National Quality Forum
2022 Measure Set Review Meeting of the Measure Applications Partnership Coordinating Committee
Wednesday, August 24, 2022

The Coordinating Committee met via Video Teleconference, at 10:00 a.m. EST, Chip Kahn and Misty Roberts, Co-Chairs, presiding.

Co-Chairs:

Charles "Chip" Kahn, III, MPH, Federation of American Hospitals
Misty Roberts, RN, MSN, CPHQ, PMP, onehome

Organizational Representatives:

Ashrith "Ash" Amarnath, MD, MS-SHCD, Covered California
David Baker, MD, MPH, FACP, The Joint Commission
Mary Barton, MD, MPP, National Committee for Quality Assurance
Leah Binder, MA, MGA, The Leapfrog Group
Heidi Bossley, RN, MBA, American Medical Association
Katie Boston-Leary, PhD, MBA, MHA, RN, NEA-BC, American Nurses Association
Michelle Dardis, MSN, MBA, The Joint Commission
Elizabeth "Liz" Goodman, DrPH, JD, MSW, America's Health Insurance Plans
Emma Hoo, Purchaser Business Group on Health
Libby Hoy, Patient & Family Centered Care Partners
Rebecca Kirch, JD, National Patient Advocate Foundation
Parul Mistry, MD, MA, AmeriHealth Caritas
Carol Peden, MB ChB, MD, FRCA, FFICM, MPH, Blue Cross Blue Shield Association
Amir Qaseem, MD, PhD, MHA, FACP, American College of Physicians
Clarke Ross, DPA, American Association on Health and Disability
Julie Sonier, MPA, Civitas Networks for Health
Kiran Sreenivas, MS, CPHQ, American Health Care Association

Subject Matter Experts:

Dan Culica, MD, PhD

Janice Tufte
Ronald Walters, MD, MBA, MHA

Hospital Workgroup Members:

Akin Demehin, MPH, American Hospital Association, Chair

Federal Liaisons Present:

Michelle Schreiber, MD, CMS

NQF Staff:

Jenna Williams-Bader, MPH, Senior Director
Katie Berryman, MPAP, PMP, Director, Project Management
Tricia Elliott, DHA, MBA, CPHQ, FNAHQ, Senior Managing Director
Ivory Harding, MS, Manager
Joelencia LeFlore, Associate
Ashlan Ruth, BS IE, Project Manager
Susanne Young, MPH, Manager
Gus Zimmerman, MPP, Analyst

CMS Staff:

Gequincia Polk, Indefinite Delivery/Indefinite Quality (IDIQ) Contracting Officer's Representative (COR), Interim TO COR, CCSQ
Kimberly Rawlings, Task Order (TO) Contracting Officer's Representative (COR), CCSQ

Also Present:

Colleen McKiernan, MS, Lewin Group
Jesse Roach, MD, American Society of Nephrology
Dana Gelb Safran, ScD, President and CEO, National Quality Forum

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(12:04 p.m.)

Welcome, Introductions, Overview of Agenda, Disclosures of Interest, and Review of Meeting Objectives

Ms. Williams-Bader: All right. Good afternoon, everyone. My name is Jenna Williams-Bader. Thank you so much for joining us today for the 2022 Measure Set Review with the Coordinating Committee.

A couple of quick housekeeping reminders before we get started, you can mute and unmute yourself throughout today and tomorrow's meeting. So please go ahead and use that feature. You can also raise your hand in order to get into the queue and then unmute yourself when called upon, and we'll go over that in another slide.

If you are a call-in user, please remember to state your first and last name. And we do encourage you to keep your video on throughout the event. Lastly, if you do have anything that you need to communicate with NQF staff, please feel free to go ahead and use that feature. Okay. If we could go to the next slide, please.

We also have some ground rules that we'd like to remind everyone about. This is really about respecting all of the voices on the line, remaining engaged and actively participating, making sure to link your comments and recommendations back to the measure review criteria and guidance we've provided, as much as possible, keeping your comments concise and focused, being respectful of others, and sharing your experiences. We really want everyone on the line to be able to learn from the other participants. Next slide, please.

I'm sure many of you are used to using the Webex platform. But just in case you need a refresher, as I

said, you can mute and unmute yourself using the mute button along the bottom of the screen where you see the one. If you would like to access the participant or chat button, you can do this along the bottom right-hand side.

And then to raise your hand, there is a raise hand function under the reactions tab. And that's also where you can lower your hand as well once you're done talking. Next slide, please. All right. Well, hello, everyone.

Once again, welcome to the Measure Applications Partnership Coordinating Committee 2022 Measure Set Review Meeting, Day One. My name is Jenna Williams-Bader, and I'm a Senior Director in the Measurement Science and Application Department at the National Quality Forum. We really appreciate all of you joining us today and appreciate that you're prioritizing this work within your busy schedules, especially since we're in the middle of summer. We know that's a busy time for people.

Additionally, we'd like to thank CMS for funding this important work. Okay. If we could go to the next slide, please. Thank you. Right. So we're going to start today with welcome and introductions as well as disclosures of interest and a review of the meeting objectives.

We'll then have CMS give some opening remarks. We'll have NQF staff review the Measure Set Review process and the measure review criteria as well as the voting categories and the general flow for today and tomorrow's meetings. We'll then have an opportunity for public comment on the Measure Set Review recommendations for the Hospital Outpatient Quality Reporting Program.

We'll then be discussing five measures within that program that are not on the consent calendar. We'll wrap up with the next steps and then adjourn for day one. And as a reminder, we do have a day two meeting tomorrow.

One other reminder is that we are piloting the use of a consent calendar during this meeting. So there are going to be a set of measures we discuss that are not on the consent calendar. And we're talking about those measures, both today and the earlier part of tomorrow.

And then the latter part of tomorrow we'll be looking at measures that are on the consent calendar giving the Coordinating Committee an opportunity to pull any additional measures and then discussing two measures that have already been pulled by Coordinating Committee members ahead of the meeting. We'll be covering this in more detail as well. But if you do have any questions about the consent calendar, please feel free to ask.

Okay. If we could go to the next slide, please. Okay. And one more. So I will now turn it over to Dana to give some opening remarks.

Ms. Gelb Safran: Thanks, Jenna. And good afternoon and welcome to everyone. It's really my pleasure to welcome you to today's MAP Coordinating Committee meeting and specifically our meeting on Measure Set Review.

This is the final 2022 Measure Set Review meeting. NQF is as always extremely honored to partner with CMS in the convening of MAP. As all of you are very well aware, MAP brings together all of the key stakeholder groups that are important voices in the issues around measurement and the uses of measures for driving improvement in quality outcomes, affordability, and equity.

Specifically, MAP brings together representatives from quality measurement, research, and improvement fields. It brings together purchases, public health agencies, community health organizations, health professionals, health plans, consumers, and suppliers. As you know last year, NQF collaborated with CMS and the MAP Coordinating Committee to pilot the Measure Set

Review process for the first time offering a holistic review of quality measures and considerations of measures that the committee sought to recommend to CMS ones to consider removed from its program.

We did so using measures from the hospital programs. And I think this was widely recognized and appreciated in the broader community which has for many years been highlighting the ever increasing numbers of measures. And so the idea of reviewing measures and considering their removal from programs was really a welcome addition to the MAP's work.

In 2022, the MSR processes expanded beyond the pilot, bringing in the three setting specific MAP workgroups and also the two MAP advisory groups. And those groups have at this point had their participation, hospital, clinician, and post-acute care setting specific groups as well as the Rural and Health Equity Advisory Committees. And it is the recommendations from those entities that come forward for consideration here.

In this two-day meeting, the Coordinating Committee will finalize recommendations to CMS on measures that committees have selected for potential removal from federal programs. During the meeting that Coordinating Committee members will discuss and vote on acceptance of the workgroup recommendations, Jenna has mentioned the consent calendar which is a new innovation that the team is bringing forward to this work and some of our other committee work. And really it's meant to create efficiencies so that items that really don't require any further discussion can be quickly agreed to by the committee.

And the committee can therefore be efficient and effective with its use of time, focusing on the more complex or sophisticated or nuanced measures that warrant some attention. So just before closing, I want to thank each and every one of our committee

members, our federal liaisons for their time and effort on this very important work. We want to thank all of our colleagues at CMS and the program leads who've been enormously helpful throughout this process.

Thank any members of the public who've chosen to join us and participate in this process. That is a critical part of MAP's work. And finally and very importantly, a special thank you and word of appreciation to our co-chairs, Chip Kahn and Misty Roberts, for their leadership and dedication to MAP's work over so many years. So with that, I will hand it back to you, Jenna, to move through the rest of the introduction to the meeting. Thanks.

Ms. Williams-Bader: Thank you very much, Dana. Okay. If we could move to the next slide. So now we're going to hear from our co-chairs, Chip Kahn and Misty Roberts. Chip, I'll turn it to you.

Co-Chair Kahn: Well, I'd like to join Dana with all the thank yous for everyone that's made this possible and particularly the Coordinating Committee members that are on the line and participating today. This is the second year of this effort. Last year, we had a very abbreviated period to do our work.

This year, we've had a little bit better amount of time. But most importantly, we have the input of the workgroups to our process which I think is going to be very, very important. But we are in the second year

From my experience in the past with the Coordinating Committee, our process will evolve. Last year on our other work, the consent calendar seemed to be very helpful. So hopefully, it will be helpful in this process.

But I think people on the phone or on the line from the committee need to be patient with Misty and I as we -- and the staff as we work our way through

this because I think it still is somewhat of an organic process -- developing process. And we're learning what the best way to have our deliberations are. And we really look forward to your input to improve this process as we go.

Let me sort of conclude by saying that I think it is really critically important through this process when we do vote that we have quorum. And so I ask the committee members to sort of be aware if they have to come in and out at all of when we are having votes and that they can make themselves available at that point because I think for our recommendations it really is critically important that we follow process and that we have everyone represented for those votes. So with that, I'll just say thank you for your volunteering time, today and in the future, and I'll pass it off to Misty.

Co-Chair Roberts: Thanks, Chip. Well, I think first welcome. I'm excited about the next two days. I think that dividing this up is really going to be helpful, dividing the time up into two days.

Chip and Dana really touched on a lot of the things that I was going to touch on. But I will echo the thanks to everyone on the Coordinating Committee, also to those on the workgroup who have put in a tremendous amount of time prior to things even getting to us. So appreciate that.

Also appreciate the hard work of the NQF and putting this together. There's definitely a lot of things that happen behind the scenes that people aren't aware of. And to Chip's point, we will continue to evolve.

So we do have to be patient. But it was over a year ago, I guess, that we decided to add this responsibility to the Coordinating Committee. And I do think that it was a welcome responsibility, although it did a little bit more to our plate. And we had to kind of rethink things.

But I'm also excited about the consent calendar that we're going to be using. I do think -- I think to Dana's point, this really is going to make things a little bit more streamlined and efficient and really allow us to focus our time on some of those more complex discussions. So just be patient with it, though, because I think it is something that we're kind of learning into of how this works, what makes sense.

But also I think it allows the opportunity to pull things from the consent calendar. But I do think it makes sense to have a deeper discussion. So looking forward to the next couple days. Again, thanks for everyone's time. And I'm ready to get started.

Ms. Williams-Bader: Chip and Misty, thank you so much for those welcoming remarks. If we could go to the next slide, please. We'll now start on the disclosures of interest.

As a reminder, NQF is a nonpartisan organization. Our of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendos, or humor relating to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting. While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others.

We'll combine disclosures with introductions. We'll divide the disclosures of interest into two parts because we have two types of MAP members, organizational members, and subject matter experts. And we'll start with organizational members.

Organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests. And because of your status as an organizational representative,

we ask you only one question specific to you as an individual.

We ask you to disclose if you have interest of 10,000 dollars or more in an entity that is related to the work of this committee. So we'll go around the table beginning with organizational members only, please. We'll call on anyone on the meeting who is an organizational member. When we call your organization's name, please unmute your line, state your name, your role at your organization, and anything that you wish to disclose.

If you did not identify any conflicts of interest after stating your name and title, you may add, I have nothing to disclose. If you represent an organization that is a measure steward or developer and if your organization developed and/or stewarded a measure under discussion today in the past five years, please disclose that now and then we ask you to recuse yourself from the discussion and poll for that measure later in the day. So I'll now turn it over to Gus to run us through the organizational disclosures.

Mr. Zimmerman: Thanks, Jenna. So we'll start with the American Academy of Hospice and Palliative Medicine.

Okay. American Association on Health and Disability.

Member Ross: Hi, I'm Clarke Ross. I'm the public policy director for the American Association on Health and Disability. We're a nonprofit organization representing public health professionals who focus on disability, both academics and practitioners. And I have no disclosures.

Mr. Zimmerman: Excellent. Thank you. The American College of Physicians.

Member Qaseem: Good afternoon, everyone. Good to see you all over here. I'm hoping for an in-person

meeting soon.

Amir Qaseem, I'm chief science officer here at the American College of Physicians. And I have no disclosures that reach to a conflict level. But I already disclosed them, so you guys can probably have access to them.

Mr. Zimmerman: Thank you. The American Health Care Association.

Member Sreenivas: Hi, my name is Kiran Sreenivas. I'm the senior research director at American Health Care Association. We're a trade association for post-acute long-term care providers. No disclosures to report.

Mr. Zimmerman: Thank you. The American Medical Association.

Member Bossley: Hi, Heidi Bossley. I'm consultant to the AMA filling in while Karen is on maternity leave. I have nothing to disclose.

Mr. Zimmerman: Thank you. The American Nurses Association.

(Simultaneous speaking.)

Member Boston-Leary: Hello, my name --

Member Wade: Hi, good afternoon. My name is --

Member Boston-Leary: Go ahead.

Member Wade: Good afternoon. My name is Roberta Wade. I'm a member of the American Nursing Association, and I have no disclosures.

Member Boston-Leary: Katie Boston-Leary from the American Nurses Association as well, and I have nothing to disclose.

Mr. Zimmerman: Thank you both. America's Health Insurance Plans.

AmeriHealth Caritas. I'm sorry if I mispronounced it.

Member Mistry: AmeriHealth Caritas. Hi, good afternoon. This is Pearl Mistry. I'm the senior vice president for medical excellence and clinical solutions. I have nothing to disclose.

Mr. Zimmerman: Thank you. The Blue Cross/Blue Shield Association.

Member Peden: Hi, I'm Carol Peden. I'm executive medical director of clinical quality for the association which represents the federation of the 34 Blue plans across the U.S. And I have no relevant disclosures. Thank you.

Mr. Zimmerman: Thank you. Civitas Networks for Health.

Member Sonier: Hi, my name is Julie Sonier. I'm representing Civitas Networks for Health as one of their member organizations. I'm the president and CEO of Minnesota Community Measurement. And we are a measure developer, but none of -- there are no measures under consideration in the next two days that we have worked on. And I have nothing else to disclose.

Mr. Zimmerman: Thank you so much. Covered California.

Member Amarnath: Hi, everyone. As Amarnath, Senior Medical Director, Covered California. Nothing to disclose.

Mr. Zimmerman: Thank you. HCA Healthcare.

The Joint Commission.

Member Baker: Good morning, everyone. I'm David Baker, Executive Vice President for Healthcare Quality Evaluation. I oversee our standards and survey method development as well as our performance measures. I have nothing to disclose. We are a measure steward, but we don't have any

measures up for removal today. And Michelle Dardis, the Director of Quality Measurement, is also on the call today. Do you want to say hi? Michelle? Maybe not. Thanks.

Mr. Zimmerman: Thank you. The Leapfrog Group.

The National Committee for Quality Assurance.

Member Barton: Hi, this is Mary Barton. I'm vice president of the National Committee for Quality Assurance. I believe we do have a measure that's being considered sometime in the next day and a half. But I cannot put my hands on which one it is. But I will recuse myself at the appropriate time.

Mr. Zimmerman: Thank you. The National Patient Advocate Foundation.

Member Kirch: Hi, Rebecca Kirch representing the National Patient Advocate Foundation. I have nothing to disclose. I'm executive vice president of policy and programs. And we help support patients and families who are limited resource and require financial and social needs.

My colleague, Rebecca Angove, is also on this call. She's representing the health equity workgroup of NQF. But she will be cycling on to the MAP Coordinating Committee as I cycle off. So I welcome her here too. She's off camera, but she's here. So you have the benefit of two Rebeccas today, no disclosures.

Mr. Zimmerman: Thank you. The Patient and Family Centered Care Program.

Member Hoy: Good morning, everyone. Libby Hoy, founder and CEO of PFCC Partners. And we are a patient and family driven organization. With me today is Ting Pun as well, and Ting will be similarly replacing me on this committee. So we welcome him to listen in today. And we have no disclosures.

Mr. Zimmerman: Thank you. And the Purchaser

Business Group on Health.

Member Hoo: Hi, everybody. Emma Hoo with the Purchaser Business Group on Health. No disclosures.

Mr. Zimmerman: Thank you. And I did note in the chat that Elizabeth Goodman has joined from America's Health Insurance Plans with nothing to disclose. Has anyone else joined since I started roll call that did not get a chance to speak up?

Member Suk: Yeah, hi. This is Michael Suk representing a trustee of the American Medical Association. Nothing to disclose.

Mr. Zimmerman: Oh, sorry. Michael Suk from AMA. Thank you.

Member Suk: Yeah, thanks.

Mr. Zimmerman: And who else had joined? Was that the only person? All right. I'll turn it back over to you, Jenna.

Ms. Williams-Bader: Thank you very much, Gus. Thank you to all of our organizational representatives. So now we'll move on to disclosures for our subject matter experts.

But subject matter experts sit as individuals, we asked you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of the workgroup's work.

We are especially interested in your disclosure of grants, consulting, or speaking arrangements but only if relevant to the workgroup's work. And again, if you are a measure steward or developer and if you developed and/or stewarded a measure under discussion today in the past five years, please disclose that now. And then we ask you to recuse

yourself from the discussion and poll for that measure later in the day.

Just a few reminders, you sit on this group as an individual. You do not represent the interests of your employer or anyone who may have nominated you for this committee. I also wanted to mention that we are only -- not only interested in your disclosures of activities where you were paid.

You may have participated as a volunteer on a committee where the work is relevant to the measures reviewed by MAP. We are looking for you to disclose those types of activities as well. Finally, just because you disclosed does not mean that you have a conflict of interest.

We do oral disclosures in the spirit of openness and transparency. Please tell us your name, what organization you're with, and if you have anything to disclose. And Gus will call your name so that you can disclose. So we'll begin with our co-chairs, and I'll turn it over to Gus to run us through our subject matter experts.

Mr. Zimmerman: Thanks, Jenna. We can start with Chip.

Co-Chair Kahn: I am -- in my day job, I am president and CEO of the Federation of American Hospitals. But as an outside -- as an expert today, I have nothing to disclose.

Mr. Zimmerman: Thank you. Misty.

Co-Chair Roberts: Hello, Misty Roberts, Vice President of Quality Performance at onehome which is a company of Humana. And I have nothing to disclose.

Mr. Zimmerman: Thank you. Dan.

Member Culica: Hello, everyone. It might be good morning. It might be good afternoon. I think we are on both time zones.

So hi, my name is Dan Culica. I'm with the Medicaid program and Health and Human Services in Texas. In terms of disclosing aspects, I'm also associated with NQF Leadership Consortium and CSAC. And regarding any other issues, I do not have any problems. So thank you for having me.

Mr. Zimmerman: Thank you. Janice.

Member Tufte: Hi, good morning. I've been having technical issues. So I probably turned my video off. I'm sorry. But I do not have anything to disclose at this time. I looked over everything. I believe there's no -- I haven't been directly involved with any of the issues that we're discussing today. Thank you.

Mr. Zimmerman: Thank you. And Ron Walters.

Member Walters: Ron Walters, I'm a medical oncologist at MD Anderson Cancer Center for 43 years. And now I'm in the Chief Quality Office. I have nothing to disclose and no conflicts of interest. I am on the Measures -- I mean, I'm on the Scientific Methods Panel and also a member of the National Quality Partnership.

Mr. Zimmerman: Thank you. Do we have anyone from our program liaisons, the Agency for Healthcare Research and Quality?

Ms. Grace: Hi, my name is Erin Grace, and I'm the acting director of our Center for Quality Improvement and Patient Safety and also the designee on the NQF Board of Directors. And I have nothing to disclose.

Mr. Zimmerman: Sorry. We actually don't require disclosures from our program liaisons. Thank you anyway. Center for Disease Control and Prevention.

Mr. Dantes: Hello, this is Ray Dantes, Medical Advisor to CDC's National Healthcare Safety Network, Centers for Medicare and Medicaid Services.

Ms. Schreiber: Michelle Schreiber, we have a number of staff from CMS on the call as well today.

Mr. Zimmerman: Thank you. And then the Office of the National Coordinator for Health Information Technology.

Do not hear anyone, so I will turn it back over to you, Jenna.

Ms. Williams-Bader: Thank you very much, Gus. And thank you to everyone else for your disclosures today. I'd like to remind you that if you believe you might have a conflict of interest at any time during the meeting or any of our meeting, please speak up.

You may do so in real time at the meeting. You can also message one of the chairs who will come to NQF staff, or you can directly message NQF staff. If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may also point this out during the meeting, approach one of the chairs, or go directly to NQF staff. Does anyone have any questions or anything you've like to discuss based upon the disclosures made today?

Ms. Binder: Can you hear me?

Ms. Williams-Bader: Yes.

Ms. Binder: Oh, good. Okay.

Ms. Williams-Bader: I can.

Ms. Binder: That's all. Actually, that is all I wanted to know because you couldn't hear me before. This is Leah from Leapfrog. So now I'm happy.

Ms. Williams-Bader: Oh, good. Glad you're able to join us. And did you have any disclosures?

Ms. Binder: I said it, but I guess you couldn't hear it. So yes -- no, I have no disclosures.

Ms. Williams-Bader: Great. Thank you. Okay. Well, again, thank you all so much. As Chip mentioned, quorum is very important for this meeting and all of our meetings. And so we hope that you're able to join us for all of today and tomorrow.

However, if you do need to step away, if you could please let NQF staff know in the chat so that we can keep an eye on quorum, that would be greatly appreciated. And I'd like to welcome and say that our -- we do have a few of our workgroup co-chairs who will be joining us today and tomorrow to provide information about the workgroup discussions and some of the measures up for discussion today and tomorrow and to answer questions that Coordinating Committee might have about workgroup discussions of measures. And we really appreciate them joining us today and tomorrow.

So if we could go to the next slide, please. Just like to acknowledge our MAP staff who are on the line. We have Tricia Elliott who is our senior managing director. As I said, I'm Jenna Williams-Bade, senior director.

We have Katie Berryman who is our director of project management. Udara Perera, he's our senior manager, Ivory Harding and Susanne Young who are managers, Ashlan Ruth, our project manager, Gus Zimmerman who's the analyst supporting our work, and Joelencia LeFlore who's the associate supporting our work. Next slide, please.

Also, I'd like to say a big thank you to the CMS staff who are supporting our work and who are on the line today, Kim Rawlings and Gequincia Polk. Next slide, please. The objectives for today and tomorrow's meeting will be to review the 2022 Measure Set Review process, measure review criteria, voting categories and the process for the day's meetings. We will also be finalizing recommendations on measures selected for

potential removal from federal programs for clinical, hospital, and post-acute care, long-term care settings.

And then we will have an opportunity tomorrow. We will be asking the Coordinating Committee for your feedback on the Measure Set Review process and the use of the consent calendar during this meeting. We hope you're all able to join us for that discussion as we welcome your feedback and want to hear your thoughts on this process. Next slide, please. And then one more. So we'll now turn it over to Dr. Michelle Schreiber for her opening remarks.

Centers for Medicare & Medicaid Services Opening Remarks

Ms. Schreiber: Jenna, thank you very much. And on behalf of CMS, welcome to all of you. Thank you so much for being here today. Your conversations and your opinions really matter greatly.

This has been an interesting process so far as you are all aware. We have had five of the committee meetings so far on measures removal. They have been the Rural Committee, the new Equity Committee, the Hospital Committee, the Clinician Committee, and the Post-Acute Care Committee.

So there's been a lot of discussion on these measures already. The discussion was really robust, and it's actually the details of the discussion that have really -- that really help inform our work at CMS. And so we're looking forward to today's discussion as well.

Lots of people have said thank you already. I will say the same thank you, first of all, to all of you on the committee. The time that you spend, and the opinions that you bring are really very valuable and in particular to Chip and Misty who always do such a wonderful job in co-chairing this committee.

To NQF, Jenna, for hosting us all today and to

everybody at NQF, they're really is a lot of work that goes into these committees. And we thank you so much. I'd also like to note we have many CMS staff on the phone as well as many of our contractors who are here to help answer questions or provide points of clarification. And hopefully that will be helpful.

I'd like to thank them for getting on the call. And I would like to take just a moment to introduce you, the Coordinating Committee, to a new member at CMS because hopefully we'll see her in the future. Stephanie, I don't know if you want to turn your video on so people can have a hello to you.

Dr. Stephanie Clark is our new medical officer for the Division of Quality Measurement. And she will be joining me on the MAP calls in December as well. She'll be leading a lot of our work around quality measurement.

Stephanie is a pediatric nephrologist from Children's Hospital of Philadelphia, from CHOP, who has done a lot of quality work at CHOP. And we are delighted that she has joined us now at CMS. Stephanie, do you want to just give a shout out for a moment?

Ms. Clark: Sure. Thank you so much for letting me join today, and I really look forward to working with this group and being a part of the work that you all do. So thank you so much. It's nice to meet you all.

Ms. Schreiber: Thanks. We are again delighted that you're here. Not only are we looking forward to today's conversation, but we're really looking forward to being with all of you again likely in December where we think we have an exciting slate of new measures. So this whole process of new measures being introduced, older or measures that perhaps are past their prime potentially being removed is really part of a cycle of how CMS continues to improve these programs and make them relevant for the country.

So these discussions help inform our work. We greatly appreciate them. And once again, a big thank you to all. And Jenna, back to you.

Review of the MSR Process and Measure Review Criteria

Ms. Williams-Bader: Thank you so much, Dr. Schreiber. Okay. And with that, I think we will now move along to a description of the process. How did we get here today, and what will we be doing today and tomorrow? And I will turn it over to Susanne Young to take us through this.

Ms. Young: Thank you, Jenna. Yes, now we would like to review the MSR process and the measure review criteria. Sometimes we refer to that as the MRC. Next slide, please.

This gives you a visual representation of the 2022 MSR process and its four steps. Some of those steps, we've already completed and we are at the final step of this process. So first step was to prioritize.

CMS and NQF prioritize programs for discussion this year for the 2022 MSR process. The NQF staff refines the list of measures and created a survey as a way to narrow the list the measures from a very large list of measures to a more manageable list of measures that the committees, the workgroups could review. The second step, survey, is where the workgroup and the advisory group members nominated measures to discuss for potential removal using the measure review criteria as rationale. And we'll go over that criteria in the next couple slides.

NQF compiled the survey results, selecting measures with the most votes to determine the narrow list of measures. And in the third step, prepare, after compiling the list, those measures were presented for public comment. And then NQF staff then prepared measure summary sheets for

review by the advisory group and workgroup members.

And then our very last step which we are here today, the advisory groups discuss the measures under review. They discussed all the measures. So that was the Health Equity Advisory Group. And the Rural Health Advisory Group met in June to discuss all the measures.

And then our three setting specific workgroups, hospital, clinician, post-acute care, long-term care, they met to discuss and vote to recommend maintaining or removing a measure. And then now we are here at our meeting this week, today and tomorrow, where committee members will discuss and vote to accept the workgroup recommendations. And those recommendations will be published in early fall.

And as a reminder, these recommendations are one factor in the CMS measure evaluation discussion. Next slide, please. Okay. Now I want to give you a list. Now this might be -- you might've seen this list before if you are in some of our other meetings and also our education meeting or the meeting we had at the beginning of the process.

This is the 2022 MSR Measure Review Criteria. These are the first seven of which there are ten criterion. So for the MSR pilot year, NQF created a set of pilot measure review criteria.

And then based on feedback from the Coordinating Committee members following the pilot, additional clarifying language was added to this criteria. Next slide, please. And now this is Criteria 8 through 10. As we highly anticipated, the criteria will continue to evolve as we gain experience within the MSR process.

We heard from Chip and Misty earlier today. It's a process. Last year was the pilot. This is only the second year. We're expanding and we gather

information. And speaking of process, we know will be looking for an opportunity from the Coordinating Committee with feedback on the MSR process. And we will have that discussion towards the end of our meeting day tomorrow. Next slide, please.

And then here are the 2022 MSR decision categories. And we'll go into detail over those decision categories on the next couple slides. But starting with support for retaining, then we have conditional support for retaining, conditional support for removal, and support for removal. Next slide, please. Okay.

So let's start with support for retaining. So this -- the definition of this first category, decision category, is MAP supports retaining the measure as specified for a particular program. After discussion, MAP determines that the measure does not meet review criteria for removal.

We're going to measure at least one review criterion. But MAP does think that this measure benefits retaining in the program because it outweighs the MAP criterion. And then additionally, MAP has not identified any changes for the measure.

So some examples of this decision category are the measure is PRO-PM that's associated with reporting burden. But MAP feels it's important for the measure to patients. Another example is the measure is not reported by some entities due to low volume. But it's a meaningful measure for those entities that can report it. Next slide, please.

So our next decision category is conditional support for retaining. So MAP supports retaining the measure for a particular program. But I had identified certain conditions or modifications that would ideally be addressed the measure meets at least one review criterion.

But MAP thinks the benefits of retaining it in the

program outweigh the MAP criterion. MAP however supports for retaining it is based on certain conditions or modifications being addressed. So some examples of those would be receiving CBE endorsement, aligning it to the evidence, is respecified as an electronic clinical quality measure, or the measure is modified so it no longer meets review criteria. Next slide, please.

So our third decision category, conditional support for removal, MAP supports removal of the measures from a particular program but has identified certain conditions that would ideally be addressed before removal. The measure meets at least two review criteria. But MAP thinks that removing the measure will create a measurement gap.

Therefore, MAP does not support removal until a new measure is introduced to the program. Examples are the measure is integrated into a composite measure or a process measure is replaced by an outcome measure or PRO-PM. Next slide, please. And our final decision category is support for removal.

MAP supports removal of the measure from a particular program. The measure meets at least two review criteria. MAP does not think that removal of this measure will create a measurement gap.

An example is the workgroup determines that the measure no longer meets program priorities and removing it will not lead to a measurement gap. For example, the measure is topped out. Next slide, please. And well, just to review the voting principles, these voting principles are the same as we used during the mock process.

Quorum as mentioned earlier today is vitally important to our process here. And quorum is defined as 66 percent of the voting members present for live voting to take place. NQF staff will establish quorum prior to voting. And if quorum is not established, members will vote via electronic

ballot after the meeting.

MAP has established a consensus threshold of greater than or equal to 60 percent of voting members voting positively and a minimum of 60 percent of the quorum figure voting positively. Abstentions do not count in the denominator. And lastly, every measure under review for MSR will receive a decision category. Next slide, please.

And now we want to go over the process for our meeting today and tomorrow. We want to start with the non-consent calendar measures. So the first thing, NQF staff would introduce the program in which the measure is currently included.

Next as Jenna mentioned, we will have some workgroup representatives. And they will review the workgroup decision for the measures under review. We also will have lead discussants provide a summary of public comment on the workgroup's recommendation, and they will highlight any information from the measure summary sheet that provides context to the public comment.

Lead discussants will review and present their findings on the measure. And then the third step, we will have a co-chair ask for any clarifying questions from the committee. And as mentioned earlier, we do have CMS leads on our meeting today and tomorrow. And our CMS leads will respond to clarifying questions on the specifications of the measure.

And the workgroup represented will respond to any clarifying questions that the committee may have on the workgroups's decision. Step 4, the co-chair will facilitate a discussion of the measure under review. The co-chair is going to open the floor for discussion among Coordinating Committee members.

And then step 5, the committee will vote on the acceptance of the workgroup's decision. And as we

do in MUC, this vote will be framed as a yes or no vote to accept the decision. Next slide, please. And continuing, step 6, NQF staff will tally the votes.

And as I mentioned early, if greater than or equal to 60 percent of the committee members vote to accept the workgroup's decision, then the workgroup's recommendation will become MAP's recommendation. If we have less that 60 percent of the Coordinating Committee members vote to accept the workgroup's decision, the committee will vote on a new decision. category. And at that point, a co-chair will determine if there's been a decision category to be put forth based on first the potential consensus emerging from the Coordinating Committee discussion.

If the co-chair does not feel there's a consensus position to use to begin voting, the committee will take a vote on each potential decision category one at a time. The first vote will start with conditional support for retaining, then conditional support for removal, then support for removal, and lastly, support for retaining. If a decision category put forth by the co-chair receives greater than or equal to 60 percent of the votes, the motion will pass and the measure will receive that decision.

Lastly, if no decision category achieves greater than the 60 percent to overturn the workgroup's decision, the measure will be assigned the decision support for retaining. Next slide, please. And then as we mentioned earlier, we will be piloting a consent calendar to use during tomorrow's meeting. And the process for this will be step 1, the co-chair will ask for the committee members if they would like to pull any measures from the consent calendar.

If a member requests a measure to be pulled for consideration, the member is to provide a clear and compelling rationale based on the key consideration criteria. The member requesting the measure pulled from the consent calendar will serve as a discussant

for that measure during the discussion. Step 2, the NQF staff will present the measures on the consent calendar and their corresponding recommendations.

Then Step 3, the co-chair will ask if there are any objections to the consent calendar. Step 4, if there are no objections, the consent calendar decision categories will become MAP's recommendations. And Step 5, if there are measures pulled from the consent calendar, then that process will continue as dictated by the non-consent calendar measure steps as we discussed. Next slide, please.

So I want to pause here and see if there are any questions. Know that we will review the process for consent calendar, how that process will occur tomorrow. Again, right before that section, as we know, that is a new process we will be doing. But let me stop here and see if we have any questions.

I don't see anybody's hands raised. Anybody on the phone line has a question, please feel free to come off mute.

And feel free as we go through this process, we know we're doing a few new things. Please don't hesitate to reach out to us. Okay. Next slide, please. Okay.

Now we would like to do a voting test before we get started of the day. Yesterday, you should've received a link for the PollEverywhere platform. This is the same platform we've used in the past meetings.

Again, that email would've been sent to voting members only. We would like you to look at that email and use the link to open the platform. Again, note this link is only for voting members. Please do not share this voting link.

And when you do sign into the platform, we ask that you enter your organization's name or your name. And please let us know if you're having any trouble

locating that link or the email that was sent. And our question today is, do you like cookies? And I see we do have some results.

Member Walters: Which one, the nutritional one or the electronic one?

Ms. Young: We would say any one. We didn't go into specifications of the cookies.

Member Hoo: What time was the email sent?

Ms. Young: I believe it was sent around noon Eastern Time yesterday.

Member Culica: 11:00 a.m.

Ms. Young: Thank you.

Member Culica: Central Time.

Ms. Young: Does anyone else -- anyone need the link resent? We can private message that to you. I see a total results of 18. And we should have -- I believe we have 21 on the meeting today. Is anybody having trouble locating it?

Co-Chair Kahn: I'm sorry. When you vote yes or vote however you're going to vote, it just happens, right? You don't see anything happening other than the numbers, right?

Ms. Young: Yes. Well, it's still open. So on your end, you are still able to clear that vote out and you could vote another way. Once we close the vote, then --

Member Ross: This is Clarke. After you vote, it says response recorded.

Co-Chair Kahn: Oh, well, then I didn't -- I'm not doing anything. It doesn't say. Just --

(Simultaneous speaking.)

Ms. Young: Really small, though. It's really small at

the top where it says response recorded right after test question.

Co-Chair Kahn: Yeah, I'm not getting anything.

Member Tufte: Is it blue? Because what it says under the test question, do you like cookies, and then it says, response recorded on mine. But it shows blue. I didn't think mine was recorded either.

Co-Chair Kahn: I didn't get anything that said response recorded.

Member Tufte: Is your name at the top, Chip, on the right?

Co-Chair Kahn: No, I'm just looking at -- well, now it's covering the whole screen. Now I can't see anything. I mean, all I can see is the test. The thing is taking over the whole screen.

Ms. Young: Okay. Let's close the vote and then we will -- once we close the vote, we can see on the back end --

Co-Chair Kahn: Okay.

Ms. Young: -- who has voted. And then we will troubleshoot from that point.

Co-Chair Kahn: Okay, good.

Ms. Young: Thanks, Chip. Okay. We have definitely a consensus that people like cookies on this call. Okay. Please let us know if you're having any trouble finding the link or any questions as we go along.

Co-Chair Kahn: Just let me know if you got me.

Ms. Young: Thanks, Chip. And I will turn it back to you, Jenna.

Ms. Williams-Bader: Thank you so much, Susanne. Before we jump into the discussion of the first group of measures and public comment, I did want to also

acknowledge that we may have advisory group and workgroup members on the line as well today and tomorrow. As I mentioned, we have some of the workgroup co-chairs on the call to provide a summary of the workgroup discussions to measures up for discussion.

But if we have any advisory group or workgroup measures in addition to those co-chairs who are on the line, as a reminder, this is not a mandatory calls for you. If you are here to participate, though, or like to listen in, that's absolutely fine. Just as a reminder, though, that if advisory group or workgroup members have comments to make, please make those comments during the public comment sections of the agenda.

For the actual committee discussions, that'll be limited to our Coordinating Committee members with feedback from the workgroup co-chairs as they summarize the workgroup discussions. If you have any questions about that, please feel free to reach out to NQF staff in the chat. All right. If we could go to the next slide then, please. Okay. So we have measures from two hospital programs that will be discussed today and tomorrow: Measures from the Hospital Outpatient Quality Reporting Program and the Ambulatory Surgical Center Quality Reporting Program.

For the rest of today's meeting, we will be discussing measures from the Hospital Outpatient Quality Reporting Program. And then tomorrow more we have, I believe, it's one measure from the Ambulatory Surgical Center Quality Reporting Program that we'll be discussing in the morning and then one measure that's been pulled from the consent calendar, if I'm remembering that correctly. So I will now if we can go to one more -- let's go to the next slide. Yeah, so I will now turn it over to Misty who will be running public comment on the measures in the Hospital Outpatient Quality Reporting Program.

Co-Chair Roberts: Thanks, Jenna. So just a reminder today because I know we talked about the consent calendar. But today, these are actually measures that are not on the consent calendar. So we will get into that consent calendar process tomorrow. I know when I first looked at the agenda, I was trying to differentiate. So hopefully that's helpful.

Opportunity for Public Comment on MSR Recommendations for the Hospital Outpatient Quality Reporting Program

And with the public comment, right now, we are going to be focusing specifically on -- I'm glad you pulled that up -- on these five measures that are not on the consent calendar specific to the Hospital OQR Program. So with that, we like to always remind you to keep your -- to limit your comments to two minutes and to ensure that the comments are focused on these five measures. So with that, I will open it up to public comment.

I'm not seeing any hands raised. NQF staff, are you all seeing any raised? I don't know if they're going to bring it to the top for me or not.

Ms. Williams-Bader: I am not seeing any at the moment either. And at the moment, I am not seeing anything in the chat.

Co-Chair Roberts: So if anybody is on the phone line that has any public comments, we'll open that up as well.

Not hearing any. I think we can go ahead and move forward. Jenna, is that you?

Ms. Williams-Bader: Yes, it is, Misty. Thank you.

Co-Chair Roberts: Okay, great.

Ms. Williams-Bader: Okay. So if we -- actually, we can stay here for just a second. So Misty might have said this. But the Hospital OQR measures that we are discussing today were discussed by the workgroup. But we did not achieve quorum either during the workgroup -- the hospital workgroup meetings or via survey after the meeting.

So there will be a vote on a decision category for these five measures today rather than an acceptance of the workgroup decision due to that lack of quorum. We did ask the workgroup members which voting category they'd like to start with. And that's what we also shared with them in the post-meeting survey.

We do have an idea of where they at least verbally wanted to start as a voting category but do not have a recommendation from them. So if we could go to the next slide, please. The first measure that we'll be reviewing is 00140-C-HOQR: Magnetic Resonance Imaging Lumbar Spine for Low Back Pain.

This measure evaluates the percentage of MRI of the lumbar spine studies for patients with low back pain performed in an outpatient setting where antecedent conservative therapy was not attempted prior to MRI. Antecedent conservative therapy may include claims for physical therapy in the 60 days preceding the lumbar spine MRI, claims for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI and/or claims for evaluation and management at least 28 days but no later than 60 days preceding the lumbar spine MRI. The measure is calculated based on a one-year window of Medicare claims.

The measure has been publicly reported annually by the measure steward, the Centers for Medicare and Medicaid Services, since 2009 as a component of its

Hospital Outpatient Quality Reporting Program. Endorsement was removed for this measure. And seven advisory group and workgroup members selected this measure in the initial survey we did with them back in April.

And just to let you know, these five measures in the Hospital OQR program, we do have this more detailed background information on the measures because again since we don't have a workgroup recommendation to work from. But if we go to the next slide, as I said, we do have information on where the workgroup had agreed to start as well as their rationale for that. And before I turn it over to Misty, I would like to see if we have a CMS program lead on the line who would like to provide contextual comments about the measure.

Ms. Schreiber: And it looks like maybe we don't. I would just say that this particular measure was really more around utilization as well as quality in that we are trying to avoid MRI utilization when for appropriate patients conservative therapy has not been tried first.

Ms. Williams-Bader: Thank you, Michelle. So Misty, I will turn it over to you.

Co-Chair Roberts: Thanks, Jenna. Just to clarify, at this point, are we going to have the workgroup representatives have a conversation before we go into voting? That's correct, right, in the process?

Ms. Williams-Bader: We will have -- the workgroup representative will let us know. Yes, we'll review the decision category the workgroup agreed to start with as well as their rationale and any other key points they'd like to raise. And then we'll hear from our lead discussants before we open for clarifying questions and discussion. And after that point, we'll do the vote.

Co-Chair Roberts: Okay, great. So the -- and I apologize. Maybe I missed something. I don't have

a list of who the workgroup representatives and lead discussants are. Is that something someone can send me?

Ms. Williams-Bader: Yes, we will go ahead and send that to you. We do have Akin Demehin on the line, I believe, from the -- who's one of our hospital workgroup co-chairs who can provide feedback on the Hospital OQR measures this afternoon.

Mr. Demehin: I'm here. Thanks. Would it be helpful if I just gave a quick rundown of what decision category we started with even though we obviously did not reach consensus here?

Ms. Williams-Bader: Yes, that would be great. And the rationale for why that was the starting category.

Mr. Demehin: Great. So with respect to this particular measure, as you can see, the workgroup started or recommended a category to start with the voting of support for removal from the program. It really boiled down to a couple of things. Number one was the -- so the Measure Endorsement Committee choosing not to re-endorse the measure back in 2016.

And the second was the MAPS prior discussion of this measure back in 2018. I think taken together, the sentiment of those that were at the table and able to participate in the conversation was that the measure may have served a purpose when it was initially adopted where it was adopted back in 2009. But given the advancement of time and the loss of endorsements, we felt it may be time for this one to be removed. So that was the rationale for offering this as a starting point.

Co-Chair Roberts: And was that Akin?

Mr. Demehin: Yes, Akin Demehin. I'm a hospital worker, co-chair, and in my day job, a senior director for policy at the American Hospital Association.

Co-Chair Roberts: Okay, great. Thanks, Akin. And then do we have a lead discussant to offer additional information?

Ms. Williams-Bader: Misty, before we get to that, I do wonder. Leah, asked if she could raise a process issue. And just in case that's going to impact the rest of the discussion, I'd like to give her the opportunity to raise that.

Co-Chair Roberts: Sure. Go ahead, Leah.

Ms. Binder: Thank you so much. I just want to understand do we have a process when the workgroup does not have a consensus, and -- or I'm sorry, a quorum. I do think that's a important point and perhaps it shouldn't have come yet to the Coordinating Committee. And the second thing related to that is do we have a list of stakeholders that were in the meeting and those that were not or didn't respond? And I'm particularly wanted to make sure that if there was no quorum that at least all the stakeholders had some presence at the workgroup level certainly before it goes to the Coordinating Committee.

Ms. Williams-Bader: Thank you, Leah, for raising that. So I am fairly new to NQF and MAP having started in February. So my understanding based on the conversations we've had is that this is a new situation. But I will -- Tricia, do you have anything to add as far as not having a workgroup recommendation for the Coordinating Committee?

Ms. Elliott: Thanks, Jenna. And Leah, to address your question, we have no encountered this situation in recent history. So that's why we felt best to bring it forward to the Coordinating Committee in its current state to move forward with discussion and voting. So it was a somewhat unique situation.

Ms. Binder: And do we know the stakeholder issue? So for instance, purchasers or consumers in

particular. I'm curiously if there were any representatives among the purchasers and consumers on this workgroup were present.

Ms. Williams-Bader: So if we can pull up the summary from the workgroup meeting and check that. The summary, though, I think will only tell us which members were present for the meeting as a whole. It wouldn't necessarily tell us who was available for each particular measure.

So we can certainly pull that up and take a look. But like I said, it wouldn't necessarily indicate all of those members were present for any particular measure discussion. So I do have the --

Ms. Binder: Okay. Well, we have a list of who the members were. I think that would be good. But I do think that the Coordinating Committee, it's really not our role to really have to dig in and really reach that consensus. That's the role of the workgroup. So it does concern me that we're in that role here.

Ms. Williams-Bader: I welcome feedback from other members of the Coordinating Committee as well. I see that Mary Barton has her hand raised. So Mary, I don't know if you're commenting along these lines or if you're raising another question or issue.

Member Barton: Actually, I just had a comment reacting to both the initial presentation and Michelle Schreiber's comment that this is an unusually useful measure that is both utilization and quality because if you get an MRI and you didn't need one, you're liable to find all sorts of things. And it can lead to untoward events. So anyway, I think that -- but I agree with Leah, that the lack of a quorum in the workgroup, man, that's a little bit of an undue burden to bring, I think, to the Coordinating Committee.

Co-Chair Roberts: And Jenna or Tricia, we kind of talked about this as well during our prep meeting. Do you all have any additional information on how

you tried to reach quorum I think afterwards with some email voting? Is that right? Do you want to share that?

Ms. Williams-Bader: Yes, we -- so we -- like I said, we took a vote during the meeting as a -- and we did not have quorum. We discussed with the workgroup where they would want to start in a survey. And then we send out the survey initially after the meeting with the meeting recording and then sent two follow-ups as well.

So we did attempt to get quorum via that email after the meeting and through the reminders. And it is possible that some of the emails were not going through we're realizing. But we did what we could at the time to try to get quorum via that email or via that survey.

Co-Chair Roberts: So is this something that we might need to take back as a group to understand why we're not reaching quorum or was this just a one-time incident that we've not seen this before? And then what we should do, establish that process to Leah's point. What should we do? It sounds like the decision was made to bring this forward. But maybe there are other opportunities before it gets to the Coordinating Committee.

Ms. Williams-Bader: Yeah, certainly I do think in some ways this could be a bit of a one-off. The Measure Set Review is a new process for MAP. It's a series of meetings that MAP is not used to attending.

And we only had so much lead time in being able to schedule the meetings. They're scheduled in June which is it is during the summer. And so it could be a difficult time for MAP members.

And then like I said, in the -- we did send reminders to two individuals after we sent out the survey to really try to get as many voting as possible. As I mentioned, some of those emails might have been

not getting through, we just recently learned. So I think we have a lot of lessons learned from this that will help us to avoid this in the future.

And again, I think as we establish a more consistent timeline and process for Measure Set Review that MAP members can sort of rely on as they -- and sort of know to expect in advance the way they do with a MUC list. Then again, that might help to address some of the quorum issues as well just during the actual meeting itself. So this could potentially be a bit of a one-off situation. I welcome other thoughts on this, though.

Member Culica: Jenna, this is Dan. I wonder if Dr. or Mr. Demehin has his hand raised. Do you have any input for the committee?

Mr. Demehin: Yeah, I do. So as hospital worker co-chair, I can tell you I personally was not happy to see that our workgroup failed to maintain quorum throughout the meeting. And I do think that Jenna raises an important point which was the novelty of this process I think meant that folks weren't used to having and maintaining a presence on the meeting and throughout the meeting to make sure that we maintain quorum as they are with the regular MUC review process that happens ever December.

And the post-meeting voting process was the process that we chose to use just because it was the best we could do under the circumstances to try to make sure that we got the voices of everybody at the committee involved in the conversation. That being said, I certainly have had a couple of offline conversations with the NQF team to try to think through how we can avoid this outcome in the future. I totally agree with those of you who have raised the point that it would certainly be our preference to make sure that we have decisions to offer all of you before it goes to the Coordinating Committee.

This is not the role of the Coordinating Committee.

There may have been some technical issues with sending those reminder emails that meant that we missed out on getting those few votes that probably would have gotten us to quorum. But we also -- I certainly recommended to the NQF team.

We think about reminder emails to the participants on the workgroup that being at the meetings and maintaining a quorum, especially when we have votes in front of us, is 100 percent essential. So just a few contextual comments about why we chose the process that we did. And as Jenna said, some opportunities for us to really make sure that we don't go through this again.

Co-Chair Kahn: But I think that to answer Leah's question, though, we don't know who voted and who didn't vote. And so for the purposes of our deliberations here which is what's before us, all we can do is really -- whether you want to call it a recommendation or just a team's view. We need to take the views that are offered to us.

And then we are -- since we have a quorum, we are the entity that will have to consider this officially. I don't think we have any choice. And we'll have to accept that role in this case and hope that what happened won't happen again.

But I don't think we have any choice right now because, one, we have a quorum. Two, we've got some information from what transpired. And we have to do with it what -- we have a cross section here. So I don't think we have any choice.

Member Walters: So you've seen my -- I agree and I really do appreciate the efforts made by the workgroups to get an answer. You certainly did an awful lot of contacts. But I agree, of course, completely with Chip that when it comes here, we have to do -- there's only two options.

It's blocked from coming to us, and you can imagine the work that takes, both this time around and the

next time around and the time after that, maybe even. Or to act on the information we have. And the information we have is that they started with the category support for removal.

Now we don't have the precise votes on that, sure. But that's the recommendation we have that is in front of us right now that has neither been supported nor removed. So otherwise imagine -- I know, reductio ad absurdum. So every measure that comes up for the next two days failed to get a quorum. What are we going to do? I mean, you know.

This could get really, really bad really, really quickly. And I think over time it will smooth out and we'll come with formal voting recommendations by the workgroups. But the first time, otherwise, we're going to be here till Sunday.

Co-Chair Roberts: We definitely don't want that.

(Simultaneous speaking.)

Ms. Williams-Bader: Sorry. I think there are some hands raised and I also did want to clarify. The measures we're talking about today, the five today did not have quorum. The measures we're talking about tomorrow did have quorum.

They are just not on the consent calendar for various reasons. So I did want to make that point of clarification. As I said, we do have a few hands raised. It's Clarke, Dan, and then Leah.

Member Ross: Thank you, Clarke Ross. I put in the chat that we have this hand process that we've used for the last several meetings. And so I don't appreciate people just butting in and making their opinion without raising their hand and being recognized.

So I wanted to make an additional observation on the process. I'm the lead discussant on the next

measure, left the emergency department without being seen. And that measure also did not have a quorum in the workgroup.

But the process I wanted to indicate is the notes indicate that the Rural Advisory Committee and the Equity Advisory Committee did consider and did vote on the measure that I'm considering, the next one. So I just want to point out to people that other forums within the MAP have taken votes even though the workgroup didn't have a quorum. The equity and rural groups did, and they express their voted opinion. So I just wanted to share that as an additional process, piece of information.

Ms. Williams-Bader: Clarke, thank you for raising that. I would point out the advisory groups did not have quorum requirements because they are only advisory. So we poll them to collect information that could be useful for the workgroups to consider.

But we don't assess whether there's quorum for either of the advisory groups. And in one case, the rural health advisory group had a relatively small number of members on the line for the discussion. So just wanted to point that out. It is a piece of information, but it's not a vote or recommendation the way we look to get information from our -- and recommendations from our workgroups.

Member Ross: That's true except if you're going to create an advisory committee and have a meeting and have votes, it should have some credibility and standing.

(Simultaneous speaking.)

Ms. Williams-Bader: Absolutely. I'm just pointing out that there was not -- there wasn't a quorum, per se, for those. We did not assess whether there was quorum for those.

Member Ross: Thank you.

Ms. Williams-Bader: Yeah. So Dan and then Leah.

Member Culica: Yes, thank you. I happen to be a lead discussant or one of the co-lead discussants on this measure. So I know we didn't reach that point yet. But as I was going through the entire package, I think there are several comments either from the health equity or from the public comments.

There is one from the Blue Cross and Blue Shield Association. So I think that there are issues and there are other issues aside from the voting one. So what I'm thinking is whether we can contemplate to do what we do in other forums to vote whether we can or we should send this back to the committee instead of making a decision right now.

Co-Chair Kahn: It's not an option. I mean, Misty, it's up to you.

Co-Chair Roberts: No, that's what I was going to say. I think we already kind of established that we are where we are. There's definitely maybe some opportunities to (audio interference) it'd be a lot of work if we had to send it back to the workgroup. And I think there are a lot of timelines set to this that we might miss.

Member Culica: Thank you.

Co-Chair Roberts: If you want to come back, Dan, to -- I know we discussed it and we'll definitely come back to you. I'm trying to get this whole hand raising thing where I can see it at the top of my screen. I do think I see Leah's hand raised. Leah, did you have another comment?

Ms. Binder: Yeah, I do appreciate that it's incredibly hard to get quorum in the summer and all of the factors that were involved in this. And that said, the decision to recommend removal of a measure should really be taken as seriously as the decision to endorse a measure. And that process does require consensus and deliberation.

And that's why it is extremely disappointing that it is not necessarily getting that level of consensus. But given that we, to Chip's point, need to do something today, then I would again ask that we get a list of who voted and I guess what their affiliations were. That will at least help in understanding the level of this recommendation. It would help to understand it since we're doing more of the work now in thinking through the removal of the measure.

Ms. Williams-Bader: So I have the meeting summary in front of me. Again, this is just who was in attendance for the meeting, not necessarily for the hospital worker meeting, not necessarily for each measure's discussion. We had our two co-chairs on.

We had several health professional organizations including America's Essential Hospitals, the American Society of Anesthesiologists, the American Society of Health System Pharmacists, the Association of American Medical Colleges, the National Association for Behavioral Healthcare. We also had some health systems or healthcare providers, City of Hope, Greater New York Hospital Association, Henry Ford Health System, the Stratis Health, and UPMC Health Plan. We had some patient advocacy organizations or patient -- those representing patient voice including dialysis patients, Citizens Kidney Care Partners -- that might actually be a health provider, sorry -- Project Patient Care.

We had the Service Employees International Union, Press Ganey, Medtronic as well on the line, and two subject matter experts, Lindsey Wisham, Suellen Shae. I'd have to go back to see their affiliations and what they're representing. But you can see that we do have a mix as far as on the line for the discussion.

It's just hard to pinpoint who was exactly on the line

for each measure's discussion. And we did have quorum for discussion. I guess I should clarify that.

We were -- we had enough members on the line for a discussion. We just did not have enough for a vote. And if I remember correctly but I'll let the team correct me if I'm wrong. We weren't short a large number of members for the vote. I think ultimately it was just -- it was maybe three or four short of quorum if that helps at all.

Co-Chair Roberts: I might propose that we move forward with the lead (audio interference). So Dan, would you like to get us started?

Member Culica: Sure. I think we lost you for a second. I think you are suggesting to go to the discussion.

Co-Chair Roberts: Yes, sorry about that.

Member Culica: No, no worries. Yeah, no, I was going through the notes. And I think that if anybody has a document, I can refer to that on page 18 on the description on the rationale for removal consideration. There are most from survey respondents.

And I was wondering who the survey respondents are. So my assumption was that they are from the committee or the subcommittee, Hospital Committee. There are some interesting comments.

The measure has no intent -- has a good intent. But without revision, this measure may not function as intended. So when it says revision, revision by who? Isn't that supposed to be done by the committee?

Also, it says that it will be interested to understand why the endorsement has been removed. Again, who are these respondents? My understanding was that they are from the committee. It seems that it's public. So lots of questions. The other one is --

Co-Chair Roberts: Can we go ahead and clarify

that? These are public comments, correct?

Ms. Williams-Bader: So there's a section of the measure summary sheet. And Dan can let me know if I'm not talking about the right section where we provide information about the survey. And I'm realizing now how that could cause confusion as we're referencing two surveys for the Coordinating Committee.

But this references the very first survey we did back in April where we asked advisory group and workgroup members to take the 200-plus measures that were in the programs being reviewed for this Measure Set Review and asked them to identify measures they would like to discuss during this year's Measure Set Review. So the survey respondents, the number that's listed and the criteria they are using and any free text comments, those are coming from advisory group and workgroup members. However, they had very basic information about the measures available at the time of doing the survey.

We were -- because of the large number of measures, we were really only able to provide them with some information about the measure specifications, which programs the measures were in, what the data source was. So they were -- they did make comments about endorsement. We did have some basic information about the endorsement status of measures.

But if they -- they might've had questions about endorsement or more detailed information about measure reporting or performance data, things like that. And they did not necessarily have that information at their fingertips when they did the survey. So I would just note that they were doing that based on some very basic information about the measures back in April. That is not in reference to the survey that we did with the hospital workgroup after the worker meeting.

Member Culica: Yeah, that was my assumption. Thank you. The next comment, it's about debate from the health equity group which it's not specific to this measure. But it's making reference to some evidence in the literature about the use of the CT scan.

I think they try to make a parallel between the use of CT scan. It has a method, a diagnostic method as opposed to the MRI which is our discussion. But they do raise the issue of underuse of the measure and some kind of a discrepancy between using a CT scan more for certain population groups and less for others.

So there is -- I think I see that as a concern raised by the health equity group about the use of diagnostic measure and differential use of you want and underuse in certain population groups. And the last comment is the one that's on the last page on page 24 which is from the Blue Cross and Blue Shield Association where it says that the question was, do you support retaining the measure in the program? And they say, yes, with certain conditions.

And I think there is somebody from the association on the call. Maybe we'd be willing to hear from them. So those are my feedback.

Member Peden: Yes, thanks.

And it's Carol from the Association. Shall I speak now?

Co-Chair Roberts: Please, Carol, go ahead.

Member Peden: Our concerns were along with those voiced by Michelle from CMS; that we think this is a measure -- you know, it's a choosing wisely category that we just want to ensure this doesn't escalate use.

But, reading with more detail, reading it, we do

understand that there are some issues around the measure because understanding whether it's been used appropriately depends on claims data, which leads to other interventions being used now. Simple analgesia and mobility might be the best things, but that won't make it into the claims data.

So, we have some concerns about removing this, but we do think perhaps this is one that -- could there be a better measure of this developed?

Co-Chair Roberts: Are you the other lead discussant on this one?

Member Bossley: Misty, were you asking me? This is Heidi.

Co-Chair Roberts: No, I'm sorry, is my audio messed up? Can you all hear me?

Member Bossley: Now it sounds fine.

Co-Chair Kahn: Yes, we can. Yes.

Co-Chair Roberts: Okay. Sorry.

Yes, Heidi, are you the other one?

Member Bossley: Yes.

Co-Chair Roberts: Okay.

Member Bossley: I am. Dr. Suk had to head off to the OR. Apologies.

So, I think just to add -- and maybe my question is more to CMS -- if there's someone who could speak to the concerns which seem to have continued throughout the use of this measure around the validity and the exclusions, and some of the proxies that are used through the claims data to determine the conservative therapies and things. I mean, those are the reasons why people have questioned the measure.

And when I don't see any performance decreasing -

- it seems to be staying the same at 40 percent -- I start wondering, are we actually measuring what we intend to measure?

So, if CMS has more detail on that, it might be helpful, if you've looked into it further.

Ms. Schreiber: Hi. It's Michelle.

I will see if we have more. I know Shaili Patel is on the line. But we think that what we're looking at for conservative therapy is actually fair.

Shaili, I don't know if you're on and able to comment.

Ms. Patel: Hi. This is Shaili.

Yes, I agree. I mean, despite the consensus, there is little value in diagnostic imaging for acute low back pain. And significant practice variations does exist for our imaging resources, including x-ray imaging, CT, MRI, bone scans, ultrasound. But use has, you know, important cost implications.

I hope this adds more to what you're asking.

Member Bossley: Yes. It's helpful. I mean, I think this is where it's hard for measures when they lose endorsement. We lose that window into how a measure is refined and changed, and the impact on the validity testing.

So, I wonder if we're actually measuring what we intend to measure. Maybe it's better to look at it, as Carol was saying, using a different data source or a different way of doing this in the future. But this has been the challenge with a lot of these imaging efficiency measures, I know, over time.

Ms. Patel: Definitely. Yes, this is Shaili again. We can definitely look into that. Thank you very much for the feedback.

Ms. Schreiber: Yes, Heidi, your point is well taken.

Thank you.

Co-Chair Roberts: Additional comments from the Committee members?

Member Culica: This is Dan Culica. Sorry, go ahead. Somebody is trying to --

Ms. Binder: No, go ahead. I didn't raise my hand. Sorry.

Member Culica: No, neither did I. It was just that the mic was on.

No, I was just thinking that I was looking again through the documents. And I think that the measures that offer this replacement, I don't think they are extremely relevant for this specific one. And I think that that would be another question, and I think probably it touches a little bit on what Heidi was trying to say. It's that we removed that, but maybe we should think about what else is out there.

Thank you.

Co-Chair Roberts: Go ahead, Leah.

Ms. Binder: I just want to kind of follow up on what more information that was just touched on momentarily, but I'd kind of like a little bit more information on or just perspective on what variation was observed. I mean, is this looking at a real problem? Is there anybody to address that?

Co-Chair Roberts: I want to add to that, too, Leah. I just want clarification because I think there is variation, but it sounded like the variation is not in the performance. It has to do with the different types of imaging. So, if you could clarify that as well?

Member Culica: I think the comment was made that there is a lack of variation.

Ms. Schreiber: Shaili, I think this comment is for you. Do we know what variation we have in performance?

Co-Chair Roberts: This isn't Jenna, is it?

Ms. Binder: Oh, I don't know. I was asking the question myself.

I thought I heard someone say that there was variation and the results showed variation, which, frankly, I would assume just some general knowledge of this literature, although I'm not an expert in this, but I wonder what is the explanation -- has this measure been valuable in any way? I assume it has. And we're not hearing that. So, I mean, given that we don't have that requirement, I think it would be helpful for us to understand what was the reason for the measure to begin with, and was there anything of value in it to begin with?

Co-Chair Roberts: Michelle, I'm sorry, I think there was someone from your team who was speaking to that, is that right

Ms. Schreiber: There is. It's Shaili Patel.

Ms. Patel: Yes. So, someone actually pointed it out. The data on the variation is on page 20 of the Hospital Committee Report. I can pull that up, but I am not sure of it off the top of my head. If you gave me a moment, I can pull it up.

Ms. McKiernan: Shaili, this is Colleen McKiernan from Lewin.

I've been holding my tongue, but I do have those data, if you would like me to speak up.

Ms. Patel: Keep going, please.

Ms. McKiernan: Okay. Thanks.

So, Lewin is the developer, along with Yale-CORE.

And so, for the current performance period -- these data are actually newer than the data that you have in your packet -- among facilities that meet the known case count from the 1st to the 99 percentile, we're 29.9 to 62.2, with a median of about 45. So, there still is variation. Obviously, there's opportunities to improve performance, since it has been in that 40ish range for the median over time, but there's substantial variation across facilities that are performing well in that 25 percent to the ceiling that we're seeing in the 60 percent range.

Ms. Schreiber: Thank you, Colleen.

Ms. Binder: So, what does 60 percent mean? Sixty percent what? I'm sorry.

Ms. McKiernan: So, that means that an MRI was performed for which no antecedent conservative therapy existed. So, the highest-performing facilities have about 60 percent of their MRIs that don't have an attempted evaluation and management in 28 to 60 days preceding the MRI, or chiropracty or physical therapy in the 60 days preceding the MRI.

Ms. Binder: So, 60 percent do not -- 60 percent are not fully performing --

Ms. McKiernan: Antecedent therapy, yes.

Ms. Binder: -- with respect to (audio interference)?

Ms. McKiernan: Correct.

Ms. Binder: It sounds high.

Ms. McKiernan: Yes.

Co-Chair Roberts: On the other end, so it's anywhere from 20 to 60 percent, I think I heard you say?

Ms. McKiernan: About, yes.

Member Bossley: Misty, this is Heidi. If I could just add, though, I think the point that I was trying to make -- and I think this is what some have said -- it's not moving. When I look at 2016 through even now, if I'm reading this correctly, even just looking at the mean or median, we're staying at 40 percent. So, we're not driving improvement potentially with this measure, and I think that's one of the questions that people have had.

And maybe it's just -- you know, I don't know why -- but that's the thing; you may see variation, but I'm not seeing incremental, even incremental improvement with this measure, if I'm reading this correctly.

Ms. Schreiber: I guess part of the challenge to that, Heidi, is it because the measure is wrong or because the country as a whole is not advancing on conservative therapy for low back pain prior to MRI? I don't think it's the measure necessarily, because it does show significant variation, including places that really aren't doing very well, what most of us would consider.

But that actually becomes a fundamental problem, then, for measures in these program. It's not a problem, but really the crux of the issue for not seeing improvement. Do we just remove the measure? Or do we refocus our efforts in something else, like quality improvement work or something else?

Member Bossley: Yes, I don't disagree. I don't think I know the answer, either. But I just wanted to make sure it was clear.

I think the other thing, though, is that, when you layer on the validity piece of this, which is what has come up in the NQF panels, and a few other things, that's where I start asking Michelle, what are we looking at, right? And I think --

Ms. Schreiber: Well, believe me, I understand your

points; I really do.

Member Bossley: Yes.

Ms. Schreiber: And they're well taken. Whether or not we're capturing the right conservative therapies in claims, I get your point about that.

Member Bossley: Yes. Yes. So, I just wanted to make sure it was clear what I was trying to say.

Thanks.

Ms. Williams-Bader: Misty, we do have a couple of hands raised, Emma and Carol.

Co-Chair Roberts: Yes. Emma, do you want to go ahead?

Member Hoo: Well, I did want to pipe in on this variation topic, because we have used more broadly the advanced imaging for low back measure in some of our value purchasing work. And we do see a fair amount of geographic variation. Specifically, the rates are actually much better in Northern California than Southern California.

And one of the questions that I have is, you know, in this context, in a business being attributed in the hospital outpatient environment, I think, more broadly, we have to look at the drivers of who's ordering the inappropriate imaging or, you know, potentially not making the referrals to more conservative treatment.

I don't think the lack of improvement is a justification for removing the measure. I mean, if anything, it just points to the need for addressing some of the underlying issues, whether it's financial or whether some of this could be addressed through some of the broader alternative payment models.

But we do see high volumes of use of advanced imaging that often leads to inappropriate surgeries. In the Centers of Excellence programs we've

operated, half the low back fusion referrals end up being inappropriate for surgery, when they're fully reviewed.

So, I think that one of the key issues is kind of thinking about the macro impact in a uniform population perspective.

Co-Chair Roberts: Carol?

Member Peden: Yes, I mean, I would agree. I think that perhaps this is an area for focus or deliberate quality improvement on a national level.

I would just draw everybody's attention to the rationale for removing from consideration Criteria 7 was that the performance does not substantially differentiate between high and low performers. And we've just seen data that showed that it does. So, again, I'm a little bit concerned about that.

Co-Chair Kahn: So, I guess I'm really confused at this point from a lay standpoint whether this measure informs people to change behavior on the provider side or not. And what's the expert view?

Ms. Schreiber: Are you asking us, Chip, or are you asking the Committee writ large?

Co-Chair Kahn: I'm asking the Committee. I mean --

Ms. Schreiber: Okay. Thanks.

Co-Chair Kahn: -- the people on the Committee. I'm sorry.

Ms. Binder: I think that it would be valuable to know if purchasers have used this. It sounds like Ammon (phonetic) has done something with -- you know, in some of your work in California, you've done work on this particular issue. I don't know if you've used this measure. But, I mean, if there's measurement and there's use of measures, and use of measures to drive change, whether it's at the

provider level or among purchasers or consumers, you know, there's different levels for using measures to drive change. So, it's kind of different than the question of whether the measure itself is useful.

But it sounds like it might have been useful. I don't know. I'd turn to Emma on that one because you just mentioned that you've used it or you've looked at this issue.

Member Hoo: Yes. And the unit of measurement for us was looking at the contracted provider organizations. So, you know, the comparison of Sutter and Kaiser, for example, in Northern California to some of the multi-specialty groups in Southern California, that was where we saw the variations. And we weren't looking at this in the context of hospital outpatient, but the referral parties.

Co-Chair Roberts: Rhonda, I think you have your hand raised? Rhonda Robinson Beale, do you have your hand raised?

Okay. Chip?

Co-Chair Kahn: Yes.

Ms. Robinson Beale: Yes. Can you hear me?

Co-Chair Kahn: I just think this makes it very difficult to make a decision, because, if we go back to the criteria, it seems this measure to me bounces around it.

Leah makes a good point about all the various uses of a measure, and I don't feel well informed enough to make a judgment, according to the sort of criteria. But, anyway, that's just me.

Co-Chair Roberts: Yes, and I'm on the same page, Chuck.

And I think what Leah said earlier really resonated.

She said, you know, if we're going to consider removing it, I'm not sure we should consider the same thoughtfulness that we do for including and implementing a new measure. So, I think that's something that really resonated with me.

Rhonda, I think maybe you were able to get your audio to work now?

Ms. Robinson Beale: Yes, I did.

And I just want to say that the measurement is one that is actively used in UnitedHealthcare. And it has been one that has helped to identify and to demonstrate differentiation amongst the providers, the hospital systems and outpatient provider systems that have a variance in a way that this managed.

So, I realize that the measure is not perfect, but it is one that, depending upon how the plan positions the measure, what they do in response to the measure -- is it a pay-for-performance; is it incorporated in the value-based contracting, or just transparent, so that the various providers see their performance in comparison to others? It has caused changes.

So, I know that I'm just an observer here, but I just wanted to bring that forward.

Co-Chair Roberts: Can someone clarify? Is this used just for reporting purposes or is it pay-for-performance?

Ms. Schreiber: Pay-for-reporting, Misty.

Co-Chair Roberts: It's pay-for reporting? Okay. Thank you.

I'm a little stumped. I feel like this happens. There's always something. It's usually the very beginning where I think we could spend -- I mean, it sounds like the Workgroup wanted to -- they have recommended the decision category of support

removal. I'm hearing a lot of mixed thoughts here, and I think concern that maybe we don't have enough information, and maybe it hasn't been vetted thoroughly enough.

I don't know if we should start -- it does sound like there's concerns over the endorsements, which, if I was reading right, was removed because of the validity. There is variation. So, it does meet some of this criteria.

I don't know if we should start with maybe voting on a conditional support for retaining with -- I'm trying to look at all the different criteria, or based on some of those elements.

What does the group think? Chip, I don't know if you have any thoughts.

Co-Chair Kahn: Well, I mean, if we voted on removal, then that sort of starts us down -- and I assume from what I'm hearing that probably wouldn't pass, and then, we could get into what kind of recommendation we have. Would that make sense?

Because removal is the ultimate thing we're talking about. So, let's just see where everybody stands on that, and then, work our way to other options. Does that make sense?

Co-Chair Roberts: Yes, I think it makes sense. I feel like we probably know that it's not going to -- well, maybe we don't know; who knows?

So, do we want to start with that vote?

I'm not hearing any disagreement to start with that.

Let me look at the comments here.

NQF Team, are you all able to get that going from a voting perspective?

Ms. Williams-Bader: Yes, we will go ahead and pull

that up. So, we're pulling up support for removal, is what I heard.

Ms. Young: Thank you.

Voting is now --

Member Culica: The suggestion was support to retain. Maybe I misheard.

Co-Chair Roberts: Yes. So, I think Chip's suggestion was let's start with what the Workgroup recommended to start with, which is support for removal. We likely won't get consensus for that, but, then, open it up for other recommendations of how to proceed. So, we are starting with the support for removal.

Ms. Young: Thank you, Misty.

Okay. Voting is now open for Measure 00140-C-HOQR: MRI Lumbar Spine for Los Back Pain.

Do you vote support for removal?

(Vote.)

Okay. I think we can close the vote. We have 20.

Voting is closed. The results are yes, 6, and no, 14. The Coordinating Committee did not come to consensus, 30 percent.

Co-Chair Roberts: So, might I suggest that, again, I just think we need to be very thoughtful when we are thinking about removal.

Recognizing support for removal did not pass, should we move down the scale to conditional support for removal, although I can't say that I have any specific items to contribute for what would be that conditional support?

Ms. Williams-Bader: So, Misty, to clarify, the conditional support for removal, really the condition is having a better measure covering that topic. So,

the way we've used that category with the Workgroups is where the Workgroups really don't believe it's a good measure for the program anymore, but they do think that removing the measure would leave a gap. So, the measurement area is important, but the measure itself is not a good fit, either for the program or is not doing a good job of addressing that topic. So, that's really the condition that gets applied for conditional support for removal.

I see Chip has his hand raised.

Co-Chair Kahn: Yes. I mean, let me suggest that, if we haven't voted -- I mean, we didn't vote to affirm what they did. It is already in the program. So, maybe we just stop where we were. Because our situation here is that we are considering measures for removal. If there's not a consensus for removal, and there's not any question of alternatives or anything else, then maybe we just move on. I mean, I'm suggesting that, but, obviously, the Committee would have to concur with that.

Ms. Binder: I mean -- Leah -- I would agree with that, too. And I would say that we should inform this Workgroup that this occurred, and if the Workgroup wants to reconvene, they could. There's issues we may have missed, but I think that we should err on the side of, if we're not removing, that's a pretty significant step, given really not that much information that we have to go on.

Co-Chair Roberts: So, I think that would be a first as well, wouldn't it, for this group?

Ms. Williams-Bader: So, this is Jenna.

I guess the way that sounds to me is that the way we would -- so, the default, if we do not have a recommendation for one of the measures, is support for retaining. So, we'd have to think about how that would get communicated to the public and to CMS. But it sounds like what's being suggested is that we

would default to that support for retaining, but not based on a vote.

We'd have to make it clear that there is no quorum from the Workgroup and that the Coordinating Committee did not -- I'd have to think of how to word it, to make it clear that it wasn't that the Coordinating Committee voted and said support for retain, but, basically, did not have a recommendation.

Ms. Binder: Well, we voted not to remove, which different from, I guess, affirming that it should be retained? But we did vote not to remove.

Ms. Williams-Bader: That doesn't exactly align with the voting categories we have, though. So, I don't -- I would not necessarily say that the negative is true in this case. Like I think that, if the Committee does want to go through the categories and vote, and achieve a vote of support for retaining, then that's sort of the process we've played out.

But, as of right now, what we have is no consensus from Coordinating Committee, no consensus from the Hospital Workgroup. Therefore, we default to support for retaining.

Co-Chair Kahn: I guess I would say, considering time -- we've spent a lot of time on this -- and considering that we could go through that process, but the trouble is that part of the reason we're taking the position we're taking is because we don't feel sufficiently informed to make any other decision, other than, I mean, obviously, a preponderance of us, maybe not 60 percent, think that this is -- that we don't want to get rid of it.

So, I mean, it seems to me it's no harm, no foul if we just leave it alone then. Because we thought about it, we discussed it. We voted, and we didn't, we didn't have 60 percent that voted -- so, it seems to me it's the best use of our time to move on, because we didn't concur. We, obviously, do not

concur with the Workgroup's recommendation, which was based not on a quorum, to sum it up.

Co-Chair Roberts: Yes. Yes, I understand what you're saying, Chuck. My concern is that, if the process is that, if we're not -- when we don't have a recommendation, they're automatically going to default to support for retaining. I don't think that's the best option, either.

I certainly don't want to waste anyone's time. But if we're going to get to support for retaining by not doing anything else, I would suggest that we continue down -- that we vote on a different category.

Co-Chair Kahn: Okay. Well, whatever. I mean, that's fine, too. We'll see what happens.

Ms. Williams-Bader: I would also suggest -- and, Misty, Chip, I welcome your thoughts -- if the Committee would be comfortable with defaulting to support for retaining, then we could also just skip the other two in the middle and vote on that, and see if we have some consensus there.

But, again, I just wanted to make it clear that, as it stands right now, how I think we would communicate it to make it clear to the public, would be that there was no consensus from the Coordinating Committee. So, if you do want consensus, then we can vote on support for retaining.

Co-Chair Roberts: Julie, it looks like you have your hand raised?

Member Sonier: Yes. So, I think there's a difference between didn't reach consensus on removal and actually didn't want to remove the measure. So, I would suggest that we vote on sort of, do we, in fact, support retaining the measure, just for clarity in the public record. I think there really is this difference between, you know, couldn't come to a

decision and actually supported something.

Co-Chair Roberts: To just clarify, Julie, you're saying to take the support for retaining to a vote?

Member Sonier: Yes.

Co-Chair Roberts: Okay.

Member Sonier: Yes.

Co-Chair Roberts: Michelle?

Ms. Dardis: Thanks. Michelle Dardis, representing Joint Commission. Dr. David Baker has dropped.

I was wondering what the conditions were for conditional support for retention, because that seems like a more, in my head, the definition there was more in line with where we're at, where I would also hesitate to support for retention, lacking the input from the stakeholders on the Hospital Workgroup. I would feel more comfortable saying conditional support for retention, and the condition there was lack of other feedback from stakeholders.

Because I think saying support for retention is a lot easier than saying support for removal. I think the default, if we can't reach consensus, is retention, anyway. So, that makes sense. But I think, just in the public record, that condition there makes a little more sense to me than a statement that looks like we were in support of retention for potentially other reasons.

Co-Chair Roberts: So, I think what I'm hearing Michelle say is to vote on the category conditional support for retention?

Ms. Dardis: Yes.

Ms. Williams-Bader: Can I ask a clarifying question, though? Because the conditions are usually something to change about the measure; for example, take it through the endorsement process

or align it with the evidence.

So, can we just clarify what the condition being suggested is?

Ms. Dardis: In this case, I think the condition would be stakeholder input. I know that's not an existing category, but maybe this measure has lost endorsement, right? So, perhaps it is endorsement because that would be the consensus process of stakeholders that indicate that the measure remains acceptable for the program.

Co-Chair Roberts: Yes, I would agree that endorsement is probably the condition. Because I think some of the things that we discussed might be the reason that it lost endorsement.

Dan, did you have your hand raised?

Member Culica: Yes. I was thinking in line with the recommendation that has been made, which was the support for removal. We should go to the next one, which would be conditional support for removal. And then, we would list one of the conditions.

So, it would be sort of within the sort of suggestions that have been made. But because we need more information, then, that would be the condition. And then, we can restore that information that we consider that is missing now.

Co-Chair Roberts: So, that's actually, just to clarify, I think you say start with conditional support for removal.

Yes, I think we're hearing just a mixed bag. And I might just suggest that we move down the line. I think different people are suggesting different starting points.

So, if we started with support for removal, which is what the Workgroup suggested starting with, that one did not pass. We could move to conditional

support for removal, and go down the line.

Co-Chair Kahn: Well, if we're going to do that, let's just go ahead and do it, and we'll see what happens. Let's vote.

Co-Chair Roberts: So, that conditional support for removal, just to clarify, Dan, what would be that conditional support for removal?

Member Culica: Sorry, I'm thinking.

I was looking into the categories that we have. What the definition is for a conditional support for removal, and then, what would be the evaluation criteria?

Co-Chair Roberts: Yes. It sounds like Jenna had explained that, typically, that conditional support for removal category is used for measures that we think we don't remove just yet because it could create a significant gap.

So, some of the examples would be replacing a measure with another measure, integrating into a composite measure. Whereas, if we were to think about conditional support for retention, some of those, the conditional support, might be -- and what was suggested would be the conditional support that it obtains NQF, you know, or CBE endorsement again.

Ms. Binder: I think going down the line with the votes on removal doesn't make sense because we already voted not to remove it; that we should now go into the retention. And I'm just trying to think this through. I guess this is tricky.

But I would say, I would suggest we go into just voting on conditional support for retention, just because it seems weird to just go down the line with removal categories, when we're already just said, no, we don't support removal.

Co-Chair Roberts: I think that's a good point, Leah.

And I think at this point I've heard more people say conditional support for retaining than removal.

So, let's start with that one. Apologies to those who are doing the voting polls. But let's start with conditional support for retaining, with that condition being receiving CBE endorsement.

And if anybody has any other conditions to add, please do.

Ms. Young: Voting is now open for Measure 00140-C-HOQR: MRI Lumbar Spine for Low Back Pain.

Do you vote conditional support retaining?

(Vote.)

Co-Chair Roberts: Do we have 19 or 20 respondents? Oh, 20; there we go. Is that the total that we should have?

Ms. Young: Yes.

Voting is now closed for Measure 00140-C-HOQR.

The results are 18 yes and 2 no.

The Coordinating Committee did meet consensus for 90 percent.

Co-Chair Roberts: Great news.

So, I think we took a little bit more time for that one. I do think that it definitely raised awareness that a Workgroup quorum is very important because I think that the Coordinating Committee, there's a lot of information that's discussed and we definitely rely on some of the work that's done by the Workgroup committee. So, it might be something that we need to take back to really understand why they were unable to reach a quorum.

So, with that, I'm looking at the agenda. Let me see here.

Should we continue with the next one or should we take a little break?

Ms. Williams-Bader: I think we should go ahead and take a break. If we can try to do a five-minute break, I know that's tough, but we can aim for that. I think that would be helpful, since we are behind schedule.

But, hopefully, now that we have a process for working through, we'll be able to move through the next ones a little bit more quickly.

So, I have that it is 2:14 right now. Why don't we say we'll return at 2:20 Eastern time?

Co-Chair Roberts: Sounds good, 2:20.

Thank you.

(Whereupon, the above-entitled matter went off the record at 2:14 p.m. and resumed at 2:21 p.m.)

00922-C-HOQR: Left Without Being Seen

Ms. Williams-Bader: I think I'll introduce the measure, which is 00922-C-HOQR: Left Without Being Seen. The success is the percent of patients who leave the emergency department without being evaluated by a physician, advanced practice nurse, or physician's assistant.

Endorsement was removed for this measure, and seven Advisory Group Workgroup members selected this measure for discussion and a survey.

If we could go to the next slide, I'll just see if we have a CMS program lead who would like to provide any contextual comments on this measure.

Ms. Schreiber: Jenna, Shaili Patel will be providing comment on this and the next measure.

Ms. Williams-Bader: Great. Thank you.

Ms. Patel: Hi. Yes, this is Shaili Patel.

I would like to start off by mentioning that this measure was implemented in a new program in 2012, and mention that I'm sure you've noticed that the performance of this measure may be an issue. And that's because of the performance could be an indication that the health system or the availability of care given within the community, rather than the quality or the performance, is the actual issue at a given emergency department.

The emergency performance issue could be due to inefficient patient flow in the ED for various reasons or inefficient community resources, which could result in higher ED patient volume -- all leading to long wait times, patient deciding to leave without being seen.

We know, based on some literature, that in some communities, due to unavailability of care or difficulty with accessing care, that EDs do serve as first line of care.

Now, leaving without being seen is the most often associated with long waits or patients whose reason for visiting the ED is not severe enough that they want to wait if the ED is crowded.

Now, with that in mind, I would want to mention that this measure is publicly reported and used to calculate overall Star Rating. And we provide facilities with their reports, which allows facilities to really review their performance and compare their outcome, like the results, to their peers to promote quality of care provided within their facilities.

And lastly, this measure does allow facilities for effective communication and coordination of care.

Ms. Williams-Bader: Thank you very much.

I'll turn it over to Misty now.

Co-Chair Roberts: Should we get -- it's Akin, right?

Ms. Williams-Bader: Correct.

Co-Chair Roberts: So, Akin, for the Workgroup --

Ms. Williams-Bader: Yes.

Co-Chair Roberts: -- do you want to give some additional information from the Workgroup, Akin?

Mr. Demehin: Sure. And this conversation of the Workgroup was really fairly brief. I think a large part of the concern with this particular measure was the fact that it did have endorsement removed, and was another one of those measures that's been a part of the 020 program for quite a while and may have -- my terms, not quite the Committee's terms -- outlived its potential usefulness at this point.

I also think, given that the measure was reported at a fairly high level, there was the comment around granularity of information, and some of those underlying drivers I think were sort of up for conversation with the members of the group around what's really driving those differences. Is it the hospital practice? Is it broader factors like work course challenges?

That's a little bit of the conversation we had. Hopefully, that context is helpful.

Co-Chair Roberts: Thanks, Akin.

Let me see who the lead discussants are on this. Let's see, NCQA, Mary?

Member Barton: Yes, unfortunately, I don't know much more about this measure than what's on the slide here.

So, I can say that I think, if the feeling is that it's not that useful -- and we received no public comments on it -- then I would say we could probably go ahead and remove it, but I'm not sure if there's more data on the performance.

Member Ross: Hi. This is Clarke Ross. I was assigned as a lead discussant, and there is more

information in the notes. So, if you like, I can summarize what you have in your notes.

The Rural Advisory Group considered this, and they had a small number in attendance. Four of six supported removal, but most important for me is the Health Equity Group considered it, and 15 of the 17 Health Equity Group supported retaining the measure.

As the CMS person has observed, in many communities, underserved communities, urban communities in this country, the emergency room is the primary care location of service for many people.

And as someone who has worked in the mental illness field for years, Friday and Saturday night the emergency room is the place of respite, shelter, and primary care for people with serious mental illness in a lot of cities in the country.

So, I'd just reflect on the Health Equity Committee, 15 out of 17. According to the notes, this measure is not tied to payment. Now, the CMS person indicated that is an element in the Star Rating. So, it has an influence, if that's correct, it has an influence on payment, but it's not directly a payment measure.

Ms. Schreiber: Hi. This is Michelle. You are correct.

Member Ross: Thank you. Thank you.

So, I understand we want to be precise on who's to blame or who's responsible, but, to me, this is a systemic measure that's very important to the communities of people with mental illness, substance use disorder, and poor folks who lack access.

And the Health Equity advisory vote of 15 out of 17 is important to me.

So, I think those are the major elements that I

wanted to cover. If it's not related directly to payment, it's an important systemic measure, and I realize certain emergency rooms and hospitals may not be comfortable with this as a measure, because the Star system reflects their performance. But this is an important systemic measure in my view.

So, thank you.

Co-Chair Roberts: Thanks, Clarke.

Libby, I think you might be the other lead discussant?

You might be talking on mute.

Member Hoy: I'm sorry, can you hear me now?

Co-Chair Roberts: Yes, we can hear you.

Member Hoy: Okay. I apologize for that. There's a double-mute button.

Yes, I was also really impacted and interested in the Health Equity vote and feeling so strongly. And I certainly share those concerns for really digging into how patients leaving in health access is contributing to our disparities in outcomes.

I did note that the comments from the Health Equity Group really supported the idea that, if this particular measure had more granularity, it would be more useful. So, I realize that we need to understand sort of what is driving people away from the EDs. As was mentioned, it's assumed that that is all about wait times, but that doesn't necessarily get to underlying causes, such as linguistic support and other factors in the community, such as employment status and transportation.

So, I think, in and of itself, it would be a much more useful measure if we had more depth of knowledge about the sort of reasons why people are leaving and not just assuming it's all in the bucket of extended wait time.

So, those were my reflections.

Co-Chair Roberts: Thanks, Libby.

Chip, I think you have your hand raised.

Co-Chair Kahn: Yes. So, I'm sorry, so this is not endorsed? Is that --

Co-Chair Roberts: It looks like it lost its endorsement, like it's hard to tell, but 2013, quite a while ago.

Co-Chair Kahn: Yes. I mean, I think one of the issues here --

Member Hoy: I think --

Co-Chair Kahn: I'm sorry.

Member Hoy: No, Chip, you just reminded me I had one more comment, and that was that I did forget it, but without current endorsement, it also doesn't seem to have a steward to kind of make those edits, if you will, to the measure as well.

Co-Chair Kahn: And I guess I should have brought it up with the last measure, but I'm glad I didn't because we had so much discussion on it.

One of our objectives on the other end of our analysis, when we look at the MUC List, is that we want every measure to be endorsed. And we go back and forth when measures aren't endorsed about the appropriateness of our approval of it. And we frequently do endorse, I mean, recommend certain measures, but, usually, with the proviso that it become endorsed.

So, I respect the importance of this measure in terms of what it's trying to measure, but, frankly, it's not for us to -- we don't -- it's difficult for us to adjudicate its appropriateness, except to say, if it's not endorsed, I mean, then that should be an issue for us because it's been a measure for an age. And

if it's not endorsed, that should say a lot because we don't want to ever have -- I mean, it is our policy generally that endorsement is mandatory over time.

So, regardless of the importance of the measure, I think that alone, after all this time, should qualify it for being removed.

Co-Chair Roberts: Thanks, Chip.

Leah?

Ms. Binder: I think, certainly, when we are considering the MUC List, I agree with Chip -- well, we've all agreed for a long time that we should definitely be considering endorsement.

I think for recommendation of removal is slightly different, in that I think we should also be looking at the issue that was brought up earlier, which was about the use of measures. If a measure is actually being used ineffectively in demonstrating improvement, then I think that's a consideration that should go into the removal question. Obviously -- not obviously -- but, in general, I don't think that's such a criterion for the MUC List, but removal, I think it would be.

Ms. Williams-Bader: Misty, you might have said something I'm not sure if others heard.

Co-Chair Roberts: I was saying, "Janice?" She has her hand raised.

Member Tufte: Hi. You know, I was for really keeping this on, but, obviously, it looks like it's, you know, it's leaning the other way.

And I agree that, and I can see why the DEI community felt it was important. But it also could be used the opposite way, where if the individual, the patient, has checked in multiple times and left without being seen, it may be punitive in some places, right, against the patient?

And so, I just wanted to add that. Thank you.

Co-Chair Roberts: Thanks, Janice.

Clarke?

Member Ross: Yes, I just had a question for either CMS or the National Quality staff.

I agree with Chip in principle that non-endorsed measures, or no longer endorsed measures, create a problematic situation, but I want us to be consistent. It's a factor, but it's not a requirement, is that correct?

Ms. Schreiber: It is correct.

Ms. Patel: This is Shaili from CMS.

That is correct. Statutorily, the OPR program is not required to have endorsed measures, as long as the due process has been given, such as this.

Member Ross: Thank you.

Co-Chair Roberts: Anyone else?

Ron?

Member Walters: No problem.

Yes, I agree completely, and that became apparent when the cancer hospitals got a special all written about them.

Remember that we sometimes confuse endorsement, which is the perfect situation, with being involved in a governmental program. Michelle will validate the Secretary has the authority -- and delegates that, obviously, to people like Michelle -- to put measures in a program, whether or not they're endorsed. And that depends primarily on a lot of the factors we get talking about in committees like that: how is it used? Could it translate to improvement, and all these things?

So, in a perfect world, maybe 100 percent of the measures would be endorsed, but in an actual world, not all of them will pass the endorsement process. And that's okay. They can still be utilized in various governmental programs and by insurers and all the other people for quality improvement, et cetera, et cetera.

Correct me if I'm wrong, Michelle.

Ms. Schreiber: Sorry, Ron, I was on mute.

Yes.

Ms. Patel: This is Shaili Patel from CMS.

Just one more thing we also need to consider in terms of endorsement removal. There may be other factors involved. A third-party measure developer, whether they have -- you know, it takes resources and money to seek endorsement. And they may have not sought endorsement, you know, the second time around; it's due to that, not because the measure is not relevant, if you will.

Co-Chair Roberts: So, who is the measure steward on this one?

Co-Chair Kahn: There isn't one.

Co-Chair Roberts: There is not one?

Ms. Williams-Bader: I believe it's now CMS.

Member Hoy: Now, in the notes that I read, there was no steward and CMS had tried to contact the previous steward, and they were not interested in reapplying for endorsement, is what I read.

Ms. Patel: That is correct. This is Shaili Patel again. Yes.

Co-Chair Roberts: Is that something we should take into consideration? I mean, if the steward is not finding it valuable enough to move forward with

endorsement, is that something that the Committee should consider? It would be interesting to understand if it really is due to the effort and resources and financial components.

Chip, go ahead.

Co-Chair Kahn: Yes. No one's arguing about the authority of CMS. That's the problem. We have to stand by endorsement. If we don't stand by NQF and endorsement, then we undermine all the discussions we have at the MUC.

And if the reason there isn't a steward, and that's one of the reasons it became unendorsed, then maybe that's a good reason that we should call for this to be dropped. Endorsement is our issue, not CMS's issue, because CMS, with respect to CMS, you know, live without endorsement.

Ms. Schreiber: But, Chip, you know that we value endorsement.

Co-Chair Kahn: I know, and you value endorsement. So, I'm just saying we should particularly value endorsement, because endorsement is a process that provides a thorough review and it's not perfect. Everybody will agree to that.

But that is the expert review that, if we had a Workgroup here, we had a Workgroup, a consensus can do somewhat, but that's what we stand by. And if something has been aged and is not endorsed, then I think we are hard-pressed to come back and say, "Well, we think it's a good measure. So, we don't care whether it's endorsed."

I think it undermines our credibility when we argue that CMS ought to be always seeking endorsement on measures they bring to us in the MUC process that are not endorsed yet. I think it sets us down a road in which that inconsistency undermines our own credibility as the Coordinating Committee, and

I think everybody on the Committee ought to think about that. Otherwise, do we just not care about endorsement? I mean, I'm serious.

That's my two cents; a strong letter to follow.

Co-Chair Roberts: Thanks, Chip.

So, it looked like Julie had some comments, and maybe Robert has some additional information.

Robert, do you want to share?

Mr. Dickerson: Yes. Julie, I can address some of your questions about performance on here, and please jump in, as I walk through this, if I'm not getting to the points that you're making.

So, this measure has been --

Co-Chair Roberts: Sorry, Robert, real quickly --

Mr. Dickerson: Oh.

Co-Chair Roberts: -- remind us where you're from?

Mr. Dickerson: Yes. I'm sorry. Thank you.

Yes, my name is Bob Dickerson. I'm with Mathematica. We maintain this measure for CMS.

Co-Chair Roberts: Okay. Thank you. Go ahead.

Mr. Dickerson: Yes. So, the stewardship issue is the hospital system that created this measure, and initially endorsed it, when it came up for re-endorsement, for whatever reason -- we don't know why because this was several years ago -- opted not to seek re-endorsement.

The measure has been in the program since, I believe someone said about 2012. So, it's been in the program for quite some time.

The national performance rate is right around (audio interference) percent, which means that about

nationally --

Co-Chair Roberts: Sorry, what was that? I don't know if it went out on my end. What was that national performance rate?

Mr. Dickerson: Oh, it is about 2 percent.

Co-Chair Roberts: Okay. Thank you.

Mr. Dickerson: So, in Julie's comment, less than 1.5 percent (audio interference). I just pulled down the most recent information from the CMS Provider Data Catalog that has national and hospital performance rates for this measure.

So, the national average is around 2 percent of patients leave without being seen. The 90th percentile is zero, which is the top-performing hospitals.

And then, when you look at the performance rates kind of breaking this down a little bit more, there's only about, out of 3,624 hospitals, 504 have a left-without-being-seen rate that is 2 percent or greater. So, that's about 14 percent of the hospitals reporting on this measure have a left-without-being-seen rate that is greater than 2 percent.

So, in terms of when we're looking at variation, not very much variation. The national average, about 2 percent, that's where this measure has been sitting for many years. So, we haven't seen a lot of variation, and the hospitals that tend to have higher left-without-being-seen rates -- and this may be an important thing when we're talking about application to rural settings and that type of thing -- tend to be hospitals with low sample sizes. So, in other words, a smaller number of patients coming to their ED.

Co-Chair Roberts: Thanks, Bob.

Real quickly, Julie, since you have some comments, is there anything else that you wanted to add?

Member Sonier: The only additional thing was that, you know, kind of this question about, if the performance is that high and unvarying, is it worth the effort that's needed to calculate this measure, which seems like it must have to be manually calculated because there are no claims in this case.

Mr. Dickerson: Yes, and, Julie, thank you. Great question. I apologize I didn't address that part of your comments.

So, the measure itself is -- and I'm not sure exactly whether it's a code -- but when a patient leaves without being seen in a hospital, their record is flagged as left without being seen. And then, what hospitals do for this is they submit an aggregate. So, they have a lot of patients that were seen in the ED. That's their denominator, and then, the numerator would be those same group of patients that left without being seen, flagged in their medical record.

But you're right, it's not claims-based, but there is some type of code that they enter.

Co-Chair Roberts: Liz, I think you have your hand raised?

Ms. Goodman: Sorry, the hand and the mute -- there's a lot going on.

My comment went back to Chip's about endorsement. So, in the -- I don't know -- two years I've been on this Committee, we have recommended measures for inclusion almost entirely with a request that they seek endorsement, with a qualification that they seek endorsement.

And so, I think I'm trying to understand, Chip, if your point is that, in all cases, if a measure is not endorsed and it's on this list, we should recommend it be removed because it's not endorsed. Because we just had another measure that was relatively similarly situated.

And so, I think we would all like to see the measure steward seek endorsement, that we have no authority to do that, as the Coordinating Committee. And so, I'm not sure -- I think lacking endorsement is a factor, but I'm not sure it's the determining factor.

Co-Chair Kahn: But here, we're talking about measures -- and maybe I should have stressed it in the last one -- we're talking about measures that have been online for a long time.

So, it's one thing to be upfront talking about new measures that are developing; they want to be brought on. They may not have gotten to endorsement.

But I would say you have to have a very strong reason to say something that's been on for a long time that's on this list, that's not endorsed -- it seems to me it should be -- maybe it's not a completely defining criteria, but it ought to be a really strong one. Because, otherwise, I mean, it's interesting, both of the last two we've gone to were not endorsed. I don't know about the others. It will be interesting to see whether all these are not endorsed.

And it seems to me that makes a strong case that maybe all of these should be removed. Because either we believe in endorsement or we don't. And it's one thing to talk about developing measures or new measures. It's another thing to talk about measures that have been around for -- I don't know -- 8 or 10 or 12 years to me.

Ms. Goodman: I think endorsement is an important criteria. I don't think it's the only criteria. That's my only point.

And I think that, with the previous measure, the lack of alternative measures to identify overutilization, I'd rather see a new measure come in and be exchanged out for the previous measure.

I can't speak to this measure in the same way.

Co-Chair Kahn: Okay.

Co-Chair Roberts: Clarke? Clarke, did you have additional comments?

Member Ross: I'm sorry, I forgot to unmute.

And so, I had a question for Bob Dickerson and CMS. So, Bob introduced their role as maintaining the measure. Maybe he could describe a little bit more, is the responsibility just a reporting from the hospitals who aggregately report the percent of people who left? So, we've got endorsement and no endorsement. And now, we have maintenance. And I'd just like to know what that means.

Ms. Schreiber: In point of fact, it looks like CMS is the steward, although we weren't the original developer. The original developer, the university I think was Baylor.

And so, as measures are in our program, we will maintain them and we usually use, you know, as you can see, contractors to help us do the maintenance. So, you can assume that at the moment we're the measure steward.

Mr. Dickerson: And then -- this is Bob -- to add, to help clarify a little bit, I think, what Clarke was asking about regarding what maintenance means, we do literature reviews relevant to the measure. We also answer questions from hospitals and implementers and reporters about the measure.

Does that help?

Member Ross: Yes. Thank you.

Co-Chair Roberts: Heidi?

Member Bossley: So, I don't know if it helps to know, but I'll admit it, it's the past the five years, but I was the person who removed endorsement on

this measure. It was an orphan back when we ran the maintenance process.

I've been trying to see if it was tested or if it was one of the time-limited, but, quite honestly, I don't know if it's an issue now.

But I think where I come down to it is I've seen this measure really move the needle and improve patient care, but I'm not seeing any variation now. So, given the fact that there is some requirement from the hospitals -- like more labor; it's not a claims-based measure -- I do wonder if this is one that might be worthwhile considering removing, regardless of an endorsement or not.

And then, if they can come back with something that looks more with an equity lens, which I think is critically important and would be good, that would be useful. But I'm just not sure that this one is worth continuing, just because of data collection burden alone, from what I understand, and lack of variation.

Co-Chair Roberts: Thanks, Heidi.

I do have just one question maybe for Michelle or someone from CMS.

Recognizing that this measure has, you know, it hasn't been endorsed, I know you all do value endorsement, but it's not a "must have." However, it continues to be used in the program. I'm just wondering, what is the value that you all see from continuing to keep it in the program? Is there something that we might be missing?

Ms. Patel: Yes. This is Shaili.

Ms. Schreiber: Go ahead, Shaili.

Ms. Patel: Sorry, please add, Michelle.

But I would say that this measure is publicly reported, and on our Care Compare website, and

also used to calculate overall Star Ratings for hospitals.

Authorities, we correct authorities with reports, right, how they look on paper with their data. And they can use that as an opportunity to improve, make improvements, and compare how they are compared to their peers, right, within geographical location, and really, you know, make changes in how they work and facilitate effective communications amongst their patients and coordination of care.

Ms. Schreiber: So, Misty, it's Michelle, and I agree with what Shaili said.

I think the reason for retention in the program is, No. 1, accountability for performance in the emergency department. And as we all know, the emergency departments fall under the ambulatory part of hospitals, HOPDs.

Left without being seen we think is important for several reasons. One is that it may reflect not only lack of access, but for some patients, lack of feeling as if they're being attended to appropriately in the emergency department. And that is why some of them choose to leave.

So, it's really a reflection of whether or not the hospital is adequately attending to patients, attending to patients rapidly or in a way that they find satisfied or that they have access.

We agree that 2 percent appears to be a relatively small number, but I know I've seen others, you know, on the chat, doing the math. It's still a lot of people, you know, who are leaving emergency departments without being seen. And that's why we have continued it, and that's the value that we've seen.

Ms. Patel: If I may add, Michelle, this will also provide CMS with an opportunity to really look at

disparities, right? These patients that are leaving the emergency departments without being seen, what is the true reason?

Once we go deep into those characteristics, we learn more. Is it the insurance? Is it the demographic? What really is the reason for people leaving without being seen?

Member Hoy: So, this is Libby.

If I could ask just to clarify that again? Because I certainly am concerned about why patients and families are leaving EDs. I certainly want to understand that.

But what I keep getting a little bit hung up on is that just whether they left or didn't leave doesn't seem to dive into that. But what you just stated is that CMS is using this in some way to help you understand that, is that right?

Ms. Schreiber: I think --

Member Hoy: It would help us -- sorry.

Ms. Schreiber: Yes, let me just --

Member Hoy: Sorry, Michelle.

Ms. Schreiber: Thank you.

Anyhow, I think we have that opportunity, Libby. I'm not saying that we have done that yet. But, as CMS and all of you who've seen that some of this is starting to happen, that CMS looks at its various measures and starts stratifying them around equity, this would, for example, be one of those measures that would probably be important to look at in that theme, so that we can gain that understanding. I'm not saying that we have so far, but, directionally, I think this is one of those measures where that actually would be important to understand.

Member Hoy: Thank you. That is really helpful.

So, if I'm thinking of it in the reverse, if this measure were to be removed, does CMS lose an opportunity to do that, to take those next steps in stratifying?

Ms. Schreiber: Yes, for this particular circumstance. Okay?

Member Hoy: Okay.

Ms. Schreiber: There are other measures of ED performance, but, for this particular circumstance, people who leave the emergency room without even being seen, you're right, this is the data that tells us that and would give us the opportunity to look at that and stratify it by whatever disparities.

Member Hoy: Thank you.

And so, my final question is, then, do we have an opportunity to recommend for retaining the measure with modifications, or like we do when we're voting in measures? No?

Ms. Schreiber: I believe that's the NQF staff.

Co-Chair Roberts: Yes, I mean, I think we certainly can, but my question around that is, without a measure steward -- and it sounds like Mathematica is maintaining -- and let's say if we're recommending some modifications, who is it that would do that? Is that Mathematica?

Ms. Schreiber: CMS.

Co-Chair Roberts: It would be CMS? Okay. Okay. That's helpful to understand.

Janice?

Member Tufte: Thank you for calling on me.

Yes, I don't know about you, but when I check into the ED, the demographics are not asked for at that point in time. And actually, we prefer that they're

not because the time of people that come in, it could be triggering asking a lot of the SDOA stuff.

So, if they don't have a record, you know, some sort of medical record, all we do is we sign in and say that we're responsible for paying. And if there's demographics, it's more than likely what somebody has assigned to them, unless they have insurance and they're able to be traced through where they live and more of that demographic information. But a lot of people aren't.

And left without being seen, another thing is they maybe have checked in. I mean, to me, this is ambiguous. They maybe have been checked in and they're waiting and waiting and waiting, and they haven't been seen by the doctor. It's not clear who has not seen them, right? A nurse could have seen them and not the doctor.

And so, that's something I would like to say about this. You know, there's a lot to add in, the SDOA stuff. I think it would be better to have a new measure, perhaps part of a patient satisfaction bundle, or something. I don't know, but that could be better defined.

Because left without being seen, one person might think that they -- and the hospitals might even think differently; I don't know. You know, I'm not sure.

Co-Chair Roberts: Thanks, Janice.

I do see a couple of people who have hard stops at 3:00. I do think it's probably important to get a vote in.

I might just ask Michelle, I see you still have your hand raised. Any additional information that maybe we haven't discussed?

Ms. Dardis: Thanks.

My only comment or question was that I don't know

that this measure currently includes demographic data collection because it's a chart-instructed measure and not claims. And so, I was wondering if CMS or Mathematica, if they have the data available to do stratification. Because if not, we're talking about a pretty long process, potentially, to modify the measure, collect data, and then, understand if there's variations in performance by disparity conditions.

Ms. Schreiber: Michelle, in a number of the measures we do not have the direct data. We are looking at other means of stratifying data that doesn't require the direct collection of some of this information because, frankly, we don't have it.

Ms. Dardis: Thanks.

Co-Chair Roberts: Okay. Appreciate all the comments.

I am going to recommend, Staff, we move forward with voting on what the Workgroup recommended in terms of starting with the decision category of support for removal.

Ms. Young: Okay. Voting is now open for Measure 00922-C-HOQR: Left Without Being Seen.

Do you vote conditional support for removal?

Member Sonier: So, the question is, we're voting for removal or conditional support for removal?

Ms. Binder: I think it should be removal. We haven't discussed conditions. Specifically, we would --

Co-Chair Roberts: Yes, support for removal. Yes, that's what the Workgroup recommended starting with.

Thank you.

Ms. Young: Thanks, Misty.

Voting is now open for Measure 00922-C-HOQR: Left Without Being Seen.

Do you vote support for removal?

(Pause.)

I see 18. I don't know if we've lost two people.

We'll give it a few seconds.

I think we can close the poll now.

Ms. Williams-Bader: Yes, agree.

Ms. Young: Voting is now closed for Measure 00922-C-HOQR: Left Without Being Seen.

The votes are yes for 12, and no, 7.

Consensus not reached for 63 percent.

Co-Chair Roberts: Sorry, you said consensus was not reached?

Ms. Young: No.

Ms. Williams-Bader: Can you restate that?

Ms. Young: I'm sorry.

Ms. Williams-Bader: Isn't that greater than 60 percent?

Ms. Young: You're correct. Yes, thank you.

(Audio interference) greater or equal to (audio interference).

Closed for Measure 00922-C-HOQR: Left Without Being Seen.

And the responses are yes, 12; no, 7.

Consensus was reached with 63 percent.

Co-Chair Roberts: Thanks for clarifying that.

Ms. Young: Thanks, Misty.

Ms. Williams-Bader: So, we are at time and have three more items up for discussion today. How should we proceed? Do we have any proffer for tomorrow?

Co-Chair Roberts: So, we wanted to ask a question. We do have a buffer as long as no additional measures will be pulled from the consent calendar tomorrow. I'm not trying to influence anyone's -- what anyone will be doing tomorrow, but we would like do a quick assessment to see, does anyone, based on what you know now, does anyone plan to request to pull any measures from the consent calendar tomorrow?

Perhaps if you could raise your hand if you do. We don't have to get into it, but we're just trying to see if we're going to need that time.

We do have two measures during that time slot that were already pulled, but we do have some buffer in that timeframe, if we are not pulling any additional measures.

Ms. Binder: I'd like to make the suggestion that, given I think the fact that there wasn't a quorum in the Outpatient Workgroup, I think that what we saw from today's conversation is that that is a major problem. It caused us to have conversations that we would not otherwise have, and that's part of the reason for the extended time of this meeting.

Maybe we skip the outpatient measures and come back to them, if there's time at the end of tomorrow? And if there's not, then we send it back through the process that it should have gone through to begin with, recognizing that delays things, but I think, given that we may be in that situation around doing something, it should not be the measures where the Workgroups have brought us more thought-through recommendations.

Co-Chair Kahn: Well, I think that's great, but I don't we have -- that's not possible, considering the timeline, right, Jenna?

Ms. Williams-Bader: That's correct. We would not be --

Co-Chair Kahn: I mean, I appreciate the point you're making, but I think we need to barrel through tomorrow. I don't think we have any choice.

Member Tufte: So, to clarify, we'd either vote on all of them to be removed or conditionally to be removed, just to go through? Or you said there was only two that were pulled. Is that in what still remains today on top of tomorrow or?

Ms. Williams-Bader: So, we have three more that we were planning to discuss today that were consensus not reached. I'd have to look at the slides here to see what the decision categories were. I don't think they were all support for removal. I think there were some that were conditional support for retaining.

Co-Chair Kahn: We spent a lot of time today with process discussions. So, I think that we've got our process down. So, tomorrow I think we will just be discussing merits pretty much, whether we have recommendations or not. So, I think we need to barrel through tomorrow. I don't see we have a choice.

Ms. Williams-Bader: So, back to the question, and again, there will be a public comment tomorrow was well. So, we recognize that might impact influence Committee members' decision whether they want to pull any measures, or recommend pulling any measures from the consent calendar.

But is there anyone who is planning to request pulling measures? It looks like we might have some requests from Liz Goodman.

Leah, I see you have your hand raised as well.

Anyone else?

And, Leah, do you have a sense for how many measures you're requesting to pull?

Ms. Binder: I don't have a final answer to that right this second.

Ms. Williams-Bader: Okay.

Ms. Binder: But I don't know yet. I can't give you that.

Ms. Williams-Bader: So, I think based on that, I do have a concern about how many we have to get through tomorrow, if there are additional ones to pull. We have a little bit of a buffer, but not that much.

I think we do have a slide asking, just while we determine what our plan is, I think we have a slide asking if people can stay over. Can we go ahead and pull that up?

And let me just touch base with the team and see what we might want to do here while we pull that up.

Co-Chair Roberts: To clarify, this is today or tomorrow?

Ms. Williams-Bader: This is today for right now.

Co-Chair Roberts: This is today? Okay.

Ms. Williams-Bader: Uh-hum.

Co-Chair Roberts: Okay.

Ms. Dardis: Let it just be noted that I voted for tomorrow. I can stay today, but I can't stay tomorrow.

Member Bossley: And I guess (audio interference), I

can go to 3:30, and then, I have a hard stop.

Ms. Williams-Bader: Fair point. Let's say 3:30. Try to get through one more.

Co-Chair Roberts: So, I only see 13 people. Do we know who -- I think we know Carol and -- sorry I can't remember who else -- both had to leave. So, we know we lost two. Do we know if we've lost anybody else already?

Co-Chair Kahn: Well, you've got to have a -- we've got to have a quorum because we can't --

Co-Chair Roberts: Yes, that's what I was trying to get at.

Co-Chair Kahn: We can't have any discussion without a quorum.

Ms. Williams-Bader: Agreed.

Co-Chair Kahn: So, we need 16 to say yes?

Ms. Williams-Bader: That is correct.

We have someone else who's dropping. Mary Barton is dropping.

Co-Chair Kahn: Well, I think staff should sort of figure out for the Chairs how much time, if we're going to make it within our time tomorrow we can spend on each one.

And I think Misty and I just have to be very disciplined with the group and that we keep the discussion to the number of minutes for each measure. And, I mean, if we have to go over with the measure, we will. But, I mean, I think that's the only way to deal with it, if we're going to make sure we finish tomorrow.

Ms. Williams-Bader: Yes.

Co-Chair Kahn: So, maybe you should do another annotated agenda for us that gives, for the ones I'm

going to do and the ones she's going to do, gives us a clock. I mean, you know, gives us some limits, and then, we'll just tell the Committee, "This is what we've got." And if it takes longer for one, then we have to cut back on time for another in terms of discussion. I think that's the only way to get it done.

Member Walters: Yes, this is Ron.

Most of everybody on the Committee has been with the NQF for a while. We understand that NQF could last for three or four days, if you let it, because there's always something to talk about.

But I agree, it's management of the expectations. So, here's what's allotted to each measure and there's a hard stop there. If it becomes less than a hard stop, then, I'm sorry, that's going to subtract from -- it's going to change the hard stop in other measures.

Co-Chair Kahn: Right.

Member Walters: It's not an insensitive way to do things. It's just you get sucked into these commitment problems, and we absolutely must maintain a quorum or the Board is going to be very unhappy with us.

Co-Chair Kahn: Yes, I agree, but I think that we spent a lot of time today, justifiably, in terms of working through the process issues. And tomorrow, we should -- we talked about process -- now tomorrow, we just need to get the work done.

Ms. Williams-Bader: Okay. Well, thank you all so much. Really appreciate those of you who have been able to stick on a little bit longer to talk through this.

Staff will definitely take this back and, also, touch base with CMS to figure out how we want to manage tomorrow.

Co-Chair Roberts: A quick question before, because I'm kind of concerned. And maybe I'm not understanding Liz's comments. And she may have dropped.

But she said, "If the consent requires voting for retention or removal by a measure type, I will request removal." Wouldn't that be all of them? Or am I misunderstanding what she is saying?

Member Walters: I saw that, too. I think she was asking a blanket vote to cover the worst-case scenario, say, that all of them were of the same type. She actually would vote. I think it also became moot, once we just made that last decision.

Co-Chair Roberts: Okay.

Member Walters: So, we shall be here and we'll restrict our time, and she'll be fine.

Co-Chair Roberts: Okay. I just didn't want to come tomorrow and all of them are getting pulled from the consent calendar. So, okay.

Member Tufte: I hope not.

(Laughter.)

Co-Chair Kahn: Okay. Well, thank you, and I look forward to hearing from staff on the amount of time you allocate to each measure.

Ms. Williams-Bader: Sounds good.

Thank you all so much and have a good evening. We'll see you tomorrow.

Co-Chair Kahn: Thanks.

Co-Chair Roberts: Thanks, everyone.

Adjourn

(Whereupon, the above-entitled matter went off the record at 3:13 p.m.)