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

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

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

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

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

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

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

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

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

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

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

few closing remarks and adjourning.

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

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

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

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

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

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

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

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

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

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

our time together.

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

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

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

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

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

you to say hello.

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

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

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

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

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

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

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

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

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

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

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

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

talk about measure removal.

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

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

So, with that, I hand the baton back.

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

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

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

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

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

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

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

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

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

American Academy of Hospice and Palliative Medicine?

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

MS. HAYNIE: Thank you, AmeriHealth Caritas?

MEMBER GELZER: Good afternoon, this is Andrea Gelzer.

MS. HAYNIE: Great, American College of Physicians?

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

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

MEMBER GIFFORD: David Gifford from AHCA.

MS. HAYNIE: American Medical Association?

MEMBER FERGUSON: Scott Ferguson, AMA.

MS. HAYNIE: Thank you. American Nurses Association?

MEMBER BOSTON LEARY: Katie Boston Leary from the ANA.

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

MEMBER GOODMAN: Liz Goodman from AHIP.

MS. HAYNIE: Blue Cross Blue Shield Association?

MEMBER MARINKOVICH: Hi, Wendy Marinkovich for BCBSA.

MS. HAYNIE: Thank you. HCA Healthcare?

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

MS. HAYNIE: Great, the Joint Commission?

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

MS. HAYNIE: Welcome. The Leapfrog Group?

MS. BINDER: Leah Binder from The Leapfrog Group?

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

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

MS. HAYNIE: National Patients Advocate Foundation?

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

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

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

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

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

MS. HAYNIE: Pacific Business Group on Health?

MEMBER HOO: Emma Hoo representing PBGH.

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

MEMBER SONIER: Rob Fields, National Association of ACOs.

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

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

MS. HAYNIE: Jeff Schiff?

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

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

MEMBER WALTERS: I'm here.

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

MEMBER FIELDS: Yes, sorry, I forgot

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

So, I am still here.

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

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

MS. HAYNIE: Thank you. Sean Morrison?

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

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

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

MS. HAYNIE: Aaron Garman? All right,

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

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

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

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

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

MEMBER VAN ELLEN: Hello, it's Linda Van Ellen, I'm the Vice President for Care Management at Tenet Health. MS. HAYNIE: Thank you. American Geriatrics Society? American Occupational Therapy Association? American Physical Therapy Association? MEMBER BELL: Hi, this is Alice Bell, representing American Physical Therapy Association.

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

MS. JOSEPH: Hello this is (Audio

interference.)

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

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

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

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

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

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

MS. HAYNIE: Kindred Healthcare? Leading Age?

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

MS. HAYNIE: Thank you. Memphis Business

Group on Health? Michigan Center for Rural Health?

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

MS. HAYNIE: Thank you. Minnesota Community Measurement?

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

MS. HAYNIE: National Association for Behavioral Healthcare?

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

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

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

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

MEMBER WAGNER: Hi, this is Janet Wagner

from RWHC.

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

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

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

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

MR. SRINIVASAN: Hi, Arjun Srinivasan, CDC.

MS. HAYNIE: Centers for Medicare and Medicaid Services?

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

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

Information and Technology?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Just a little bit of follow-up, we are

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

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

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

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

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

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

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

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

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

Thank you once again.

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

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

healthcare safety network.

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

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

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

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

daily basis.

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

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

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

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

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

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

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

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

Next slide.

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

developed for COVID-19.

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

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

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

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

Vaccination and proven outbreaks of disease in healthcare settings, including

reducing mortality among their patients.

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

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

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

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

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

real time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

in different circumstances.

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

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

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

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

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

pandemic period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

comfortable using as part of quality measurement.

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

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

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

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

The data sources are the same and there

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

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

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

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

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

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

report.

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

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

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

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

facilities for their Staff.

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

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

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

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

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

validity plan in conducting validity studies.

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

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

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

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

Pharmacy Partnership Program.

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

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

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

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

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

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

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

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

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

Hearing these figures, again, it's

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

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

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

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

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

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

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

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

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

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

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

CHAIR KAHN: I have a question. You had

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

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

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

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

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

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

that correct?

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

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

Which is really a big difference between that and this.

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

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

healthcare personnel necessarily.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR KAHN: Sam, that's a question?

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

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

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

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

the implications of that.

MR. STOLPE: Sounds good, Chip.

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

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

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

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

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

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

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

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

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

Dan?

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

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

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

use of authorization currently.

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

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

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

MEMBER GIFFORD: Chip, this is Giff.

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

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

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

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

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

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

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

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

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

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

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

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

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

just a handful each week.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, does that address some of the concerns?

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR KAHN: Is that it, Leah?

MEMBER BINDER: Are we just asking questions now?

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

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

CHAIR KAHN: I thought you had a question.

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

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

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

anything to do with this.

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

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

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

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

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

So, what was your motivation here?

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

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

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

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

CHAIR KAHN: Sure.

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

And two, for public transparency as

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

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

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

DR. BUDNITZ: Thank you.

CHAIR KAHN: Jeffrey?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR KAHN: Akin, do you have a question?

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

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

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

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

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

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

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

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

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

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

month.

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

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

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

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

So, this is why we are suggesting the

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

MEMBER DEMEHIN: Got it, thank you.

CHAIR KAHN: Okay, anymore questions? I assume from looking at the chart that Giff has comments and Leah has comments. Michelle, did you have a comment?

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

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

almost every clinic to get it.

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

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

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

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

CHAIR KAHN: Leah, did you have a comment?

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

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

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

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

And I think that it's going to be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER QASEEM: And Michelle, at this

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

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

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

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

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

So, this is giving us the flexibility of

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

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

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

Dan, correct me if I'm wrong.

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

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

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

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

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

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

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

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

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

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

DR. SCHREIBER: We are thinking of NQF endorsement.

MEMBER QASEEM: All right.

CHAIR KAHN: Okay, any other questions or discussion?

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

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

Is that correct?

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

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

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

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

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

all these.

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

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

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

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

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

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

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

MR. STOLPE: Thanks very much, Misty.

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

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

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

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

Now, we've included the actual language,

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

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

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

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

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

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

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

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

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

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

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

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

process.

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

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

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

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

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

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

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

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

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

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

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

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

Could we go to the next slide, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Misty?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

like.

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

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

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

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

playing this role.

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

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

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

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

But I think this is a great opportunity

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR ROBERTS: Thanks, Scott. Amir?

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

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

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

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

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

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

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

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

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

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

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

Because what we did today is

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

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

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

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

CHAIR ROBERTS: Thanks, Amir. Leah?

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

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

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

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

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

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

And that is particularly the case for

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

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

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

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

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

Thank you.

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

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

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

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

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

for each category.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Did that help with the timeline though?

MEMBER SONIER: Yes, very much. Thank you.

DR. SCHREIBER: Okay. Thanks.

CHAIR ROBERTS: Thanks, Michelle. Liz?

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

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

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

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

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

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

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

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

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

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

CHAIR KAHN: Mm-hmm.

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

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

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

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

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

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

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

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

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

DR. SCHREIBER: Yes.

CHAIR ROBERTS: And to Amir's point, I

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

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

CHAIR ROBERTS: Yes.

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

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

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

But holistically, you know, I find that

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

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

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

alignment of measures across programs.

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

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

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

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

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

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

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

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

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

I think Collette might have had her hand

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR ROBERTS: Mm-hmm.

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

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

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

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

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

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

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

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

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

So with that being said, we want to

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

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

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

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

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

CHAIR ROBERTS: Yes, go ahead, Michelle.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We are adjourned for now. Take care.

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

Q

C E R T I F I C A T E

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

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter