

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP (MAP)
COORDINATING COMMITTEE

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MONDAY
MARCH 15, 2021

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The Coordinating Committee met via Video Teleconference, at 1:00 p.m. EDT, Charles Kahn and Misty Roberts, Co-Chairs, presiding.

PRESENT:

CHARLES KAHN, III, MPH, Federation of American Hospitals, Chair

MISTY ROBERTS, Humana, Chair

DAVID BAKER, The Joint Commission

CRYSTAL BARTER, MS, Michigan Center for Rural Health

MARY BARTON, National Committee for Quality Assurance

ALICE BELL, American Physical Therapy Association

LEAH BINDER, The Leapfrog Group

KATIE BOSTON-LEARY, PhD, MBA, MHA, RN, NEA-BC, American Nurses Association

COLLETT COLE, RN, BSN, CPHQ, Minnesota Community Measurement

AKIN DEMEHIN, MPH, American Hospital Association

MIA DeSOTO, Agency for Healthcare Research and Quality

TRICIA ELLIOTT, The Joint Commission

SCOTT FERGUSON, American Medical Association

ROB FIELDS, MD, National Association of ACOs

ANDREA GELZER, MD, AmeriHealth Caritas

FRANK GHINASSI, National Association for

Behavioral Healthcare

DAVID GIFFORD, American Health Care Association
 LAUREL GOLDIN, HCA Healthcare
 ELIZABETH GOODMAN, America's Health Insurance
 Plans
 LISA HINES, Pharmacy Quality Alliance
 EMMA HOO, Purchaser Business Group on Health
 ARIF KAMAL, American Academy of Hospice and
 Palliative Medicine
 REBECCA KIRCH, National Patient Advocate
 Foundation
 ANNA LeGREID DOPP, American Society of Health-
 System Pharmacists
 DHEERAJ MAHAJAN, AMDA, The Society for Post-Acute
 and Long-Term Care Medicine
 WENDY MARINKOVICH, Blue Cross Blue Shield
 Association
 R. SEAN MORRISON, MD, National Coalition for
 Hospice and Palliative Care
 DENISE MORSE, City of Hope
 IRA MOSCOVICE, PhD, University of Minnesota
 School of Public Health
 SANTOSH MUDIRAJ, MBBS, MPH, Henry Ford Health
 System
 HAROLD PINCUS, MD, Individual Subject Matter
 Expert
 AMIR QASEEM, American College of Physicians
 JEFF SCHIFF, MD, MBA, Individual Subject Matter
 Expert
 MICHELLE SCHREIBER, Centers for Medicare &
 Medicaid Services
 JULIE SONIER, Network for Regional Healthcare
 Improvement
 ARJUN SRINIVASAN, Centers for Disease Control and
 Prevention
 AARON TRIPP, LeadingAge
 JANICE TUFTE, Individual Subject Matter Expert
 LINDA VAN ALLEN, American Case Management
 Association
 JANET WAGNER, Rural Wisconsin Health Cooperative
 RONALD WALTERS, MD, MBA, MHA Individual Subject
 Matter Expert

NQF STAFF:

QUERAM, CEO and Interim President Chris

**MICHAEL HAYNIE, Senior Managing Director, Quality
Measurement**

BECKY PAYNE, Senior Analyst

UDARA PERERA, Senior Manager, Quality Measurement

**SAM STOLPE, Senior Project Manager, Quality
Measurement**

**SHERI WINSPER, Senior Vice President, Quality
Measurement**

ALSO PRESENT:

**DAN BUDNITZ, Centers for Disease Control and
Prevention**

MICHELLE DOLL, The Health Collaborative

**ALAN LEVITT Centers for Medicare & Medicaid
Services**

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

1:00 p.m.

MR. STOLPE: Hello and welcome, everyone. This is Sam Stolpe with the National Quality Forum.

I'm delighted to welcome you back to our MAP Coordinating Committee, to our colleagues at CMS and CDC, to the general public, as well as some of our meeting participants from the Work Groups of MAP.

For today's meeting, this is a reconvening for the purposes of discussing the COVID measures. One in particular we're going to be talking about, as well as a couple of strategic items that we were looking to address with the Coordinating Committee.

And normally, we would be doing this a little bit later in the year but we get the chance to get you all back together again and have this discussion. We really appreciate your time and attendance today.

Before we get started, just a couple

1 of housekeeping reminders. We would invite you
2 to please mute your computer or phone line when
3 you are not speaking.

4 And this is also your opportunity, as
5 we get going to please make sure your name is
6 displayed correctly inside of the Zoom platform.
7 You can do so by right-clicking your picture and
8 changing your name to whatever you think would be
9 most appropriate.

10 For those of you who will be
11 participating in our meeting, we would just
12 invite you to please turn on your video during
13 the measure discussions just to keep the
14 engagement up.

15 If you would like to change the
16 display on your computer, you can do so by right-
17 clicking view in the upper right corner and
18 select speaker or gallery, depending on what your
19 preference is.

20 We are going to be having a structured
21 discussion, which will be facilitated by our Co-
22 Chairs, Chip Kahn and Misty Roberts. And if

1 you'd please use the raise-hand feature at that
2 point to provide a point or raise questions for
3 the group.

4 I also wanted to point out that we
5 have a chat function so if you want to use the
6 chat to message either the NQF Staff or send a
7 group chat to everyone to share your thoughts, we
8 welcome you to use the chat function as well.

9 Let's go ahead and move forward with
10 the slides, please. At this point, I would like
11 to just review the agenda briefly.

12 We're going to be reviewing attendance
13 in our meeting objectives shortly and then we'll
14 do a quick walk through of the discussion we had
15 related to the COVID measures in January with the
16 Coordinating Committee, at which point we'll have
17 a presentation from CMS and CDC on the COVID-19
18 measures.

19 We'll have an opportunity for public
20 comment, we'll have a discussion around the
21 COVID-19 measures, and then we'll pivot to our
22 strategic discussions for MAP before offering a

1 few closing remarks and adjourning.

2 At this point, I want to recognize NQF
3 leadership. We have both Chris Queram, our
4 interim CEO and President, as well as Sheri
5 Winsper, Senior Vice President for Quality
6 Measurement joining us today.

7 I'd like to hand it over to the two of
8 them for some opening remarks. Chris?

9 MR. QUERAM: Thank you, Sam. Good
10 afternoon or good morning, depending on where
11 you're dialing in or participating from today.

12 Let me begin with a heartfelt thanks
13 for taking the time from your schedule to
14 participate in this meeting and for your
15 continued commitment to the Measure Application
16 Partnership.

17 Sam has done a very nice job of
18 previewing the agenda so I won't repeat his
19 comments other than to just underscore the
20 importance of the COVID-19 measures and the
21 opportunity for focused discussion on those as a
22 follow-up to the January meetings.

1 Also, I'd like to just acknowledge
2 that we have been spending quite a bit of time in
3 what is labeled as the strategic discussion as it
4 pertains to how best to leverage the Measure
5 Application Partnership and its related Work
6 Groups in fulfilment of a statutory opportunity
7 that has been presented to CMS, NQF, and the MAP
8 to consider a process for removing measures.

9 Or as we are often referring to it,
10 stewarding the evolution of measures that are
11 used by CMS and their various regulatory and
12 payment programs.

13 So, I very much look forward to all of
14 your comments and your advice as we continue to
15 hone our thinking around fulfilling that
16 statutory promise.

17 So, with that, let me conclude and ask
18 my colleague, Sheri, to add her remarks and I
19 look forward to the discussion today.

20 MS. WINSPER: Thank you, Chris. I'm
21 so excited to be here with you all today and he
22 did such a wonderful job as well of overseeing

1 our time together.

2 I just wanted to offer and additional
3 thanks because I know this is voluntary and extra
4 time out of your day and a busy schedule. Those
5 of you that have been working the front lines or
6 playing leadership roles in COVID this year.

7 I completely agree, this is an
8 important opportunity for you all to provide your
9 input and expertise into the consideration of the
10 COVID-19 vaccine measures in addition to the
11 strategic discussions that Chris just mentioned.

12 So, I appreciate your time and know
13 that we are committed to ensuring this is a
14 really productive afternoon. So, thank you and
15 I'll turn it back to you, Sam.

16 MR. STOLPE: Thanks so much. At this
17 point, I'd also like to recognize our two Co-
18 Chairs who will be facilitating our discussions
19 today, Misty Roberts and Chip Kahn.

20 I did want to afford them an
21 opportunity to provide a welcome to our Committee
22 as well. Misty and Chip, I'll hand it over to

1 you to say hello.

2 CHAIR KAHN: Okay, Misty, why don't
3 you go first?

4 CHAIR ROBERTS: Sure, thanks, Sam. I
5 don't have much additional to add, I think Sheri
6 and Chris really covered it and Sam gave a good
7 overview.

8 But again, I would just echo that we
9 thank you for your time today.

10 I'm actually calling this myself a
11 special session, I don't know if that's the right
12 terminology. But I'm still hopeful that one of
13 these days we will get to do this in person
14 again.

15 So, hopefully it's not too far away
16 but certainly, thank you for your time today and
17 your continued commitment. I think this is going
18 to be a great opportunity for us to provide input
19 into something and I don't think we knew we would
20 have this opportunity.

21 So, I'm excited for this discussion
22 and I'm hopeful that it can be a productive

1 discussion and we can end on time as we did with
2 our last meeting in January. So, thanks,
3 everyone.

4 CHAIR KAHN: Thanks, Misty, I'd like
5 to welcome everyone and just say two things.

6 One that I appreciate this meeting
7 being so close to our last and I think the
8 opportunity, which will be my second point, that
9 we are offered and we'll discuss at this meeting
10 taking on additional tasks.

11 We'll have two real opportunities,
12 one, we'll have a real opportunity to affect the
13 measure process over at CMS in even a more
14 effective way.

15 And two, I just think it will make us
16 as a group more effective through the continuity
17 of being together, working through process
18 together as well as hopefully coming to important
19 conclusions on policy.

20 Second, as I mentioned at the last
21 meeting, the legislation does offer us an
22 opportunity to actually, on the one hand we can

1 talk about measure removal.

2 But really, I think develop a real
3 feedback loop where we are not only looking at
4 the measures upfront in the CMS process, we're
5 looking at the measures over time and coming back
6 to CMS with recommendations about the evolving
7 measure process.

8 So, I think it offers us a great
9 opportunity and I hope that when we get beyond
10 today, not only will we be looking at measures
11 from CMS but also looking at suggestions and
12 recommendations from the outside world as well as
13 CMS itself to affect the CMS process.

14 So, with that, I hand the baton back.

15 MR. STOLPE: Thanks very much, Chip
16 and Misty. I do want to acknowledge our CMS
17 colleagues and our colleagues for the CDC who are
18 on the call.

19 I'll afford them an opportunity to say
20 hello just as they tee up their presentation.

21 But I did want to say thank you very
22 much to Dr. Shreiber, to Dr. Levitt, and Dr.

1 Budnitz today. I'm very much looking forward to
2 your presentations.

3 Why don't we moving forward move
4 forward with our attendance? Can we go to the
5 next slide, please?

6 I'm going to hand it over to my
7 colleague, Michael Haynie, our Senior Managing
8 Director of Quality Measurement at NQF for the
9 attendance. Michael?

10 MS. HAYNIE: Thank you. So, just a
11 clarification, we're not doing disclosures of
12 interest today, we're just trying to keep track
13 of who we have.

14 So, as I call your organization name
15 if you could tell us who's here representing
16 that? As we go through these, always, always
17 someone cannot get off of mute.

18 Don't worry, it's just so you can use
19 the hand-raise function or tell us in the chat
20 and I promise we'll loop back. So, without
21 further ado, we have seen Chip and Misty already
22 so I will not call you separately.

1 American Academy of Hospice and
2 Palliative Medicine?

3 MEMBER KAMAL: Hi, good afternoon,
4 this is Arif Kamal, Member of the Board of
5 Directors for them. I'm happy to be here.

6 MS. HAYNIE: Thank you, AmeriHealth
7 Caritas?

8 MEMBER GELZER: Good afternoon, this
9 is Andrea Gelzer.

10 MS. HAYNIE: Great, American College
11 of Physicians?

12 MEMBER QASEEM: Good afternoon,
13 everyone, I'm Amir Qaseem with American College
14 of Physicians. Sorry, I have to remember who I
15 am and who am I representing.

16 MS. HAYNIE: Happy Monday, Amir.
17 American Healthcare Association?

18 MEMBER GIFFORD: David Gifford from
19 AHCA.

20 MS. HAYNIE: American Medical
21 Association?

22 MEMBER FERGUSON: Scott Ferguson, AMA.

1 MS. HAYNIE: Thank you. American
2 Nurses Association?

3 MEMBER BOSTON LEARY: Katie Boston
4 Leary from the ANA.

5 MS. HAYNIE: Thank you. America's
6 Health Insurance Plans?

7 MEMBER GOODMAN: Liz Goodman from
8 AHIP.

9 MS. HAYNIE: Blue Cross Blue Shield
10 Association?

11 MEMBER MARINKOVICH: Hi, Wendy
12 Marinkovich for BCBSA.

13 MS. HAYNIE: Thank you. HCA
14 Healthcare?

15 MEMBER GOLDIN: Hi, this is Laura
16 Goldin from HCA.

17 MS. HAYNIE: Great, the Joint
18 Commission?

19 MEMBER BAKER: David Baker and Tricia
20 Elliott from the Joint Commission.

21 MS. HAYNIE: Welcome. The Leapfrog
22 Group?

1 MS. BINDER: Leah Binder from The
2 Leapfrog Group?

3 MS. HAYNIE: Morning. National
4 Business Group on Health? National Committee for
5 Quality Assurance?

6 MEMBER BARTON: This is Mary Barton
7 from the National Committee for Quality
8 Assurance.

9 MS. HAYNIE: National Patients
10 Advocate Foundation?

11 MEMBER KIRCH: Hi, a happy spring
12 ahead Monday. It's Rebecca Kirch.

13 MS. HAYNIE: Yes, it's afternoon where
14 I am and I said good morning to someone earlier
15 so sorry about that.

16 MEMBER KIRCH: It's even afternoon
17 where I -- I'm in Washington D.C. What am I
18 thinking? Today's been a long week.

19 MS. HAYNIE: I agree. Network for
20 Regional Healthcare Improvement?

21 MEMBER SONIER: Hi, this is Julie
22 Sonier representing NRHI.

1 MS. HAYNIE: Pacific Business Group on
2 Health?

3 MEMBER HOO: Emma Hoo representing
4 PBGH.

5 MS. HAYNIE: Patient and Family-
6 centered Care Partners? All right, anyone we
7 didn't get to?

8 MEMBER SONIER: Rob Fields, National
9 Association of ACOs.

10 MS. HAYNIE: Thank you. Great,
11 Individual Subject-Matter Experts, Harold Pincus?

12 MEMBER HOO: Hi, I'm here over the on
13 the line.

14 MS. HAYNIE: Jeff Schiff?

15 MR. STOLPE: Jeff mentioned he would
16 be joining a little late, Michael.

17 MS. HAYNIE: Great, Janice Tufte?
18 Ronald Walters?

19 MEMBER WALTERS: I'm here.

20 MS. HAYNIE: Thanks. All right, for
21 our MAP Work Group Co-Chairs, Rob Fields?

22 MEMBER FIELDS: Yes, sorry, I forgot

1 since I'm now Co-Chair of the MAP that I'm
2 actually representing myself as the Co-Chair of
3 the Commission Work Group, not NACO.

4 So, I am still here.

5 MS. HAYNIE: No worries, you're right
6 with us. Diane Patton? Akin Demehin?

7 MEMBER DEMEHIN: Good afternoon, it's
8 Akin Demehin and I'm a Director of Quality Policy
9 with the American Hospital Association. Glad to
10 be back with you.

11 MS. HAYNIE: Thank you. Sean
12 Morrison?

13 MEMBER MORRISON: Sean Morrison, in my
14 day job I'm Chair of Geriatrics and Palliative
15 Medicine at Mount Sinai. I'm glad to be here.

16 MS. HAYNIE: Thank you. Gerri Lamb?
17 Kurt Merkelz? Ira Moscovice?

18 MEMBER MOSCOVICE: I'm here, I'm from
19 the University of Minnesota, School of Public
20 Health, and Co-Chair of the Rural Health Work
21 Group.

22 MS. HAYNIE: Aaron Garman? All right,

1 team, I think there's another slide of checking
2 in here. Oh, yes, there is.

3 These are our COVID-19 measure lead
4 discussants from across the different Work
5 Groups.

6 Could I have the rep from AAPM&R?
7 AMDA?

8 MEMBER MAHAJAN: It's Dheeraj Mahajan.
9 I'm participating from AMDA.

10 MS. HAYNIE: Thank you. American Case
11 Management Association?

12 MEMBER VAN ELLEN: Hello, it's Linda Van
13 Ellen, I'm the Vice President for Care Management
14 at Tenet Health.

MS. HAYNIE: Thank you.
15 American Geriatrics Society? American
16 Occupational Therapy Association? American
17 Physical Therapy Association? MEMBER BELL:

18 Hi, this is Alice Bell, representing American
19 Physical Therapy Association.

20 MS. HAYNIE: Thank you. American Society
21 of Anesthesiologists?

22 MS. JOSEPH: Hello this is (Audio

1 interference.)

2 MS. HAYNIE: Okay, you were a
3 little garbled there but thank you for checking
4 in. American Society of Health-System
5 Pharmacists?

6 MEMBER LEGREID DOPP: Hi, good
7 afternoon, this is Anna Legreid Dopp with ASHP.

8 MS. HAYNIE: Association of American
9 Medical Colleges? City of Hope?

10 MEMBER MORSE: Good morning, Denise
11 Morse, City of Hope.

12 MS. HAYNIE: Thank you, Denise.
13 Dialysis Patient Citizens? Eugene Nuccio? Henry
14 Ford Health System?

15 MEMBER MUDIRAJ: Good afternoon, it's
16 Santosh Mudiraj from the Henry Ford Health
17 System.

18 MS. HAYNIE: Kindred Healthcare?
19 Leading Age?

20 MEMBER TRIPP: Hi, this is Aaron Tripp
21 with Leading Age.

22 MS. HAYNIE: Thank you. Memphis Business

1 Group on Health? Michigan Center for Rural
2 Health?

3 MEMBER BARTER: Good afternoon, this is
4 Crystal Barter with Michigan Center for Rural
5 Health.

6 MS. HAYNIE: Thank you. Minnesota
7 Community Measurement?

8 MEMBER COLE: Hi, this is Collette Cole
9 from Minnesota Community Measurement.

10 MS. HAYNIE: National Association for
11 Behavioral Healthcare?

12 MEMBER GHINASSI: Hi, this is Frank
13 Ghinassi representing NABH. Thank you.

14 MS. HAYNIE: National Association of
15 Rural Health Clinics? National Rural Health
16 Association? Paul Mulhausen? Pharmacy Quality
17 Alliance?

18 MEMBER HINES: Hi, this is Lisa Hines
19 from PQA.

20 MS. HAYNIE: Thank you. Rural Wisconsin
21 Health Cooperative?

22 MEMBER WAGNER: Hi, this is Janet Wagner

1 from RWHC.

2 MS. HAYNIE: Service Employees
3 International Union? Terrie Black? All right,
4 did I miss any lead discussants or you couldn't
5 get off of mute when I called you?

6 All right, team, I think we have one
7 more slide. There we go. Our Federal Government
8 liaisons who is here representing the Agency for
9 Healthcare Research and Quality?

10 MS. DeSOTO: Good morning, this is Mia
11 DeSoto from AHRQ.

12 MS. HAYNIE: The Centers for Disease
13 Control and Prevention?

14 MR. SRINIVASAN: Hi, Arjun Srinivasan,
15 CDC.

16 MS. HAYNIE: Centers for Medicare and
17 Medicaid Services?

18 DR. SCHREIBER: Michelle Schreiber from
19 CMS and I am joined by a number of others from
20 CMS.

21 MS. HAYNIE: Thank you, Dr. Schreiber.
22 Office of the National Coordinator for Health

1 Information and Technology?

2 All right, stop, no one needs to -- Sam,
3 I will turn this back over to you for the Staff
4 instructions?

5 MR. STOLPE: Thanks very much. No roll
6 call needed but I just did want to recognize our
7 Staff and thank them for their support.

8 So, of course, Michael oversees this
9 project as the Senior Managing Director.

10 I'm the senior Director but we also have
11 Katie Berryman as our Senior Project Manager and
12 Udara Perera as our Senior Manager, Chris Dodson
13 as our Manager, and Becky Payne as our Senior
14 Analyst.

15 So, a very big thanks to the team for
16 all the support. Let's go to our next slide,
17 please. I'm just going to provide a brief recap
18 before we hand it over to our CMS colleagues.

19 So, as you know, when we convened this
20 last cycle, we reviewed 20 measures in total
21 across our three Work Groups and, of course, by
22 the Coordinating Committee itself.

1 So, in this, we had those 20 measures
2 but 1 measure was considered for 2 programs and 1
3 measure was considered for 8, and that was one of
4 the COVID measures.

5 Just as a breakdown of the total
6 measures by Work Group, you'll likely notice that
7 these don't add up to 20 because 1 measure was
8 considered across Work Groups.

9 So, 11 measures were considered inside
10 the clinician, 7 for hospital, and 3 for PAC/LTC.
11 Among the three COVID measures, we have one that
12 we're going to spend our time focused on today
13 and that's 44, SARS-CoV-2 covering among
14 healthcare personnel.

15 We did have two other measures, one that
16 was considered for MIPS, one for ESRD QIP,
17 vaccination by clinicians and then vaccination
18 covers for patients in ESRD facilities.

19 Now, all of these measures were given
20 conditional recommendation by the MAP
21 Coordinating Committee, with the conditions being
22 that CMS accelerates the development of the

1 specifications and brings those measures back for
2 consideration and discussion with the MAP
3 Coordinating Committee.

4 And that's specifically why we had this
5 group together today is to follow up on that
6 item. So, with that being said and without
7 further ado, I'd like to hand it over to -- let's
8 go to the next slide, please -- our colleagues at
9 CMC and CDC for their presentation.

10 So, we have Doctors Michelle Schreiber,
11 who's a Deputy Director for Quality and Value and
12 CMS, Alan Levitt, the Medical Officer at CMS, and
13 Dr. Dan Budnitz, who's the Director of the
14 Medication Safety Program.

15 So, I'll hand it over to our federal
16 colleagues to take it from here.

17 DR. SCHREIBER: Well, thanks Sam and
18 thank you to the Committee, this is Michelle
19 Schreiber and on behalf of CMS also, thank you
20 for participating again today with an extra
21 session for the MAP meetings.

22 Just a little bit of follow-up, we are

1 going to be discussing the COVID vacation for
2 Staff measures. As you've seen, that crosses
3 many different programs.

4 The COVID vaccination for patients, the
5 one for MIPS, will not be brought forth yet this
6 year.

7 We're still evaluating it and still
8 there are too many unknowns in terms of
9 vaccination for patients, when it will be
10 available and so forth and so on. In end-stage
11 renal disease it will not be brought forward in a
12 payment program at this time.

13 And so today, we really want to focus on
14 the COVID vaccination for healthcare personnel
15 and we have representatives from both CMS, Alan
16 Levitt and from the CDC, Dan Budnitz, and I will
17 turn this over to them. Thanks guys.

18 DR. LEVITT: Yes, Hi, this is Alan
19 Levitt, I'm the medical officer in the Division
20 of chronic and post-acute care.

21 I wanted to thank again the NQF Staff
22 and the entire Committee and the Co-Chairs for

1 meeting today and for the continued flexibility
2 in terms of working on this measure with us
3 during this time of public health emergency.

4 I also in particular want to thank my
5 colleagues in the CDC who have been an amazing
6 team to work with throughout this pandemic and
7 who have brought all this additional material
8 today to really try to help in terms of providing
9 some clarification and understanding as to the
10 measure that we are moving forward with.

11 And also, to bring as best as possible
12 up to date information to help you best in terms
13 of your deliberation and understanding of these
14 measures. And Matt, I'll turn it over to you,
15 Dan.

16 Thank you once again.

17 DR. BUDNITZ: So, great, thank you very
18 much and good afternoon.

19 As Sam, Michelle, and Alan introduced,
20 my name is Dan Budnitz, I'm with the CDC's
21 Division of healthcare quality promotion, the
22 Union of CDC that operates the national

1 healthcare safety network.

2 And for the last several months, I've
3 been focusing on developing and deploying the
4 NHSN COVID-19 vaccination modules for conducting
5 surveillance for healthcare worker vaccinations
6 and also for long-term care facility residents
7 and dialysis facility patients.

8 We in the NHSN work closely with our
9 colleagues in the Immunization Services Division,
10 thanking them for some content, support, and
11 expertise in those COVID and influenza
12 vaccination, surveillance, and quality
13 measurement.

14 Next slide. So, I'll start with some
15 brief background that's probably most familiar to
16 everyone on this call but the MUC updated
17 information since the last time the Coordinating
18 Committee met.

19 And I'll actually even verbally add
20 some even more updated information since these
21 slides were submitted for this presentation.
22 Because, as you know, things are changing on a

1 daily basis.

2 So, as of Friday, there were over 29
3 million cases of confirmed COVID-19 reported in
4 the U.S. and approximately 528,000 deaths.

5 The deaths remain concentrated in older
6 adults with 81 percent occurring among people 65
7 years of age or older.

8 But the good news is the number of cases
9 is declining, a 78 percent decrease in the 7-day
10 average case rate since its peak January 11th.
11 And the number of Americans getting vaccinated is
12 rising, now with over 98 million vaccine doses
13 administered as of Friday.

14 Next slide. Folks also are aware that
15 there are now three vaccines which all have
16 received authorization for prevention of
17 COVID-19.

18 The Pfizer/Moderna mRNA two-dose
19 vaccines approved for individuals 16 to 18 years
20 old respectively in the Janssen, an activated
21 adenovirus, a single dose of vaccine approved for
22 individuals 18 years of age and older as well.

1 Next slide. Folks are familiar that in
2 December of last year the Advisory Committee on
3 Immunization Practices identified healthcare
4 personnel as a priority group to be recommended
5 to receive COVID-19 vaccines at the earlier
6 phases, Phase 1A.

7 And as of March 12th, there were more
8 than 131 million vaccine doses delivered to
9 jurisdictional partners.

10 As I mentioned, 98 million have been
11 administered to patients and now approximately
12 not 19.9 but 25 percent of individuals 18 and
13 older have been vaccinated in the U.S. with at
14 least one dose of COVID-19 vaccine, and not 10
15 but 13 percent now have been fully vaccinated.

16 Next slide.

17 And since the last presentation to the
18 MAP, there have been a few updates to vaccine
19 safety, including this report on the left that
20 based on nearly 7000 adverse event reports to the
21 vaccine adverse event reporting system and Be
22 Safe, a safety monitoring system specifically

1 developed for COVID-19.

2 We found low adverse event rates in the
3 first month of vaccination. And from these data,
4 we were able to just add some clarifications on
5 contra-indications as well.

6 Really, there are very few and in fact,
7 an issue of concern is specifically delayed local
8 injection site reactions should not be considered
9 a contra-indication to vaccination.

10 Next slide. Nonetheless, although
11 there's been recent progress in vaccinations, as
12 of at the end of last week, there has been over
13 422,000 healthcare personnel that have been
14 diagnosed with COVID-19 and nearly 1400 of those
15 healthcare professionals have died.

16 Next slide. Vaccinations protect
17 healthcare personnel from acquiring COVID but can
18 improve care delivered by reducing worker
19 absences and disruptions of care to those who
20 they care for.

21 Vaccination and proven outbreaks of
22 disease in healthcare settings, including

1 reducing mortality among their patients.

2 And vaccination has been shown to reduce
3 overall nosocomial transmission of measles,
4 mumps, influenza, and pertussis.

5 Finally, another reason to increase
6 vaccination covering from providers is that it's
7 a powerful predictor and vaccine update of
8 patients of all ages, particularly shown for
9 influenza.

10 We have received an influenza vaccine by
11 healthcare providers is associated with the
12 influenza vaccination in patients.

13 Next slide. And as we introduced
14 earlier this year, NHSN is a web-based system for
15 monitoring healthcare adverse events, healthcare
16 worker vaccinations, and other prevention
17 practices.

18 It's been operational since 2005 when it
19 replaced some predecessor CDC systems that have
20 been in use since the 1970s. There are 37,000
21 participating facilities in all 50 states and
22 once the data is entered, they are available in

1 real time.

2 There are facility level clinical
3 performance measures for hospitals, nursing homes
4 and other healthcare facilities, and it's also
5 used for state and national health surveillance
6 and prevention. That's been its primary purpose
7 related to COVID-19 thus far.

8 But it also has been used for public
9 reporting of facility-specific data to CMS for
10 Medicare reimbursement purposes and we'll talk
11 more about that today.

12 Next slide. Now, one of these measures
13 that has been used by CMS and is an NQF
14 endorsement measure is the healthcare personnel
15 influenza vaccination quality measure, or NQF-
16 0431.

17 This was first endorsed in 2012 and it
18 the denominator for this measure is healthcare
19 personnel that physically work in the facility
20 during influenza season.

21 And the numerator is the number of
22 healthcare personnel vaccinated, either at the

1 facility or outside the facility. There are some
2 sub-measures of healthcare personnel reported
3 with medical contra-indications and healthcare
4 personnel who refused vaccines.

5 Now, this measure is what we based our
6 COVID-19 vaccination measure on early on and
7 you'll hear about some of the modifications we
8 made for public health surveillance.

9 Now this measure has been reported, the
10 CDC's national healthcare safety network since
11 2012 with over 5000 facilities participating in
12 CMS's hospital and patient quality reporting
13 program, long-term acute care hospital reporting
14 program, an inpatient rehabilitation facility
15 quality reporting program currently.

16 Informally, this measure was used in
17 measures for ambulatory surgery centers,
18 outpatient dialysis facilities, and inpatient
19 psychiatric facilities.

20 Next slide. Now, the facility types
21 that participate in NHSN, there will be 4000
22 acute care hospitals, 1200 critical access

1 hospitals, over 400 long-term acute care
2 facilities and 378 inpatient rehabilitation
3 facilities.

4 And one point I want to clarify about
5 these facilities, these are just free-standing
6 facilities listed here. They're also our units
7 that report in NHSN.

8 For example, there's over 789 inpatient
9 rehabilitation locations within acute-care
10 hospitals that also separately report. And
11 almost 1000 inpatient psychiatric units that also
12 report that can be added to these numbers you see
13 here.

14 We mentioned over 7000 outpatient
15 dialysis facilities, ambulatory surgery centers
16 and nearly 18,000 long-term care facilities. Of
17 those long-term care facilities, most of them are
18 skilled nursing facilities, nearly 17,000.

19 And a large majority of those are the
20 CMS certified skilled nursing facilities, about
21 15,400.

22 Next slide. So, now I'll get into a

1 little bit more detail about the measure
2 specifications. Now, MUC-0044 is COVID-19
3 Vaccination Coverage Among Healthcare Personnel
4 Measure.

5 The primary measure is simply the
6 percent of healthcare personnel who received a
7 complete vaccination course of COVID-19 vaccine.
8 It is notable that the vaccine manufacturer is
9 collected as part of this measure.

10 The denominator is the number of
11 healthcare personnel eligible to work in a
12 facility for at least one day during the
13 reporting week.

14 Now, one thing that we'll get into a
15 little bit is that currently, the data-crunching
16 is a little bit different than NQF-0431 for
17 influenza vaccination.

18 But a point is that as we move into
19 quality measurement phase, we do plan to align to
20 use the same denominator as in the influenza
21 vaccination covering measure but we'll talk a
22 little bit more about the details of that.

1 The numerator for this measure is the
2 number of healthcare personnel who received a
3 complete COVID-19 vaccination course since the
4 vaccine was first available or under a repeated
5 interval if vaccination on a regular basis is
6 needed.

7 It's a little bit complicated phrasing
8 but we tried to have some flexibility because, as
9 we know, the initial COVID-19 vaccine required
10 two doses. Although, some now require a single
11 dose.

12 And it does allow some flexibility as
13 vaccination or booster vaccination might be
14 recommended in the future. Next slide.

15 The exclusions for this measure are
16 patients with medical contra-indications and as
17 noted before, that's actually a quite small set
18 of folks, folks that have a history of allergy to
19 one of the components of the vaccine.

20 And I'll note that a declination or
21 unknown status of particular sub-measures but not
22 exclusions as with the flu measure NQF of 431.

1 Now, the frequency I'd like to go over
2 a little bit more of this measure. One is the
3 data collection interval and as I mentioned
4 before, right now the interval is weekly.

5 Now, that's important in this pandemic
6 phase but reporting every week may not be
7 required on a long-term basis. For example, it
8 might be that only one week of reporting per
9 month might be part of a measure requirement.

10 Similarly, the submission interval right
11 now for public health surveillance, we are
12 receiving data on a weekly basis but data
13 submitted to another entity like CMS might not be
14 required at that frequency.

15 It could be, say, quarterly. And to
16 calculate the actual measure, again, I think
17 there is availability for some flexibility.

18 Right now we'll see some data where the
19 measure is calculated weekly and cumulatively but
20 the data could be calculated on a monthly,
21 quarterly, or even annual basis. I'll talk a
22 little bit more later about why one would do that

1 in different circumstances.

2 And finally, the data sources, the data
3 sources for this measure are Human Resources
4 information systems, occupational health measure
5 records, or dedicated COVID-19 vaccination
6 tracking systems.

7 And a key point is that documentation of
8 vaccination is required outside of the facility,
9 as with NQF 0431. Next slide.

10 There are some optional sub-measures
11 listed. As mentioned before, COVID-19, the
12 initial vaccine were two dose vaccine regimens so
13 we want to collect first dose as well a second
14 dose to see progress towards completed
15 vaccination.

16 And the number of healthcare personnel
17 documented contra-indications to be declined
18 could be used as additional exclusions or for
19 alternative analysis.

20 As mentioned, we do collect the vaccine
21 manufacturer as an important piece of information
22 for public health surveillance during this

1 pandemic period.

2 Next slide. I did want to address some
3 of the public comments that were received earlier
4 this year. Now, these are listed here and we'll
5 kind of go through these one by one.

6 Next slide. The first set of public
7 comments involved addressing vaccine availability
8 in statuses of emergency authorized products.

9 Next slide.

10 And this is an evolving area of course
11 but since the last presentation to the measure
12 applications partnership, the Federal Government
13 really has made more commitments to increase
14 vaccine supply, including a number of commitments
15 by federal agencies by introducing strategies to
16 accelerate production of vaccines, including the
17 most recent one by Janssen and J&J.

18 And now we have projections that we do
19 think that there will be adequate vaccine supply
20 for all Americans by the end of May.

21 Next slide. There also were public
22 comments that suggested that we align as closely

1 as possible with the data collected for influenza
2 healthcare vaccination measures and I started to
3 address that comment to clarify how healthcare
4 personnel are defined.

5 We'll go into that next. And to
6 consider only medical contra-indication as
7 conclusions, I think we went over that already.
8 And address vaccine refusals.

9 Next slide. So, this is where I'd like
10 to talk a little bit about real-world public
11 health surveillance that we're doing.

12 And NHSN really at this point has been
13 used as a method of data collection for the
14 public health response during the pandemic phase
15 of the COVID-19 pandemic.

16 And so we really define, for example,
17 our denominator by what mattered clinically. We
18 have clinical roles and categories not identified
19 by employment but often by their function.

20 So, for example, respiratory therapist
21 was a category of healthcare personnel
22 specifically identified in the current vaccine

1 module. For obvious reasons, particularly at the
2 early stage of the pandemic when there was a
3 particularly high risk of infection.

4 But as we move into the next phase of
5 the pandemic, the transition phase and the inter-
6 pandemic phase as you see in this figure, as the
7 number of cases decline as we are seeing now and
8 hopeful will continue, particularly as we
9 progress throughout this year.

10 And I think we would like to transition
11 from a public health response, emergency
12 response, mode into one that is more for quality
13 assurance during the transition or inter-pandemic
14 phase.

15 And that's where we can begin to align
16 with the NQF 0431 definition of healthcare
17 workers. That is broken down into employees,
18 license-independent practitioners, and adult
19 students, trainees, and volunteers.

20 And this is a denominator that has been
21 validated, has been in use for approaching a
22 decade and one that the facilities will be

1 comfortable using as part of quality measurement.

2 Next slide. This table summarizes the
3 measure denominator and numerator components of
4 the MUC measure, 0044, and the NQF-0341 measure,
5 just so you can see side by side.

6 And the thing I want to emphasize is as
7 we move to this NQF-0431 similar denominator, the
8 data collection from facilities is essentially
9 the same as for A1 influenza.

10 This Section, of course, with COVID-19
11 vaccines require two doses to have complete
12 vaccination as opposed to influenza. So, we
13 collect that vaccine information.

14 Next slide. And again, here we see MUC-
15 0044 next to the NQF influenza measure and you
16 see for exclusions, again, the same data
17 collection. The proposed frequency is a little
18 bit different with the data collection is for the
19 week. But the data reporting interval could vary
20 to be monthly or in the data submission interval
21 could vary even to quarterly or yearly.

22 The data sources are the same and there

1 are options for doing sub-measures with contra-
2 indications, declamations, and with the addition
3 of a partial course of vaccination for the
4 influenza measure.

5 Next slide. And the final set of
6 comments asked to ensure that this new COVID-19
7 vaccination measure was feasible for data
8 collection.

9 So, the final section of this
10 presentation I'd like to talk a little bit about
11 -- next slide -- feasibility and validity. So,
12 if we could go to our next slide?

13 The first question is just can
14 facilities actually report the data?

15 And the short answer is yes so I'll
16 present some data on COVID-19 vaccination
17 covering on skilled nursing facility Staff
18 through the week ending February 28, 2021.

19 And thus far, we've had 2608 skilled
20 nursing facilities report data to NSHN. I will
21 emphasize right now this data is completely
22 voluntary reporting. There is no requirement to

1 report.

2 So, these are 2600 facilities that
3 voluntary have submitted data at least once to
4 NHSN. What we see is 45.4 percent of the Staff,
5 that's 132,000 were reported to have received any
6 COVID-19 vaccination, either a first or second
7 dose.

8 And you can see the distribution of
9 these facilities on the right with the X-axis
10 being the percent covering in the facility and
11 the vertical axis being the number of facilities
12 who have reported covering in that range.

13 We see as of the end of last month 30
14 percent of all Staff have completed their
15 COVID-19 vaccination series and I can report
16 based on data just from last week that it's
17 increased almost 10 percent to approaching 40
18 percent.

19 And next slide. And you see the same
20 data about a little bit different way. This
21 figure charts the progress of vaccination
22 covering by week in the skilled nursing

1 facilities for their Staff.

2 The grey line and the white vertical
3 axis represents the number of facilities that
4 report each week and you can see there's an
5 average between 600 and 900 facilities that
6 typically report their coverage in a week.

7 And the green bars in the left vertical
8 axis represent the percent of Staff who received
9 the vaccine each week for that reporting week.

10 The light green represents the Staff who
11 have received one dose or a partial vaccination
12 and the dark green represents those who receive
13 both doses.

14 And we can see progress in completing
15 vaccination courses but plateauing of the number
16 of Staff or portion of Staff at about 45 percent.
17 Again, this is just for the facilities that
18 voluntary report although there are 2600 of them.

19 So, I think that addresses some of the
20 feasibility of reporting these data. Now, what
21 about the validity? Now, in the midst of a
22 pandemic it's kind of difficult to do a formal

1 validity plan in conducting validity studies.

2 So, we thought about trying to use the
3 data that we had available and one of the places
4 for data on vaccination covering is from the
5 Federal Pharmacy Partnership for Long-term Care
6 Program for a vaccination program.

7 Which is the program the delivered
8 vaccine to skilled nursing facilities at our
9 long-term care facilities.

10 Vaccination clinics, they delivered
11 vaccines to 11,000 skilled nursing facilities and
12 as of the first month of the program, they found
13 that among these facilities that were visited
14 through the Federal Pharmacy Partnership Program,
15 37.5 percent of the Staff were vaccinated with at
16 least one dose.

17 This data was published in a recent
18 MMWR. Next slide. Here on the left-hand side you
19 see histogram from that MMWR personal
20 publication, with the portion of vaccination
21 covering in facilities by the percentage of
22 facilities, as collected through the National

1 Pharmacy Partnership Program.

2 On the other right, you see that same
3 histogram with data collected from NHSN during
4 the same period, December 18th through January
5 17th.

6 We calculated the figure a little
7 bit differently, we looked at total workers and
8 the number of portion vaccinated per week found
9 40.4 percent of Staff during this progress were
10 vaccinated with at least one dose of COVID-19
11 vaccine with a very similar distribution.

12 So, that is some reassuring data but
13 next slide, we want to try to do a comparison at
14 the facility level and do some facility-level
15 validation of data reporting from these two
16 completely independent systems for assessing
17 vaccine doses delivered.

18 So, we identified skilled nursing
19 facilities which voluntarily reported to NHSN and
20 also had their first Federal Pharmacy Partnership
21 Program vaccination clinic in the weeks ending
22 January 3rd, January 10th, and January 17th.

1 And to assess the simple correlation of
2 the number of Staff received as reported through
3 NHSN and through this Federal Pharmacy
4 Partnership Program.

5 Now, we know there might be some
6 potential discrepancies. For example, NHSN does
7 include in its definition healthcare personnel
8 that might have been vaccinated elsewhere.

9 So, there is some reason to expect that
10 there may not be a perfect one-to-one
11 correlation. additionally, the Federal Pharmacy
12 Partnership Program may vaccinate others who
13 would not be counted as facility Staff.

14 If there were extra doses that were
15 across the clinic and they did not want to waste
16 them, for example. Next slide.

17 And this is just preliminary data but
18 wanted to show you that we actually found quite
19 high correlation between these two programs. We
20 saw correlation that approached 88 percent in the
21 final week that was assessed.

22 Hearing these figures, again, it's

1 preliminary data that may not be completely clear
2 but we want to at least share that with the MAP.

3 On the horizontal side we see a number
4 of Staff receiving doses from the Federal
5 Pharmacy Partnership Program on the x axis, the
6 number of Staff receiving reporting to NHSN.

7 We received a pretty close one-to-one
8 correlation. Next slide. We did do one minor
9 adjustment here, we excluded Federal Pharmacy
10 Partnership Program facilities that report more
11 vaccinations than the total Staff reported.

12 According to NHSN, again, additional
13 doses were brought and were given and they did
14 not want to waste it so we excluded those
15 facilities and modestly increased the correlation
16 to a 90 percent in the final two weeks of that.

17 So, in summary I just wanted to conclude
18 with a few key points, one is for the denominator
19 and definition for healthcare personnel.

20 I tried to describe how we start right
21 now with a public health response definition but
22 we plan to move as the pandemic hopefully begins

1 to subside into a transitional phase to align
2 with the NQF and 0431 definition of the
3 denominator.

4 Again, the contraindications are
5 collected similar to NQF, although it might be
6 slightly different in the calculation the data
7 collected by the facility is identical. Again,
8 declinations are collected and not included as
9 the primary measure but can be included as a sub-
10 measure.

11 And then finally, the reporting period
12 issues. I think we still would like to collect
13 data on a weekly basis to be consistent with
14 other COVID-19 reporting throughout the period.

15 So, that's data collection but reporting
16 may not be required weekly. It may be able to be
17 done one week a month and submitted to CMS on a
18 less than weekly period.

19 And so that, I think that's the end of
20 our slides and I'm happy to answer some questions
21 and to have a follow-up discussion.

22 CHAIR KAHN: I have a question. You had

1 a great correlation between the deliverer of the
2 vaccines and the delivery of the vaccines to
3 Staff.

4 But in the hospital area you don't have
5 the same uniform delivery so what was confirmed
6 here as a good indicator is something that's
7 different in the hospital area.

8 And that's actually a big difference
9 that could affect significantly the results.

10 DR. BUDNITZ: So, let me just make sure
11 I understand the question and make sure that I'm
12 clear. So, the Federal Pharmacy Partnership
13 Program data is not just dropped-off delivery.

14 It means injected into arms, just to
15 make sure that's clear. You're right that it is
16 a single clinic visit but that's correct. But I
17 just want to clarify that it is counting
18 administrations, I should made sure I used that
19 term correctly.

20 CHAIR KAHN: I think the big problem
21 we're going to get here is that they received
22 enough vaccines for all the workers, right, is

1 that correct?

2 DR. BUDNITZ: That is the intent. When
3 our partner, typically CVS or Walgreens, filled
4 out that they had enough.

5 CHAIR KAHN: But we know on the hospital
6 side that there are points at which the States or
7 jurisdictions have decided to stop delivering to
8 the hospitals and just told the hospital your
9 workers have to get it in the community through
10 whatever means it's available in the community.

11 Which is really a big difference between
12 that and this.

13 DR. BUDNITZ: I'm sorry, let me clarify
14 one thing to make sure I just -- I don't know how
15 important it is. But the key point is that what
16 the federal pharmacy partnership program came to
17 do was to vaccinate the residents primarily.

18 So, if they had enough for healthcare
19 personnel then they would do healthcare personnel
20 as well and they would hope to. They would try
21 to but they prioritize residents, just to
22 clarify. So, they didn't always get all the

1 healthcare personnel necessarily.

2 And the second point in terms of vaccine
3 supply, the intent and the expectation is that
4 there will be adequate supply for all who desire
5 a vaccine. That's the intent by the summer and
6 certainly by the fall.

7 That is the intent. Again, we cannot
8 always predict the future but that is what the
9 intent of the vaccine response is, that there
10 will be a vaccine.

11 MR. STOLPE: Chip, this is Sam. We are
12 about to move into a public comment period but I
13 see we also have questions from the Committee.

14 So, perhaps we could invite the
15 Committee to just hold their questions for a
16 moment for Dr. Budnitz, while we have the public
17 comment and then return to that.

18 Because I think the comments and
19 questions will natively feed into the discussion.
20 How does that sound?

21 CHAIR KAHN: Okay, great. I'll take the
22 baton and now we'll have public comment and if

1 those who would wish to comment will remember our
2 guidelines here.

3 Limit comments to the COVID-19 measures
4 that we're discussing, limit comments to two
5 minutes, and please let us know where you're from
6 if you're representing an organization.

7 So, with that, let's open it up.

8 MS. PERERA: First off, we have a hand
9 raised from D. Gifford.

10 MR. STOLPE: David Gifford is part of
11 the Committee.

12 CHAIR KAHN: Yes, this is just public
13 comment. For those on the Committee, this is
14 just from outside lines. Any outside comment?
15 Going once, going twice?

16 CHAIR ROBERTS: I think I see a Michelle
17 Doll. I don't think she's on the Committee, is
18 she?

19 DR. DOLL: No, this is Michelle Doll.
20 I'm here with the Society for Healthcare
21 Epidemiology of America. And I just had one
22 clarifying question.

1 It looked like it kind of skipped over
2 the issue of these vaccines being under EUA. I
3 was wondering if you could address how that is
4 going to work?

5 We have typically mandated the influenza
6 vaccine to increase compliance in our facility
7 and under the EUA that's not feasible. Thanks.

8 CHAIR KAHN: Sam, that's a question?

9 Do we entertain questions during the
10 public comment or just comments and then should
11 we save that question for when we get to the next
12 part or should we take it up now?

13 MR. STOLPE: I'll defer to you on that
14 one, Chip. If we want to hold off on inviting
15 Dr. Budnitz to answer, that's fine and we can
16 invite others to --

17 CHAIR KAHN: Let me say if that's the
18 only comment or question from the public then why
19 don't we do this?

20 Why don't we move to the next phase and
21 then that will be a question that we'll ask in
22 the next phase about the emergency acceptance and

1 the implications of that.

2 MR. STOLPE: Sounds good, Chip.

3 CHAIR KAHN: So, do you go through it
4 now, Sam?

5 MR. STOLPE: Sorry, what was the
6 question, Chip?

7 CHAIR KAHN: I'm sorry, I asked you to
8 briefly go through the measure I think.

9 MR. STOLPE: Sure. I'll read the
10 measure description and then I'll have to
11 reorient us but Dr. Budnitz covered this.

12 The measure description is the tracking
13 of the SARS-CoV-2 vaccination coverage among
14 healthcare personnel in IPPS hospitals,
15 prospective payment system hospitals and patient
16 rehab facilities, long-term care hospitals,
17 inpatient psychiatric facilities, ESRD
18 facilities, and the ambulatory surgical centers,
19 hospital outpatient Departments, skilled nursing
20 facilities, and PPS-exempt cancer hospitals.

21 Level 1 analysis is at the facility
22 level and there's a number of programs under

1 which this is being considered. I'll leave those
2 up on the slide for your consideration for both
3 hospital and PAC/LTC programs.

4 CHAIR KAHN: So, now we'll entertain
5 clarifying questions I guess from the Committee,
6 however, why don't we start off, though, with
7 this question that we just had in the public
8 session regarding the emergency?

9 How this is a different consideration
10 because, I guess, the flu vaccines are totally
11 approved? And these are only approved under
12 emergency prerogative of the FDA.

13 Dan?

14 DR. BUDNITZ: I don't know if I have a
15 satisfactory answer to that question. The
16 surveillance that we do now, of course, is for
17 pandemic response, for emergency response.

18 So, emergency authorization is exactly
19 what we are surveilling. As a quality measure, I
20 think that certainly can be a consideration.

21 I don't know if I have the answer for
22 how to consider a vaccine that's under emergency

1 use of authorization currently.

2 I think the expectation and hope is that
3 manufacturers submit for a formal FDA approval
4 but I don't know if I can comment. I don't know
5 if the FDA wants to comment on how that process
6 may work.

7 CHAIR KAHN: Isn't it partly that the
8 responsibilities -- and maybe I'm getting this
9 completely wrong -- and the role of the facility
10 is somewhat different regarding its Staff with
11 something that is not full approval of a vaccine
12 for example?

13 Isn't that part of what the issue is
14 here, that's being raised by the questioner?

15 MEMBER GIFFORD: Chip, this is Giff.

16 The EUA status prohibits the Federal
17 Government from mandating the vaccine. States
18 and employers can as long as they follow EOC
19 rules about it, just like they do with influenza.

20 This uses a measure and depends on the
21 way CMS might use it and write it in the rules
22 would mandate that we submit data and we support

1 a measure but there's no mandate on as part of
2 employment or other issues to take the vaccine.

3 So, I don't see that as a problem with
4 this, but that would be a question for HHS.
5 We've asked the HHS that question before, that's
6 why I know what the answer is but we probably
7 need to go there.

8 But that's not why I had my hand raised,
9 I'm just clarifying that point.

10 CHAIR KAHN: Okay, and I'll just go on
11 to say that at least from my experience, few
12 facilities have -- I don't know of any
13 facilities, frankly, that I know of that have
14 chosen to mandate this privately on their
15 employees.

16 But I don't know how important that is.
17 Let's go to questions. Giff, you've got a
18 question?

19 MEMBER GIFFORD: Yes, I want to thank
20 Dan for this and just start off with my comment
21 that both ACHA is really proud that there's so
22 many folks leading the way with the number of

1 people submitting data so you can do the analysis
2 on this.

3 And that our Board has set a goal of 75
4 percent Staff vaccination rate, along with
5 Leading Age, the other trade association. And we
6 are begging anyone and everyone to use and do
7 this so we're very excited this is going forward
8 with that.

9 That said, a few comments, Dan. I think
10 on the exclusion side we agree with your
11 exclusion, except for what about individuals who
12 have had COVID and aren't supposed to get
13 vaccinated in the next 90 days. Or have received
14 vaccinations as part of their employment and
15 coming on Board.

16 As you know, turnover is high in our
17 area and they're to be delayed in the
18 vaccinations.

19 Then to the feasibility timing issue, as
20 you know, to avoid wastage you have to have these
21 clinics done in aliquots of five or ten and the
22 average number of new Staff coming on board is

1 just a handful each week.

2 So, doing a weekly data collection may
3 not -- for public health and quality improvement
4 purposes, we do not object to weekly data
5 collection.

6 But maybe for reporting purposes and
7 measuring purposes you want a larger time window
8 that's out there.

9 DR. BUDNITZ: Thank you very much for
10 the questions and let me go through these one by
11 one for some clarifications. What is the
12 exclusion about having COVID?

13 And I just want to clarify and make sure
14 that I'm up to date, feel free, anyone, to
15 correct me if I'm not. But it's not that folks
16 cannot have a vaccination within 90 days of
17 having COVID.

18 It's that if one is prioritizing COVID
19 vaccine in a context of a shortage of vaccine,
20 one would not prioritize someone who has had
21 COVID in the last 90 days because it's presumed
22 they have some immunity.

1 But there's not an exclusion saying you
2 cannot be vaccinated within 90 days. I just want
3 to make that clarification in terms of this
4 exclusion.

5 Obviously, if someone does have COVID-19
6 you might not want to vaccinate them the first
7 day they recover.

8 I don't think there's exact
9 determination of when you should vaccinate but
10 it's not an exclusion that you cannot vaccinate
11 for 90 days. I don't think that's correct.

12 But it does get into the point that it
13 does take time, especially with the two-dose
14 vaccine series to get vaccinated. And with the
15 weekly reporting, obviously, you can have partial
16 vaccines so we do collect that.

17 So, that is a sub-measure that you can
18 do so as soon as you get the first dose of the
19 vaccine you can be reported. So, that is one
20 piece of the response.

21 The other question was asked about
22 wastage. I think that is going to be hopefully

1 in the future and with the J&J vaccine, Janssen
2 vaccine, it's less wastage potential because of
3 the way it's packaged and delivered.

4 But I do take seriously the point that
5 this is a measure that is for the week rather
6 than the entire flu season like flu influenza.

7 And the reason for that is although we
8 hope we'll be entering this transition phase of
9 the pandemic and then the post-pandemic phase, we
10 can't be certain.

11 So, we don't want to change our interval
12 for a measurement prematurely to like, let's say,
13 three months when there might be resurgence or we
14 might need to look at data a little bit more
15 frequently than every three months.

16 So, I'd like to keep the weekly measure
17 for data collection but for reporting, again,
18 that could be changed.

19 For example, just one week a month and
20 then if someone was missed during that week they
21 would appear in the subsequent month as someone
22 that is vaccinated, if they were hired, say, the

1 day after the weekly vaccination rounds were
2 being done for that facility.

3 So, does that address some of the
4 concerns?

5 CHAIR KAHN: Okay, assuming it does, I
6 think Leah has a question?

7 MEMBER BINDER: Yes, I wonder if I could
8 get some more clarity on declinations and how
9 that's treated in the measure and the sub-
10 measure.

11 I think declinations is going to be
12 a very important aspect of really tracking this
13 issue. And I'm just wondering , it sounds like
14 from the main measure it's not really accounted
15 for at all but in the sub-measure it is accounted
16 for.

17 I wonder if you could just clarify that
18 and how it compares with how we track
19 declinations for the flu measure?

20 DR. BUDNITZ: Thank you for bringing
21 that up and that is something that I would like
22 to hear thoughts about from the Committee.

1 Like flu, declinations is not considered
2 in the primary measure, it's just number of
3 vaccinations that are considered.

4 It is mandatorily reported the number of
5 declinations, to my understanding, for the NQF
6 annual flu measure. It is an option right now,
7 optional reporting, in the NHSN module that could
8 be made mandatory certainly and facilities, of
9 course, are free to report it.

10 The reason we made it optional, again,
11 is this kind of responding to a pandemic. And we
12 were not certain what a declination meant in the
13 context of constrained supply.

14 Maybe you were declining because you
15 wanted someone at higher risk to be vaccinated or
16 maybe if something is not being offered to you
17 what is a declination and how does a facility
18 measure declinations when there's restricted
19 access maybe initially?

20 So, I think this is a reflection of
21 public health surveillance happening in the
22 context of an active phase of the pandemic and

1 then trying to transition to a more stable
2 situation where there will not be planned vaccine
3 supply issues.

4 And so I think declinations could be
5 collected just as they are for influenza quality
6 measurement.

7 CHAIR KAHN: Is that it, Leah?

8 MEMBER BINDER: Are we just asking
9 questions now?

10 CHAIR KAHN: We were just asking
11 questions and I was going to go to Michelle if
12 you're finished. Michelle?

13 DR. SCHREIBER: I'm sorry, I'm not
14 following your question, Chip.

15 CHAIR KAHN: I thought you had a
16 question.

17 DR. SCHREIBER: No, I didn't have my
18 hand up.

19 CHAIR KAHN: I thought you did from
20 before. Okay, Ron?

21 MEMBER WALTERS: Well, I put my hand
22 back down because I know Dan doesn't have

1 anything to do with this.

2 But first of all, there's a lot of
3 things about the measure that I realize are based
4 on imperfect knowledge and you're hearing about
5 most of those. But the idea is very good.

6 I put my hand down because you don't
7 really write a measure to target its purpose.

8 But I would like to see how you felt if
9 this measure were applied to a value-based
10 program versus just being used for quality and
11 performance improvement as a measure of how
12 things are going.

13 You feedback the information to
14 different places. Because for the life of me, as
15 much as I want to make 100 percent the target, I
16 don't know what the right target is for any of
17 these and I'm sure it's not 100 percent.

18 And there's so much difference between
19 these things, I would feel very -- if CMS chose
20 to put this in a value-based payment program, I
21 think you'd get an awful a lot pushback.

22 So, what was your motivation here?

1 DR. BUDNITZ: So, I think the motivation
2 here was similar to influenza vaccination
3 coverage measure that has been around for a
4 while.

5 And that to encourage vaccination
6 through reporting but I don't think -- again, as
7 you mentioned, CDC doesn't set a minimum
8 vaccination coverage level.

9 And how it might be used I think is a
10 CMS determination. But the motivation was
11 measurement as a means of encouragement and
12 improvement.

13 DR. SCHREIBER: I'm sorry, this is
14 Michelle, can I try and answer that question as
15 well, please?

16 CHAIR KAHN: Sure.

17 DR. SCHREIBER: These are not, as you
18 pointed out, in payment programs. They are in
19 public reporting programs and we felt that it was
20 important, one, to promote Staff getting
21 vaccination, as Dan already pointed out.

22 And two, for public transparency as

1 well. So, this will be in the future available
2 on the public transparency site.

3 We believe that consumers have the right
4 to know if Staff are being vaccinated in the
5 facilities that they are going to. In addition
6 to which we are hoping that high vaccination
7 rates among healthcare facilities is also a sign
8 of reassurance to the general public about
9 getting vaccinations and another way of
10 encouraging vaccination amongst all Americans.

11 Whether or not it gets included in a
12 payment program, I think we're quite honestly
13 years away from that.

14 DR. BUDNITZ: Thank you.

15 CHAIR KAHN: Jeffrey?

16 MEMBER SCHIFF: This kind of follows on
17 the declination a little bit but I wanted to know
18 whether or not, Dan, there was any consideration
19 about stratification beyond by the facility site.

20 And I'm really thinking about equity
21 issues, about whether or not we would know
22 whether folks who are black, indigenous, people

1 of color, or are being vaccinated as much as
2 other Staff Members.

3 And I think that brings up an ability or
4 a responsibility that this group may have to try
5 to address an equity issue even internally in an
6 organization.

7 So, I wonder if you looked at that or
8 looked at the ability to collect that data?

9 DR. BUDNITZ: Thank you for the
10 question. It's definitely an issue of concern
11 and interest by CDC.

12 I think our main concerns about trying
13 to collect that information through this
14 mechanism was that we don't have something to
15 look towards for measure reliability like we did
16 with the influenza existing vaccination measure.

17 So, we don't collect that information.
18 It's not that we don't want to and it's not that
19 we don't think it's important.

20 It's that we don't know if it's feasible
21 and reliable and so we wanted something rather
22 than nothing, basically.

1 MEMBER SCHIFF: And if I could just add
2 a follow-on question if that's possible.

3 Was a similar thought process given to
4 collecting the data by the profession or the
5 status of the individual in the facility, an aid
6 versus a nurse versus a physician?

7 DR. BUDNITZ: Thank you for the
8 question. That is the way we collect data
9 currently for, again, the public health response
10 purposes by the Staff function.

11 We're proposing for this quality
12 measurement that because that was a
13 classification that was based on a emergency
14 response and we are not able to necessarily
15 validate that in a timely way for assurance of
16 feasibility and reliability, that we're
17 suggesting moving, as we transition into the
18 post-pandemic phase, to go to a denominator that
19 has been validated and that's to make it
20 consistent with the influenza denominator.

21 And again, at a very high level just to
22 address the concern of one of the public comments

1 or similar public comments, to make it align with
2 the influenza vaccination coverage measure.

3 If facilities are collecting influenza
4 vaccination coverage, it would stand to reason
5 that the denominator would be the same for a
6 COVID-19 vaccination coverage measure.

7 And so we were planning to align to that
8 validated and consistent denominator.

9 CHAIR KAHN: Akin, do you have a
10 question?

11 MEMBER DEMEHIN: I do, thanks, Chip.
12 And this question I think is mostly for Dan,
13 potentially a little bit for Michelle.

14 I think you partially answered the
15 question I have, which was which healthcare
16 professional would you use for the measure that's
17 actually being put into the IQR?

18 If I heard you correctly, the intent is
19 to use the definition that is part of NQF-0431,
20 which is the flu vaccination definition.

21 So, is the current definition more
22 inclusive than that and include the list of rural

1 groups that you included? And I would say that
2 aligning to that single definition of personnel
3 would be a very desirable thing.

4 I'm thinking in particular of the
5 provision around collecting information for
6 licensed independent practitioners.

7 You could imagine that for certain kinds
8 of role groups in hospitals collecting
9 information from contract Staff could end up
10 being extremely complicated.

11 If it's the physician group that you're
12 contracting with or even the nurse staffing
13 agency you're contracting with, there's a decent
14 chance, especially for the physicians, that the
15 same physicians are working at the facility time
16 and again.

17 So, it makes a lot of sense that they
18 would be included in the definition.

19 But for environmental services or for
20 nutrition and dietary services, you may have
21 Staff who rotate among several facilities who may
22 or may not be at a facility, even within a given

1 month.

2 So, you would say all kinds of
3 fluctuations in that definition that would make
4 the data fairly noisy. So, I'm just confirming,
5 am I hearing you right on that?

6 DR. BUDNITZ: So, the short answer is
7 yes, the current definition is more inclusive and
8 does not make a distinction between contracted
9 personnel and those that are directly employed at
10 a hospital.

11 Again, in the context of an emergency
12 response, we thought having these functional
13 roles would be the most appropriate in this
14 context. But moving into quality measurement, we
15 recognize the challenges of getting consistently
16 reliable data on contracted Staff.

17 And why we would like that and down the
18 road we might validate such a measure, in the
19 near term we didn't see that as feasible to
20 change the denominator to the contracted
21 personnel.

22 So, this is why we are suggesting the

1 denominator that aligns with the flu measure,
2 which does include Staff, directly employed
3 Staff, does include certain independent
4 practitioners, physicians, nurse practitioners,
5 PAs, and the trainee volunteers that are
6 registered with the facility but does not include
7 other contracted Staff.

8 MEMBER DEMEHIN: Got it, thank you.

9 CHAIR KAHN: Okay, anymore questions?

10 I assume from looking at the chart that Giff has
11 comments and Leah has comments. Michelle, did
12 you have a comment?

13 Why don't I go to Giff first? So, now
14 we're in the conversation period so why don't I
15 go to Giff first? Because he may want to express
16 what he said in the chat, then Leah, then let me
17 know who else. Let Udara know who else wants to
18 comment.

19 MEMBER GIFFORD: Thanks, Chip. I raised
20 my hand just to comment on the disparity equity
21 issue. At least in our setting, there was
22 adequate supply of vaccine for all Staff at

1 almost every clinic to get it.

2 But we did see large differences in
3 uptake by ethnicity in anecdotal reports from
4 different members out there. We also have seen
5 differing uptake between different job titles
6 with housekeeping and dietary taking it more
7 often than doctors and nurses.

8 And that actually matches some of the
9 data from my public health days in Rhode Island,
10 where we did collect declination forms and
11 information from hospitals. And doctors and
12 nurses were lower than others in taking the
13 influenza vaccine.

14 And then on the disparity issue, though,
15 I worry about whether we adjust for that or not
16 because a lot of it is due to the trust level and
17 a lot of it is due to historical issues.

18 This is not an access problem and if you
19 start doing it, I wonder about the unintended
20 effects of not wanting to hire or move minorities
21 out so they don't count in your measure because
22 they're just taking the vaccine at a lower rate.

1 CHAIR KAHN: Leah, did you have a
2 comment?

3 MEMBER BINDER: I wanted to emphasize
4 the issue around declinations. I think it's a
5 public health challenge of the first order for
6 this vaccine to be successful, vaccination
7 program to be successful.

8 So, it concerns me that it wouldn't be
9 mandatory to report declinations. I think it
10 would be helpful certainly, I'm sure, for CDC and
11 CMS to be able to track patterns.

12 If there's, for instance, a particular
13 community where there's a high level of
14 declinations, that should be flagged quickly and
15 something that can be at least looked into.

16 I just think it's so important and
17 there's a certain level of viral misinformation
18 that travels around vaccines, as we all know, and
19 very quickly the whole vaccination campaign can
20 be in trouble because of some kind of
21 misinformation that's spreading very quickly.

22 And I think that it's going to be

1 critical for us to be on top of that and it's
2 very important that the healthcare community and
3 all of us are on top of that as well because we
4 have a role to play in building trust in the
5 community. We have to be able to work together
6 very quickly on that.

7 So, I would encourage us to think about
8 a mandatory reporting of the declinations.

9 CHAIR KAHN: Okay, are there other
10 comments from the Committee? I have a question
11 of Michelle Schreiber.

12 One thing I don't quite understand,
13 because we're sort of going back and forth as to
14 how often this would be asked and what is the
15 plan right now for actually implementing this?

16 Unless I'm missing something, it's just
17 not crystal clear to me.

18 DR. SCHREIBER: As you've seen already,
19 there is voluntary reporting to the CDC that is
20 already in place.

21 If this becomes a measure that is
22 introduced into these programs, programs will

1 actually have to submit this information as part
2 of the reporting in these programs.

3 And as we've already just seen, the CDC
4 does have the opportunity to report declination.
5 That's part of the measure that they have.

6 So, the implementation plan would be
7 making facilities aware that this is a measure in
8 these programs and then that they need to report.
9 Alternately, this would also lead to public
10 transparency as well.

11 So, the other thing, Chip, to answer one
12 of the questions in that, is that right now in
13 the pandemic facilities report on a weekly basis.

14 Dan's going to have to correct me if I'm
15 wrong here, during the course of the pandemic,
16 that is probably still what would happen but the
17 reporting from these programs' point of view
18 might be a sample of one week per a month or some
19 other summary of early data that is sent to CMS.

20 And over time, as organizations no
21 longer need to report on a weekly basis from a
22 surveillance point of view, this could become

1 that they just have to report quarterly, we're
2 just not quite there yet.

3 CHAIR KAHN: In terms of the program,
4 though, would they not be required to report
5 until, in a sense, there's full availability of
6 the vaccine, which wouldn't be until May or
7 later?

8 DR. SCHREIBER: Currently, programs can
9 report. On a voluntary basis they can do that
10 right now.

11 The fact that the measures would go into
12 these programs likely wouldn't take effect until
13 probably at the very best the tail end of this
14 year and more likely in 2022.

15 And at that point in time, as people
16 have already pointed out, we hope there is
17 vaccination availability by May. There should be
18 widespread vaccine availability by the time that
19 people have to report.

20 CHAIR KAHN: Thank you for the
21 clarification. Are there other comments?

22 MEMBER QASEEM: And Michelle, at this

1 point you're going with just a one-time shot,
2 right? Because that's all we have knowledge,
3 right?

4 Is that what it is? So, you started
5 talking about 2022 so I started thinking about
6 does it mean some are vaccinated in December and
7 by next year in December they might need a second
8 term?

9 I don't know, there's so much up there
10 in the air. So, how are you guys thinking about
11 it?

12 DR. SCHREIBER: As Dan pointed out at
13 the very beginning of his presentation, Amir,
14 this is written with some flexibility that
15 basically states that Staff have had a full
16 vaccine complement given and that includes two
17 vaccines.

18 It means you need two vaccines. If
19 there's a booster, for example, next year or six
20 months later that we determine from a variant, it
21 included the booster.

22 So, this is giving us the flexibility of

1 being able to basically embrace, really, what is
2 needed. Because we don't know, as you just
3 pointed out. We don't know if this is going to
4 be an annual vaccine.

5 We don't know if after the pandemic
6 we'll never need a vaccine again, God willing.

7 And so this was written with the
8 flexibility to basically say the Staff has
9 completed the appropriate vaccine.

10 Dan, correct me if I'm wrong.

11 DR. BUDNITZ: You're exactly correct.
12 That is the intent and the approach.

13 And the flexibility that NHSN allows is
14 that that data collection can be updated rather
15 quickly to cover those scenarios of maybe a
16 booster is needed, hopefully not. Maybe it
17 becomes an annual vaccination, similar to flu for
18 longer-term coverage.

19 MEMBER QASEEM: And the way at least I'm
20 looking at this measure is that EOA's going to go
21 away pretty soon and we all know the work is
22 happening in that direction.

1 So, the implementation is probably --
2 I'm less concerned about the EUA piece over here.
3 And you do have an exclusion, you might look at
4 this measure.

5 Again, there's a lot of detail there and
6 the medical contra-indications is going to be an
7 automatic exclusion but that's the only one,
8 right? But we do have perhaps some flexibility.

9 What I'm hearing from you, Michelle, is
10 if need be we can modify because this is sort of
11 a measure in progress, I'm looking at it, more
12 than a mature measure.

13 So, is there a constant feedback loop we
14 can establish?

15 And again, CMS can do, of course,
16 Michelle, whatever you want with MAP but if you
17 go forward with this measure, you guys can keep
18 on, I don't know, bringing back some information
19 to us every three or so months depending on how -
20 - your frequency is going to be for collection
21 and we keep on looking at it? Is that a
22 possibility?

1 DR. SCHREIBER: We can certainly
2 continue to bring back information, Amir, and as
3 you know, if there are substantive changes to
4 these measures we will bring them back. That's
5 already baked in.

6 MEMBER QASEEM: And the final question
7 from me is are you thinking about getting NQF
8 endorsement or you're not thinking about NQF
9 endorsement?

10 DR. SCHREIBER: We are thinking of NQF
11 endorsement.

12 MEMBER QASEEM: All right.

13 CHAIR KAHN: Okay, any other questions
14 or discussion?

15 So, Sam, if I'm to understand this,
16 then, considering our earlier action with the
17 clarifications that we just asked, that's all
18 that we are doing today.

19 We're not re-adjudicating this measure
20 from our earlier action so the measure would go
21 forward -- I mean, the recommendation goes
22 forward and that's it.

1 Is that correct?

2 MR. STOLPE: Yes, Chip, that's how
3 structured our meeting today, was simply to
4 provide additional feedback.

5 CMS requested the opportunity to provide
6 feedback that the Committee had included the way
7 that we structured our conditional
8 recommendation. No need to re-vote, this is
9 simply us having the discussion that we said we
10 wanted to have.

11 CHAIR KAHN: Okay, well, I think there's
12 a nervousness in the conditionalness considering
13 some of the details here, not in terms of going
14 forward but in terms of all the implications
15 here.

16 Because the goal posts could be
17 changing regarding what we're looking at here.
18 Amir brought up one example but there may be
19 others as this goes forward.

20 So, I think that however this is
21 ultimately presented in these programs, there
22 should be I think a lot of asterisks that note

1 all these.

2 Because these issues aren't going to go
3 away, you can ultimately make decisions about the
4 way you ask the questions but there's still going
5 to be some ambiguity around what it all means, I
6 think.

7 That's my two cents. Anybody else have
8 any other comments before we close on this
9 section?

10 Okay, I don't see any in the chat box
11 and so I'll pass the baton off to Misty for the
12 next discussion.

13 CHAIR ROBERTS: Thanks, Chip. So, now
14 we're going to get into the strategic discussion,
15 which we're actually going to talk about.

16 And this is based on a federal new
17 statute that really gives us as a Coordinating
18 Committee the opportunity to consider
19 implementing a process to review measures that
20 are conserved for retirement.

21 So with that, I'm actually going to hand
22 this over to Sam -- I think it's Sam -- and

1 you're going to give an overview I think of a
2 proposal. So, Sam, take it away?

3 MR. STOLPE: Thanks very much, Misty.

4 Well, everyone, as we move into the
5 strategic planning for future MAP cycles
6 discussion, we wanted to remind everyone of a
7 piece of legislation that was recently passed by
8 Congress and signed into law.

9 Now, this statute included a number of
10 components for language related to Medicare
11 extenders, including some language around things
12 that could prospectively become MAP activities.

13 So, what the new statute has adjusted is
14 that the consensus-based entity, which NQF has
15 served as the consensus-based entity under
16 federal contract, they may have the option to
17 review measures for potential removal from
18 federal quality and performance programs.

19 So, the thought was in our discussions
20 with CMS was perhaps MAP may be used specifically
21 for that purpose.

22 Now, we've included the actual language,

1 which is rather terse, from that statute here on
2 the slide and it's just simply the modification
3 to the Social Security Act but amended to insert
4 a paragraph that the removal of measures that the
5 entity that is the consensus-based entity may
6 provide input to the Secretary on quality and
7 efficiency measures described in Paragraph 7B
8 that could be considered for removal.

9 So, that's really simple. A highlight
10 on the word may. So, it's optional. Now, as
11 this presents an opportunity for CMS to receive
12 additional input on potential measure removals in
13 their quality programs through a partnership with
14 NQF, it makes sense that we, MAP, could think
15 through how to prospectively do this.

16 Now, the idea would be that we would
17 include recommendations for prospective measure
18 removal from federal programs and this may be
19 part of discussing federal quality and
20 performance programs as part of a holistic
21 measure review, where we're looking at how the
22 overall program is structured, the nature of the

1 incentives behind it, the measure set itself, and
2 the extent to which the measures are aligned with
3 the goals of the program.

4 Next slide, please. What we're
5 proposing to do in the discussions that we've had
6 with our CMS colleagues is to implement a pilot
7 program.

8 So, we want to balance a set of ideas
9 around urgency and doing this with the right
10 amount of integrity, ensuring that we're
11 protecting MAP's process and limiting unintended
12 consequences associated with too quick of a roll-
13 out.

14 Now, this year, we have some compressed
15 timeline limitations, not just ensuring that we
16 get the right processes in place but ensuring
17 that we have contracting logistics and
18 operational considerations buttoned up.

19 So, this will limit our ability to put
20 the full process that we would like to have in
21 place, and I say we meaning the MAP Coordinating
22 Committee and MAP in general.

1 But nonetheless, we feel it's critically
2 important for us to begin this process of
3 thinking it through. Inside of the pilot year,
4 what we're proposing is for the MAP Coordinating
5 Committee to serve as the MAP body responsible
6 for conducting measure reviews in that pilot
7 year.

8 So, when we say measure reviews, looking
9 at measures that CMS would propose for
10 prospective removal.

11 Now, the initial year, activities as
12 highlighted will use that opportunity to gather
13 input not just from the Coordinating Committee
14 but also from other stakeholders on the approach
15 to inform decisions that we'll make collectively
16 on how to roll out a more robust program, which
17 would be intended for cycle year 2022 and 2023.
18 So next year.

19 Now, the idea would be that we would
20 continue just the usual interim process that we
21 follow in MAP, the same that we did to construct
22 what we have now in our tenth year as our

1 process.

2 So, drawing on this input, both NQF and
3 CMS Staff and the experience of the pilot will
4 draft something for the Coordinating Committee to
5 react to.

6 And the MAP Coordinating Committee will
7 ultimately determine and finalize the appropriate
8 processes, procedures, evaluation criteria, and
9 voting categories if necessary for how we would
10 conduct this in the future.

11 Let's go to the next slide, please.
12 Just speaking to the timing and frequency of this
13 pilot year, we're thinking that the frequency
14 will just be once.

15 We'll convene during the late August or
16 early September of 2021 for either a one or a
17 two-day meeting of the Coordinating Committee,
18 with the intention of sharing final feedback and
19 recommendations related to the measures
20 considered for removal to CMS by October 1, 2021.

21 Now, this pilot year agenda will consist
22 primarily of reviews of federal programs for each

1 of the three Work Group settings and we may or
2 may not include a formalized voting on measures
3 selected by CMS for prospective measure removal.

4 Depending on how robust we feel the
5 process is and whether or not it just generally
6 makes sense for us to do so.

7 On the right of the slide you'll notice
8 just the overall timeline for how the lifecycle
9 of the measure would progress through MAP under
10 this proposed approach.

11 So, of course, before the measures are
12 even reviewed by MAP they're developed and tested
13 and considered by CMS for a MUC list.

14 After being reviewed by MAP, CMS
15 considers MAP feedback, potentially implements
16 them into federal programs, and then once they're
17 there, there's feedback and analysis and the
18 measure would be identified prospectively once
19 it's done the work that it's supposed to or if
20 there's issues associated with the measure.

21 The measure would be reviewed by MAP
22 once again for consideration for removal. That

1 feedback will be provided by CMS and of course,
2 CMS will then take that feedback and decide
3 whether or not it makes sense for the measure to
4 be removed from a given program.

5 Could we go to the next slide, please?

6 The intention after we conduct this
7 initial pilot year would be that we would then
8 re-engage with the Coordinating Committee and
9 with a broad group of outside stakeholders to be
10 able to determine what next steps should be and
11 how to further develop this function of MAP.

12 So, during the course of the pilot and
13 well into 2022, NQF working with CMS and the
14 Coordinating Committee will talk about exactly
15 how we can develop that process.

16 So, this would include discussions with
17 MAP Coordinating Committee and MAP Work Groups as
18 appropriate, engagement with the public for
19 public comment periods, as well as the
20 development of guiding documents such as what we
21 currently use, which is MAP member guide book, as
22 a repository of our processes and decision points

1 that we've been making around the development of
2 MAP.

3 Here's a side-by-side comparison of how
4 we're looking to implement things within the
5 pilot year and in our vision for 2022 and beyond.

6 So, once again, the convening body
7 during the pilot year will be the Coordinating
8 Committee and they will determine based on this
9 what the most practical and efficient approach
10 for us to implement this long term to the extent
11 to which we would engage the Work Groups in this
12 process, et cetera.

13 The scope of this initially will be
14 measure review but beyond that, we may include
15 things such as targeted program review and
16 discussions.

17 Our initial review list is to be
18 developed by CMS but moving beyond, we would
19 prospectively look to include things, both
20 additions proposed by MAP itself as well as
21 inputs from the public in regards to overall
22 program stewardship of the measure set.

1 For evaluation criteria during our
2 initial phase, due to time sensitivity, we'll be
3 using CMS's measure evaluation criteria.

4 In the future, we would want to use that
5 measure evaluation criteria and supplement it
6 with inputs from the MAP on how to have a more
7 robust approach.

8 But keeping in mind that we want to
9 align with CMS's measure criteria as much as
10 possible. During the pilot year, voting will be
11 either yes-no voting or we may not be looking
12 necessarily to have voting at all.

13 But this will be determined of course
14 before the meeting and we'll make sure that it's
15 very clear what the approach is going to be
16 before rolling it out.

17 The future state, we would like to use
18 a MAP-developed set of voting categories and
19 perhaps use consensus voting in the same process
20 that we used during our MUC list evaluations.

21 For public comment, we will of course
22 accept public comment during meetings as part of

1 NQF's traditional open and transparent process
2 but limit written comments based on the overall
3 feasibility of making it operational.

4 Of course, in the future iterations we
5 would want this to be much more robust, a full
6 written public comment periods in addition to the
7 public comment that we have during our normal
8 meetings.

9 Okay, Misty, I'm going to be handing it
10 over to you for a Committee discussion. Of
11 course, I won't need you to walk through each one
12 of the questions that we have presented on the
13 slide here.

14 Misty?

15 CHAIR ROBERTS: First, I just want to
16 add a few comments and this, I think, the removal
17 of measures is something that I think is even
18 just as important as the selection of measures.

19 It's important in terms of reducing
20 burden, it's important in terms of aligning with
21 the overall goal of ensuring that we have
22 meaningful measures that matter.

1 So, I certainly appreciate this
2 opportunity for the MAP to expand its scope.
3 We'll say I do have some concerns in terms of
4 what exactly is that process going to look like?

5 And I know Sam laid out a proposed
6 process. I'm a little bit concerned about the
7 timing, how do we fit everything in? But
8 overall, I'm really excited about the opportunity
9 here in front of us.

10 So, with that, we're going to open this
11 up to a Committee discussion. This is a little
12 bit opposite of what we did with the COVID
13 measures.

14 I think the first comments are going to
15 be reserved for NQF, CMS, and MAP discussion, if
16 I recall, and then we will open it up for public
17 comment.

18 So, with that, there's a few questions
19 that we definitely want to discuss around the
20 pilot itself that was proposed, whether or not we
21 should vote, whether or not we should be the sole
22 reviewer, and then discussion around how many

1 measures we think we could review, which I think
2 will get interesting.

3 So, with that, I see that Ron has his
4 hand raised so I will leave it to you. Hold on
5 just a second, I think Chip might want to say
6 something else.

7 CHAIR KAHN: Thanks. I really
8 appreciate the effort that went into this and
9 thinking through the questions. And I think a
10 couple of things, though, ought to be here as a
11 baseline when we examine these questions.

12 One, we actually have, and I'll just put
13 it on the table first so we don't need to discuss
14 it, a very practical problem which we'll need
15 help with CMS later on.

16 Which is that they will have to
17 reprogram to fund this, which can be done the
18 first year. But as you remember, in Year 2 and
19 Year 3 of the three-year funding for NQF, they
20 gave us a \$5 million haircut the second two
21 years.

22 So, we're going to have to go back and

1 talk the Hill into giving us more money to ensure
2 that we can continue this once we get started.

3 Second, I think one of the issues, we
4 can talk about voting, is even though we will
5 have a process, which I think is a good way to
6 start, from CMS the first year, I think in that
7 first year we're going to have build in at some
8 point extra time to talk about our own formative
9 stage of what we want Year 2 to look like.

10 We can't wait until Year 2 to develop
11 that. So, in some ways, we're going to need some
12 extra time.

13 I'm not sure, two days, at least two
14 days, together might work in terms of the process
15 but we may need extra time because we're going to
16 have to talk about -- I assume we want to vote,
17 did we like the way the voting process went,
18 their changes?

19 What do we think about the CMS criteria?
20 Those questions, we're going to be going through
21 a process that we're going to then have to have a
22 period to discuss what we want our future to look

1 like.

2 And then finally, I think to me, I don't
3 know how much we will get from the outside but I
4 think ultimately in Year 2 and Year 3, we think
5 of this in a three-year cycle, we really do want
6 to come up with a robust way of asking the field
7 or asking our own organizations and asking MAP
8 itself or NQF itself to come up with additions to
9 whatever the list is we get from CMS.

10 And I think part of this going to have
11 to be a good feedback loop by CMS just in terms
12 of the treatment of measures that we made the
13 previous year and other years so that we can
14 assess that.

15 There may be measures that NQF, the
16 Coordinating Committee, might look at that CMS
17 didn't put in for removal that we think should be
18 on that list. This is obviously in Year 2 and
19 Year 3, but we've got to think about how to
20 structure that.

21 So, those are my major comments but I
22 really appreciate that CMS has an interest in MAP

1 playing this role.

2 Ultimately whether it's just the
3 Coordinating Committee or the Coordinating
4 Committee and the Work Groups, I think these are
5 all process questions we're going to have to work
6 through.

7 But I think they're all answerable and
8 I think if we look at the early days of the
9 Coordinating Committee and the Work Groups, I
10 think you could see that we could really handle a
11 lot of measures.

12 If you go back to our earliest days in
13 2014, for example, we considered 202 measures.
14 We're now down, I guess, in '17 to about 32, '18
15 it was 39, I don't remember how many it was this
16 year but it was in that range.

17 So, we know what we can do in a short
18 time and I don't know whether the world of
19 measures to be considered for removal is going to
20 be all that great or will be all that great over
21 a number of years.

22 But I think this is a great opportunity

1 and I hope that we can get it started in Year 1
2 as a pilot and then continue into Year 2 and 3.

3 CHAIR ROBERTS: Thanks, Chip, definitely
4 a good point about the funding. Ron, did you
5 have a question?

6 MEMBER WALTERS: I did. I have an
7 answer to the third question too. The third
8 question depends on how good we are at finding
9 the criteria and a little bit to Question 1.

10 If we don't get those right, the answer
11 to Question 3 is they've got a lot more work to
12 do over one to two days. And we appreciate the
13 work the Staff does.

14 I like being involved in this process.
15 Again, it's advisory so when we go back to
16 Question 1, I think just a simple vote can convey
17 how the group felt, including its tie, 50-50.

18 That provides information itself and I
19 don't think there needs to be necessarily as
20 detailed a process as we have in place for the
21 way we process forward direction right now.

22 Question 2, no, I don't think -- maybe

1 Year 5, 6, 7, or 8 after we get the bugs worked
2 out on the other ones. But otherwise, that just
3 introduces extra work and makes it look like the
4 old endorsement process even more again.

5 So, I actually am very optimistic that
6 we can accomplish this pretty easily for, yes,
7 even 50 measures with just making sure we get
8 right how we're going to do it and make the
9 process as streamlined as possible.

10 What we're doing again is giving
11 feedback to CMS. All the comments will be
12 available, the individual input and so on and so
13 on but the voting is all we really want anyway.

14 MS. DeSOTO: Hi, this is Mia DeSoto from
15 ARC. I just quickly wanted to add to what Ron
16 was mentioning.

17 If we have very clear and robust
18 criteria on how we are deciding to recover the
19 measures, has the measure topped off, are we
20 taking a lifecycle approach?

21 I think the Committee should be able to
22 direct in a fairly transparent and objective way.

1 I was also going to mention that perhaps we can
2 use a peer review approach where there are
3 primary and secondary reviewers for measures that
4 are getting retired.

5 That way, when you bring it to the
6 Committee, the entire Committee doesn't have to
7 spend too much time but the primary and secondary
8 reviewers would do a solid discussion and then
9 people can do a vote.

10 CHAIR ROBERTS: Thanks, Mia. Mary, I
11 think you were next?

12 MEMBER BARTON: Thank you. I would want
13 to repeat the previous two speakers who said you
14 need to have very clear criteria.

15 But I think it really makes a lot of
16 sense to include the setting-specific Committees
17 because when you think about retiring, you want
18 to be looking at the measures that are there in
19 the context of the program.

20 And even topped out is an assessment
21 that might vary from program to program. And so
22 I think it really makes a lot of sense that the

1 setting-specific Work Groups be a feeder for
2 their recommendations up to the Coordinating
3 Committee.

4 CHAIR ROBERTS: And Scott, I think you
5 might have been next?

6 MEMBER FERGUSON: Mary stole my thunder,
7 that's exactly what I was going to say. I think
8 it would be important to have setting-specific
9 Work Groups review it for the very reasons she
10 said.

11 We're not all in the same settings and
12 that funneling to the MAP Coordinating Committee
13 I think is an important part of the process. And
14 I do like us being involved in the removal
15 process but as the others said, it needs to be
16 done right.

17 And I think that's right, as far as yes-
18 no voting, I think it's exactly -- and as the
19 others stated, I think it's probably all they
20 want.

21 They don't want to a whole lot of other
22 stuff or need a whole lot of other stuff. And I

1 think if we follow through Work Groups and we do
2 a yes-no vote, I think we can get to quite a few
3 measures.

4 CHAIR ROBERTS: Thanks, Scott. Amir?

5 MEMBER QASEEM: Thanks, Misty. This is
6 a wonderful idea. I was joking in the text chat
7 as well.

8 I think what's concerning about what CMS
9 did today, this call we had for the conditional
10 recommendation on the measure.

11 I think that was a really wonderful
12 idea, something I encourage us to do moving
13 forward as well as for many of the other measures
14 that end up generating a lot of discussion.

15 I think that was really nice. Michelle,
16 I really appreciate it and this idea that we're
17 talking about retiring the measures, it requires
18 a lot of thinking.

19 We already heard the process piece but
20 the method piece is also going to be important.
21 So, I like pushing CMS to its limit so the pilot
22 year I see it as being utilized that if there is

1 an opportunity for us to work together with CMS
2 to figure out how do you operationalize some of
3 the things?

4 And essentially, the science and
5 methods, how do we retire the measure? I see the
6 pilot will work out better that way rather than
7 just CMS doing it and then MAP takes it on.

8 Because you get a lot of people on this
9 group who can -- and actually, the whole
10 Committee, I think you can get some good input on
11 it. And then, of course, because that's where
12 the rubber hits the road.

13 How are we going to operationalize it?
14 So, that's the bottom line but it's a wonderful
15 idea, I strongly encourage us doing that.

16 And a general comment about this one to
17 two days or three days or something, I feel like
18 there needs to be a frequency of MAP meetings.

19 This has come up over the years, Misty
20 and Chip, you remember that. Should it be like
21 every three months or something like that?

22 Because what we did today is

1 essentially, we're meeting every two, three
2 months later was beneficial. This traditional
3 way of doing it once a year, we all lose
4 momentum.

5 Next year, I'm sometimes really thinking
6 which MAP are currently meeting because there are
7 three others with the measurement and you guys
8 know that, right?

9 So, I think it's going to be very
10 valuable as we're thinking through when we're in
11 the process phase, should we have a January and
12 then every three months or so meeting for one
13 days or two days or whatever the frequency is
14 going to be.

15 And I'm sure Michelle will be happy to
16 fund our fancy dinners and drinks unlimited.
17 Thanks, guys.

18 CHAIR ROBERTS: Thanks, Amir. Leah?

19 MEMBER BINDER: Yes, on the first
20 question, I think that yes or no voting is not
21 sufficient and I think that it would be more
22 valuable for the Committee's contribution to the

1 process if their conversation was reflected more
2 with CMS because it is advisory, which is fine.

3 I think it should have some substantive
4 content to that advisory, especially to make sure
5 minority views are always represented in CMS's
6 understanding of how a removal or a new measure
7 actually is considered.

8 I also support the idea of this process
9 for removal, I think it's a good opportunity.
10 But I also think that there will be times when
11 there will be one measure that will be of great
12 concern to the group for removal.

13 And I think we see that anyway with just
14 the MUC list, there's usually one or two measures
15 are of particular debate.

16 In this there will be the same thing and
17 when we have so many measures in one meeting,
18 like 50 measures across 19 programs, that is
19 burdensome and might not give us enough time to
20 actually focus on the ones where there really is
21 important considerations that have to be debated.

22 And that is particularly the case for

1 the burden on purchasers and consumers because
2 they really have to, usually, look across the 19
3 programs and they're not representing people from
4 one or another program, they're representing
5 people who could be in any of those programs.

6 And so they -- and they're not
7 clinicians typically, we're not the ones who have
8 the deep knowledge of any of this. So, they need
9 a lot more preparation time and 50 measures is a
10 lot.

11 So, I think perhaps there needs to be
12 built into this process a way of offering early
13 consideration and maybe some briefings on
14 measures that are up for consideration for
15 removal, opportunities particularly for consumers
16 and purchasers to hear more about the measures
17 and then decide from there at the meeting, what
18 are the handful of measures that should really be
19 discussed in great depth by the Coordinating
20 Committee?

21 That would be my recommendation, some
22 kind of process so that when the Coordinating

1 Committee convenes, they're really focused on the
2 high-priority debated measures.

3 Thank you.

4 CHAIR ROBERTS: I appreciate that
5 comment, Leah. I just wonder if you can still
6 expand on that a little bit.

7 I understand the more discussion around
8 the measure but what would you recommend other
9 than the yes-no? Because right now a lot of it
10 stems upon conditional upon NQF endorsement for
11 the voting on the measure.

12 Any thoughts in mind on what we might
13 have in addition to the yes, no?

14 MEMBER BINDER: I would think that just
15 notes from the Staff of the meeting that we could
16 approve? I could send them around if anyone
17 wants them.

18 I think just notes from the Staff on
19 some of the comments that were made or some of
20 the considerations or allow members to submit
21 comments, maybe after the meeting, if they wish
22 to, to go into the documents that are sent to CMS

1 for each category.

2 I don't think it needs to be extensive
3 but I just think it needs to be an opportunity to
4 reflect back to CMS what were the concerns of
5 different stakeholders, if there was in fact some
6 debate?

7 CHAIR KAHN: If I could add, I think we
8 could use the criteria. I think there was some
9 discussion of the criteria.

10 I think how good the criteria and how
11 tight they are here offer us an opportunity here
12 to give feedback on the criteria as well as the
13 yes.

14 So, if we did, yes, it should be
15 removed, then we should have pretty firm answers
16 on these criteria that would fill in Leah's point
17 pretty well.

18 So, I think we should think about how to
19 robustly deal with the criteria and come up with
20 some kind of answer to the questions. Because
21 this is going to be almost logarithmic, it could
22 be.

1 We could have an algorithm that gets you
2 to a yes or no.

3 MS. DESOTO: All right. This is Mia.
4 I just wanted to add to what Chip and Leah
5 mentioned, I think very critical points.

6 Also, I think it will help people to
7 understand that, you know, if we are making
8 decisions in terms of accountability programs
9 then the feedback would be related to that
10 accountability programs, however the measures
11 would be used for quality improvement, for
12 example.

13 So I agree with Leah that we have to
14 have some qualifiers of if we make this yes/no
15 voting available to CMS.

16 CHAIR ROBERTS: Okay. I thought there
17 was somebody else that had their hand raised.
18 Let me see here. Julie, I think you had a
19 comment, did you want to touch on that that you
20 had a clarifying question about the timeline?

21 MEMBER SONIER: Sure. So my question
22 was just to clarify sort of if there is a meeting

1 in the Fall of 2021 that whether it's
2 consideration for removal in Performance Year
3 2022 or 2023.

4 I think it's the latter because there
5 will already be a proposed rule out for
6 Performance Year 2022, but I just wanted to make
7 sure that I understood that correctly.

8 DR. SCHREIBER: So this is Michelle, and
9 let me try and clarify that. The reason for the
10 meeting being in the late summer/early fall is to
11 try and make sure that we can incorporate your
12 comments as we go into the next rule-writing
13 cycle.

14 So the comments, you know, in the
15 summer, end of summer/fall of this year, 2021,
16 would help inform CMS in their rule-writing cycle
17 for 2022, which generally starts around January,
18 okay.

19 And then that would go into rule writing
20 2022 which would likely affect the programs in
21 2023, although as you know sometimes it extends
22 beyond that.

1 You know, we may leave a measuring for
2 a year and it doesn't happen until 2025, but the
3 reason it's important actually to have this
4 meeting sometime in the late summer/early fall is
5 that we already start our process of thinking
6 about what is going to be removed from programs
7 in the summer, because we're already thinking
8 through what changes do we want to put into rule
9 writing because rule writing starts with a bang
10 in January really right after the MAP meetings
11 where we are putting temporary proposal documents
12 in place to be cleared up through CMS and so we
13 want to make sure that we can get the MAP
14 consideration early enough to help us inform the
15 rule writing. So I hope that answers your
16 question, ma'am.

17 The other thing is, you know, it is not,
18 you know, you may or not think this is true, but
19 it is actually not random what measures we try to
20 remove from programs.

21 Some of this is cyclical. You know that
22 we do have measure removal criteria that have

1 been posted in rule writing and that when we
2 remove a measure we actually also in rule writing
3 indicate what is the rationale behind that.

4 But we are really very much looking
5 forward to seeking the comment from the MAP. We
6 already do seek public comment through rule
7 writing but we think this is a way to kind of
8 have more -- I think this is an opportunity for
9 the Coordinating Committee to really be a
10 coordinating committee, to have more of a broader
11 oversight as to what is in these programs, what
12 goes into them, maybe what can come out of them,
13 suggestions for how to morph some of the measures
14 that are in them.

15 It may not be removal, it might be
16 morphing them to something that is slightly
17 different. We are really looking forward to it.
18 From a timing point of view, just so all of you
19 are aware, Chip was right, this was an unfunded
20 mandate for this year.

21 Number one, that means we have to modify
22 a contract and we can't actively start working on

1 this probably until June. You know, we can't
2 start doing work on this until the contract is
3 modified, so that gives a relatively short runway
4 for this year.

5 And then as Chip also pointed out we'll
6 have to either re-look at all of the task orders
7 that CMS has with NQF or go back to the well,
8 which is, you know, Congress.

9 Did that help with the timeline though?

10 MEMBER SONIER: Yes, very much. Thank
11 you.

12 DR. SCHREIBER: Okay. Thanks.

13 CHAIR ROBERTS: Thanks, Michelle. Liz?

14 MEMBER GOODMAN: So I am listening and
15 watching the chat and, Katie, I also agree with
16 you about it's a lot, it's a heavy commitment and
17 we need more of a rationale than just yes/no.

18 I do think, Chip, your comment about
19 there could be some kind of an algorithm would
20 get us most of the way there. I don't know how
21 much free text narrative we need, but I am not a
22 measure developer.

1 My question is more about how this pilot
2 process, which I am very supportive of, works and
3 over time how the rest of the measure sets get
4 incorporated.

5 I am just trying to think about what the
6 time window is and how that affects this other
7 question about how frequently the MAP meets.

8 CHAIR KAHN: Well, just to answer your
9 question partially I think Michelle just outlined
10 the point in the year that we would need to be
11 relevant to sort of the ongoing cycle of CMS
12 policymaking on measures.

13 So I think we've got to be late
14 summer/early -- Well, actually, not even, I think
15 really late summer because summer goes till
16 September 21st, I guess. I mean we need to be
17 right in that sort of period otherwise we'll miss
18 the train.

19 Since the cycle is an annual cycle you
20 don't want to miss it because then you're really
21 two years, you've got two years before things get
22 in the cycle.

1 So I think that's what we would end up
2 doing. We would probably -- Once we get going we
3 could probably have preliminary work done in
4 July, but I think we've got -- And, also, I think
5 this 50 is, I have no idea, I think this is a
6 good question for Michelle as to when you go
7 through this process, you know, what's the number
8 that you all consider for reprogramming or
9 kicking out?

10 DR. SCHREIBER: I mean the truth is it's
11 variable. So we look at every program, every
12 measure, and we usually do that in the summer and
13 have, you know, fairly high-level discussions.

14 There are some measures, let's not all
15 forget, that are statutory that frankly the only
16 way to get them out is an act of Congress, and
17 we'll flag, obviously, which ones those are.

18 CHAIR KAHN: Mm-hmm.

19 DR. SCHREIBER: There are some measures
20 where it is clear that they are topped out or the
21 evidence has changed and so that becomes
22 relatively straightforward.

1 We usually -- The biggest removals
2 usually have been coming from the MIPS program,
3 largely because that's the largest number of
4 measures in a program where there are well over
5 200 measures actually in the MIPS program as
6 opposed to the other ones which are smaller.

7 It depends on the program also. There
8 are some programs that dealt, you know, by some
9 people's thoughts don't have enough underlying
10 measures and we wouldn't seek to be removing.

11 There are some programs that are felt to
12 be more burdensome and we do seek to remove. So
13 I'd say 50 is not a bad number if you are talking
14 about measures removal because that's about 10
15 percent of the measures that are in a program.

16 It may be less than that, probably
17 generally a little bit less than that, but I
18 don't know that you just want to look at the
19 measures that CMS is proposing to remove.

20 I would suspect you want a sort of more
21 holistic view of each program and sort of what
22 are the measures that may be your top spots that

1 you want to remove, your sort of pet peeve
2 measures that have been in there and you really
3 never understood why, you know.

4 Maybe PSI 90 is a pet peeve measure,
5 maybe it's not. And so I think the first couple
6 of years it's going to have to be a lot of
7 familiarity with these programs and the measures
8 that are in the programs and then, you know,
9 people will get into a cadence of being very
10 familiar with them.

11 CHAIR ROBERTS: Yes, I definitely think
12 that we are going to have to have a better
13 understanding of all the measures in the federal
14 program to your point, Michelle, and then not
15 just focus on those measures that CMS is
16 proposing to retire, although I do see this as
17 something that is really going to evolve over
18 time where we start off doing it one way and then
19 we recognize and basically take lessons learned
20 to improve it.

21 DR. SCHREIBER: Yes.

22 CHAIR ROBERTS: And to Amir's point, I

1 think that we are definitely going to have to
2 meet more frequently than we do now, especially
3 if we are expanding our scope.

4 DR. SCHREIBER: No, Misty, we completely
5 agree with you. It may be that, you know, the
6 CMS removal criteria shift depending on things
7 that we learn during this process, too.

8 CHAIR ROBERTS: Yes.

9 DR. SCHREIBER: We have to put that in
10 rule writing. So if we shift our criteria for
11 measure removal that, too, would have to go into
12 rule writing, but I think over time there is
13 certainly that opportunity to do that.

14 CHAIR ROBERTS: Yes, makes sense. Emma,
15 I think you have a question.

16 MEMBER HOO: Yes. I just wanted to echo
17 the comment about looking at the programs
18 holistically because, you know, over time, you
19 know, so many process measures have evolved and I
20 think there is a case to be made for looking at
21 replacing some of the ones that have topped off.

22 But holistically, you know, I find that

1 there are still a lot of opportunities to explore
2 what we can be doing more in the way of cost and
3 efficiency measures as well as patient-reported
4 outcomes.

5 As a purchaser, you know, having greater
6 focus on those areas would develop, you know,
7 some of more value-based payment models and
8 support accountability over the long haul rather
9 than, you know, having what often, you know, our
10 experience is, you know, small tweaks to existing
11 measures, which are important for refinement, but
12 at the end of the day, you know, some of the
13 opportunities really lie in capturing patient-
14 reported outcomes and taking a broader look at
15 cost and efficiency.

16 DR. SCHREIBER: Yes. Thank you. And
17 CMS completely agrees with you on that. So if
18 you have followed, you know, the CMS quality
19 measure action plan the key action steps that we
20 are trying to take over the next several years
21 are, number one, alignment, and that means
22 alignment of the measures, but it also means

1 alignment of measures across programs.

2 So how are we starting to make the
3 connection between say post-acute care and
4 hospital programs and between that and ambulatory
5 measures, how does this sort of form a larger
6 continuum, so alignment.

7 The second is the move to digital
8 measures. We are truly fully committed to moving
9 all of our measures to digital and so for those
10 measures in the program that would mean moving
11 those as well.

12 Patient-reported, patient-censored,
13 patient-directed, however you want to say that,
14 measures is extremely important and we are
15 looking for more patient-reported outcomes,
16 patient-directed measures, and, finally, the
17 promoting equity and making sure that we are
18 trying to close the disparity gap either through
19 our measures or new measures or stratification of
20 measures.

21 So these are sort of goals of CMS that
22 I think align with what you are all talking about

1 as well, and so we are really looking to do the
2 same thing.

3 CHAIR ROBERTS: Any other questions from
4 the Coordinating Committee? I don't think I see
5 anything else in the comments. Okay. Why don't
6 we -- Oh, Scott, go ahead.

7 MEMBER FERGUSON: Yes. I just think in
8 the removal process we'll need to think about
9 when we think about positions and different
10 practices we need to think about specializations
11 and make sure that each specialty still has an
12 adequate number of measures.

13 I know in my particular area there are
14 not and we have to pilfer from other areas to try
15 to make up to get six MIPS items, so it's
16 something our work groups need to pay particular
17 attention to I think and CMS as well.

18 CHAIR ROBERTS: Yes, that's a fair
19 point. Why don't I open it up to public comment
20 now and see if anybody else from the public has a
21 comment.

22 I think Collette might have had her hand

1 raised earlier. Collette, do you still have a
2 question?

3 MEMBER COLE: I think points have been
4 adequately made. I just wanted to comment that I
5 do appreciate the possibility for criteria to be
6 applied and that process be transparent.

7 I know that there was a point made on
8 the slide, a concern about possibly 50 measures
9 being up for retirement in that process and part
10 of that might be the move towards MIPS Value
11 Pathways and that consideration and CMS has gone
12 through the process, as was said before, of
13 really applying that criteria and giving the
14 rationale for topped-out measures.

15 So I think really a holistic view of
16 measures is important in how those measures are
17 being applied in programs. So actually I am
18 reiterating what has been said before. Thank
19 you.

20 CHAIR ROBERTS: Thanks. Do we have any
21 other comments from the public? Okay. So let me
22 try to summarize what I think I heard and to

1 Amir's question around the next steps, and I'll
2 probably need a little bit of help with that, but
3 I think that the summary in terms of answering
4 those direct questions, you know, will yes/no
5 voting be sufficient.

6 I think that we agree, although there
7 might be a little disagreement, but it's probably
8 going to be a little bit smoother if we have some
9 criteria to determine whether or not we should be
10 voting a yes or a no.

11 The second one about the work groups I
12 think that we agreed that we do think that there
13 will need to be work group involvement. I think
14 a lot of that prep work needs to be done before
15 it comes to the Coordinating Committee.

16 And then I think the third one was
17 really just that we are going to have to have a
18 clearly-defined process in order to really
19 simplify and align, and I don't think that that's
20 going to happen right out of the gate.

21 While I haven't been on the MAP for ten
22 years like Chip and others, I think that it has

1 taken quite a while to actually get to where we
2 are today in terms of a more streamlined
3 approach.

4 So I don't think that this is going to
5 happen right out of the gate, but I do think that
6 the more clearly defined process that we can put
7 in place and then evolve with lessons learned I
8 think that's certainly going to help streamline
9 everything.

10 So I think I have summarized the
11 conversation. Chip, would you add anything to
12 that?

13 CHAIR KAHN: No. I really appreciate
14 what you said, but I think, one, there is a sense
15 of enthusiasm about going forward with this.

16 CHAIR ROBERTS: Mm-hmm.

17 CHAIR KAHN: I think there is a little
18 concern about the breadth of it, but I think
19 we'll all just have to take a breath and proceed.
20 I appreciate the commitment of CMS to go forward
21 and be patient with us as we, you know, design a
22 pathway.

1 I think clearly though, you know, yes/no
2 is easy but we really will need to have pretty
3 firm criteria and we will need to have I think
4 sufficient time to meet to both consider the
5 measures but really to come up with, to go over
6 what the Staff comes up with regarding process so
7 we can put our own mark on that process and be
8 comfortable with it as a committee.

9 CHAIR ROBERTS: Yes. So in terms of
10 next steps I think that's what everybody wants to
11 know. It seems like it would make logical sense
12 to, I am guessing, for the NQF team, and correct
13 me if I am wrong, I am always leaning on Sam
14 here, to help put together what this criteria
15 might be.

16 I am sure we can potentially lean on
17 what CMS has already put together for their
18 process. Then we would need to probably
19 reconvene before that, I think the pilot day if I
20 remember, late summer, I think we would need to
21 reconvene before then and such is the point of
22 more frequent meetings.

1 We probably need to figure out what that
2 cadence is as well.

3 MR. STOLPE: Yes. Thanks so much, Misty
4 and Chip, and NQF Staff. We are hearing the same
5 thing that you are, that there is a lot of
6 enthusiasm about this and it's more appreciated
7 than you probably realize.

8 We are excited to get started on this,
9 too. We do have some things that we need to work
10 out from a contracting standpoint with CMS before
11 we can get it going.

12 It's important for us to do this
13 conscientiously and carefully and to make sure
14 that we are doing things according to contract.
15 So those stipulations are going to have some
16 impacts on our timeframes.

17 So to Amir's point, we do need to be
18 thinking about our next steps, but we have to do
19 so fairly carefully within the guardrails that
20 are put in place between contracting with CMS and
21 NQF.

22 So with that being said, we want to

1 afford the Coordinating Committee opportunities
2 to provide feedback on the process that we put
3 together both for this year and for subsequent
4 years.

5 It's important for the Coordinating
6 Committee, as Chip said, to have ownership of
7 this process and to be able to make your mark and
8 make sure it aligns with the overall intent.

9 So in the spirit of that we will of
10 course need to sit tight momentarily while we
11 work through contracting with CMS, but as soon as
12 we have that in place we'll be able to put
13 forward some ideas for the Coordinating Committee
14 to react to.

15 CHAIR KAHN: Great. I think we got a
16 plan.

17 DR. SCHREIBER: Hey, can I just comment
18 on one other thing, Misty?

19 CHAIR ROBERTS: Yes, go ahead, Michelle.

20 DR. SCHREIBER: I would hope that as the
21 committee develops their plan, and, frankly,
22 knowing most of you I know that this will happen,

1 but measure removal hopefully will be as data-
2 based as possible, and so what is even the
3 analytics that we want to be sure are in place as
4 we evaluate measures that are in programs.

5 I think that might almost be its own
6 separate conversation, but we have to make sure
7 that our measure removals are actually founded in
8 data of how these measures are performing and how
9 are we doing that rather than just, you know,
10 somebody who doesn't happen to like this measure
11 or that measure, but we try to have data evidence
12 behind it.

13 It's not always available and I think
14 that might be another issue that comes up and is
15 actually highlighted, so thanks for that. We are
16 very excited about this, by the way.

17 And to Amir's question we are happy to
18 share our criteria for measures removal, we're
19 happy to talk about, you know, kind of how
20 measures get in, get out, because we enjoy the
21 measure application partnership and look forward
22 to the feedback.

1 CHAIR ROBERTS: Thanks, Michelle. And
2 I think that we would definitely appreciate
3 understanding that better, but that I am sure
4 that our committee will also have some ideas of
5 their own.

6 DR. SCHREIBER: Oh, I am certain that's
7 true.

8 CHAIR ROBERTS: Always. All right.
9 Sam, what's next? I think -- I don't want to say
10 that we are going to end early, but I think we
11 are going to end early.

12 MR. STOLPE: I think we are. I know
13 we're at a very high risk of ending early. Let's
14 go ahead and go to the next slide, please.

15 At this point we're just going to wrap
16 things up. So, Chip, Misty, any parting comments
17 for the Coordinating Committee to consider as we
18 are getting ready to adjourn?

19 CHAIR KAHN: I just appreciate all the
20 discussion today and look forward to continuing
21 to learn about the measure that we talked about
22 and about this process.

1 CHAIR ROBERTS: Yes. I appreciate,
2 always appreciate, the robust discussion. It
3 seems like I always learn something at these
4 meetings as well, but definitely appreciate the
5 opportunity also from CMS to expand the scope and
6 excited to see what this looks like moving
7 forward. So thanks, everyone.

8 MR. STOLPE: I certainly echo that,
9 Misty and Chip. I really appreciate your
10 leadership in helping us to get through today's
11 meeting, great facilitation as always.

12 So it just remains for me on behalf of
13 the NQF Staff to give a thanks to our
14 Coordinating Committee members, to our colleagues
15 from the other work groups who were able to join
16 today, to our colleagues at CMS and CDC, thank
17 you so much for the presentations and for the
18 discussion, and to our members of the public,
19 thank you for joining us today.

20 We are adjourned for now. Take care.

21 (Whereupon, the above-entitled matter
22 went off the record at 3:23 p.m.)

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This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership
Coordinating Committee

Before: NQF

Date: 03-15-21

Place: teleconference

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