?

DR. ETZ: The data, we provide endorsement data through the manner specified. So we did it through electronic collection. Patients were -- received an email invitation and were able to fill out an online form. However, when we were testing this, we did it both through an online service and mail paper service and in-person service. We looked at tablet versus desktop versus smartphone. And in all cases, the findings were statistically the same.

At the point of care, the measures did skew more positively. But we are not specifying this for use at point of care as a performance measure. We are specifying it once a year per

patient as a performance measure. Point of care would be used specifically for quality improvement efforts.

MEMBER PINCUS: Years ago, I was involved with a similar study, more or less. We did find a difference between mail versus telephone.

DR. ETZ: Yes, we did not try telephone with this. We only did paper, in person, and electronically.

MEMBER PINCUS: Thanks.

MEMBER QASEEM: Can I ask a question from the NQF team, Sam, your team? Is that okay to ask?

CO-CHAIR ROBERTS: Sure.

MEMBER QASEEM: My question to you guys is, did you guys dive deeper into some of the measurement -- some of the numbers over here because I am not finding it? What's your take on that? Is it a reliable valid measure or not? As I said, I went through it again. I can't find that information.

DR. STOLPE: Thanks, Amir. So it essentially included -- there's the highlights that you'll see inside of a preliminary analysis, summarized the score level of reliability testing. So this was assessed by the Scientific Methods Panel, and they returned a positive result. So for all instrument-based measures, we have to look at both the score and the data element level, reliability, and validity. So we have a very high level requirement for scientific acceptability for all instrument-based measures. The SMP felt comfortable with passing this on to the Workgroup for their -- excuse me, for the primary care committee for their consideration.

CO-CHAIR ROBERTS: One more quick question. I agree with some of the comments around this is a step in the right direction. There's a comment in the chat box which intrigued me around whether or not this is really a patient reported outcomes measures. Or is it a patient experience measure? Because if we're kind of comparing it to CAHPS, CAHPS really is more about

patient experience than patient reported outcomes for the most part. So maybe you could clarify that, Rebecca.

DR. ETZ: Sure. And that's why I say there's that one question overlap. But largely, the PCPCM covers a different area from CAHPS. So CAHPS really focuses on the consumer experience of care. So it asks a lot of questions about communication and friendliness of environment and openness and things like that. This measure does not focus in that area. This measure focuses on the patient assessment of care delivered.

So it looks at access, coordination, comprehensiveness, continuity. It looks at taking into account family and community and social determinants. It looks at health goals as well as help with overall health status. It really provides a broad look at all aspects of primary care delivery considered by experts, stakeholders, and the literature to be important. CAHPS does not cover that area.

I did hear once before people wonder

about, can you have an outcomes measure if it is not disease-specific or targeting a specific clinical outcome? And my answer is to say, yes, this is much needed in primary care. I think when we start to talk about patient outcomes, their outcomes of significance aren't always the clinical intermediate markers that we identify.

And accepting patient reported measures has to include accepting their understanding. But at the same time, primary care involves 80 percent of interactions that are not driven by a diagnosis. Eighty percent of the work they do is not specific to a disease or guideline. And therefore, they are in dire need of a measure that's able to address the majority of their care.

CO-CHAIR ROBERTS: Thanks. Sam, can we hand it over to you for a quick summary before a vote?

DR. ETZ: And Sam, I might ask you if you'll feel comfortable with me heading off because of the time.

DR. STOLPE: Yeah, I think that you definitely stayed longer than we have a right to keep you. So appreciate your flexibility.

DR. ETZ: Thank you very much. I appreciate this.

CO-CHAIR ROBERTS: Thank you, Rebecca. Thanks, Rebecca.

DR. ETZ: Thank you. Take care.

DR. STOLPE: All right. So just to summarize, the Workgroup recommendation was conditional support for rulemaking and an NQF endorsement. Chris, would you open it up for a vote?

MR. DAWSON: Voting is now open for MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure for MIPS. Do you vote to support the Workgroup recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no? It looks like we have 18 votes. Would you like me to close the poll?

CO-CHAIR ROBERTS: Yes, please.

MR. DAWSON: Voting is closed. The results are 17 yes and 1 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure for MIPS.

CO-CHAIR ROBERTS: Great. So Sam, we'll move to the next measure, Intervention for Prediabetes.

DR. STOLPE: Well, actually, let's go --

CO-CHAIR ROBERTS: I'm sorry. We have to go back a slide, 34, the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates.

DR. STOLPE: Excellent. Thank you so much. Okay. One moment. Okay. Sorry. Thank you for bearing with me. This is the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System.

Now this is the annual risk-standardized rate of acute unplanned cardiovascular-related admissions among Medicare fee-for-service patients aged 65 years and older with heart failure or cardiomyopathy. And this received a conditional support for rulemaking from the Workgroup with the condition being receipt of NQF endorsement. The Workgroup noted a few concerns related with the increased mortality associated with heart failure and the outpatient setting and that the relative severity of heart failure may not be appropriately accounted for in the measure.

They further suggested that the measure may be more appropriate at the accountable care organization level. The developer responded by clarifying that the differences between this measure and a similar measure that was used within the Shared Savings Program. A number of the comments that we received, which you'll know from this slide that we had a total of 13, also reflected those

concerns that perhaps most reoccurring concern was that attributing this to clinicians may not be the best idea given that a larger entity that's more acclimated with a population health-based approach to managing risk associated with cardiovascular events and heart failure might be more appropriate.

So it's suggesting specifically that the measure inside of the Shared Savings Program might be more appropriate for accountability purposes. Let me just look for a couple of other items in the public comments. There's opposition expressed for generally use of measures that rely on claims. And also again, more iterations that this be used at the population level rather than for individual clinicians and groups. Dr. Fields had to step away and unfortunately won't be able to return. But just we'll pivot to Dr. Padden for any other supplementary comments.

DR. PADDEN: I guess I would just add, Sam, that some of the discussion from the MAP group was the importance of addressing population

disparities for this measure. And then there was kind of a lengthy discussion about the stage of heart failure and the criteria for what the stage was for that admissions criteria.

DR. STOLPE: Thank you. Misty, over to you.

CO-CHAIR ROBERTS: Sure. I'll open it up to the Coordinating Committee for questions.

MEMBER SCHIFF: This is Jeff Schiff. I was one of the discussants for this measure, and I was wondering why -- I was thinking it should be a do not support with potential mitigation because of the risk adjustment, the concerns about treating clinicians, and the severity of the congestive heart failure. So I'll just pass that along.

CO-CHAIR ROBERTS: Does the measure developer -- well, I guess I don't know if that would go towards the measure developer or the Workgroup to comment on that.

DR. PADDEN: I guess I'll just add as

one of the co-chairs. As I said, there was a robust discussion about that. And from my recollection, the vote was very, very close. It was not a huge majority that felt like it should be the conditional support from NQF because of some of the questions that were raised and what I stated about the clarity of the readmissions and identifying the classification of heart failure.

CO-CHAIR ROBERTS: David --

DR. SCHREIBER: This is Michelle from CMS. You're right. The vote was very close. It was exactly at 60 percent. We have our measure developer here on the line. Maybe they can provide a little bit of background to the measure that would be helpful.

DR. DRYE: Sure. Hi, it's Elizabeth Drye. So a bunch of important points were made in a prior discussion and then reiterated again today. I think it's just to reorient you to this measure and how it's a little bit different than readmission measures in particular because some

of the speciality society comments were focused on readmissions.

This is admissions among patients with heart failure. As you know, very common condition, very fractured care in the fee-for-service environment. And the outcome is acute unplanned cardiovascular-related admissions. So it's narrowed down to outcomes that are related to cardiovascular care. And as we noted before, it's now -- it's going -- it's now aligned with a measure specified for the merit-based incentive payment system that will have a similarly narrowed outcome. The denominator is admissions per 100 person-year.

So these are patients in care. It's a measurement year approach, so during a measurement year. And if the patient dies, they're no longer in the denominator. So one comment that competing mortality has been raised as a concern as it should be in this population. And if the patient -- first of all, we know that we have higher rates of admission among patients

who have high mortality rates. So we're not worried that providers are going to require that patients die.

And also the best way to look good and have a higher score in the measure is to have your patients stay alive but not be admitted. So I just wanted to address that concern. Some of these concerns carry over from discussions of readmission letters. Other things that were raised, the disparities risk measure was risk adjusted for the AHRQ SES index. It is not adjusted for dual eligibility. There is a program adjustment, a payment adjustment, and that's for dual eligibility at the moment.

But that takes into account area level factors that our technical expert panels and clinicians felt would be relevant to some of the provider control over the risk of admission. The AHRQ SES index includes housing, education, income factors that reflect the resources in the community. It does attribute to a single provider who favors cardiologists that they've

seen the patient prior to this admission to any admissions. And it only attributes to PCPs and cardiologists.

This was a tricky issue. We vetted it with CMS convening a clinician committee that included frontline clinicians, including from rural and underserved areas and also the specialty societies to really work through this attribution. And in the end, balancing a concern that was mentioned here which is no one person is responsible for an exacerbation of heart failure leading to an admission with the concern that care for fee-for-service patients is really, really fragmented.

And we need some incentives for providers to consider themselves and be held accountable for exacerbations of a chronic disease which is really what we're using admission here to measure. Those are the main points that I think -- oh, just one last point. And this is, I think -- Dr. Schreiber, if you could speak to this as well.

The idea -- one of the reasons to include it in MIPS as well as the Medicare Shared Savings Program is there are a lot of large providers in MIPS. Just looking at providers who have at least one heart failure patient eligible for this measure, there's about 12 percent of providers who have 16 or more providers in their group. And a big group has 100 or more providers.

So MIPS includes -- the MIPS program includes providers from the individual level, providers who are reporting all the way to large clinician groups. This measure would focus on larger groups because we need, as you know, to have enough patients to have a reliable score for the measure. So it disproportionately leaves out individual clinicians and focuses on -- and would be reported depending on exactly what thresholds CMS set for the larger groups, more than for small groups.

So I think those are most of your questions. But if I missed any, I'm happy to

fill in a gap. Thanks for the opportunity to contribute.

CO-CHAIR ROBERTS: Thanks, Elizabeth. Good to see you. David, do you have a question?

MEMBER BAKER: Yeah, question for Elizabeth. So as you know, the number one predictors of heart failure admission are patient's level of physical functioning, NYHA class, and their ejection fraction. And it looks like this is the only risk adjustment for this is claims space measures which doesn't capture those.

And there's been quite a bit written about the problems of risk-adjusted outcomes or claims-based risk-adjusted outcomes for patients with heart failure and the inaccuracies. So I just want to confirm, first of all, this only uses claims data for the risk adjustment. And how do you respond to those concerns?

DR. DRYE: Yeah, it does only use claims data. And within those limitations, we tried to pull out the most patients for whom the

outcome of admission is less likely to be a signal of quality. So the measure excludes patients who've had a heart transplant, who have inotropic therapy, who have a left ventricular assist device places, who have end-stage renal disease or are on dialysis, who are in hospice.

That was the clinician and technical panel input, the scope of what clinicians felt was really appropriate to pull out, again, with the goal of keeping in the measure patients for whom exacerbation of a chronic -- of heart failure could be influenced by a physician. We don't expect the admission rate to be zero. We don't expect the death rate to be zero in this disease either. So as you point out, it's a risk-adjusted measure adjusted for comorbidities. And the AHRQ SES index is an indicator of community resources, trying to account for that and limiting the scope of the patients in the measure to whom -- for those for whom it would be a meaningful outcome to measure.

MEMBER BAKER: So those exclusions

are probably, I would guess, one, maybe two percent of all the patients with heart failure. And if you look at all the clinical trials, the classic clinical trials, and you look at the admission rates by, again, New York Heart Association class and ejection fraction, there's just enormous differences. So I just don't think this is going to adequately risk adjust. And I think that those clinicians that are caring for very sick heart failure patients, cardiologists in general but particularly heart failure clinics, are really -- they may not look good on this measure. And I don't think that's an accurate reflection of the quality of care.

DR. DRYE: So we will take the measure to NQF and we are looking by clinician type. We did look at that during development as well because that's definitely a concern that providers caring for sicker patients would not look as good. And we have some numbers on that. I don't have those to present to you at this moment. But they will go in front of the

steering committee at NQF.

CO-CHAIR ROBERTS: Leah, you have a question?

MEMBER BINDER: Yeah, I guess it's for David actually, David Baker. Just are you saying that you don't think the clinicians have more than, like, a -- they have very little, maybe one percent or some very small percentage impact on the likelihood of admission for -- I mean, it seems like --

MEMBER BAKER: No, no, no.

MEMBER BINDER: -- it's reasonable to think they have some impact. And that could be gauged in this.

MEMBER BAKER: I was just talking about -- Elizabeth, I thought you -- she was talking about these exclusions. So the patients -- it's one or two percent of people would be excluded. As a former primary care physician who took care of a lot of patients with heart failure, I think you can keep the vast majority of patients out.

But again, if you look back on the classic studies like Michael Rich's classic study showing that you can keep patients out of the hospital. He actually excluded Class 4 patients because they'd done a pilot project that showed that even the experts couldn't keep them out of the hospital. So those sickest patients, it's just -- I mean, they -- somebody next to them eats a potato chip and they go into fluid overload because of the grain of salt that they inhaled.

I'm just joking obviously. But there are some patients that are incredibly fragile. So I really do support this measurement concept, but I just don't think that the risk adjustment without the -- I mean, without the most important variables that have been shown in all of these studies to predict admission.

This is probably a good one when we get to the day of digital measures and you can capture this information. Then you could do a better job with risk adjustment. And Elizabeth, it would be really interesting if it's possible

for you to look at some of the major academic medical centers that have big heart failure programs and be able to see how this -- what would they look like on this measure. And I suspect that they'll look worse despite the fact that their care is outstanding.

DR. DRYE: Just a routine thing, we look at the performance of the risk model across all levels of admission risk. So, looking at the actual patient outcomes and how well we're predicting those.

And we do see good discrimination up at the high-level of risk but as I mentioned, we started to do some of those looks because, again, we have representatives from these organizations helping us with this measure.

And we're confident that we're doing well but the kind of specific focused study is that kind of thing that would usually come out in a Steering Committee review, a Steering Committee review of the measure as well.

As you know, we start with that

concern, that we don't want to disadvantage providers in any way caring for the most complex, sickest patients.

We're bringing the measure forward because we think it is functioning well but I think asking for those kinds of focused looks is a reasonable thing.

CO-CHAIR ROBERTS: Why don't we go ahead and move to vote on this measure? Sam, if you want to summarize the work group recommendation?

DR. STOLPE: Thanks very much, Misty. So, this is conditional support for rulemaking pending NQF endorsement.

So, Misty, before we vote on procedural questions, can I ask, the process question I was going to ask you was if we do vote on this measure as nil, then do we have vote again that what we are saying, essentially -- how is that going to work?

At this point, there are enough concerns now, right?

CO-CHAIR ROBERTS: If we vote not to support, if we don't have consensus then what we'll do is as the Chair I'll bring forth another recommendation for the Committee to vote on.

DR. STOLPE: Let me just point out something, Amir and this would be to David's point as well.

So, you've raised a bunch of concerns that I think are really interesting, and we did discuss this inside of the Work Group as well, just that they're concerned that the measure doesn't adequately adjust for clinicians that are dealing with serious patients.

What the Work Group felt is that the NQF endorsement process would include a reality check around whether or not the measure is valid. And that validity concern is also encompassed inside of what you expressed.

So, if we are moving to do not support with potential for mitigation, the question then is what are the mitigation points?

CO-CHAIR ROBERTS: This is similar to

what we did earlier where we ended up, essentially, revoting and changing our mind because we recognized that the NQF endorsement process would address the concerns that we had mentioned.

And with this one it seems like some of the concerns are around the reliability, validity, and those are the concerns that will be addressed in the NQF endorsement. So, just keep that in mind as we're voting.

MEMBER QASEEM: But can I just say, Misty, that mitigation is NQF endorsement? Because my worry is just saying that NQF endorsement historically is sending not as strong as a message considering the significant concerns we are dealing with over here with CMS.

But CMS doesn't have to bring this measure guide because we are going with the mindset that CMS will bring it to NQF. That doesn't necessarily happen. That's one thing.

And we already heard just now even the measure developer team, they're saying that at

the group level this measure works but individual clinician level it doesn't.

That makes me even more concerned to go in the direction of NQF endorsement and I feel like we need to send a stronger message here.

CO-CHAIR KAHN: May I ask a question?

CO-CHAIR ROBERTS: Yes.

CO-CHAIR KAHN: What's the likelihood -- I'm sorry, is this endorsement process now, Sam?

DR. STOLPE: No, this hasn't been submitted.

CO-CHAIR KAHN: So, what's the likelihood that CMS, which does go ahead often without endorsement, would go ahead with this?

DR. STOLPE: We have CMS on the line.

CO-CHAIR KAHN: I'd like to have an answer to that question.

DR. SCHREIBER: I'm not terribly sure I can answer that either. Those decisions have not been made.

CO-CHAIR ROBERTS: That was similar

to the question that I asked earlier around the percentage of NQF-endorsed versus non-endorsed that moved forward.

MEMBER QASEEM: But that's Chip's point, though, right? And that's why I think we need -- Chip, you're right on the money, what you're talking about right now.

CO-CHAIR ROBERTS: But to go back to the comment on why would this not be the do not support with potential for mitigation, and it really goes back to the criteria that we addressed in the beginning.

You don't have a good poker face, Amir.

CO-CHAIR KAHN: No, but we have to be careful here.

There is a fine line I think, where if we are actually against the measure and we're slowly depending on endorsement to blow the measure up, then I think sometimes we have to say no rather than waiting for endorsement.

I leave it to the body to agree

whether this is the case here but it seems to me once we say conditional support, if I'm CMS, with respect to CMS that's on the phone, then we said yes.

And we condition it on endorsement but then they have their own agenda or they can wait for endorsement and say no, on this case we're not going to wait for endorsement.

DR. DRYE: I don't mean to interrupt, it's Elizabeth. It's just that I do want to clarify this measure is already submitted to NQF and under the CMP's review, scientific method --

(Simultaneous speaking.)

And just quickly, I didn't mean to imply that this would not work for clinicians. Clinicians had many, many heart failure patients that were at a reliable sample size.

I didn't mean that, I was just saying within the mix there are many, many large group providers so they don't look so different than some of the shared savings program provider groups.

MEMBER FERGUSON: I agree with Chip and Amir. I'm not comfortable moving forward saying, yes, we have conditional support.

I would explain it somewhat. I don't think I could. So, I think it needs to be --

CO-CHAIR ROBERTS: Go ahead, Leah.

MEMBER BINDER: I think we do have to think carefully before we overrule a Work Group's recommendation too. I think that's another question for this group.

I think they spent some time on this. It's not our role to completely redo exactly what the Work Group did. Why do we all have to do it twice?

I think our role is to look and say did they make a judgment call that we think is very wrong? If they made a very wrong call, then I think that's a reason to override them but I don't see that's the case here.

It seems to me conditional support is reasonable.

CMS can do whatever CMS wants to do

regardless but the issue is the message we're sending based on our respect for the work of the Work Group and the thinking through which has been done of this measure, which some of us do think is a good measure.

So, I think we just need to --

CO-CHAIR ROBERTS: What I'm going to do is recommend that we go ahead and move forward with the vote. We are significantly behind.

I think that all the concerns have been raised, I think that we are well aware of those. If for some reason this does not move forward, then we will need to put another decision category on the table.

And I know for me I'll have to be very clear on what the additional criteria is the NQF endorsement would not address. That's something that's still not clear to me.

So, let's move forward with the vote and then we can determine whether or not we need to come up with a different option.

DR. STOLPE: Very good. Chris, would

you please open up the measure for a vote?

MR. DAWSON: Voting is now open for MUC20-0034, Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the MIPS.

Do you vote to support the Work Group's recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: It looks like we have 18 results. Yes, go ahead.

MR. DAWSON: Voting is now closed. The results are 7 yes and 11 no.

The Coordinating Committee does not support the Work Group's recommendation of conditional support of the rulemaking as it coordinates to the recommendation for MUC20-0034, Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the MIPS.

CO-CHAIR ROBERTS: So, with that being said and probably a procedural question, what

would be the next step?

Is it that we revote on a different decision category, which seems like it would be do not support for rulemaking with potential for mitigation?

Or do we move to the lead discussants?

DR. STOLPE: It would be at your discretion.

If you feel like the discussion thus far has carried us towards the point where we can come up with the mitigation points with the Coordinating Committee, that might be an appropriate way for us to try to get some time back.

Because as you noted, we are quite a bit behind.

CO-CHAIR ROBERTS: So, a couple people that raised concerns.

I know Chip, you did, as well as Scott, I can't remember if it was David. Can someone help clarify what other mitigation there would be besides something that NQF endorsements would

address?

That's where I'm not clear yet.

MEMBER FERGUSON: This is Scott. I'm not sure what the NQF endorsement would address and not address. I just know didn't like this moving forward.

I think Amir made some points and David, I think, made some points specifically about staging of heart failure and attribution and the validity between a primary care person and a cardiologist at a big medical center.

And I'm none of those, so if they would comment on that, that would be great.

CO-CHAIR ROBERTS: Anyone from NQF want to comment on whether or not the NQF endorsement process would look at those concerns around the staging of attributes and validity?

DR. STOLPE: This is what we discussed in the Work Group when we were talking about the overall concerns associated with clinicians potentially dealing with more serious patients.

But this would be a validity concerns

that would be addressed through the endorsement process. And my apologies, once again, to the developer representing its submission status. It'll be reviewed in February.

CO-CHAIR ROBERTS: David, actually we have two Davids.

David Baker?

MEMBER BAKER: So, I would like to see additional analyses done to show that the adequacy of the risk adjustment methodology from claims data is reasonably correlated, shall we say, with a gold standard of risk adjustment using those other characteristics.

And I'll say even though those other characteristics, ejection, infraction, the measures to physical functioning are these hugely important predictors, the question is are they equally distributed across all of the providers?

And if they're not, if they're all pretty similar, I don't think that's true, but if it's all pretty similar with the exception of the transplant centers in the U.S., which as

Elizabeth said would presumably be excluded, then it might be okay.

But I just think I mentioned there are good studies now on multiple different areas showing the problems with risk adjustment for claims-based measures and how when you do that study that I just talked about, you show differences in the ranking.

So, I think that should be part of the mitigation strategy, additional analyses to show operability with gold standard risk adjustment methods.

CO-CHAIR ROBERTS: And David Gifford?

MEMBER GIFFORD: So, I agree with Leah that if we're going to rely on a Work Group recommendation, we should have good reason for it.

Also if we're going to talk about adding other conditions or mitigation, it should be something that goes outside of what's already incorporated into the NQF endorsement.

What I'm hearing is a lot of stuff

that's going to be covered in the NQF endorsement. Or we do know there are measures that are NQF-endorsed that are not appropriate for rulemaking for how CMS wants to use them.

And so this is before NQF endorsement. If it got endorsed as a specified, I think David Baker's and others' comments are this is not probably the right measure for this rulemaking.

And then it does make sense for us to vote that way.

But what I have not heard is anything that would convince me that's not covered by the NQF endorsement process, and whether it's appropriate for the rulemaking that it's being proposed for.

CO-CHAIR ROBERTS: David, I'm with you in terms of I haven't seen anything that wouldn't be addressed. It seems that the question might be do we just not agree that this is a measure for rulemaking?

And if that's the case, then we need a different decision category.

MEMBER GIFFORD: There are measures that come before us that are pretty well specified that are not NQF endorsed yet. So, yes, I think that condition is they're not NQF endorsed.

And there's measures that come before so they're not well specified and clearly they aren't well thought out. They really have some significant problems that probably shouldn't get NQF endorsement or need a lot of changes.

Or they're just not ready for a rulemaking. And so I'm okay with distinguishing between those things and this may be one of those measures that's just so poorly define or there are so many concerns that we don't want to say it's ready for rulemaking.

Because saying it's ready for rulemaking with NQF endorsement sometimes has been interpreted by the CMS as it's implicit, it's good enough to go.

At other times, based on our comments here, I've seen CMS pull it back and other times

they have not. And as you say, it's really advisory on the point.

I do think in the end all of the comments and the concerns need to be summarized in the reports back to CMS so they can clearly hear that this measure, as from the previous measures, elicited a lot more concern from us that needed them to think about it rather than jumping forward on it.

Because also, as I think Sam has said, once it comes through us, it never has to come back to us again.

Now, previous leadership with CMS has said they would bring stuff back to us but they don't have to bring stuff back to us.

CO-CHAIR ROBERTS: So, I'm at a little bit of a loss on what to do. Chip?

CO-CHAIR KAHN: I think there have been a couple of different concerns expressed. You can argue those concerns would be considered in the endorsement process.

I don't see why we can't just describe

those concerns about risk adjustment or whatever, the two or three of them, in the mitigation and see whether there's 60 percent of the people here for do not support with potential for mitigation.

Obviously, we went through a very difficult process over time, coming up with these four categories -- I think it's four categories -- we have of recommendation.

The problem is if one thing is saying endorsement, it's another thing to send a signal saying it's got to be more than endorsement. It's just got to be right.

So, I think we pick up a few of the points here and go with that in terms of defining what mitigation is.

DR. STOLPE: Let's just be explicit on what those mitigation points might be and see if we can get to coalescing around some voting criteria.

So, if we're going with mitigation then obviously we're going to stick with the NQF endorsement but what else should we add?

(Simultaneous speaking.)

DR. SCHREIBER: Sam, it's Michelle.

What I'm hearing as the big concern, and you can all correct me if I'm wrong, is that we're not appropriately taking into consideration the very sick heart failure patient.

So, not the transplant patient because they're excluded but the patient who, I don't know, maybe needs to be given infusions or the really sick heart failure patient who keeps bouncing back to the emergency room.

And so that's the biggest concern that I'm hearing and I guess my thought would be whether or not an ICD-10 code appropriately can determine that. Maybe, maybe not, and I don't think people use them correctly all the time.

And we can certainly go back and evaluate it. I think we've all heard loud and clear the concern about this may not be ready for primetime for the MIPS program.

Did I get that concern correct?

DR. STOLPE: Sure, let me see if I can

succinctly capture it.

It's a mitigation point that CMS performed an analysis to ensure that the risk model appropriately adjusts for clinicians dealing with more serious patients.

Is that what we're looking towards? And let me just put it to the Committee to confirm or deny.

CO-CHAIR ROBERTS: That seems to be the consensus to me.

MEMBER BAKER: And I'll say yes, I agree with what Michelle said, that there may be a variety of mitigation strategies, whether it's ICD-9 codes or others.

Again, we know what the gold standard is and we just want to be able to get closer to there so that we're not penalizing those clinicians who are taking care of the sickest heart failure patients.

MEMBER FERGUSON: I would agree with that too. I think that's where you want to go.

MEMBER BINDER: I think part of the

reason for the risk adjustment strategy too is to recognize that when you risk adjust using the gold standard, sometimes that actually creates burden, additional burden.

And that's something the endorsement process, I think, is meant to address as well.

So, yet another reason why I think the endorsement process is a powerful tool and an important one to recognize in the course of our deliberations.

DR. DRYE: It's Elizabeth again. I just wanted to jump in and note this measure does have some novel risk adjusters in it.

We use frailty indicators like oxygen and other durable medical equipment.

This is how we're evolving and using claims per ASPE's reports, trying to better capture those at-risk patients.

So, we haven't looked against clinical charts specifically. We've looked a lot of different ways, whether we're getting those frail patients appropriately.

But I think that might be what you're asking us to look at, specific clinical heart failure severity level. I'm not sure that would be doable but I just want to clarify, is that what you're suggesting?

MEMBER BAKER: Yes, and I'm not sure.

The Work Groups have so much to go through and maybe just some focused additional information on the analyses that you've done and additional analyses might be enough to make sure that the NQF deliberations are really getting it.

I think this is the biggest threat to this measure, and it's not a threat to the measure, it's how the measure is used, right? It may mislabel some providers.

CO-CHAIR ROBERTS: I was speaking on mute. I said, David Gifford, why don't we take your comment and I'll offer a suggestion?

MEMBER GIFFORD: I guess my question is to the discussions and the people who have these concerns.

If the developer addressed these risk

adjustment concerns and then NQF endorsed the measure with those changes, would we recommend this for rulemaking?

MEMBER BAKER: I would say yes. I do think it's a really important measure and it's an important clinical activity, as I said.

The vast majority of patients with heart failure can be kept out of the hospital but the sickest of the sick, that's extremely difficult.

MEMBER GIFFORD: I just go back to Leah's earlier point.

Why are we overriding a Work Group where the recommendation is going to NQF endorsement? It's going before the endorsement, and I think the points that are made here, I feel like I'm licking my wounds from my earlier thinking I did earlier this morning.

So, it's a little ironic that I'm making these statements but I think I learned I'm licking my wounds from this morning.

MEMBER BAKER: I'll turn it around and ask why did the Work Group not raise more concerns

when there are multiple published studies on this topic?

MEMBER GIFFORD: Good point.

MEMBER BAKER: And I have really tried to be good.

Chip will remember the days when I would try to get deep into the measures and I've backed off and tried to kind of -- this is the one that I just found that I couldn't help but address.

It's that seventh criteria of unintended consequences and to me, it's not the five points of the risk adjustment methodology, it's the potential unintended consequences of mislabeling providers that are caring for sicker patients.

And I didn't see any arguments about that in the Work Group.

CO-CHAIR ROBERTS: So, let me make a recommendation that we vote. It seems there's a concern that the NQF endorsement process may not take into consideration some of these concerns.

So, why don't we vote on do not support with potential for mitigation, with those

mitigation points being NQF endorsement, and then second, perform an analysis to ensure the risk model appropriately adjusts for physicians with more serious patients?

Are we comfortable with that?

DR. STOLPE: Let's vote. Chris, would you please open up the vote?

We have two mitigation points, the first being NQF endorsement and the second being that CMS conducts analysis to ensure the risk adjusted to account for disease severity, especially for clinicians dealing with serious patients.

MR. DAWSON: Voting is now open for MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for MIPS.

Do you vote do not support with potential for mitigation, yes or no?

CO-CHAIR ROBERTS: Okay, we have 18 votes.

MR. DAWSON: Voting is closed, the results are 16 yes and 3 no.

The Coordinating Committee does not support the rulemaking with potential for mitigation, MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for MIPS.

CO-CHAIR ROBERTS: Okay, great. I am getting some requests for a short break. Should we take a five-minute break or just let people take a break as needed?

DR. STOLPE: I think five minutes is fine. Let's go ahead and take a very brief reprieve. The time I have is 3:47 p.m. Let's reconvene at 3:52 p.m.

CO-CHAIR ROBERTS: Thanks.

(Whereupon, the above-entitled matter went off the record at 3:45 p.m. and resumed at 3:52 p.m.)

DR. STOLPE: All right, Misty, ready when you are.

CO-CHAIR ROBERTS: I think we've got three more measures in this category before moving to PAC/LTC. Hopefully we'll get caught

up a little bit.

So, let's start with 0040 Intervention for Prediabetes. Sam, you want to give an overview of the Work Group recommendation?

DR. STOLPE: Yes, thanks very much.

Okay, so this measure is 0040, Intervention for Prediabetes, it's the percentage of patients is 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention.

This measure was recommended by the Work Group as do not support with potential for mitigation. The mitigation points being that the measure be re-specified so that it includes an adequate range of interventions for prediabetes available to the clinician.

Beyond prescription of metformin, we're referring the patient to an external service as well as NQF endorsement.

Note that this measure was not supported for NQF endorsement by the Primary Care and

Chronic Illness Committee during their Spring 2020 measure evaluation cycle.

And the rationale being that the set of interventions did not adequately reflect the range of interventions that are available to clinicians to address prediabetes.

They were specifically concerned that the options for clinicians were either to prescribe metformin or to refer the patient to an external service. So, this is the primary focus of the discussion.

There were quite a few public comments that were received for this measure. We have 18 in total, many voicing support for the measure and others supporting the recommendation of the Work Group as well as the Primary Care and Chronic Illness Committee.

I'll just turn it over to Diane to see if there's any supplementary requirements?

DR. PADDEN: We have nothing else to add.

DR. STOLPE: Thanks, Diane. Misty,

over to you.

CO-CHAIR ROBERTS: Okay, I will hand it over to questions to the Coordinating Committee. It looks like Ron has his hand raised?

MEMBER WALTERS: I think this one I was something for, lead discussant or something.

So, I think during the day I've discovered the line between conditional support and do not support with mitigation, and this is it. This got so many negative comments.

It's a great idea, there's absolutely no question about support behind the idea but I think probably the part that is a minor rewrite of the major that really should come up in validity but it would involve rewriting the measure anyway is the number of choices given to the people to achieve the numerator, as was pointed out.

So, I think this one with just a little bit of tweaking could be a very good measure, but right now I support the do not support with potential for mitigation.

CO-CHAIR ROBERTS: Thanks, Ron. Liz?

MEMBER GOODMAN: Sorry, pressing hand and the mute, I apologize. I'm the other lead discussant.

The only other thing I would raise is as we think about alignment of measures, this requires evidence of a referral and it also includes lab results that may be difficult for plans to get a hold of.

So, it's just worth thinking about the burden in the way that the measure is currently designed in terms of using it for purposes other than the reason we're reviewing it right now.

CO-CHAIR ROBERTS: Any other questions or concerns, Amir?

MEMBER QASEEM: Scott, close your ears, okay, so you don't start hating me.

You and I agree and all my MIPS friends, guys, it's first of all -- can I just start off with the prediabetes? That really gets me going.

We really need to avoid using these pre-terms, they're all pre something. Perhaps a

better terminology could be treating normal glucose or something along those lines.

Even if I get past that, I'm looking at this measure that puts metformin in there. Some have metformin have the first line and some have diagnosis diabetes.

Starting giving medications, especially if you don't have any evidence when it comes to giving metformin in prediabetes individuals, if you are going to use the term that's been used or has any benefit, I actually have not seen that.

And even if you look at the U.S. remaining services tax recommendation, they all talk about lifestyle changes, diet, exercise, and all that.

So, I am struggling with this measure. It's almost like if the intent of it is putting pharma at the same level as non-pharma, I start struggling with it.

And then of course, I'm not going to get into the CAHPS fiscal boards and all that. I think there are some issues over there. So,

there's just a couple concerns.

Some already voice I think something similar that maybe I'm missing.

CO-CHAIR ROBERTS: Okay, it seems that we are probably all on the same page for this one so why don't we go ahead and move forward with vote? You want to summarize real quickly, Sam, the mitigation points?

DR. STOLPE: Yes, do not support with potential for mitigation and the mitigation points were receipt of NQF endorsement and re-specifying the measure to include an adequate range of interventions available to front-line clinicians in addressing patients with abnormal blood glucose.

Just a reminder that Scott Ferguson will be recusing himself as the AMA representative for the vote.

MR. DAWSON: Voting is now open for MUC20-0040: Intervention for Prediabetes for MIPS.

Do you vote to support the Work Group

recommendation of do not support with potential for mitigation as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: Okay, it looks like we've got 18 and I'm assuming Scott did not vote.

MR. DAWSON: Voting is closed, the results are 18 yes and 0 no. The Coordinating Committee does not support for rulemaking with potential for mitigation, MUC20-0040: Intervention for Prediabetes for MIPS.

MEMBER FERGUSON: I did not vote.

CO-CHAIR ROBERTS: All right, let's move to the next one. We've already discussed 0042 so we'll go over to 0043, Preventive Care and Wellness, Composite Measure.

DR. STOLPE: Excellent, thank you, Misty. This is the percentage of patients who received age and sex-appropriate preventive screenings and wellness services.

The measure is the composite of seven component measures that are based on recommendations for preventive care by the U.S.

Preventive Services Taskforce and Advisory Committee on Immunization Practices, and American Association of Clinical Endocrinologists, and American College of Endocrinology.

The NQF Work Group recommendation was conditional support for rulemaking pending NQF endorsement.

MIPS expressed support of upstream preventive healthcare of screening and preventive care, however, they also expressed concerns that the measure may be a check-box measure and may be more meaningful with directly connected outcomes.

The Work Group also expressed concerns that some of the components may be topped out. Matt further suggested that the measure encourages practice integration, holistic patient care, and parsimony of measures.

The developer noted a linear weighting of the measures but the Work Group suggested there may be more priorities considered by CMS for some of the components over others.

They noted that each of the seven

components of this composite measure are currently used in MIPS and the resolution of potential redundancies with the singular measures for the composite measure already in MIPS may improve data interpretability burden for recording entities, and would make tracking of care easier and comprehensive.

The measure itself received a total of nine comments and I'll just summarize those briefly.

So, this was general support by a couple of the commenters but a number of the commenters also suggested that there was a burden associated with data collection, that the measure may be premature.

And there were also votes that oppose it due to the fact that a patient may be up to date on many components but the composite score itself might not be especially useful in determining where to focus quality improvement efforts.

Diane, anything else you would like to

add?

DR. PADDEN: The only comment I would add is that the group also supported this measure contingent that the current seven measures would then be retired, which also would decrease that somewhat as a burden.

But certainly the parsimony has got that measure in that.

DR. STOLPE: Thanks, Diane. And CMS did represent that is in fact the case but thank you for bringing that up.

Misty, over to you.

CO-CHAIR ROBERTS: I'll open it up to the Coordinating Committee for questions.

MEMBER FERGUSON: My comment on this, Scott, is simply to say that bungling these seven items and removing individual measures I think is not going to be good for patient care.

And I don't believe it would be good for physicians trying to have people to back this station in items like that.

I don't think this moves us in the right

direction, I think it moves us in the wrong direction. And I would ask that we do not support it rather than the current recommendation.

I say we just do not support it.

CO-CHAIR ROBERTS: Thanks, Scott. Amir?

MEMBER QASEEM: Yes, actually, Scott is right on the money on this one.

I would say this recommendation is do not support with the NQF endorsement or something like that, is that what we're -- my thing with this is composite measures in general. I struggle with the composite measure.

The composite of this measure, if I understand correctly, is the average of scores, right?

So, if it's an average of scores and the sum of the components that are being measured over here may have small denominator and others will have a large denominator.

And a single measure can contribute

making it look like someone is doing a very good job when that might not be the case, considering the denominator varies across.

So, a physician can have such that a smaller denominator from mammography but they can have a bigger one for colorectal cancer. And they can make the measure look really good when the goal is you need to improve across all.

So, methodologically I've always struggling with the composite measures and then the individual recommendation, the individual measures that are in there, I think when we discuss it even with the NQF, we may have supported some but not all.

So, if you go in the composite direction, it makes it so that we're supporting them all. Anyway, I think I support Diane and the Work Group Chairs, I support their recommendation.

I think this is not ready yet. If that's the recommendation. I have to look it up. Sorry, guys, I'm forgetting now.

DR. STOLPE: Just for clarity, Amir, it was conditional support for rulemaking pending NQF endorsement?

MEMBER QASEEM: That's fine but I struggle with the last one, with NQF potential for NQF to endorse mitigation being fixed the measure. Anyway, that's a separate issue.

I don't want to delay the dinners tonight. I'm looking at the clock and Misty's going to be like shut up, let's vote.

CO-CHAIR ROBERTS: You all are getting ready to hear my six-year-old and three-year-old soon, just a warning.

We'll go to Katie next.

MEMBER BOSTON-LEARY: Hi, I agree with my colleagues here on this and there's a lot here. And I appreciate the intent of everything that's listed here because we do need to focus on wellness and preventive health.

And a lot of these were rooted in evidence and this is where we should be focused. But the data-mining that this will require, and

we talked about burden, this is one of those measures that will create a really heavy burden on organizations to manage.

So, that's why I feel it's too early and I think when we get to some form of digitizing for these measures, maybe so, but it's too soon. That's my comment.

CO-CHAIR ROBERTS: Thanks, Katie. Jeff, I think you're next? Or Julie? Sorry.

MEMBER SONIER: I had my hand up and I don't know why it went down but I just want to add a different viewpoint, which is support for the idea of the measure as being more patient-centered than a whole set of disparate measures right now.

So, as a patient, the question is: are providers providing patients with all of the recommended preventive care services?

So, because of the fact that it's a composite of measures that are already in use, I don't feel like there's a lot of additional burden.

I'm assuming that information will still be available on each of the components, the providers will know which pieces of it are actionable.

But I really feel like it's good progress in making them more patient-centered and easier for patients to understand.

CO-CHAIR ROBERTS: Thanks, Julie. Jeff?

MEMBER SCHIFF: I'm just going to agree with Julie and also point out that I think, just looking at the measures, they are pretty evenly distributed I would say as far as the risk of having patients with these diseases in your practice.

And then the second thing is that as opposed to some other composite measures which talked about actually having tobacco sensation, this is really just about identifying and following up and the same for BMI.

So, we're not asking clinicians to actively change behavior -- we're asking

clinicians to identify behavior and potentially refer, not to necessarily be able to fix things.

So, there is a balance between the longer-term things like tobacco and obesity and the single effort things like mammograms and colorectal screening.

MEMBER QASEEM: Misty, before we vote can I ask a clarification question? I didn't really catch that.

So, if we go with this composite measure, whatever is the recommendation of the clinician, CMS is going to remove seven measures as individual measures?

Did I hear it right?

CO-CHAIR ROBERTS: I'll let Michelle clarify.

DR. SCHREIBER: That would be the long-term plan, yes. And it might not happen immediately but that would indeed be the long-term plan.

MEMBER FERGUSON: This is Scott. I think it's just a real mistake to do away with

the individuals and to do a bundle.

And I think we need to change this recommendation to do not support because I think this is a poor direction.

CO-CHAIR ROBERTS: Daniel?

DR. GREEN: Thank you. So this is Dan Green from CMS. I work with -- under Michelle. I just want to -- there's somebody that -- and Michelle already commented that we would plan to try to retire eventually the seven component measures.

I just would suggest that this -- somebody mentioned it was a check-box measure. I kind of look at this measure as on the contrary. I mean, this is giving a clinician a snapshot, if you will, of how well they're doing overall in preventive services.

As I'm sure you all are well aware, and certainly those of us at CMS see it every day, docs pick the measures that they score the highest on and that they routinely do. And it's really not necessarily driving an improvement of

care, we're just measuring different activities.

And in this way, we're at least saying hey, Dr. X is doing a great job at preventive care because he or she is completing, you know, six of seven of these activities, or maybe hopefully all seven.

So it's really a maturation process, if you will, of the individual preventive services by assessing the complete picture. So thank you for allowing me to comment.

CO-CHAIR ROBERTS: Thanks, Dan. It seems that we have some mixed views here. So why don't we go ahead and get to vote? Sam, if you want to summarize briefly?

DR. STOLPE: Sure. So where the Work Group landed was conditional support pending NQF endorsement. There's been a number of concerns expressed around just having a composite in general.

We'll go ahead and move to a vote, and then -- on upholding the Work Group recommendation, and then we'll try to tease out

what those mitigation points might be if the group does not reach the threshold for supporting the Work Group recommendation.

Chris, do you want to open up the vote, please?

MR. DAWSON: Voting is now open for MUC20-0043: Preventive Care and Wellness (Composite) for MIPS. Do you vote to support the Work Group recommendation of conditional support for rulemaking as the Coordinating Committee recommendation? Yes or no?

CO-CHAIR ROBERTS: Okay, we're at 18, I think we can close it out.

MR. DAWSON: Voting is closed. The results are 11 yes and 8 no. I believe that's == we have 19 results here so I believe that you can -- I can show the percentage here, but I believe is just shy of what we need.

DR. STOLPE: Yeah, it's 57 percent, Chris.

MR. DAWSON: So that is 58 percent. So in that case the Coordinating Committee does not

support the Work Group recommendation of conditional support for rulemaking for MUC20-0043: Preventive Care and Wellness (Composite) for MIPS.

MEMBER QASEEM: Isn't that the threshold for recount? I'm kidding. I'm kidding.

MEMBER FERGUSON: This is Scott. My chat function has quit working, but I would like to see us move to do not support this measure, is what I'm trying to put in the chat, and I can't reach it.

But that's what I would like to see us do.

CO-CHAIR ROBERTS: So let's talk about that a little bit. So do not support, but then there's still going to be seven individual measures if CMS doesn't move forward with this and decides to keep the individual measures. And I'm just worried about maybe some unintended consequences with that.

CO-CHAIR KAHN: Well, but wait, Misty,

didn't Michelle say that they're not ready to go ahead with the composite anyway?

They were going to deal with these as one-offs and then eventually move to a composite. So if that's the case, then we're not slowing down the train if they accepted our recommendation.

I'm just -- I don't know whether we had a recommendation. I don't know if we can get to 60 percent here because I think we have a great divide.

CO-CHAIR ROBERTS: No, Chip, what I was saying is that if we vote do not support, which is what Scott is recommending, does that mean that CMS will keep the seven individual measures separately?

We don't know what CMS is going to do obviously.

CO-CHAIR KAHN: No, but we made different recommendations on --

(Simultaneous speaking.)

CO-CHAIR ROBERTS: What was that,

Michelle?

DR. SCHREIBER: I said we would most likely keep them separate, at least --

CO-CHAIR ROBERTS: Yeah, that's what I'm thinking --

(Simultaneous speaking.)

MEMBER FERGUSON: And that's what I would like to see done and then if they want to one-off them as they go, fine.

But I would like to keep them separate and individual. That's why I would like to -- do not support this measure.

DR. SCHREIBER: And then it probably won't and can't happen in this meeting, but I think then we all need to have some understanding of composite measures and their use or non-use. Because clearly we have some mixed opinion.

CO-CHAIR ROBERTS: Janice, did you have your hand raised?

MEMBER TUFTE: Yes, I just want to say as a patient, I see -- you know, I hear so many people that don't have this test or that test so

it seems like there definitely would be providers who could benefit from a composite.

But you brought up some very good points as if some of -- you know, they might score just fine and still not do part of the measure or whatever.

So I think some of that has to get worked out, but overall it seems to me it would be less of a burden and a doctor would have to -- a clinician would have to look at it and really say oh, wow, this person hasn't had this test or whatever. It would all be right in front of them.

CO-CHAIR ROBERTS: Okay. Jeff?

MEMBER SCHIFF: I'm going to suggest that instead of voting for do not support, we vote for do not support with potential for mitigation.

We got almost to 60 percent for support so I just feel like we're -- I think that some of these things could be taken into account -- I think that in the process here we should just go

to the next category down.

CO-CHAIR ROBERTS: So, Jeff, just a point of clarity for if it's do not support with potential for mitigation, obviously we would want NQF endorsement. What other mitigation points would you suggest?

MEMBER SCHIFF: I think there's been some concern about weighting these equally. So I think that would be something that we would potentially look at as well. So I guess I would -- that's probably --

(Simultaneous speaking.)

CO-CHAIR ROBERTS: Okay. Emma?

MEMBER HOO: Yeah, I would echo changing that to do not support with mitigation because when I think of different audiences, for consumers and purchasers looking at seven different measures is a lot.

And the uses for quality improvement are different than consumer information, and I liken this to the early days of looking at composite diabetes measures where there were certain

categories where performance was very poor.

And over time, you know, the -- you know, all boats rose across the different diabetes composite measures.

CO-CHAIR ROBERTS: Thanks. Any other points, additional points for mitigation?

Okay, so I suggest that we move to vote on do not support with potential for mitigation pending NQF endorsement and weighting of the measures equally? Does that sound reasonable?

MEMBER SCHIFF: I think the point was evaluating differential weights for the measures if we --

CO-CHAIR KAHN: Yeah, I -- what if we said weighting the measures appropriately? I think the issue of equally could --

CO-CHAIR ROBERTS: Got it.

DR. STOLPE: Okay, Chris, why don't you go ahead and open up the vote.

Just to reiterate, the mitigation points that we're going to be voting on are NQF endorsement and an appropriate balance of

weighting inside of the summary score.

MR. DAWSON: Voting is now open for MUC20-0043: Preventive Care and Wellness (Composite) for MIPS.

Do you vote do not support with potential for mitigation, yes or no?

CO-CHAIR ROBERTS: It looks like we have 18 results, 19.

MR. DAWSON: Voting is closed. The results are 18 yes and 1 no.

The Coordinating Committee does not support for rulemaking with potential for mitigation, MUC20-0043: Preventive Care and Wellness (Composite) for MIPS.

CO-CHAIR ROBERTS: Okay, and I think we need to move to the next slide, last one in this category.

This is for MSSP, MUC20-0033, ACO-Level Days at Home for Patients with Complex, Chronic Conditions. Sam, if you want to summarize the Work Group recommendations?

DR. STOLPE: Thanks, Misty. I think

before we do that we wanted to --

(Simultaneous speaking.)

CO-CHAIR ROBERTS: Oh, yeah, that's right, sorry.

DR. STOLPE: We are running so far behind at this point that we need to poll the availability of our Coordinating Committee members, availability to stay on past 6:00 p.m.

We think we'll likely run over up to an hour. So let's go ahead and open a poll for that to see if we can maintain quorum.

MR. DAWSON: I'll have that for you in just a second.

DR. STOLPE: Thank you, Chris.

DR. SCHREIBER: Sam, the CMS folks and the contractors don't and can't vote, but I think some of us may have a lot of difficulty.

DR. STOLPE: All right, we'll do the best we can. Thank you, Dr. Schreiber.

MEMBER QASEEM: If David Baker and I hang up, it will help cause -- go much quicker too. That's an option.

DR. SCHREIBER: You know, Amir, we weren't going to recommend it but --

MEMBER BAKER: Notice how quiet I've been, Amir?

CO-CHAIR ROBERTS: I think we'll be able to catch up a little bit, but we'll see. Okay, we've got 16. It seems a couple people may not have voted.

MEMBER HOO: This is Emma, I can stay on. I lost the connection and have to reconnect.

CO-CHAIR ROBERTS: Okay. You said you can?

MEMBER HOO: Yes.

CO-CHAIR ROBERTS: Okay, great. Okay, so we're at 17, plus Emma, 18.

DR. STOLPE: Let's go ahead and share responses, Chris. It looks like with Emma we're -- are we keeping quorum?

CO-CHAIR ROBERTS: Yeah, that's what I was -- are we still missing a vote though?

DR. STOLPE: Mary Barton says she's okay to stay on, so that puts us at 15 and keeping

quorum. Okay, let's go ahead and go on to the next measure and try to be quick.

Thanks, everyone, for bearing with us.

CO-CHAIR ROBERTS: All right. I think we were on the MSSP. If we'll move the -- advance the slides forward. Sam, you want to give a summary?

DR. STOLPE: Very good. Thanks, everyone. So this is for the Shared Savings Program measure. Sorry, my slides kind of got away from me.

This is a measure of days at home or in community settings, which is to say not in unplanned, acute, or emergent care settings, for patients with complex chronic conditions in the Shared Savings Programs, ACOs.

So the measure includes risk adjustment for differences in patient MIPs across ACOs, with an additional adjustment based on the mortality risk at each ACO.

For this measure, MAP offered conditional support for rulemaking contingent on

NQF endorsement. The Work Group expressed concerns related to how residents in nursing homes may impact the measure.

And it was noted that ACOs results on this measure adjusted based on the use of nursing facilities and that patients who reside in nursing facilities are only included when they transition to acute settings.

This one didn't generate too much discussion, that was the main focus on the concerns of the Work Group, which were adequately addressed by the developer, and hence the recommendation.

Just as a further note, we did receive quite a few public comments, 13 in total, which I'll just briefly summarize.

Just one moment. So there were quite a few organizations that supported this measure. There was also concerns expressed that patients who end up in nursing homes after hospitalization with or without a SNF stay in between.

And usually, from a medical condition

in which there's loss of activities of daily living would count against a bunch of people who might be held accountable for the measure.

There was concern that days at home may not be possible for all patients with chronic conditions and better to track days out of the hospital.

There were several expressions of do not support, suggesting that it's not an outcomes measure and that other measures already address the measure's intended outcomes, that ACOs are already accountable to cost and quality and therefore incentivized to keep patients in the lowest-cost, most appropriate care setting.

There was also concerns expressed that it was unclear why the measure adjusts risk based on mortality rather than by ACCs.

Let me just hand it over to Diane to see if there's any additional comments that she might have. Diane?

DR. PADDEN: No additional comments. Thanks, Sam.

DR. STOLPE: Very good. Misty, over to you.

CO-CHAIR ROBERTS: I'll open it up to the Coordinating Committee for questions. It looks like David has his hand up. David Gifford?

MEMBER GIFFORD: Thanks. It was kind of interesting to note that all the hospital associations oppose the measure and all the home health associations love the measure.

But if you set that aside, there -- and somehow we forgot to comment on this measure, if you set all that aside, I think the most striking thing was the fact that there was not a lot of variation in this and that the -- it's really almost a, as pointed out, a -- probably a very highly correlated measure with some of the cost measures and the rehospitalization measures. Because this is almost all driven by in-patient hospital stays and cost measures that are out there.

And so while I think we -- I support the initial support of the rulemaking, I think a

message back to CMS should be before they put it in rulemaking they should really look to see how correlated this measure is with their cost measures and their rehospitalization measures.

Because it may not be -- I mean, on the face of it, it sounds like a great measure, but from a measurement standpoint, it may be no different than those other measures. Then they just have to pick which measure they want to use.

CO-CHAIR ROBERTS: Thanks, David. Okay, I see no other comments, so why don't we summarize the Work Group recommendations and move to vote?

DR. STOLPE: Very good, thanks very much. The Work Group recommendation was conditional support for rulemaking pending NQF endorsement.

Chris, will you please open up the vote?

MEMBER QASEEM: And then, Sam, before you open the vote, a quick question I have is I can't find the testing data. Am I missing something, guys? There's no testing data for

this measure?

DR. STOLPE: If there was testing data presented it would be included inside of the preliminary --

MEMBER QASEEM: I am not seeing that, and, I mean, again, I think we can stick to what the -- and probably, Diane, you guys looked at it, hopefully, the testing data? Because I'm not finding -- without testing data how can we go with the measure?

MEMBER GIFFORD: It's a new measure that I was reading, and they had a test that was -- got three different risk adjustment measures within it. And -- but I -- they have not submitted it yet for NQF endorsement, so they didn't have all the -- all the full stuff in there.

But it was just the summary that's within the Work Group there, so I didn't actually see because it's not a -- there's no measure to be submitted with the full extent.

MEMBER QASEEM: Right, so which is

important one, right, guys? So if you're -- depending on -- sorry, Sam, to interrupt because you were just about to click on what we are voting on, and I want to be very cautious about that one.

We can't really support the measure when I don't even know if it's a good measure or if it's not a good measure at this point. I don't have enough information. So for me to say that we support the measure and only on the basis of NQF endorsement, I'm not sure if that's -- I can't even do that. Let's vote on it. Let's see how everyone else thinks.

I cannot make an educated guess right now. I don't have enough information. So just going with the face value that the conceptual -- measures sounds good -- is good enough perhaps because I trust Michelle, which I do, Michelle, don't take me wrong, but I think I need to see some numbers backing it up before I can vote yes to it.

And again, Diane, I really apologize, I

really hate overturning clinician Work Group recommendations. That's why I'm bringing you guys in the loop, if you guys did look into this basic question?

CO-CHAIR ROBERTS: Diane, do you recall?

DR. PADDEN: I do not, I'm sorry, I do not recall. And I believe that Rob took the lead on this one as he has a lot of experience in this area. Am I -- that's my recollection, Sam. I don't have any specific notes.

DR. STOLPE: Yeah, and I'm going through the measure specifications now, but just a reminder, we don't include reliability and validity as explicit criteria inside of our own measure evaluations.

We rely on the NQF endorsement process, and, in fact, one of the things that we frequently bring up is that we don't intend MAP to readjudicate the endorsement process, is the term that we use.

So the -- there's a note in the state

of development details for this measure. I'm sorry -- sorry, this is the days at home measure.

Is the developer prepared to speak to any of the analyses that were performed associated with reliability and validity?

I did see that there was an analysis inside of the description where there was a high agreement between split samples with inter-class correlation coefficient of 0.828 in mortality-adjusted days at home.

But we'll allow the measure developer to speak to anything else related to reliability and validity.

DR. SCHREIBER: Sam, Michelle, I don't know, and I don't know if we have a CM -- MSSP on the phone.

MS. LARBI: This is Fiona from the Shared Savings Program. I know Yale was actually on the call earlier on, but I don't know if they have dropped off because they would be the ones to actually speak to this.

CO-CHAIR ROBERTS: Thanks. You said

Yale? That's Elizabeth, right?

MS. LARBI: Yeah, actually -- yeah, Elizabeth or Susannah. I know Susannah was on earlier on, but I think she seems to have dropped off.

(Simultaneous speaking.)

PARTICIPANT: Susannah is trying to jump in. Oh, and Kelly. Great.

DR. KYANKO: Hi there, this is Kelly Kyanko from Core (phonetic). We have not yet conducted validity testing, but the reliability, the inter-class correlation was 0.833. But validity testing is pending.

CO-CHAIR ROBERTS: And just to reiterate I think what Sam was getting to, that will go through with this if we vote conditional support, pending NQF endorsement? That will be addressed with NQF endorsement. Leah?

MEMBER BINDER: Never mind, I'm fine.

CO-CHAIR ROBERTS: Okay. Why don't we move forward to vote on the Work Group recommendation?

DR. STOLPE: Just to summarize --

(Simultaneous speaking.)

MEMBER QASEEM: -- for a very, very long time. Can you guys hear me?

CO-CHAIR ROBERTS: Sorry, who was that?

DR. STOLPE: Sorry, Amir, were you saying something?

CO-CHAIR ROBERTS: Okay, Sam, why don't you summarize the Work Group recommendations?

DR. STOLPE: Thanks very much. So the Work Group recommendation was conditional support pending NQF endorsement. Chris, go ahead and open up the vote, please.

MR. DAWSON: Voting is now open for MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions for the SSP.

The vote to support the Work Group recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

CO-CHAIR ROBERTS: We've got 15. We're missing a few votes.

MEMBER TUFTE: I lost my link. I have to look it up again. So I'll chat it to who? Sam?

CO-CHAIR ROBERTS: That works. Still missing a couple. That'll give us 16.

DR. STOLPE: Okay, and we've got one more vote for yes. So that gets us to quorum, so we can go ahead and close.

MR. DAWSON: Voting is closed. The results are 14 yes and 2 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions for the SSP.

CO-CHAIR ROBERTS: Okay, great. So I'm going to hand it over now. I think I'm handing it over to Chip, but I don't know if we're going to do this break or not.

CO-CHAIR KAHN: I think we should keep rolling through, don't you think, Sam?

DR. STOLPE: I agree.

CO-CHAIR KAHN: Okay, so we now are going to the PAC long-term care programs and we

have a few measures here.

The first part of that obviously will be to open up to public comment, so we'll open the lines and look down at our participants to see if we get any hands on public comment.

Remember, if you do comment, we need you to limit to recommendations on PAC/LTC. We need to limit your comments to no more than two minutes. And we need you to talk about MUCS or opportunities to improve the current PAC/LTC measure set at this time. Do I have any takers? Going once, going twice.

I don't see anybody. Sam, anything? Okay, one more second, and we'll start in, and it looks like we're on -- Amy Moyer will provide a quick overview of the Work Group decisions, and then we'll get into the measures.

Is that correct, Sam?

DR. STOLPE: That's correct.

MS. MOYER: Good afternoon, everyone. This is Amy Moyer with NQF, the Director that worked on the PAC/LTC project.

As you can see, we had measures across several of our programs for consideration. I believe there's two we're going to talk through right now, and the remaining we will cover later as part of the COVID measure discussion.

The first measure up for discussion is -- I'm sorry, first, the Work Group themes, getting through these. So, at a high level, there were three real main focuses that came up throughout the PAC/LTC Work Group.

One was a focus on care coordination. This came up both in the discussion with CMS at the beginning of the day and threaded throughout the gap discussions on every single program.

Patients who are in the post-acute care and long-term care setting frequently move among different providers and in and out of settings, and the need for care coordination for safe and effective care transitions and across all providers and all care team members was a real theme of the discussion.

The Work Group was also very passionate

about the involvement of patient and family, both in care design and goal-setting. For many of the settings they felt care aligned with patients' goals was a very important gap that was not being met in the programs.

And they felt that including patients and families in that goal-setting was foundational to working on patient-centered goals.

We had, in the course of the gap discussions, while we feel our group is very patient-focused, it was stressed that patients themselves should be involved in discussions around gaps of care and setting priorities for measurement.

And there was an urging of CMS to engage patients directly in those discussions on what would be most meaningful and most useful to patients as they try to navigate the healthcare system.

Next slide. So our first program with a measure under consideration is the Hospice

Quality Reporting Program. This is a pay-for-reporting and public reporting program.

Hospices have a reduction in their payment increase if they do not report the measures under this program. The measure under consideration is a Hospice Care Index, which is a fairly complex measure.

We had a lot of robust discussion echoing some themes that I'm hearing in the group today, including a recognition that NQF endorsement would get into a lot of the details and the weeds of this complex measure.

And so we really tried to focus on usefulness for the program, as challenging as that was. This index includes ten measures that are rolled up into an overall score.

Facilities receive a point for meeting the cut-off for each measure. So you get a point for each measure where you are in the positive range of the measure, if that makes sense.

And this made a lot of sense to us from the perspective of usefulness for patients and

for individuals making decisions.

It is a new measure that has not previously been included in MAP or in other programs, and really filled a gap.

We felt the measure was developed in response to comments and feedback from both patients, purchasers, MedPAC, and GAO. And the Work Group recommendation was that -- conditional support with -- contingent on NQF endorsement.

And, again, the recognition that as a complex measure, this measure would go through significant review and part of the endorsement process, and enhanced our review of the scientific properties as part of the Scientific Methods Panel.

We did receive quite a few comments kind of supportive of the concept. Some of the concerns raised were the measure -- whether the measure took into account patient and family preferences and whether it accounted for patient and family behaviors.

A question on whether all indicators

accurately reflect quality of the program or might be more program integrity indicators.

A request to include survey data, so it would incorporate more of the voice of the patients and families, broadening the types of providers who are included in the measure, and a request for no new implementation during COVID, and a consideration of the impact of COVID on the measure.

So making sure that telehealth and alternate methods of providing care were included.

And with that, I will --

CO-CHAIR KAHN: So we need our discussants -- have any comments?

MEMBER GOODMAN: So, Chip, I'm one of those two discussants. You know, I think there was general support among our, you know, among the AHIP member plans for the measure, which we think is probably generalizable beyond just this program when we look at the issue of aligning measures.

And that these are -- you know, there's evidence to support that the areas addressed by the measure represent significant quality problems, but we do hear the concerns from hospice providers around, you know, some of the lack of control over some of the cost issues that the measure seeks to address.

So we generally would support the Committee's recommendation of conditional support with mitigation.

CO-CHAIR KAHN: Okay, do we have questions on -- any technical questions? Let me look here at the -- Janice, do you want to say anything?

MEMBER TUFTE: Yeah, I just wrote in there, but I read over the public comments, and I saw that there was more than one comment regarding the HOPE assessment and they hope that it aligns with that. I'm not sure if anybody can respond to that.

CO-CHAIR KAHN: Sam, does -- or Amy?

MS. MOYER: Alignment with HOPE did not

specifically come up during our discussion. I believe this supplements HOPE, but we may have someone on the line who can speak more thoroughly to that than I just did.

MEMBER TUFTE: If somebody is doing it. I just saw that people were concerned about it, so I was hoping that that will be addressed.

DR. LEVITT: This is Alan Levitt from CMS. I'm not sure if you can hear me, but --

CO-CHAIR KAHN: Yes, we can hear you.

DR. LEVITT: Okay. This is a measure that's based on claims, and, again, the -- what we were able to do and, again, why we were so in favor of moving this measure forward was actually the fact that these different hospice care practices that were put together in the composite was associated with the CAHPS score.

So, in other words, those hospices that seem to have more or better practices, so to speak, actually did better in terms of the family satisfaction on the CAHPS scoring.

It was not meant to be aligned or not

aligned really with the HOPE assessment itself. Obviously, we're looking forward to the further development and implementation of the HOPE assessment.

And, you know, once that comes out, we will have measures that will be associated with those items. And, again, we'd hopefully be able to correlate different measures in terms of the measurements within that assessment instrument with different factors going on with claims.

But this isn't directly related with that.

MEMBER TUFTE: Thank you for clarifying. CO-CHAIR KAHN: Okay, other questions? Why don't we move to a vote and see where we stand then on it?

I guess, Amy, do you want to summarize or -- before we proceed just to remind people?

MS. MOYER: Sure. So the Hospice Care Index is a summary of ten measures that look at a variety of aspects of hospice care, covering the entire hospice stay.

We had robust discussion about it as a Work Group, and there were a lot of public comments. I think it is worth noting the Work Group was very aligned on supporting the Work Group -- the preliminary recommendation, which was conditional support pending NQF endorsement.

The final vote was 16 yes and 1 no. So had a lot of discussion, but at the end of the day a strong agreement among the group.

CO-CHAIR KAHN: Okay, well let's go to vote then. Can you put up the voting?

MR. DAWSON: Voting is open for MUC20-0030: Hospice Care Index for the HQRP.

The vote to support the Work Group recommendation of conditional support for rulemaking as the Coordinating Committee recommendation, yes or no?

CO-CHAIR KAHN: What's our magic number on quorum? Is it 16? 15? I don't remember.

MR. DAWSON: I believe that it's 16.

CO-CHAIR KAHN: Okay, it looks like we've got 18. I think 18 or 19 was the high

water mark. Why don't we call it?

MR. DAWSON: Voting is closed. The results are 17 yes and 1 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0030: Hospice Care Index for the HQRP.

CO-CHAIR KAHN: Okay, Amy, can we move to the next one quickly?

MS. MOYER: Absolutely. The next measure is for the Skilled Nursing Facility Quality Reporting Program. Again, this is a pay-for-reporting and public reporting program.

The measure under consideration is a Healthcare-Associated Infections Requiring Hospitalization. This is also a claims-based measure, similar to the last one, and is looking at a range of infections that are serious enough to require admission into a hospital.

It is one of the -- I believe the only hospital-acquired infection measure in the SNF program, or would be. So it definitely fills a gap in that area.

It is an outcome measure, and the

developer provided literature on the ability to reduce healthcare-acquired infections.

A point that was a focus for the Work Group was that this is a combined measure. It is not broken out by infection type, and the goal with that is really to provide an evaluation of overall infection control from kind of a systemic viewpoint for a SNF.

And so the interventions that would be implemented to effect this measure would affect all infections, so handwashing and better overall programs, which is really what's supported by the literature. Rather than introducing like a narrower infection-specific intervention.

So there was a lot of discussion about that with the Work Group. and it is a theme in the comments as well. Kind of the pros and cons of that. It's a different approach than a lot of other infection measures.

That said, the Work Group unanimously supported this with a conditional support for rulemaking contingent on NQF endorsement. They

felt it added a lot of value to the program and was very useful information to patients and other decision-makers.

We did receive several public comments. There were, as mentioned, concerns about using claims as a source and the usual concerns that come up in a claims-based measure around inaccuracies in coding, potentially concerns on attribution, and the ability to correctly identify infections.

There were concerns from commenters, similar to the Work Group, around having a measure that reported all infections versus breaking it out. And we did receive some comments on reliability thresholds.

This is a complex measure as an outcome measure, and so as part of the endorsement process, again, it would receive that heightened scrutiny of scientific acceptability by going to our Scientific Methods Panel for evaluation.

And I believe I skipped this step last time, and I apologize. Gerri Lamb may be on the

line with us.

She's one of our Co-Chairs on the Work Group, and, Gerri, anything to add?

DR. LAMB: Thanks, Amy. I would just reinforce that we did have a very robust discussion about the use of this measure as a general measure of infection, and came to the conclusion that some of the details would be reviewed through the NQF review. And, as Amy said, there was 100 percent support for conditional support.

CO-CHAIR KAHN: Great. Thank you, Gerri. Any of the discussants have any comments?

(No response.)

CO-CHAIR KAHN: Okay.

MEMBER BOSTON-LEARY: This is Katie. I have a --

CO-CHAIR KAHN: Okay, sure. Go ahead.

MEMBER BOSTON-LEARY: Sorry about that. I have a comment. I completely support this. I think it aligns with some of this that's been a measure in the acute care setting for a very long

time. I think this also would help with a measure we discussed previously around sepsis because we tend to see a lot of these patients fall into that bucket. And I personally believe it's long overdue. It may not be perfect because it's focused on claims data, but it's a start. So I completely support it.

CO-CHAIR KAHN: Thanks. David? Does David have a comment?

MEMBER GIFFORD: Yes, thank you. As the lone nursing home representative, I would not be doing my job if I didn't say something about the only nursing home measure for the whole day.

We generally support with the conditions of NQF endorsement. But I think, you know, we all understand the limitations of claims and diagnoses. But, as the many of the comments with many of the infectious disease associations for this measure, we know, particularly UTI and sepsis and others are really terribly coded in the claims.

And I just want to make sure that as we

proceed with that improvement process and the NQF endorsement that that really gets looked at closely, because I really think that we know these diagnoses are way overcoded by the hospitals.

CO-CHAIR KAHN: Okay. Leah?

MEMBER BINDER: Yeah, I was reading the comments by Premier. They had a question about why they used claims data instead of NHSN? And I was curious about that. Having said that, I think this is an incredibly important measure and am supportive of it. But I was hopeful that we could move toward using NHSN as a source of infection data.

MEMBER GIFFORD: I can answer that, Leah. We are not required to use NHSN like the hospitals. We are required to do it for COVID diagnoses, and they started to do it for C. diff., and we are doing optional for UTI. But none of it is required. So the breadth of the diagnoses are not very good here. It would have to be -- CMS would have to make a requirement to use NHSN.

And even CDC admits that the NHSN platform has not been well-designed to transition from hospital to nursing home.

CO-CHAIR KAHN: Okay.

MEMBER GIFFORD: But it would be ideal if all those things were fixed. But that means this measure wouldn't happen for probably five years.

MEMBER BINDER: In that case, forget it.

CO-CHAIR KAHN: Yeah, you can only go to the war with the army you have.

Okay. Any other questions, thoughts, comments?

(No response.)

CO-CHAIR KAHN: Amy, why don't you sum up? And then let's go vote.

MS. MOYER: Absolutely. So, again, this is a claims-based healthcare-associated infections requiring hospitalization measure. It covers major serious infections arising in a skilled nursing facility. And it was unanimously

the recommendation of the workgroup to conditionally support it for rulemaking pending NQF endorsement.

CO-CHAIR KAHN: Okay. So let's do the voting.

MR. DAWSON: Voting is now open for MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization for the SNF QRP. Do you vote to support the workgroup recommendation of conditional support for rulemaking? That is the Coordinating Committee recommendation. Yes or no.

CO-CHAIR KAHN: Okay. It looks like we're at 18. So what's the vote?

MR. DAWSON: The voting is closed. The results are 19 yes and 0 no. The Coordinating Committee conditionally supports for rulemaking MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization for the SNF QRP.

CO-CHAIR KAHN: So I think that concludes the PAC/LTC. And I'm now going to turn

it over to Misty to chair the COVID portion. And I think she'll turn it over to Sherri, but I'll turn it over to Misty.

CO-CHAIR ROBERTS: Yeah, I think I'm going to turn it over to Sherri to make some remarks on the COVID measures.

MS. WINSPER: Am I unmuted? Can you all hear me?

CO-CHAIR ROBERTS: Yes, we can.

MR. STOLPE: Yes, we can.

MW. WINSPER: Okay. I have two places to unmute myself, so, thank you. I'll be very brief.

I just wanted to speak briefly on behalf of NQF that, related to COVID-19 vaccines, NQF is absolutely, 120 percent in support of vaccination. Really, vaccination not just for COVID, but anything that would be a preventable illness or disease.

But, as you know, the preliminary recommendation from the NQF staff in the analysis was do not support with mitigation, which is

entirely related to us making sure that we followed our process for reviewing the measure specifications that were available at the time.

And I just wanted to mention that those are really two different issues. So, NQF supports vaccination in general, and particularly for COVID considering that it's one of the most promising ways for us to get a handle on this pandemic, but that, really, this group is tasked with looking at the measure, and this was the best way to measure it as specified.

So, that's all I wanted to say, just to clarify that when we say do not support with mitigation that doesn't mean we don't support vaccinations in general. And that's all.

CO-CHAIR KAHN: Okay.

CO-CHAIR ROBERTS: Thanks, Sherri. I think we want to hand it over to CMS for a quick presentation?

DR. SCHREIBER: Yes. Thank you, Madam Chair. Thank you for your comments. I see we've gone from 100 percent to 120 percent of NQF

support for vaccination. So, it's gone up in a few days.

We're going to try and save some time here, actually, and not go through all of the slides. So, Sam, I'm not going to call for slide advancement. I'm just going to speak overall for a few minutes. You have both CMS and CDC on the call to answer questions. And hopefully we can proceed fairly shortly to the discussion of the measures from the group, and then subsequently a vote.

We certainly recognize that there's very little recourse but to vote the way it was because we don't have full measure specifications in the way that people would sort of anticipate and want them. We don't have enough information about vaccines, including even the types and numbers of vaccines nor how many doses will necessarily be acceptable. That will be vaccine dependent. We don't have all of the exclusions, obviously, and the vaccines are still under an EUA.

So we recognize that we couldn't bring

forward a lot of the information that would be wanted. And so it makes it hard to really vote on a measure. But we wanted to make sure that we were bringing forward to this committee the concept of these measures, certainly, for discussion. And, as we continue to evolve them, I'm sure you will see them come back in the future with substantive revisions to them.

That being said, CMS recognizes the absolute importance of vaccination during this pandemic. And we want to be as timely as possible with introducing vaccination measures. The soonest that these could go into effect would be 2022, so please keep that in mind. We would have to propose something in rule-writing this year, 2021, to take effect in 2022.

So, certainly, there will be a lot of advances in what our knowledge is around vaccination. And, hopefully, you know, god willing, we get one vaccination, all of us, and we don't have to worry about this again. But we really don't think that's the case. We think

COVID vaccination will be something that is ongoing for the foreseeable future.

We don't know if that will be annual or not, but we are considering this sort of like flu vaccination, of annual vaccines, and that's why we're bringing these measures as something that we would like, at least in the reporting and value-based payments.

There are three specific types of measures that we're bringing forward for you to consider. The first is vaccination for healthcare personnel or healthcare staff. Most people report -- not most people, but a number of facilities already report flu vaccination. And this is done through an NHSN module. I should say that the measure steward for all of these is the CDC and the information source will be the NHSN.

And there is currently a module already for healthcare vaccination, certainly for flu. And this would be very similar. This would be vaccination for the COVID vaccine for healthcare

staff. And it would apply to hospitals, inpatient rehab facilities, long-term care facilities, inpatient psych facilities, end-stage renal disease facilities, ambulatory surgery centers, hospital outpatient departments, skilled nursing facilities, and cancer hospitals.

You may say, why not home health? And the reason for that is because this is through NHSN; home health currently is not registered with NHSN, and that would be thousands of organizations who had to enroll with NHSN.

The measure here would be healthcare workers who have received a completed vaccine series. That could be a single vaccine, depending on the vaccine that's used. That could be two vaccines, you know, for the current Pfizer and Moderna. This is left open to say a completed vaccine series. And the denominator would be the eligible staff to work in that facility for one day in the current year, which is currently how flu vaccine is given.

There is an exclusion only for contraindications; largely allergy, but contraindications. There is no exclusion for refusal. Refusal is counted as not given. And this would be reported quarterly.

So that's one major type. And it really gets at vaccination of healthcare personnel. This does not, however, set a precedent that vaccination for healthcare personnel is mandatory. But this does get at the safety of the healthcare personnel within a facility who has been vaccinated.

The second measure that is being proposed is for end-stage renal disease patients for the ESRD-QIP program. This is the number of completed vaccine courses also, with the denominator of the patients under care for at least two working days in the ESRD facility. The contraindications are -- the exclusions are just contraindications; there's no exclusion for referrals.

You may say, well, why did you do

patients in ESRD but not patients in SNF facilities? And, really, the question to that is that there is some conversation about whether or not CMS has the legal authority to collect that information.

That's something that's being actively looked at. It may take another legislative act in one way, shape, or form. But, just so you know, that's why it wasn't being brought forward as a measure in skilled nursing facilities. Of course, from a clinical point of view, it would make a lot of sense that we would want to measure there.

And, finally, in the MIPS program, we're bringing forward the conversation about vaccination for patients who are seen by eligible MIPS clinicians. This would be all patients who are greater than 18 who've had a visit during the measurement period.

And this one was a little bit different because we tried to be as inclusive and flexible as possible, although it would be interesting --

and I look forward to hearing in your comments about the numerator here, because the numerator in this case is self-reported or, obviously, if the clinician has direct knowledge. But, patients who report ever having received either a full vaccine series or even a partial vaccine -- so if they got one out of two. The exception to this is patient contraindication, but we will measure refusals and count them separately.

So, those are the measures that we bring forward to you. We look forward to the conversation, if you agree with the principles, if you agree with including these in programs, if you would change them in some way. And, again, both CMS and CDC are on the phone and happy to take questions and look forward to your comments.

So, Misty, thank you, and I will turn this back to you.

CO-CHAIR ROBERTS: Thanks, Michelle. So, I will open this up to the Coordinating Committee for any questions. It seems like, well, Chip has a question. Go ahead, Chip.

CO-CHAIR KAHN: Yeah, I guess I'm really interested in the refusal, because, for the individual practitioners there's a refusal, but for the institutions there's not.

There are all kinds of personnel and other issues regarding mandating. Right now, I don't think any of the hospitals that I work for are mandating.

DR. SCHREIBER: No. We don't know of any.

CO-CHAIR KAHN: I think you've got to invent -- I mean, since this is prospective, it's off in the future, I don't think it's fair to measure a facility if you don't have a category for a refusal. You know, unless you want to push facilities into mandating, and then that's going to raise a lot of other issues.

The second issue I would raise is I don't -- I think this is -- first, obviously, you have to work out all of the specifications for this, but I think that it is only appropriate to apply this. I don't see how you can apply it in

2022, in the timeline you described, because you'd have to come back to us in December.

Well, if you came back to us in December, you're actually talking about regulating it in 2022, and then it doesn't happen until '23, right? Am I missing something?

But, anyway, the point I want to make is that, right now, the inoculations are not readily available. There's a presumption that they would be available later in the spring. You know, obviously, we've got Johnson & Johnson, and that may be a game-changer. But it also seems to me that this could only really go into effect once you have readily available vaccinations, like you do with flu where there's no argument the flu is sufficiently available.

It seems to me both those circumstances -- the refusal is a problem. And, obviously, every institution is going to really be pushing their employees as hard as they can, but there's only so far you can go with that. Those are my thoughts.

DR. SCHREIBER: That's still something that's under discussion. I will say that we view this largely as a safety issue. We recognize that there are issues of refusal, serious issues of refusal, for lots of different reasons.

But, as a patient, if you're looking at a facility, I think that you would want to know whether or not their staff has been vaccinated or not. For whatever reason, if they're not, you wouldn't expect 100 percent, and certainly not at the beginning, because there will be all kinds of mitigating circumstances to that. But, really, what is the percentage who have indeed been vaccinated? And over time we would hope that that would climb.

CO-CHAIR KAHN: I'm with you 100 percent, but I guess the question is: could it be included, though?

DR. SCHREIBER: Your point is well-taken, Chip, and we'll continue to work with CDC on this.

CO-CHAIR KAHN: But would it be included

in value-based purchasing? That's the question. I think if it's just reported, that's one thing. But if it's actually put in purchasing, I mean into the system, then I think there's got to be some adjustment.

DR. SCHREIBER: Thank you, actually, for bringing that up, Chip. The intent would be that this would just be used for reporting, not for payment, and would probably, at least for a while, just be put in the Provider Data Catalog as opposed to public. But it would be available at least.

CO-CHAIR KAHN: Okay. Well, that's good. That's good at least.

DR. SCHREIBER: But thank you for saying that.

CO-CHAIR ROBERTS: Thanks for that clarification, Michelle.

I think there was a comment from David Gifford. Do you want to bring that up?

MEMBER GIFFORD: I guess my comment was, if this is going to be for, you said rulemaking

in 2022, or implementation in 2022, that would mean, kind of what Chip was saying, these would be rules that would be coming out in 2022. Why not bring these measures back under the MUC List in December? Because, as has been said before, once they come through the MUC list here, we don't have to see them again. Unless they are going to go in rules this year for implementation later this year in 2021 or 2022.

I mean, I think, the same with Chip, I will just echo Chip that if it's for payment, that's different than public reporting or initially used for quality improvement given the issues. But I think the categories that you described all make sense. But the devil is always in the details on all these measures that were out there.

And the last point I would make is, why not add in in influenza because we already know some of the manufacturers are going to be looking at joint influenza-COVID vaccine together, potentially. And we certainly know in the

elderly, in the Medicare population, influenza has a high morbidity and mortality, even amongst those who are immunized. And a lot of times they get it from healthcare workers.

And so if you're looking at it from a safety standpoint, it would make sense to also add in that. Because, frankly, it's looking like the vaccination rates for COVID are mirroring the vaccination rates for influenza amongst healthcare workers and amongst patients.

DR. SCHREIBER: That's a good comment. Thank you. We already have the influenza, so you're right.

CO-CHAIR ROBERTS: Leah, do you have a question? Oh, Chip, did you have a response?

CO-CHAIR KAHN: No, I just want to add that we're seeing at our hospitals really depressed flu. So, I don't know whether more people got the shots or the masks are making a difference. But, I mean, I'm talking about 50, 60, 70 percent less occupancy from flu than normal.

MEMBER TUFTE: That's national, Chip. Nationally they're seeing that.

MEMBER BOSTON-LEARY: That's right. That's right.

DR. SCHREIBER: We've heard the same.

CO-CHAIR ROBERTS: Leah, do you have a question?

MEMBER BINDER: Yeah, thanks. I just want to make sure or ask if pediatric hospitals are included on this list and if this -- I guess for 044. And also whether there is a way to speed this up. I feel like this is, like, kind of slow, to be honest with you. It's like, we're in a national emergency, and this is kind of pathetic that we can't even count, you know, this kind of basic thing until 2022. To be honest with you, I wish we could come up with a different method to get this thing moving faster.

DR. SCHREIBER: Thank you, Leah. To speak to that, you know, there are other mechanisms of this being counted. We recognize there's counting that is ongoing now. But to

make this a little bit more publicly available, tied at least to reporting, not payment programs, at the moment is something that we feel strongly about, too. Which is why we're bringing it to you on such an accelerated timeframe, really without all the measure specifications that you've come to expect from us. We think that it's such a vital issue that that's why we're accelerating the course here.

MEMBER BINDER: Thank you.

DR. SCHREIBER: To answer your question about pediatric hospitals: you know, I don't have an answer for you. Generally speaking, we do this, as you know, through the Medicare program. I'd have to take this back and ask more about the pediatric hospitals and what authority we have there. So, thanks for the question.

MEMBER BINDER: Thank you.

CO-CHAIR ROBERTS: **J**ulie?

MEMBER SONIER: So, I've got a question for Michelle. If you could speak a little bit more to the rationale for the patient refusal as

an exclusion in the MIPS measure. So, just thinking about other immunization measures, like the NCQA measures, refusal is not typically an exclusion. So, I just wanted to hear more about your thinking on that.

DR. SCHREIBER: It wasn't so much an exclusion per se; we were going to report them separately. But I will say, Julie, that's still under conversation.

CO-CHAIR ROBERTS: Any other quick questions for Michelle before I open it up to public comment?

MEMBER FERGUSON: Yeah, this is Scott. Like some others had mentioned, is there a good reason that we can't wait until we have better data and more information until December to relook at this?

I think we're all about vaccines. We're all about public health and wanting to see this done. But we don't have a tremendous amount of information right now. And I think we'd like to see that.

DR. SCHREIBER: We'll keep working through the timing. It is potentially a possibility of having a separate meeting for COVID vaccination measures. We're still having a lot of discussion around this. So, we're bringing this into you at the very beginning.

MEMBER FERGUSON: Right. And this is a tremendously important issue. And I think we all on the call realize the importance of it. We'd like to get more data to be able to make a good decision and help you the best way we can.

DR. SCHREIBER: Absolutely. Thank you.

MEMBER BINDER: But, at the same time, I don't want the MAP process to be seen as a ball and chain around the ability of CMS to do something in a national emergency that makes a difference. I mean, I don't think we should be on the side of delay.

And I do appreciate that CMS brought this forward early and, you know, kind of broke a few rules with us. I'm fine with that. We're breaking a lot of rules with COVID right now.

And we're going to save a lot of lives if we do this faster.

So, you know, I think full speed ahead, and we should be helpful to that. Whatever it takes. If you want us to meet at midnight, you know, next week and go through it again, fine. You know, that's our job. We need to make this move and I think waiting two years for this is absurd. So I think we should try to put all our resources and break a few rules ourselves to make sure this works and you get what you need for CMS.

CO-CHAIR ROBERTS: Ron?

MEMBER WALTERS: So, Leah may have just answered this, but, Michelle, what's the value to you of having a do not support, which we all know doesn't mean that, with mitigation, of potential mitigation, versus a no vote right now? I mean, what's the practical -- not a no vote, but I mean just a no-vote. Not a no vote, but a no-vote. What's the practical significance of that to CMS?

DR. SCHREIBER: That's an interesting

question, Ron, and I don't know. Because, I have to say that we're kind of in Leah's camp here, you know. To us, this is full speed ahead and if we have to break a few rules, this is a pandemic; all of us have broken rules trying to do everything we possibly can to respond to this.

And so I don't know that there's a practical answer except that it does help us to have a formal vote. If I want to be really picky for the statutory language, it has to be that there's a formal vote on the measures for a program.

CO-CHAIR ROBERTS: David Gifford?

MEMBER GIFFORD: Why can't we meet again in two months or three months when you have a little bit more specification?

DR. SCHREIBER: We could potentially look at that as well.

MEMBER GIFFORD: I mean, as Leah said, we're all -- I mean, and you summarized it. We're 120 percent behind the idea of measurement. And, you know, we don't want to be bureaucrats

and say we have to wait until the MUC List in December and go through January of next year.

The other thing is to think about how you split this between -- use your emergency authority to do this for sort of quality improvement measures versus payment and public reporting measures. And I think there's a distinction there. I mean, you did that for the nursing home setting. You guys issued an interim final rule and publicly reported the number of cases and everything else without coming through the MAP. And, you know, there was no squawking about that.

DR. SCHREIBER: Yes. And you're right, I mean, the truth is we could do that here as well. We had preferred not to. We really did want to try and follow the process. We did want to engage the MAP in the conversation.

MEMBER GIFFORD: I mean, frankly, we've been begging CDC and CMS for measures on the vaccine uptake rate for the facilities for quality improvement purposes. But, you know, I

don't think it would be good for public reporting and payment at this time, knowing all the issues around it I think some of the people raised here.

But, yeah, the faster we can get the measures out there from a public health safety standpoint, we absolutely need it. Whether it's payment and public reporting and how much that plays in the role I think is a broader question for rulemaking.

CO-CHAIR KAHN: Well, what's to stop us -- I mean, we have a process, but what's to stop us for this purpose -- this is an emergency situation. What's to stop us from endorsing or in supporting the measures with our recommendation that CMS come back to us in a special session to consider the measures when they're ready for primetime?

So, we haven't turned down the measure. We've supported it. We haven't done the negative, asked for mitigation. Clearly, the measures are not ready right now. But we've simply invented a proposition that fits the

situation.

And Michelle and Lee control the money, so if they want to have another meeting of the MAP -- which I'm going to talk about when we get to the next issue, anyway -- it's up to them. I mean, if they want to pay for the meeting, you know, the great amount we get, you know, we're happy to show up. So I think we could be positive about it. We don't have to stick to our rules, it seems to me, in this emergency situation.

DR. SCHREIBER: So, let me check. I need to ask some of my CMS colleagues on the phone if, from a statutory point of view, we need a vote.

Maria, Kim, any of you guys on the phone, can you answer me? I will have to find that out.

DR. STOLPE: So, from previous conversations that we've had from CMS, we do need to get, statutorily, a vote.

DR. SCHREIBER: That's what I thought, Sam.

DR. STOLPE: But what Chip is suggesting isn't saying that we don't vote.

DR. SCHREIBER: Okay.

DR. STOLPE: It's just that either the conditions for support would be to reconvene at a later point when you have more specifications. So it's just moving it up a grade from do not support to conditional support.

DR. SCHREIBER: Okay. Alright, Sam. Thanks.

CO-CHAIR KAHN: And that's what I was suggesting.

MEMBER BINDER: I would agree with Chip. And I would even add to that another reason for us to consider this important for us to do, is that MAP could be becoming irrelevant very easily. If we're seeing the biggest national emergency probably in any of our lifetimes and we're not able to move this along and take some leadership role in saying we want action, we want measurement, this is a moment when safety really is important -- and public reporting, frankly, of

safety is really important. It's a core aspect of what we do at MAP. So I actually think that it's important for us to take that stand.

CO-CHAIR ROBERTS: Amir?

MEMBER QASEEM: So, Michelle, as you're going to be thinking about if you're going to be bringing this back, I think we need to again think out of the box over here, COVID-19 versus other vaccines or other issues that we dealt with.

At this point, when it comes to COVID-19, is this the problem that we're trying to address of physicians or whoever need to vaccinate? Because I don't see that being the issue, at least in the coming months.

I think it's going to keep on changing, too. I don't know. Based on my knowledge, I wouldn't be that optimistic -- or I would be really -- I would be optimistic about COVID-19 vaccinations, but I don't know if I have enough knowledge to be able to tell you that it's going to be annual at this point. We don't know. There are a lot of fundamental issues that we're

dealing with, including with the different strains and how quickly we'll have to change vaccinations and then bring it back to the population and all.

So I strongly encourage CMS and the CDC to think beyond the traditional approach of your typical flu vaccination. I don't think that's going to really help, because that isn't an issue right now in our practices. Physicians are not vaccinating because they don't want to vaccinate, right? We all know that.

DR. SCHREIBER: Correct.

MEMBER QASEEM: Physicians are still not getting the vaccine for various reasons, and that is not going to change in the next six to eight months. I just don't see that changing. And you know that, right? We're not going to have enough vaccine. We will only have 100 million vaccines by the end of the summer, perhaps. That does not even come close to vaccinating all.

So, having a measure like this is not

going -- going back to Leah, what you're saying, you're absolutely right. We need to all chip in and come up with something to address the performance measure. But then, having said that, this measure is not going to change anything, even if you implement it right now. We hope that in 2021 perhaps it will make a difference. I don't think so.

So, I feel like I'm a little concerned that we -- well, I strongly encourage you to think about it, and encourage CDC to think about it. But then keeping in mind that some of the realities out there, that this traditionalistic approach, I feel like this is where CDC might be heading in the direction of getting a check box. Hey, guess what? COVID-19 is important. I want to chip in with a measure over here as well. I don't think that's going to help, though.

MEMBER PINCUS: Michelle, what would be the most helpful thing to vote on? At what level of specificity would help you in moving things ahead as quickly as possible?

DR. SCHREIBER: I think what would help is to make it conditional support with the conditions of bringing it back, bringing it back to this committee, developing it further. That would be most helpful.

MEMBER PINCUS: And adding a timeline to that as well?

DR. SCHREIBER: I've learned from my group that we technically don't have to have a vote, but it would be nice to at least have a vote on record.

CO-CHAIR ROBERTS: Before we get to voting though, I think that we still have to open it up for public comment. So I don't want to miss that step. Is that right, Sam?

DR. STOLPE: That's correct. Chip, did you want to say something?

CO-CHAIR KAHN: I just want to say one more thing. I think there can be a bifurcation here. I think the issues that Amir raised are critically important for the expectation for practitioners. But I think that Michelle raises

a very important point about institutions and facilities.

And the question of a publicly reported metric on -- and I don't know what point of the year it's justified, but at some point during the year, every facility, particularly all the hospitals, will have received their vaccine.

So I think the question for patients choosing a facility is one thing, you know based on whether or not, you know, 80 percent or 90 percent of the people have gotten the shot, versus what a doctor's office needs to do.

So I think we really need to bifurcate this. And also we need to remember, I don't think that -- these measures have not been written. So, we don't really know what they are yet. They don't exist. They're conceptual. But I think we really need to bifurcate that when we get down to it, because I think they serve different purposes.

MEMBER QASEEM: Chip, can I ask -- sorry, Misty, whoever is chairing, can I just ask

a clarification on, Chip, what you just said?

CO-CHAIR KAHN: Sure.

MEMBER QASEEM: So we already have that data, right? Because CDC, we have to report to CDC about the vaccination and all. So CDC actually is sitting on that data.

CO-CHAIR KAHN: Right.

MEMBER QASEEM: How much has been distributed to, let's say, Chip's hospital and how much vaccination he's done.

So what are we going to gain then, Chip? Just curious. We have that information. At this point --

MEMBER BINDER: But the public doesn't have it. It's not publicly reported, is it?

CO-CHAIR KAHN: Well, it's not publicly reported.

DR. SCHREIBER: It's not publicly reported, and it's not at a facility level.

MEMBER QASEEM: Well, they can get that, Michelle. Actually, CDC can get that data at the facility level. And my problem is then CDC needs

to report it, right? They are not doing it. They are sitting on the data.

So, just because now you have a performance measure, how is that going to change? Because there's some other issues that we're dealing with over here, just like we don't even know how much vaccine Chip's hospital has of this. You cannot get that data.

MEMBER GIFFORD: Amir, CDC can't get the data at the facility level. They're having to estimate it in a number of ways. We've been working with them on the nursing home side. The IIS system does not link data back to facilities. And so you have it coming in -- well, I see Dan there.

DR. SCHREIBER: Yes, Dan's on the line.

MEMBER GIFFORD: Sorry, Dan. I didn't realize CDC was on the call. Sorry, Dan.

DR. BUDNITZ: Sure. Good afternoon. This is Dan Budnitz. I'm at CDC. I'm working with the NHSN system to collect this data precisely because we have to, as David said,

estimate particularly the denominator, the number of healthcare workers or residents or dialysis patients, as the case may be. We do have information on the number of vaccines delivered, the number of vaccinations administered, but not this critical denominator that's being estimated right now. So that is the niche that these measures could fulfill.

I do want to mention one other thing. And that is the first two points brought up by Chip Kahn about refusal and declinations and availability are actually intertwined. Because of low availability, we didn't feel it was appropriate or really feasible to collect information about refusals or declinations because it was only being offered to certain folks. So, that could be changed over time with increased supply. So, I just wanted to make those two comments.

MEMBER GIFFORD: Dan, at NHSN how often is COVID vaccine among staff mandated for the different settings that are listed here? Because

I know for nursing homes it's not mandated. It's optional.

DR. BUDNITZ: I don't know if I'm the expert on that. I don't believe it's mandated.

DR. SCHREIBER: It's not mandated anywhere.

MEMBER GIFFORD: Right. So you would need it -- it goes back to Amir. Michelle needs it in rulemaking to make something mandated. Whether it's NHSN or wherever, they would need it mandated in rulemaking for submitting the data.

DR. SCHREIBER: Correct. Correct. Unless the law changes through whatever vehicle it changes. It's not mandated anywhere right now.

MEMBER GIFFORD: As my son said, if you're waiting for Congress to solve your problems, that's probably not a good strategy these days.

DR. SCHREIBER: Yeah. We're trying to be proactive.

CO-CHAIR ROBERTS: Okay. Oh, go ahead.

MEMBER BINDER: I appreciate that very much, again. And I think we should be helpful. As NQF and as MAP, we should be as helpful as possible in moving this very quickly. The public does want to know this.

Nursing homes are a great example of every -- I don't know of anybody who cares about nursing homes that doesn't absolutely want to know the rate of vaccination of the workforce. That is going to be a huge issue going forward. And I think it's just great that CMS is taking this kind of leadership and this bold approach. And I hope that we can be as supportive of that as possible.

MEMBER GIFFORD: Along those lines, Leah, to the whole group, Michelle, would it be helpful if part of our conditions was that we did support some sort of mandated data submission or collection, not saying NHSN or anything, so that gave you a broader support to move forward with rulemaking on that venue? Because the first step is you have to collect the numerator and the

denominator.

DR. SCHREIBER: I don't know how to answer you, David, because I don't know that this group has the authority even to say to CMS, go back and make something done legislatively. You know, you can all say it, and frankly all of you have your political venues of, you know, talking to Congress.

MEMBER GIFFORD: I think the question is whether we would support a rulemaking to make it mandatory. Whether you have the authority or not, you have to decide whether you have that authority. But you've asked us for what cover, how can we help you, and I'm trying to figure out does that help you in that venue for that?

We're not telling you to go get legislative authority. That would be --

DR. SCHREIBER: Okay.

MEMBER GIFFORD: That's outside of our authority. But our authority is to give you guidance on what's appropriate for rulemaking.

DR. SCHREIBER: Correct.

MEMBER GIFFORD: You know, the measures require you to have underlying data.

DR. SCHREIBER: Correct.

MEMBER GIFFORD: So you can start with, you know, we support the condition. Come back to us with the specifications. But we conditioned putting something in rules to make the data available so you can start creating a measure. You can't even create a measure until you have the data.

DR. SCHREIBER: That is correct.

MEMBER GIFFORD: Now, I don't know if the rest of my colleagues on the group here would support that. I might get fired.

CO-CHAIR KAHN: I don't think we should get into mandatory or whatever.

(Simultaneous speaking.)

MEMBER GIFFORD: I'll step aside on that one.

CO-CHAIR KAHN: I think we should remain something like you just described but be relatively vague, because what's important here

is that we're for it. And the next piece is that hopefully we can encourage Michelle to come back to us and give us a chance to get our two cents in in a timely fashion. And I think that's really as far as we can go. I don't think we can go any further.

MEMBER QASEEM: I agree, Chip. I think that's probably as far as we should go at this point. And can we add a condition that CMS will send us dinner and drinks if the meetings run really late, past dinnertime?

(Laughter.)

DR. SCHREIBER: They're not sending it to me, Amir.

MEMBER BINDER: They can send us DoorDash.

We could also propose -- can we also, as a group, formally encourage NQF to provide stakeholder feedback for CMS in a timely way for any part of this that they need?

DR. SCHREIBER: Oh, thank you.

(Pause.)

CO-CHAIR KAHN: I think it's up to you, Misty.

CO-CHAIR ROBERTS: Yes. So, let me first open it up to public comment, and then I have a recommendation on voting.

Remember, for public comment, to please limit to two minutes, and also make sure to comment only on the COVID vaccinations.

(Pause.)

CO-CHAIR ROBERTS: Okay. I'm not seeing any public comments, unless NQF staff tell me differently.

DR. STOLPE: I'm not seeing anything either.

CO-CHAIR ROBERTS: Okay. So, it seems from, what I heard, there seems to be a consensus that instead of voting on the workgroup recommendations, which we really haven't even got to -- I think we were all a little premature, excited about this measure. So I don't know if there's any further discussion that we need in terms of the workgroup recommendations or if we

just want to move forward with a vote for the three measures.

I think one is for ESRD, one for clinicians, and then one other. And this is actually for several, to be implemented in several programs, but the consensus seems to be conditional support. And that conditional support is to bring back to the Committee with the additional information and specifications. And then there was a second conditional support that NQF provides timely feedback. I don't know if that would be considered a conditional support or a suggestion or how that works.

So, Sam, NQF, Chip, you all tell me how to proceed from here, if we need to go to the workgroup recommendations or if we can vote.

CO-CHAIR KAHN: I mean, I think it's an exceptional situation. So, Sam, I mean, my recommendation would be to follow where we were and come up with a resolution that's a recommendation that is both supportive and directly asks that CMS consider bringing back to

us these metrics when they're ready for primetime. At any point. I mean, that we would be ready to meet at any point.

DR. STOLPE: Yeah, Chip, Misty, this is where NQF/MAP rules differ quite substantially from CDP rules. So in previous -- at the Co-Chairs' discretion, we can create essentially what's called a consent calendar where we take like measures and group them and lump them under one vote where any one of those measures may be pulled for discussion by any of the Committee members.

So if, for example, we'd like to discuss the MIPS measure further, we could pull that from the consent calendar. Or we could say the same for any one program. For the healthcare personnel program, say you wanted to discuss IPFQR specifically for 0044.

So we have a lot of flexibility in how we can approach this. Or we can just do individual votes straight down the line. But if there's a strong consensus that we don't want to

follow the workgroup recommendation, then we could just do a single vote under a consent calendar, if it looks like the vote is going to pull the whole thing down or if the group is looking like we're not inclined to go with the workgroup's recommendation.

CO-CHAIR KAHN: Well, isn't it true that, for all these measures, we're at the same point? So we can package them together, then, right, if I understand what you said.

MS. WINSPER: Yes. But --

CO-CHAIR KAHN: And then have this overarching resolution.

MS. WINSPER: This is Sherri from NQF. Sam, wouldn't we want to at least separate the patient measure, which is a very different measure than the health care worker measure, and the health care personnel measure has multiple programs?

I could support us, you know, doing one vote for those. But since each of these three measures are separate measures with very

different specifications and for different people, it seems like we should have a vote for each of the three, since the workgroups provided a recommendation on each of the three.

So we could vote, you know, one vote for the one that just applies to multiple payment programs. Would that work, Sam?

DR. STOLPE: That's another approach that works. But at least the way that we've specified rules for MAP, it's at the discretion of the co-chairs to group clinically similar measures, of which these are three clinically similar measures, if you think it's going to be the same recommendation across the board with the same series of advice to CMS (telephonic interference)

If not, then absolutely Sherri's recommendation makes sense for us to split up the votes.

CO-CHAIR ROBERTS: I do feel like it's probably going to be the same recommendation. I could be wrong. Can you all hear me? I'm having

--

DR. STOLPE: We can hear you. You sound great.

MEMBER PINCUS: I think you're right. It's going to be the same recommendation. We should move ahead.

CO-CHAIR ROBERTS: And maybe if we just ask if there are any objections to that. Is that the right way to go?

CO-CHAIR KAHN: Yes.

MS. WINSPER: That's a nice idea, Misty, just to be sure.

CO-CHAIR ROBERTS: Let's do that. Let's ask if there are any objections to lumping the three measures together and voting on the same recommendation.

MEMBER BAKER: Voting on conditional support.

CO-CHAIR ROBERTS: Yes, we will -- yes. But right now, the question is does anybody want to, yes, separate, but voting on conditional support for CMS to bring back with those

additional specifications.

CO-CHAIR KAHN: And then I think we need to be specific that we want, and use the words expedited process, and then consideration of the measures with an expedited process. And if we say that, then we leave it to CMS to figure out what the definition of an expedited process is, which hopefully would be them, you know, paying for us to have another meeting when they're ready.

MEMBER BINDER: And an advisory to NQF to move, you know, quickly as well.

CO-CHAIR KAHN: Right.

MEMBER GIFFORD: These Zoom calls are really expensive.

(Laughter.)

CO-CHAIR ROBERTS: Okay. So hearing --

MEMBER BINDER: Can I just add one thing, though? I don't lose my little recommendation about pediatric hospitals. Just throwing that out there.

CO-CHAIR KAHN: Well, we could throw in another line that says, and ask CMS to explore --

MEMBER BINDER: Yes.

CO-CHAIR KAHN: -- whether they have authority to also cover pediatric hospitals.

MEMBER BINDER: That would be great.

MEMBER TUFTE: They're just starting inoculating or vaccinating children, right? I mean, I think it's already older children, isn't it?

MEMBER BINDER: Well, actually (simultaneous speaking). It's really the personnel. That's where they're vulnerable.

MEMBER TUFTE: Okay. I got it.

CO-CHAIR ROBERTS: Okay. So I think what I'm hearing, I'm hear no objections to lumping the three measures together. So the vote would be on conditional support. We would not be voting on the workgroup recommendations. We would actually vote on conditional support.

And the three conditions that I've

noted, and NQF please tell me if you have others, bring back to the committee with additional information, including technical specifications, consider an expedited process for both NQF and CMS, and explore if CMS has the authority to cover pediatric hospitals. Does that wording resonate?

MEMBER BINDER: Can I just ask one more question? Some of these program exclude U.S. territories. Is that the case for this? Just does not exclude U.S. territories.

DR. SCHREIBER: I don't believe it excludes it, but I would have to verify that for you.

DR. STOLPE: So one of the things we traditionally include in a set of conditions is receipt of NQF endorsement. Is that something that the committee does not want to keep in with the conditions?

MEMBER PINCUS: I don't think we need to now.

CO-CHAIR KAHN: Yeah. Because that

would be when they come back.

MEMBER PINCUS: Yes.

CO-CHAIR KAHN: The measures aren't even -- you know, aren't at a point where -- I mean, there are no measures, really, I mean, for them to go and endorse them.

DR. STOLPE: All right. That's a fair point. So what we have documented is bring completed specs back to MAP, that we look at an expedited process for both NQF and MAP and then we explore the possibility of inclusion of pediatric hospitals. Are those the three conditions?

CO-CHAIR ROBERTS: Yes.

DR. STOLPE: Okay. And there were no objections raised so I think we can go ahead and move forward with a vote for conditional support under those three conditions.

Chris, could you please open up the vote?

MR. DAWSON: Yeah. Sam, so let me ask you, so these questions were built into Poll

Everywhere specific to programs. I just pull one of them or do we need to because this is (simultaneous speaking).

DR. STOLPE: That's okay, Chris. It's okay, Chris. You can just go ahead and share the measures.

MR. DAWSON: And you said this is for conditional support?

DR. STOLPE: Correct. Thank you. All right, Leah. So this is going into the breaking your rules thing. You could have a slide that represents that.

So Chris, when you read this off for the record, just list all three measures, please.

MR. DAWSON: Sure. So voting is now open for MUC20-0045: CoV-2 Vaccination by Clinicians for the Merit-Based Incentive Payment System Program, MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities for the End-Stage Renal Disease Quality Incentive Program (ESRD QIP), and MUC20-0044: SARS-CoV-2 Vaccination

Coverage Among Healthcare Personnel.

So do you vote for conditional support for these measures to be the recommendation of the Coordinating Committee, yes or no? Okay. We have 17, 18 votes. Go ahead and close it and share the results. So voting is closed.

The results are 18 yes and zero no. So the Coordinating Committee conditionally supports for rulemaking MUC20-0045: CoV-2 Vaccination by Clinicians for the Merit-Based Incentive Payment System Program, MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities for the End-Stage Renal Disease Quality Incentive Program, and MUC20-0044: SARS-CoV-2 Vaccination Coverage Among Healthcare Personnel.

DR. SCHREIBER: Sam, if I may, I would really like to thank the committee for their guidance and their support. So thank you.

MEMBER BINDER: Thank you.

CO-CHAIR KAHN: Okay. I think I take it back.

CO-CHAIR ROBERTS: Yes.

DR. STOLPE: Thank you, Chip.

CO-CHAIR KAHN: Okay. So we're actually going to finish, I think, fairly close to on time.

CO-CHAIR ROBERTS: Don't jinx us, Chip. We're not quite there yet.

CO-CHAIR KAHN: I was going to compliment you for speeding us through the last discussion. So we basically, I'd like to bifurcate this discussion into two parts. One part is process and improvement.

Is there anything in our discussion today that we should consider for changing our process in the future? Any thoughts about that? So that's one discussion.

And then the other discussion, I'd like to make a proposal to the committee because, as you know, just a few weeks ago, actually, there was a new statute that added the possibility of us looking at removal of -- considering removal recommendations for metrics that are being used.

And I wanted to make a proposal to you to consider to make recommendations to NQF and CMS on that.

But why don't we start and see whether on the committee there are any suggestions, observations to CMS, to NQF or to us as a group in terms of changing, improving our process. And let me say with limited time, there doesn't have to be. I'm not hearing a lot, and I --

CO-CHAIR ROBERTS: It looks like there's a couple hands raised.

CO-CHAIR KAHN: Okay. So --

CO-CHAIR ROBERTS: David Baker, I think, may be first.

CO-CHAIR KAHN: Yeah, David.

MEMBER BAKER: Hey, Chip, I think you're the official recordkeeper for this. But I think for this meeting there was the least discussion of process that I've seen in many years.

I think all the hard work from the last few years for the decision rules and everything worked extremely well. Just kudos to the whole NQF team working on this.

The materials that went out were very clear and easier to use than somewhat in the past years. So I thought it worked really well. I don't have any suggestions for improvement.

CO-CHAIR KAHN: Great, great. So I think, David.

MEMBER GIFFORD: I'm going to echo David's comments. I think having been someone over the years who has been a stickler for process and voting on this, I think we've really come up a long way.

I do think the -- I still would like to see a little bit more from CMS on how the measures were going to be used, not necessarily the rules, because having an NQF-endorsed measure and then how it gets used in rulemaking could be very different and how with the endorsement. That would be the only thing that I think would help in trying to decide about rulemaking.

And I guess the other one, and I may have missed it in some of the earlier material related to COVID, I think someone put it in the

chat, you know, seeing how the measures that we do vote on end up getting used. Because I think that will help us in deciding and voting going forward on where we have that.

Some measures I know we've approved have never made it into rules and others made it into rules in ways that we never foresaw and other issues made into rules were great. So I think where we had concerns, and there were really not being any concerns. So I think that feedback would be very valuable to us over time.

CO-CHAIR KAHN: Good. We could ask the staff at CMS to help us with that. Janice?

MEMBER TUFTE: Yes. I just want to thank you for having me be a part of this. I was on the MAP Medicaid Adult a few years ago, and I kept applying. So I'm very excited to be on it as a public patient involved individual.

And I attended all the workgroup meetings, all three days. So this is my fourth meeting. So I really understood the measures because I'm not as well educated on these issues

as you are.

I just want to add that in the Acumen, you know, the episode cost measures and their other measures that they put forward, they gathered a lot of information from patient and family advisors. And I don't know where that ends up. But it seems like it should be available, at least to CMS if not some of, you know, the Coordinating Committee, because NQF has worked very hard to have patient and family advisors involved.

And I know that, you know, I'm sort of a -- I've been pushing this for years. And I'd love to know some of what they've stated regarding the measures that were put forward. Because what I saw was a synthesized version that was applied to each Acumen measure regarding possible stenting or lack of, you know, perhaps care might be, you know, not provided in the manner it should be.

It was still down to a couple sentences for every single one. So there might be some

interesting information there. I don't know where it goes. Thank you.

DR. SCHREIBER: Janice, I have to say thank you for sitting on so many of these meetings. And your point is well taken to maybe call out the patient and family comments. They are embedded and synthesized in the recommendations that we bring forward. So thanks.

MEMBER TUFTE: Thank you.

CO-CHAIR KAHN: **Thanks. Amir?**

MEMBER QASEEM: Yes. I just wanted to say, Chip, I have to thank you and Misty. You guys did such a beautiful job today. I have to echo what David Baker just said. This meeting went really well, guys. I enjoyed it.

The voting went really well. And I have to thank NQF staff for that. You guys listened, right? So this simply transitioning to Zoom alone made it a much easier process despite -- I mean, I would prefer sitting there in person. Of course, it's not going to happen for a while. But thank you.

And I know most of the time you're

getting no unconditional supports from us. But it's my empirical. So all hats off to Chip, Misty and NQF staff. Thank you.

CO-CHAIR KAHN: Well, thank you. And, yeah, it's a funny thing. I've had a couple of different experiences. And, frankly, I find that sometimes the Zoom it gets you so much more focused, and it actually is efficient although you don't get to do the side talk obviously.

So thank you. And if we could, let's go to the second item if I don't see any other comments.

So in the recent legislation, as I said, the Congress in its wisdom allows us to consider removal of measures. And I think the language -- was the language sent around?

DR. STOLPE: It was, Chip, yes.

CO-CHAIR KAHN: If you read it, it's exactly the way I just described. It's very simple, but there's no process. It's there and explicit. And obviously it's up to CMS and NQF staff and board to decide whether there would be

such a process.

But I would like to get a discussion going to offer a proposal. And the proposal would be that we, as the MAP, recommend to NQF and CMS that NQF sketch out a process for creating a menu and then consideration of measures for removal. And that, included in this recommendation would be to ask CMS to fund the process, which would include at least meetings or a meeting. And finally that they would come back to us with these recommendations and give us an opportunity to move forward.

I think that, at least in my view, this process should be separate from the process we're going through now. The process we go through now is designed for a specific regulatory process. Frankly, we sort of rushed through it.

And I would like to propose that, if they do design some kind of process, whether it's July or June, that it's at a different point of the year when, one, we can affect what CMS is developing, but two we can take a big-picture

look at the total array of measures and not get caught up in our task, which we just went through, which is very intense. And I appreciate all the kind comments for our guiding it through this year.

But I think if we try to put that on top of this process, that it may be too much. But obviously, this will be up to CMS ultimately if they decide to offer the funding to make this all possible.

So I put that out as a proposal. And I'm interested to hear where the committee is on whether or not we would want to offer that up to NQF and CMS. Who wants to comment first? I see David Baker.

MEMBER BAKER: So I support what you said, Chip, in multiple ways. First I think that we do need to have a rigorous process for deciding when to remove measures, and we should probably identify thresholds, for example, when a measure may be getting close to topped out.

When we've looked at that, they are very

different situations just because a measure may have a very high performance overall. There are some of the outliers in that top 10 percent that are really problematic. So I think a rigorous set of rules around that would be important or at least triggers for review.

And then the second thing I completely agree with. You know that any discussion of this, if it's at the end of the long discussion about the new measures, everybody will be tired. So I agree that it would be good to have that as a separate process to really think that through.

And as Harold was saying in the chat, this is the chance, I think, really, reviewing these measures that we can also review the data and the trends on those data. That might be a good time as well to systematically look at what's happened with the measures that we recommend or did the decisions from the previous year.

CO-CHAIR KAHN: Julie?

MEMBER SONIER: Yes. So I agree that

sometime in our process would be helpful and that this could be a useful vehicle for that.

So this is my first year going through this process. And at times I've sort of had this feeling, you know, because we have criteria for looking at the measures one at a time. But I've been a little worried that, you know, I'm just contributing to sort of siloed looks at measures. And the opportunity to step back and think about the context in which the larger picture is, I think, would be helpful.

CO-CHAIR KAHN: Leah?

MEMBER BINDER: Yeah. I agree. I think it was Amir said that this meeting was one where we didn't go on and on about the process for once, which it's true. It was really positive that way. It was really powerful.

So I would hope that this would not take us down the road of yet another development of a whole new process. I think we could take the lessons learned from this process, apply them to, you know, almost like reverse out the MUC removal

process or, you know, something like that where we're seeing measures that are proposed for removal go through the same set of screenings, the same criteria for votes, the same process so that we're not having to reinvent that.

But it does seem to me that it is a good idea to certainly look at removing some of these measures systematically.

CO-CHAIR KAHN: Great. Other comments? No? I don't see any. Anybody else? Well, I would like to -- let me ask Misty, do you have anything to add before I --

CO-CHAIR ROBERTS: No. I agree with all that has been said and your recommendation.

CO-CHAIR KAHN: So I don't know if anybody would second it, but I would like to offer that as a proposal that we make a recommendation to -- I think we make it jointly to NQF and CMS that they consider developing at least the model for such a process.

I think we heard from Leah that it would be good if that process in a sense may be reverse-

engineered from what we already do so that we have consistent rules as much as possible between the two processes and that we have it at a time different from the time we do the examination of the measures in the process that we have now. And that there be proper, you know, funding for this so that we can have a meeting or meetings to make this consideration in a careful way.

Do we want to have -- does somebody want to second it and then we'll --

MEMBER BINDER: I'll second it.

MEMBER QASEEM: I second that, too.

CO-CHAIR KAHN: Can we have a voice vote, Sam, on this or should we have a real vote?

DR. STOLPE: It's difficult to tally ayes in a virtual meeting.

CO-CHAIR KAHN: Yes. Okay. If there's no objection then I think this --

CO-CHAIR ROBERTS: Yes, I was going to say, can we just go to does anybody have any objections?

CO-CHAIR KAHN: Okay. Great. Well,

then, I think -- and there's some comments I see in the box down here in terms of the specifics that we would get into.

But at least at this point, I prefer to leave -- I think if people have ideas about this that they should send them to Sam and let's let the staff think this through. I mean, I think we really need something on paper to sort of start with.

MS. WINSPER: Chip, this is Sherri.

CO-CHAIR KAHN: Yes.

MS. WINSPER: If you don't mind, I'll just provide a brief -- thank you so much for the recommendation. We'll certainly be partnering with CMS on those recommendations. And I think it was nicely laid out. We just kind of have to, you know, we'll have to look at it. So thank you for doing that.

We just have a little bit of precedent for some process, but we'll have to work those details out, of course.

CO-CHAIR KAHN: So I think that -- I'll

close that out. I think we have -- if there's no other discussion from the body, I just want to thank the staff, thank CMS, thank all of you for the time and effort this afternoon.

We're only about six minutes over. I think we were supposed to go to 6:00. But we do need to offer an opportunity for public comment. So I'll ask, is there any public comment, either on the screen or on the phone? Going once, going twice.

I think we then -- any other comment from the Coordinating Committee? I think we can call it a day, Sam, unless anybody objects.

DR. SCHREIBER: And, Chip, this is Michelle, can I just extend my thanks --

CO-CHAIR KAHN: Sure.

DR. SCHREIBER: -- as well to the group and to you and Misty for co-chairing and facilitating. We appreciate the support, and we certainly appreciate the conversation.

We do have fairly strict criteria for measures removal, but we are happy to engage in

this conversation and look forward to it.

CO-CHAIR KAHN: Great, great.

MS. WINSPER: Hey, Chip, I just want to say thank you to all the NQF staff, as you all did, for a well-run meeting and lots of logistics behind the scenes. And also thank you to all of the committee members for your time today for a very long meeting but a very rich, rich discussion on very important topics. So thank you.

CO-CHAIR KAHN: Great.

CO-CHAIR ROBERTS: Yes. I would just close out with echoing everything. There's a lot of work that goes on behind the scenes to really help. I know, Chip and myself prepare for this. So I certainly appreciate all that work and certainly appreciate the robust discussions today too and for keeping me on my toes.

CO-CHAIR KAHN: Well, great. So, so long.

DR. STOLPE: Before we adjourn, Chip, let me just go through a couple of next steps.

CO-CHAIR KAHN: Okay.

DR. STOLPE: And then we'll officially sign off.

CO-CHAIR KAHN: Okay.

DR. STOLPE: So if we can just go to the next slide, please. Or do we have anything on the next slide?

CO-CHAIR KAHN: I don't know. It just says closing remarks and next steps.

DR. STOLPE: I think the next steps are just going to be the staff will capture the concepts of this discussion, provide a final series of recommendations to CMS and then we'll be convening with CMS in a couple of weeks to review the process.

We're going to be writing a final report that will go to CMS as well and that really will close out our cycle. So it just remains for me to say thanks to our co-chairs, to the Coordinating Committee, to our colleagues at CMS and to each of you on the Coordinating Committee, to the public and measure developers, a very big

thank you, and we look forward to reconvening in our future cycle. Thanks.

CO-CHAIR KAHN: Great.

DR. STOLPE: We're adjourned for now.

CO-CHAIR KAHN: Thanks, everybody.

CO-CHAIR ROBERTS: Thanks, everyone.

(Whereupon, the above-entitled matter went off the record at 6:08 p.m.)