National Quality Forum
2022 Measure Set Review Meeting of the Measure Applications Partnership Coordinating Committee
Thursday, August 25, 2022

The Coordinating Committee met via Video Teleconference, at 10:00 a.m. EDT, 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
Kacie Kleja, MBA, MS, CHDA, HCA Healthcare
Parul Mistry, MD, MA, AmeriHealth Caritas
Carol Peden, MB ChB, MD, FRCA, FFICM, MPH, Blue Cross Blue Shield Association
Amir Qaseem, MD, PhD, MHA, FACP, American College of Physicians
Clarke Ross, DPA, American Association on Health and Disability
Julie Sonier, MPA, 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 Managment
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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Proceedings

(10:05 a.m.)

Welcome, Summary of Day One, and Roll Call

Ms. Williams-Bader: Okay, let's go ahead and get started.

Welcome, everyone. As a reminder, I am Jenna Williams-Bader, Senior Director of the Measure Applications Partnership here at NQF.

Let's go ahead and go to the next slide, please.

Quickly, again if you could remain engaged and actually participate today, respect all voices. Keep comments concise and focused. And be respectful of others. We do have a tight agenda for today, so we definitely appreciate everyone keeping their comments as concise as possible.

Next slide, please.

I think we covered this yesterday, but please, you can mute and unmute yourself using the Webex platform. And please do remember to raise your hand if you have a comment so that we can manage the queue and make sure everyone's getting an opportunity to speak. There's also the chat. And if we -- if you would like to add comments in the chat as well, please feel free to do so.

Next slide, please.

All right. So, again, welcome everyone to Day 2 of our Measure Applications Partnership Coordinating Committee meeting, our 2022 Measure Set Review.

Thank you, again, for staying engaged yesterday. We worked through quite a few process issues, and we knew that introducing a new process with the Consent Calendar would also, it's something for us to work through. We knew there would be lessons learned.

So, really appreciate everyone's engagement yesterday and look forward to your engagement today.

Next slide, please.

So, we have made some adjustments to the agenda for today. The agenda has been updated in the meeting invite as well, and it has also been updated on the website. And we can go ahead and add that link into the chat as well for you so you can take a look.

The morning will mostly stay the same. We'll be reviewing the measure from the Ambulatory Surgical Center Quality Reporting Program. That is not on the Consent Calendar.

We'll also be reviewing a measure from the Medicare Shared Savings Program that was not in the Consent Calendar.

And then before lunch we will be presenting the measure set review recommendations for the Consent Calendar, preceded by a public comment. And that will be an opportunity to Coordinating Committee members to pull, or to recommend pulling any additional measures from the Consent Calendar.

If we could go to the next slide, please.

So, we'll have a 20-minute lunch break today instead of a 30-minute break. And then we will pick up the measure set review recommendation for the Hospital OQR Program. We have three measures there from yesterday that we're going to review.

And then we will discuss recommendations for measures pulled from the Consent Calendar. And as a reminder, we had two pulled previously before the meeting. And this will be the section where we discuss any other measures pulled today.

Depending on the number of measures that are

pulled, we might need to do the CQM Coordinating Committee feedback on the MSR process offline. We can cut into that time as well.

There will be one last opportunity for public comment at the end of the day.

So, please let us know if you have any questions about this updated agenda.

If we could go to the next slide, please.

Okay. So, yesterday we did have quite a bit of discussion about two of the measures from the Hospital Outpatient Quality Reporting Program. I think we're in a good place with the process now as far as how we're going to handle the rest of those.

We'll hear from our Workgroup co-chair and the program lead, and then have a discussion of those measures, followed by a vote.

And we do welcome our Workgroup co-chairs to provide information on, on those discussions that happened at the Workgroup.

So, and I think we've got some more slides. Before we jump into today we do want to do some refreshers as well on some other key points for today.

If we could. There we go.

We do want to remind people of our measure review criteria, and really to make sure that these are the foundation for the discussions that we're having today.

Again, these are the reasons why a measure would be recommended for being removed from a program. We do want to makes sure that our discussions are, are linked to these criteria.

And, also, later in the day when we talk about the measures, if anyone's recommending to remove

measures from the Consent Calendar, again linking back to these criteria as well.

So, we have the measure does not contribute to the overall goals and objectives of the program;

That it's duplicative of other measures in the program;

That it's not endorsed by the Consensus-Based Entity, or lost endorsement;

That performance or improvement on the measure does not result in better patient outcomes;

The measure does not reflect current evidence.

And we have two criteria around performance:

So, it's the performance is uniformly high and lacks variation;

Or if it does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation.

These could be reasons to remove a measure.

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Could also be that the measure leads to a high level of reporting burden for reporting entities;

That it's not reported by entities due to low volume, entities not having data, or entities not selecting to report a voluntary measure;

And, lastly, measure has negative unintended consequences.

So, please do keep these in mind throughout today's discussion. And we can pull these up at any point if anyone would like to see these again.

And then if we could go to the next slide.

Also a reminder about the decision categories.

So, if we could go to the next slide.

Support for retaining is really for those measures that MAP thinks that the Coordinating Committee feels continue to meet the, meet the program goals; that it is the right measure for measuring what it is measuring; and that they think that it belongs in the program as specified.

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Conditional support for retaining would be measures that the Coordinating Committee feels still meet the goals of the program but perhaps there are things about the measure that could -- that the Coordinating Committee would like to see changed in order to make sure it is still the right measure for the program.

So, for example, this could be that the measure needs to receive CBE endorsement; or if it's fallen out of alignment with the evidence; or it needs to be reclassified as an eCQM. And for this one we would also want to hear the conditions that Coordinating Committee feels need to be met.

Next slide.

Conditional support for removal, as we discussed yesterday, would be measures that, that the Committee does not feel continue to meet the goals of the program; that removing it would leave a significant measurement gap, so the condition is really that a better measure needs to be in place and then this measure should be removed.

And then, lastly, support for removal would be that the Committee feels that the measure does not belong in the program anymore, and that removing it does not create a measurement gap.

So, please let us know if you have any questions about those as well.

And then just a couple, one or two more reminders before we continue.

So, again, the recommendations that are being made by the MAP today are for, are for removal of measures from programs. But CMS should still take any, any potential removals of measures through their rulemaking process. So, in no way do the recommendations today mean that a measure is immediately pulled from a program. CMS should still be taking those, the remove, the potential removal of measures through the rulemaking processes.

And then, also, just a reminder that the MAP is focusing on the use of measures in federal programs.

We do recognize that measures may be used in other programs as well, private payer programs, things like that. But and we do also recognize that whether or not a measure is used in a federal program may impact whether others are using it. But we are focused today on the use of these measures in federal programs.

So, let me just pause quickly there. Any, any questions for me about any of that?

Leah, I see your hand's raised. Go ahead.

Ms. Binder: Thanks. Thanks for that overview. That was helpful.

Just on the last part about use by federal programs, I think if we're look -- we're recommending to remove a measure, we're going to look at any way that the measure is used. I mean, that has to be part of our consideration from our perspective. And we're certainly going to do that for my own in terms of thinking about removing a measure, which is a very, you know, it's a substantial recommendation.

So, recognizing that we need to be advising CMS. I guess CMS would consider how CMS used it. But for

us, we need to look at it holistically.

Ms. Williams-Bader: Does anyone have any thoughts, reactions to that before we move on?

Thank you, Leah.

Co-chair Roberts: Yeah. I would say, you know, Leah certainly understands your points. But if we, our recommendations are specific to the federal programs, and any recommendations that we make does not mean that it cannot be used by these other, these other groups or areas.

So, I just think that we need to take that into consideration as well. I recognize that people may choose, if it's removed from a federal program, not to look at it anymore. But I do think that we really need to focus on the fact that we are designed to look at measures in each of our programs.

Ms. Binder: Well, Misty, I appreciate that, but I just want to clarify that.

If it happens that it's removed from CMS, in most cases then it's not available to any other entity, any other stakeholders. So, they select the data as well, so we wouldn't have it available.

So, so we do have to consider it from, from the perspective of the many stakeholders in the public who would lose it there, because it wouldn't be available in theory if it's removed.

Co-chair Kahn: What do you mean it wouldn't be available in theory to other people if it's removed? I don't understand.

Ms. Binder: If it's removed, if the measure is removed from CMS it's not going to be available to anyone.

Ms. Schreiber: I'll give you an example of that.

Co-chair Kahn: Why? Why?

Ms. Schreiber: Let me give you an example, Chip.

It is true what Leah is saying and Misty is saying. There may be instances where these measures are still used by, say, I don't know, Blue Cross, or a Blue Cross program, or a quality improvement program someplace.

On the other hand, there are organizations who pull these data directly from CMS and use them in their programs. We've used those to some degree, for example. U.S. Digital Report does to some degree. Other agencies do to some degree. And so if CMS were to pull them they would not be available to those other organizations.

Co-chair Kahn: You mean the Medicare information, you mean the information on the website would not be available. Why is the measure not available for them to use?

I guess I'm confused by that.

Ms. Schreiber: Because we're also the data collector. They use the data that we collect. If we pull the measure, we stop collecting the data.

Co-chair Roberts: But it still allows the, the organizations themselves to collect their own data for their own purposes.

Ms. Schreiber: They would have to, they would have to have a way of collecting their own data. That's correct.

Ms. Binder: But, so that's why I'm saying other constituents have to be considered because a consumer cannot collect data, nor can an individual.

Co-chair Kahn: Well, then why are we having this process, Leah? I mean, you're just -- we, we only deal within the Medicare context. And we're making a decision for Medicare.

Ms. Binder: Medicare is a public program. And the

data that's made public as part of CMS is important to a number of constituents besides CMS. And I'm coming to the table from that perspective.

Like, would I want to see this measure removed? Is it used, is it useful for consumers and purchasers? And that's why we're, that's what --

Co-chair Kahn: Well, I, I -- Okay.

Ms. Williams-Bader: I see Clarke has his hand raised.

I would like to suggest, I mean, I have a lot of experience as a measure developer as well, and if I could suggest that this is useful. And, Chip and Misty as our co-chairs, please let me know, and others. But all of these measures are in use today, obviously. That's why we're talking about them.

And measures that are in use by CMS then also do tend to be used in other places because those are the measures that are available. And I do think that the discussions we want to have today are really about whether those are the measures we should be using. A little less, there's a little less focus on whether those measures are used, because just because they're used does not mean they're good measures or the best measures to cover that topic. It means that those are the ones that are available.

So, if it would help to frame it in that way, that really trying to take a look at are these the right measures for the topics that they're covering, that might help. Because otherwise I do think that we'll end up none of these measures would ever be suggested for removal because they are in use. And then because CMS is using, they do tend to be used elsewhere as well. Just as a suggestion.

Ms. Williams-Bader: Clarke, I see your hand is raised.

Member Ross: Yes. I'm still trying to sort through

this discussion with yesterday's discussion of leaving emergency room unseen. And a decision criteria has endorsement by a consensus entity and should emphasize that in our discussion yesterday.

And, yet, the measure is used by CMS nationwide. And CMS has a contractor, Mathematica. So, we can say no consensus entity, no endorsement, it's out.

But then I would say what is the role of this group in trying to say out on a measure that a federal agency, in this case CMS, is using and has used for a long time?

So --

Co-chair Kahn: But, Clarke, that's the whole reason --

Member Ross: -- I'm just trying to sort through --

Co-chair Kahn: Clarke, that's the reason for this discussion. They're using measures and we're evaluating the measures that they use. We're only making recommendations.

I mean, using the logic that you just described we wouldn't have a process because if CMS has already decided to use it and has been using it for years, then we have nothing to recommend to them. We are evaluating what they are doing and making a recommendation to them.

We have standards. Those standards include, you know, include on this list endorsement. If we think as a group that the fact that it hasn't been endorsed for many years is a problem, we're saying to them we think this is a measure that they shouldn't use anymore.

First, they still have the ability to decide whatever they want to decide. But the logic of what you just described would give us no role at all because, by definition, if they were using it it's a measure that should be used.

Member Ross: I guess I'm saying there's a gray area.

So, you're saying no consensus entity, no endorsement, out.

And I'm saying CMS is performing the role of a steward and --

Co-chair Kahn: No. No. I'm saying this group can use whatever criteria we want to make a recommendation to them. We are independent of CMS.

If you think this is a good measure and shouldn't be dropped, for whatever reasons, then that's how you voted yesterday. But to say that just because CMS is using it it is good, it seems to me contradicts the whole reason that we exist.

We don't have to use endorsement on every measure. I agree with that, I mean, because that's up to, it's up to you. I, I feel strongly that endorsement is an issue. If you don't think endorsement's an issue, then you vote how you can to vote on the Coordinating Committee. But the fact that CMS is using it is actually not material, other than we're looking at all the measures that CMS is using.

It's not a supporting -- to me, it doesn't support a measure that they are using it. That's why we're doing an evaluation of it. And it's only a recommendation. CMS is still going to do whatever they're going to do, they're just going to take our recommendation into account.

Ms. Binder: The issue is not whether they use it, and I would argue anyone uses it. The issue is if it's used effectively to create change.

I mean, none of us care about the measures per se because we want to see them beautifully lined up on our bookshelf. We're doing this because we want to

see change in culture. And so, are they effective in any way?

If they're not, then we should recommend removal. That's to the uses about how if they're used effectively. And by -- and it doesn't matter if it's CMS or anyone else. If it's being used effectively by key stakeholders to make change. And if not, to remove it.

Co-chair Kahn: And those are criteria that you're, that you use to make your decision when you vote. That's what I mean.

Ms. Binder: Right. That's what I'm saying also.

So, I'm saying not just CMS.

Ms. Binder: It's up to you how you want, what criteria you want to use.

Member Ross: Okay, thank you. I've got the issue.

My concern is 19 people voted and the message that the National Quality Forum is recommending to CMS that a measure be dropped, that some of us in the equity disability and mental health field think it's very important. But that's my personal organizational approach.

So, thank you for entertaining and listening and reacting.

Ms. Williams-Bader: Okay. It feels like that discussion is coming to a close. There are some additional comments in the chat, so I encourage people to look there.

But in the interests of time why don't we go ahead and move to the next slide.

We do need to do a quick roll call. If you were not on the call yesterday, please do go ahead and include a disclosure, a conflicts of interests when we get to your name. And I'll turn it over to Gus for the

roll call.

Mr. Zimmerman: Excellent. Thank you, Jenna.

So, I will start with our organizational members.

The American Academy of Hospice and Palliative Medicine.

Okay. The American Association of Health and Disability.

Member Ross: Hello. I'm here. Clarke.

Mr. Zimmerman: The American College of Physicians.

Member Qaseem: Hi. This is Amir. I'm here.

Mr. Zimmerman: Thank you.

The American Health Care Association.

Member Sreenivas: Hi. This is Kiran. I'm here.

Mr. Zimmerman: Thank you.

The American Medical Association.

Member Bossley: Hi. It's Heidi. I'm here.

Mr. Zimmerman: The American Nurses Association.

Okay. America's Health Insurance Plans.

Okay. AmeriHealth Caritas.

Member Mistry: Hi. This is Parul. I'm here.

Mr. Zimmerman: Thank you.

Blue Cross Blue Shield Association.

Member Peden: Good morning, everyone. It's Carol. I'm here.

Mr. Zimmerman: Thank you.

Civitas Networks for Health.

Member Sonier: Good morning. Julie Sonier is here.

Mr. Zimmerman: Thank you.

Covered California.

Member Amarnath: Good morning. Ash Amarnath, here.

Mr. Zimmerman: HCA Healthcare.

Ms. Kleja: Good morning, Kacie Kleja. And was not present yesterday. And I do, to disclose, I do have stock in HCA Healthcare.

Mr. Zimmerman: Excellent. Thank you.

The Joint Commission.

Ms. Dardis: Good morning. Michelle Dardis, present.

Mr. Zimmerman: The Leapfrog Group.

Ms. Binder: Good morning. Leah Binder, present.

Mr. Zimmerman: Thank you.

National Committee for Quality Assurance.

Member Barton: Good morning. This is Mary Barton.

Mr. Zimmerman: Thank you.

National Patient Advocate Foundation.

Member Kirch: Good morning. Rebecca Kirch, present.

Mr. Zimmerman: Thank you.

Patient & Family Centered Care Partners.

And Purchaser Business Group on Health.

Member Hoo: Good morning. Emma Hoo, present.

Mr. Zimmerman: Let me double check.

Okay, has anyone joined or who was not present while I was reading off the organizational list?

All right. And I know our two co-chairs are here.

Let's just run through our SME members.

Dan.

Member Culica: Good morning, everyone. Dan is here.

Mr. Zimmerman: Janice.

Member Tufte: I'm here. Thank you.

Mr. Zimmerman: Ron Walters.

Member Walters: Present and glad to be here.

Mr. Zimmerman: Excellent. Thank you.

And then is there anyone from our non -- our Federal Government Liaisons. AHRQ? Okay.

Ms. Grace: Yes, this is Erin Grace. I'm here.

Mr. Zimmerman: Thank you,

From CDC?

Okay. From CMS?

Ms. Schreiber: Yes. Michelle Schreiber. And there are a number of CMS folks, as well as our contractors on the line.

Mr. Zimmerman: Thank you.

And then from ONC?

All right. I will turn it back over to you, Jenna.

Ms. Williams-Bader: Thank you very much, Gus.

And as a reminder, quorum is very important. And in particular today, we do have some times where a quorum, we will be right at quorum. So, please do let NQF staff know if you need to step away. And if you are able to stay on for a vote, we would greatly appreciate it

Okay. If we could go to the next slide, please.

Opportunity for Public Comment on MSR Recommendations for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Ms. Williams-Bader: All right. So, now we are going to do public comment on the measure within the Ambulatory Surgical Quality -- Center Quality Reporting Program. That is not on the Consent Agenda.

I will turn it over to Misty for this public comment.

Co-chair Roberts: Yeah, thanks, Jenna.

Yeah, I believe my limit, please limit your comments to two minutes. And focus specifically on this one measure and the ASCQR Program. It's been pulled from the Consent Calendar.

So, with that, I will open it up for public comment.

Not seeing any hands raised. If there's anybody on the phone, please speak up.

Dr. Lum: This is Dr. Lum from the American Academy of Ophthalmology. And we wanted to say that we don't think that this measure is at all applicable to ASC because it's a 90-day follow-up. And I believe that the surgeon is responsible for the patient visible function outcomes after cataract surgery.

It's not feasible for ASCs to follow-up patients after such a long time period.

Thank you.

Ms. Williams-Bader: Misty, I am not seeing any other hands raised, and nothing in the chat.

Janice has her hand raised.

Member Tufte: Hi. Isn't it within 90 days? So, it's not after 90 days, it's within. I just wanted to clarify.

Ms. Bhatia: Hi. This is Anita Bhatia with the ASC Quality Reporting Program.

The title of the measure is "within 90 days."

Member Tufte: Right. I thought the individual said 90 days and it was too long. So, just wanted to make that statement.

Ms. Bhatia: Let me check the scratch, if there's a, if there's a minimum on that.

Co-chair Roberts: Okay. Well, while Anita's checking that -- if you don't mind, Anita, maybe putting that in the chat.

And then, Jenna, is the stage to you?

Measure Set Review Recommendations for the ASCQR Program

Ms. Williams-Bader: Yes.

We close the public comment.

And just I also want to let the committee know that Matt Pickering, who is another one of the senior directors here at NQF in the Measure Science and Application Department has joined us today. And he will be helping to manage the chat and vote hands raised as well. So, we might hear from him, and Chip, and others as he's helping to manage that.

So, all the help we can get.

Okay, so, if we could go to the next slide, please, and then the next one. Okay, thank you.

01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Ms. Williams-Bader: So, the two measures that we will be discussing this morning do have recommendations from the Workgroup. So, the first one here being 01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Functioning -- Function within 90 Days Following Cataract Surgery.

It did receive a conditional support for retaining from the Workgroup.

Let me see if we have a CMS program lead on the line who would like to provide a 1-minute comment on contextual information about the measure.

Ms. Schreiber: Jenna, it's Michelle. If I may start for a moment, then I'll turn it over to Anita Bhatia.

But this, we think, is an important measure from CMS' point of view because this is actually a measure of functional status from the patient's point of view after cataract surgery.

And I would like to address that we believe that ASCs, like hospitals and other facilities, are, indeed, responsible for the care of providers who work at their facilities. And it's not unreasonable then to be looking at the function of patients after a procedure in an ASC.

Anita, did you want to add any other of our comments such as the performance of the measure?

Ms. Bhatia: I can do that.

I don't need to add to what you said. In terms of the performance of the measure the most, the most recent data, which is on the quality reporting type, just to give a promo, we do have facility level, state level, and national level data for measures for the ASC Practical Reporting Program on the Quality Reporting site. And for the most recent data -- and

there is a drop in the number of states reporting in relation to the pandemic and due to this actually being fully voluntary data. This is not required.

So, in that time period there was ASCs in 33 states reporting out of the most of the states do have high rates of 100 percent, but there are some outliers that trail off on the end to the 10th percentile of 99.7. And this constitutes 120 facilities that did report voluntarily.

And the numbers are a little bit higher. The total numbers in previous years, again, related to the public health emergency.

So, facilities are reporting on this data. It's a small number, but it is a voluntary measure.

And we do intend in the near future we're going to be looking -- we're going to try to talk to some of these facilities to see what they're doing and how they do this. And we're going to take a look at this measure for the future.

Co-chair Roberts: Thanks, Anita.

So, we want to go to the Workgroup co-chair, Akin.

Mr. Demehin: Thanks.

So, our conversation about this measure focused really on a couple of aspects of it. I think that a lot of folks around the table weren't necessarily here to see the measure go from the program because it does reflect somewhat of a patient reporting outcome. And there is a real desire to try to have some measures of that.

But there was also a lot of conversation about the practical and operational challenges of collecting the data.

We also spent some time talking about the endorsement status of the measure and the fact that it had its endorsement removed, but it was

because there was some retooling happening to the measure. And so, I think there were a couple of things that really came across here.

There is a desire to use that new survey instrument across here. There is a desire to use that new survey instrument.

And, number two, there was conversation about the extent to which this measure of visual function aligns with other measures that are out there with respect to visual function, and real desire to make sure that those measures were aligned across programs.

So, provided those two conditions were met, the Workgroup felt that retaining the measure in some form in the ASCQR would be appropriate.

Co-chair Roberts: Any discussion?

Let's see, Ron, did you have anything to add?

Member Walters: I did. And it might have changed just in the last 5 minutes. So, I'll be brief.

But, yes, the recommendation was initial report for retaining. And I was not going to support that, and recommend removal.

It meets a number of the categories for removal. One, you heard, it's not endorsed: Category 3.

Number -- the biggest one is there's multiple versions of the survey, as you've heard already. And so, the variation is there.

There's a question of how much areas for improvement since the median is 100 and the mean is 96. And as you heard, it skewed significantly to the left. So, there is opportunity for improvement in some providers. But, certainly, well, a median of 100 tells you the whole story right there.

The burden of collection kept coming up. That's

Category 8. And the ASCs did not feel they could get the data directly and easily from the providers.

And, let's see, it has been, it was endorsed in 2012, as you heard. And then in '18 it was removed, pending a better version of the measure.

So, pertinent to our discussions yesterday, that's a story that's frequently repeated. So, where is that new measure?

And I think if we give conditional support for retaining, we ought to really be certain that that comes out with a newer measure very quickly.

By the way, the Rural Health Group was 6 for 6 against it, mostly due to burden. And the Health Equity Group did not have a comment.

I will say that this is a great measure for MIPS. Doctors can report it voluntarily. The American Academy of Ophthalmology supported it. But, as you heard, ASC does not think it belongs in their program.

That's all.

Co-chair Roberts: Thanks, Ron.

Emma, did you have anything to add?

Member Hoo: Yeah.

I would reiterate Michelle's point that it's important to have these functional outcome measures in the program. And I, you know, I think there would be an expectation that the ASCs coordinate with the providers. And the fact that some organizations have solved for this, you know, indicates that there are, you know, opportunities to improve the number of ASCs reporting.

I do think that the consolidation in terms of the survey instrument is important to create the alignment and comparability.

I also, you know, in reading the comments, disagreed with some of the perceptions around seniors requiring more assistance to answer surveys. In our experience, seniors are actually the ones that we see the highest rates of response among the populations that are considered. And that from a health equity perspective, sometimes, you know, what is often raised is whether health literacy or other issues may interfere with the response.

And in our perspectives we think that there are ways in which to solve, you know, for the communication and outreach to individuals to ensure a wide response across different segments of the population.

Co-chair Roberts: Thanks, Emma.

Parul, anything additional?

Member Mistry: Yes. I mean, I support all of the comments. I think this is an important measure because it's a case-reported measure.

As far as an additional comment on this, I think as we're looking at a new survey instrument, the possibility of digitizing the survey instrument so that the information can be shared between the providers and the ASCs, and also having the ability to capture the health equity data as part of the new survey will definitely make this measure more robust, and also kind of tackle a couple gaps that we have at this time.

Co-chair Roberts: Thanks, Parul.

Anita, you have your hand raised.

Ms. Bhatia: I was trying to type that.

Just to clarify, the existing surveys are not different per se. They are built off of a base survey which has a large number of questions. So, the different versions of the surveys have different numbers of

questions, but they has been, there has been work that has validated the measured outcomes for the different surveys.

I will preface that one of the surveys does have a few questions. So perhaps we should took at not including that one as an option. And also, that we are going to do a deep dive on the methodology and what the questions are in those surveys in this next year.

And then regarding the update, we are looking forward to the updated survey. Our understanding is that the measure will be updating the survey instrument. So, if the survey instrument is updated, that's substantially -- that's a substantial change to the measure.

So, again, we look forward to an updated measure.

Co-chair Roberts: Thank you.

I'll ask if there are any clarifying questions from the committee? Looks like Leah has her hand raised.

And, Leah, I have to say, we coordinated well today, didn't we?

Ms. Binder: I know. We help each other.

Co-chair Roberts: Yeah.

Ms. Binder: Well, so, I was going to express support. You said clarifying questions? I don't have a clarifying question.

Co-chair Roberts: Well, comments are okay, and questions.

Ms. Binder: Okay. So, strong, very, very strong support for this from our, my perspective.

The, first of all, I think the issue of collection of the data being burdensome, I really think of collection of this data as standard practice. If you're going to

perform cataract surgery, then you want to find out how it went for the patient. I think that's just standard practice, and not even considered as part of the collection burden for this.

I mean, I think it's a, it's just, it's actually kind of surprising that that would be something that would be considered burdensome when, in fact, it's just fundamentally how you find out if you got the outcome you needed.

Secondly, I think that this measure is one of those that the collection of the data is something CMS can do better than anyone. Even the health plans would have trouble being able to, to really know, you know, how the outcome was 90 days from the patient.

So, this is one of those where CMS' is particular role is essential. We have very few measures for ASCs to begin with, and almost none that are patient-reported. So, I think it's a, it's a very powerful measure as itself. And I strongly support the continuation of this measure.

Co-chair Roberts: Thanks, Leah.

Any other questions before we move to vote?

Ms. Bhatia: I just -- this is Anita again. Just one small comment regarding the data and the lack of variation.

It should be remembered that these are facilities that are voluntarily reporting. They reflect facilities that strongly believe in the measure to the extent that they will go to the effort to collect the information and voluntarily report it.

So, this is not, you said it may not be representative of the population of ASCs conducting cataract surgery. So, it's not quite fair to say necessarily that this lack of variation here, you know, is representative of the roles and the basis,.

And, secondly, being topped out is not ambient removal of a measure from a program. And the fact that we have outlier facilities even with this highly dedicated performing group shows that, indicates that, you know, there could be some room for improvement on a tail.

Thank you.

Co-chair Roberts: Chip.

Co-chair Kahn: Yeah. I just want to ask a question.

So, this is actually a small percentage of overall ASCs that are doing these procedures are a part of this survey right now. And the reporting number I just heard was, like, 100-and-something, or something. I mean, it's a very -- is that correct?

So, it's only, so very few people, very few ASCs are actually complying. Is that correct?

Ms. Bhatia: It's 120 for those ratings here. It was slightly higher if you use -- when it was, let's see, in 2018 it was -- I don't have --

Ms. Schreiber: Chip, you're correct. Because it's a voluntary measure there's a relatively small number of ASCs that are reporting.

CMS was looking and actually had made the measure mandatory but then extended it being voluntary while they are waiting for the new measure specifications with the survey clarifications.

Co-chair Kahn: Okay.

Ms. Bhatia: Just to add, in 2018 there were 42 states that have those reporting. And there's more variation.

So, the latest numbers are the truncated. But either way it is still a small number. But, again, it's a voluntary number.

Co-chair Kahn: Fine. I just wondered. Because I assume different houses, ASCs.

Ms. Bhatia: Yeah, we don't have to comply with anything.

No, it's not, well, no, it's not using ASCs, it's only if you, it's a dedicated few that are voluntarily seeing --

Co-chair Kahn: No, no, no. I meant that the total N of ASCs that are doing cataract surgeries.

Ms. Bhatia: Oh, doing cataract surgery.

Co-chair Kahn: Yeah. If you made --

Ms. Bhatia: That's larger.

Co-chair Kahn: If you made this mandatory you would have an N of, I mean, 1,500 -- 2,000.

Ms. Bhatia: That's we would have a much later N if we made this mandatory. Cataract surgery is one of the most common surgeries done in an ASC.

Co-chair Kahn: Yeah. That was my question.

Ms. Bhatia: Sorry. I misunderstood your question.

Co-chair Roberts: If we have no other comments, I will suggest that we vote on the Workgroup recommendation.

I do think we, we do have some mixed opinions. But I would say we move forward with voting on retaining, conditional support for retaining based on the conditions outlined around the new survey instrument and the writing survey.

Ms. Harding: Voting is now open for 01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

Do you vote to support the Workgroup recommendation and supporting Committee

recommendation?

Co-chair Kahn: Yeah, I'm unable to vote again. If you could send me that link again that you did yesterday?

Ms. Harding: Yeah. We'll have somebody do that.

Member Peden: Yeah. Could you send it to me, too. This is Carol.

Ms. Harding: Okay. Is there anyone else who needs access assistance?

And the number we are looking for is 16.

Member Bossley: I'm sorry. Can you remind me, is this -- was it a recommendation to remove or recommendation to retain? I lost track. I can't remember which way to vote based on that recommendation.

Co-chair Roberts: Conditional support to retain based on --

Member Bossley: Got it.

Co-chair Roberts: -- the survey --

Member Bossley: Thank you, Misty. Thank you.

Co-chair Kahn: Yeah. Are you emailing that, the link?

Ms. Harding: I'll confirm.

It was sent to you via chat.

Co-chair Kahn: Oh. Oh, I'm sorry.

It worked.

Co-chair Roberts: How many voters do we have? Is it 19?

Ms. Harding: Yes, it's 19 right now. We were looking for 20.

Co-chair Roberts: Okay. So, we have 20 that could vote.

Ms. Harding: That could vote, yes.

Co-chair Kahn: But we only need 16.

Co-chair Roberts: Yes.

Ms. Harding: Yes.

Co-chair Roberts: I think we can go ahead.

Ms. Harding: Okay. Voting is now closed.

The results are 16 for yes; 3 for no. And that gives us a percentage of 84 percent in support of the Workgroup's recommendation.

Opportunity for Public Comment on MSR Recommendations for the Medicare Shared Savings Program (MSSP)

Ms. Williams-Bader: Great. Thank you very much, Ivory. And thank you to the Committee.

Let's go ahead and to the next item now, which will be public comment on the measure that is not on the Consent Calendar for the Medicare Shared Savings Program.

If we could go to the next slide, please. And I will hand it over to Chip for this public comment.

Co-chair Kahn: Okay. I'm very excited because we're only 8 minutes off of our schedule because we're supposed to start this at 10:45.

Co-chair Roberts: Never, never say it out loud, Chip.

Co-chair Kahn: I know. I just want to really congratulate everyone. But I'll, but I'll hurry.

Chip. So, I'll remind, then, attendees, this is a public comment on the MSSP measure that is not on

the Consent Calendar. So, let's hear the comments.

And we remind you that you need to limit your comments to no more than 2 minutes. And we'll take questions if they're raised from the members of the committee.

Also, we'll create space for those dialing in on the phone.

So, Jenna will look at the hands if they're raised from the group.

So, go ahead in terms of public comment.

Ms. Williams-Bader: At the moment I am not seeing any hands raised or anything in the chat.

Co-chair Kahn: Okay. So, I think we'll close the public comment. The opportunity was provided.

Measure Set Review Recommendations for MSSP

Co-chair Kahn: And then I think I, in terms of the 00515-C-MSSP, Preventive Care and Screening: Screening for Depression and Follow-Up Plan, I'm going to pass back to Jenna to introduce the measure. And invite CMS to provide any context that we need till it comes back to me for consideration.

So, Jenna.

00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Ms. Williams-Bader: Yes. If we could go to the next slide, please. The next.

So, this measure is 00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. I will see if the CM -- if we have a CMS program lead on the line who would like to give one minute for a comment on the contextual background for the measure.

Ms. Schreiber: Jenna, I'll open again.

I would only say that we think this is one of the most important measures that CMS has. In our priorities of mental health being towards the top of the priority list, knowing how common depression is, how much it affects other conditions as well.

And I will ask Lisa Marie if she'd like to provide more comment.

Ms. Gomez: Thanks, Dr. Schreiber.

So, as Dr. Schreiber noted, mental health is a high priority topic under, under MIPS. And this measure is a measure through MIPS that the Shared Savings Program reports on.

I just want to highlight elements of how this measure reported.

Under the Shared Savings Program there are two means in which this measure can be reported: one is through the web interface; and another means is an eCQM.

This measure that is being discussed is with regard to the CMS web interface. The CMS web interface will be available through 2024. So, after 2024 this measure as to the web interface will no longer be available.

I just want to highlight that again: this measure will be in the program through 2024.

This measure is within the core quality measure collaborative, and aligns across multiple CMS programs.

Want to also highlight that in this benchmark that there is a performance gap. So, that this measure is not tapped out, so there's room for improvement in meeting the requirements for the measure, and particularly, you know, screening for depression and follow-up plan.

I also want to highlight that this measure was previously NQF endorsed.

That's all I have with regard to this particular measure.

I will ask Tim Jackson if he has anything to add for this measure.

Mr. Jackson: Hey, great. Thanks, Lisa Marie.

I would just note that kind of reinforcing what Michelle has shared, which is this is a big measure for us. It's a big priority. There is a focus on this.

And so, as Lisa Marie shared, even if it leaves the web interface, which is the current version that you're looking at on the screen, even when that goes away this measure will exist in the future. But the performance of the ACOs, the 475 that reported in 2021, their performance was very good. And we were very pleased to see that.

You know, that, we have a 99 percent reporting by ACOs. And that includes on this measure. So, just hope that that adds some understanding for the group.

And I'll stop there.

Co-chair Kahn: Okay, wait. I'm sorry. You said it was, it was -- it's endorsed now or it was endorsed?

Ms. Gomez: It was previously NQF endorsed.

Co-chair Kahn: Does that mean it's currently endorsed, or is it being upgraded or something?

Ms. Gomez: Yeah, we haven't -- So, this is a CMS measure. We have not sought endorsement. But it was previously endorsed.

Member Qaseem: Chip, can I ask a follow-up on yours? Because I'm not following the language. Can someone clarify?

Previously endorsed, I understand that part.

Is it currently endorsed or not? I'm not understanding.

Co-chair Kahn: That was my question really.

Member Qaseem: I'm still not getting the clear answer to that. Is it endorsed or not?

Ms. Williams-Bader: It is not. It is not endorsed at this time. And CMS can correct me if I'm wrong. But it's not.

Member Qaseem: And does, Jenna, do you know why it's not endorsed is what I'm just curious to hear the follow-up.

Co-chair Kahn: Yes. That's what was I was doing. Thank you.

Member Qaseem: Yeah.

Ms. Williams-Bader: So, like, can we hold these comments until we get through opening remarks from the different lead discussants and things like that? Is that okay?

Co-chair Kahn: It is. Except I think when CMS gives us context they need to give us the -- I mean, it seems to me, I'm not asking for it now. We could wait. But, I mean, when you say something is previously endorsed it seems to me you need to give more information, CMS does.

Okay, let's proceed to the Workgroup.

Ms. Williams-Bader: Yeah. So, unfortunately, our Workgroup co-chairs for the clinician workers were not able to join us today. One had a last minute emergency and was not able to join.

So, I can give a brief summary.

So, as noted on this slide, this measure did receive support for retaining from the Workgroup. They did

think that it's important for screening to take place, as it might not always be apparent to the clinician whether a patient has depression.

They also thought that removing the measure would create a gap in the program, as there is only one other clinical measure in the Shared Savings Program.

However, some concerns were raised. For example, one was around the fact that this measure does assess for screening and a follow-up plan. And so, it's difficult to determine if low rates are due to -- or if a patient does not meet the measure, if it's because they were not screened or if it was because they were not -- they did not have a follow-up plan. And, also, there might have been some burden associated with documenting the follow-up plan in a way that would meet the measure.

Also, there is some concern from the World Health Advisory Group at least about not always having resources for, for referring patients who screen positive for depression.

And there is also comments around how measures should really be moving to outcome.

I think that captures the main points from the Workgroup. So, Chip, I will turn it back to you for the lead discussant.

Co-chair Kahn: Okay. And I'm going to start -- well, do we have lead, so do we have lead discussants on it?

Ms. Williams-Bader: We do. And lead discussants for this measure are Covered California and America's Health Insurance Plans.

Co-chair Kahn: Okay. Who wants to go first? Why don't we go Covered California first.

Member Amarnath: Hi. This is Ash.

Sorry, I'm a backup to them. Our quality improvement managers are supposed to be on to do lead discussant. I am happy to speak to how we're using this measure, if that's helpful.

Co-chair Kahn: Yes.

Member Amarnath: Does that work?

Co-chair Kahn: Yes.

Member Amarnath: Okay. Thanks, Chip.

So, depression and follow-up is a measure that we are currently implementing our '23 to '25 contract. And we're asking for it as reporting only from our 12 health plans that participate in the exchange.

I mean, we feel that behavioral health is, is important. And we have a gap in measures right now in our quality reporting system which is the measure set in CMS that our plans are held accountable to. So, this is a outside of the general reporting to CMS that we're asking our plans to report.

We're also planning on looking at ways that we can stratify this by various demographic data, I mean for as this is a key measure. So, we would support the Workgroup recommendation for retaining.

Hopefully that's helpful. I can clarify any point.

Co-chair Kahn: Okay. And our other discussant, are they here?

Okay. Not hearing any comments.

So, I guess now we go to discussion.

Ms. Williams-Bader: That's right.

Co-chair Kahn: Yes.

Ms. Williams-Bader: And I can clarify first before we get into that about endorsement.

So, according to the information we collected for the measure's February sheets, this measure, endorsement was removed for this measure in 2020. And that was because the measure steward, CMS, declined to resubmit the measure for endorsement. So, it did not go through a review and was unendorsed. It just was when it came up for reendorsement CMS declined to resubmit it.

So, that's why it lost endorsement.

Co-chair Kahn: Okay. Can I, that being the case, can I ask CMS, whoever, Michelle, if you want to answer it.

Ms. Schreiber: Yeah.

Co-chair Kahn: Do you want to sustain endorsement on something that's as important as it sounds?

Ms. Schreiber: And what we're investigating right now, Chip, and I may have to get back to you, is that maybe because this is the web interface version and we knew that the web interface wasn't going to be in existence for much longer.

We'll check the eCQM version.

Co-chair Kahn: Okay. Thank you.

Any other discussion or questions? Yes?

Member Qaseem: So, just a clarification question first. Michelle or anyone on CMS, -- it's an important measure by the way, hands down. I hope, Michelle, we can, whatever is going on NQF can review the measure in more detail. That's all that is important.

One is, my read on this is I was thinking about it as what if someone is already under care? Let's say someone has comorbidity and they're already under the care of some mental health specialist or something like that, they're not excluded from this, are they?

Let's talk to that, because under exclusion that's not included. Basically, patients who might already be under care will do this. And so that's one question.

And the second one, looking at the specs, I'm thinking about it as are you thinking about patients within a physician's panel, or anyone who is seen during that measurement year?

Those are the two clarification questions looking at the, looking at the specs.

Ms. Schreiber: About patients who are already seen by mental health providers, I don't know that they're excluded. I think you're right about that.

And the web interface measure would only be patients attributed to the ACO.

Member Qaseem: Okay. So, going forward, or however it were, such it would be nice if someone is already under care, that won't make sense, there's no screening anymore. Now you're doing treatment; right? So, you don't want to do the screening; it's a waste of resources.

And but based on that I'm not sure when I'm looking at these specs and the numbers what those numbers are showing in terms of whether it's, the measure's performing well or not well in terms of what's excluded or not. So, that's a big denominator that you're not taking into account.

Ms. Schreiber: So, if, if I can, I do see that there is an exclusion in this measure for patients with an active diagnosis for depression or bipolar disorder. So, while it's not looking for them being under treatment, if they do still have an active diagnosis, they are at least excluded.

Member Qaseem: Yeah, I think someone did comment or maybe I missed it. It's like the whole follow-up and treatment is important, right? It's not about the screening. You find out that doesn't really

serve the purpose of -- it's not just about knowing who has depression.

So, I think it will be good as we move forward to figure that out. You probably have that information in CMS, maybe not, but I think it's easy to get.

Ms. Williams-Bader: Chip, it looks like we do have some hands raised, Clarke and then Libby.

Co-chair Kahn: Okay.

Member Ross: Thank you. I just wanted to reinforce an observation made that the Core Quality Measure Collaborative supports this measure, and interestingly, both the CQMC Behavioral Health Committee and the CQMC Primary Care, Patient Center, Medical Home, and ACO Committees support the measure.

So, we frequently, in behavioral health, get in this challenge of a wall between the specialists and the primary care, but in this instance, the importance of the measure is that both committees, primary care focused and behavioral health focused, support it, so, and we all know the importance clinically and on daily life of significant depression, so thank you.

Co-chair Kahn: Thank you. And the other question, the other point? You said there was one other hand, Jenna?

Ms. Williams-Bader: Yes, Libby?

Member Hoy: Hi, yeah, this is Libby. I just, you know, wanted to just voice my support for retaining this important measure. As has been mentioned, obviously we have a mental health crisis in this country and I think this is really important.

I wanted to just comment to the connection to having a plan afterwards. I think that that is really important to be connected as we hear from patients and families all of the time that, you know, I was screened and then nothing. You know, I was

screened, and I screened positive, and then nothing, and so I think it's really important.

And with regards to the rural communities who are under-resourced, I agree they are certainly under-resourced, but removing the measure because we can't provide the resource just really doesn't move us forward in the patient community. Thanks.

Co-chair Kahn: Okay, any other hands, Jenna?

Ms. Williams-Bader: I'm not seeing any. Oh, yes, Amir has --

Co-chair Kahn: Amir?

Member Qaseem: A clarification question, Chip and Misty. So, the NQF endorsement piece, before we do the final vote, and we have discussed it in the past, is it like should we place whatever we believe in terms of the final vote like how much weight we are giving to NQF endorsement or not? Did you guys talk about it a little bit yesterday or where does NQF endorsement fit in that?

Co-chair Kahn: Well, actually we've had a lot of discussion about it.

Member Qaseem: All right, so I don't want to go over it again.

Co-chair Kahn: But I think in this case though, in the past and the other measures that we had yesterday, endorsement had gone away and it wasn't clear where we stood.

If I understood what Michelle said was that this had endorsement. There are now some technical issues going on and I didn't hear that CMS wasn't going to seek endorsement.

But I guess my interpretation of what you said, Michelle, was that you were sort of in a limbo because of whatever technical issues you raised and that I assume you'd circle around for endorsement.

Is that fair to say?

Ms. Schreiber: I think that's fair, Chip, and we will certainly take under advisement the recommendations of the committee about endorsement, so thank you.

Member Qaseem: Thanks, Michelle.

Co-chair Roberts: Yeah, and Amir, I think to your question, we do have criteria for consideration, but we haven't necessarily placed any weighting on any of the criteria, so it's kind of up to your judgment.

Co-chair Kahn: Yeah, I think it really is up to judgment. Okay, if there are no other comments, or questions, or input, then Jenna, can we move to a vote? And during the vote, I need to take a quick bio break, so I'll be back just in a second, but let's do the vote unless there's --

And the vote would be support for retaining, I think, because that was the recommendation of the workgroup, and also I think I'm hearing a consensus too, so I can -- we'll see what happens when the vote takes place. Is that acceptable, Jenna?

Ms. Williams-Bader: Yeah, although I think just a quick point of clarification. I think we would be voting to support the workgroup recommendation, which, as you point out, is support for retaining.

Co-chair Kahn: Right, right.

Ms. Williams-Bader: This is the first vote, yeah.

Co-chair Kahn: Right, right, okay.

Ms. Williams-Bader: We're pulling that up now.

Ms. Harding: Voting is now open for 00515-C-MSSP, preventive care and screening, screening for depression and follow-up plan. Do you vote to support the recommendation as the Coordinating Committee recommendation?

(Pause.)

Ms. Harding: We'll give it a few more seconds. Okay, voting is now closed and the results are yes for 17 votes and no for two votes. The Coordinating Committee has voted to support the workgroup recommendation as their recommendation.

Ms. Williams-Bader: Sorry, Ivory, I might have missed it. Did you do the percentage as well?

Ms. Harding: Oh, yes, for a percentage of 89 percent. Thank you.

Co-chair Kahn: Okay, great. Well, that's a winner then.

Ms. Williams-Bader: Yes, thank you all so much. Thank you for helping us keep to the time today.

Co-chair Kahn: Yeah, so let's --

Ms. Williams-Bader: We'll try not to jinx ourselves there.

Opportunity for Public Comment on MSR Recommendations for the Consent Calendar

Co-chair Kahn: No, no, and before it turns 11:15, let's go to our opportunity for public comment on the recommendations for the consent calendar, and I think we have five slides on the consent calendar with a brief stop on each, and should I proceed with the public comment, Jenna?

Ms. Williams-Bader: Yes, we can do that. We'll just go through and remind people which measures are on the consent calendar at the moment.

One other note to make is that we do have two measures that were on the consent calendar, they're the last slide here when we get to it, that were pulled prior to the meeting, so this will be an opportunity for the public to comment on those two measures as well, and I think those are on the next

slide. So, yes, this is a public comment opportunity for any of these measures.

Co-chair Kahn: And let me remind everyone that all of the measures on here, I believe, have between 80 and 100 percent consensus support in the workgroups.

So, let's proceed, short comments once we open it up for the public, please, and address the measures that you see before you. And with that, do we have any public comment?

Ms. Williams-Bader: We don't have any yet. I would like to leave it open for a minute if we can --

Co-chair Kahn: Sure.

Ms. Williams-Bader: -- just because it is a large number of measures.

Co-chair Kahn: Okay.

Ms. Williams-Bader: But I'm not seeing any hands raised yet and nothing in the chat.

Co-chair Kahn: Okay, I'm looking at my watch. Do we have anyone raising their hands?

Ms. Williams-Bader: No hands raised. Nothing in the chat. And is there anyone on the line, on the phone line who would like to make a comment?

Co-chair Kahn: Okay, I think we should proceed, Jenna, because I don't hear anyone --

(Simultaneous speaking.)

Ms. Williams-Bader: Last chance, going once, twice, three times. Okay, I'm comfortable if you are.

Measure Set Review Recommendations for the Consent Calendar

Co-chair Kahn: So, you're going to review the process slide and then review then, and introduce

the measures, and then we'll have a discussion. Is that correct, if there's any discussion?

Ms. Williams-Bader: Yes, so, yes, what we will do is I will review the process. We will take a look at all of the measures on the consent calendar and how the workgroups voted, and then we will have an opportunity for Coordinating Committee members to pull any, to recommend pulling any additional measures, yes, so if we could go to the next slide?

Okay, so as a reminder, once I introduce the measures, we will have our co-chair who will ask if any Coordinating Committee members would like to pull any measures from the consent calendar.

If a member does request to pull a measure for consideration, we ask you to provide a clear and compelling rationale based on the key considerations' criteria and the evaluation of the measure review criteria that we've provided about why you'd like to pull that measure.

You will also -- the members who request to pull a measure will serve as the lead discussant for that measure during the discussion.

We will also have the Coordinating Committee provide any, the rest of the Coordinating Committee provide any comments about whether or not they support pulling that measure from the consent calendar.

And then once we have agreed which ones will be pulled, we will present the final measures on the consent calendar. We'll have Chip ask if there are any objections to the consent calendar, and if there are no objections, we will move forward with the final decision categories being the workgroup recommendation.

Are there any questions about that? And I would -- Chip is right. Not only did the measures on the consent calendar receive somewhere between 80 to

100 percent of the workgroup votes for that category, it would be the first vote they took was between 80 to 100 percent.

And then it also means that we did not receive any public comments after the workgroup recommendations, the draft workgroup recommendations were released that were introduced to any new information or that were in conflict with the workgroup recommendations that the workgroup hadn't already considered.

Okay, I don't see any hands or questions in the chat, so we can go ahead and move forward. All right, so first, I'm not going to go through the measures one by one, but we'll go through the categories.

So, from the PCHQR Program, we had one measure that was under review and this measure received a conditional support for retaining from the hospital workgroup, and you can see that presented here. Next slide? Thank you.

For the Shared Savings Program, we had three measures that received support for retaining from the workgroup. You can see those listed here, and then three measures that received conditional support for retaining listed here. Next slide?

For the Merit-Based Incentive Payment System, we had one measure that received support for retaining from the clinician workgroup, three measures that received conditional support for retaining, and two that received conditional support for removal listed here.

For the Home Health Quality Reporting Program, we had one measure that received support for retaining from the post-acute care and long-term care workgroup, and six measures that received conditional support for retaining, and then additionally for home health, we had two measures that received conditional support for removal from

the PAC LTC workgroup and one support for removal.

I believe that is all of the slides for this section, so Chip, I will turn it over to you.

Co-chair Kahn: Okay, so I don't -- I guess the way that your cover chart was worded, I guess, are there any objections -- knowing that some of these, I mean, some of the measures from the original list were pulled for further discussion. Are there any objections to anything on the consent calendar as it stands and presented by Jenna?

Ms. Williams-Bader: It looks like Misty has her hand raised.

Co-chair Roberts: Sorry, it's not an objection, but if you can scroll back two slides? I was little confused about something. Maybe it's the previous one, the depression measure. Right there, preventive care and screening, is this the measure we just talked about for MSSP or --

(Simultaneous speaking.)

Ms. Williams-Bader: There are -- yeah, no, I can understand the confusion there. So, there are different versions of the measure in the program. There's one that uses a web-based interface for reporting and one that is an electronic clinical quality measure.

So, the web-based, the web interface version was the one we just discussed. The ECQM version received support for retaining, and based on the workgroup vote, was on the consent calendar.

Co-chair Roberts: Okay, thanks for that clarification.

Ms. Williams-Bader: Clarke has his hand raised.

Member Ross: Yeah, is someone from the long-term care, post-acute care workgroup on our call? I have questions and concerns about two of the measures

in home health.

One is removing falls prevention, prevention of falls that lead to major injury, and the other one is removing functional assessment in care plans in home health.

So, I don't want to go further. I just want someone to clarify why these are removed. I read the notes and I read the measure, so, but.

Co-chair Kahn: Do we have somebody, Jenna?

Ms. Williams-Bader: We do. Gerri Lamb is one of our co-chairs. Gerri, are you on?

Ms. Lamb: I am, Jenna. I'm right with you. So, thanks for the question, Clarke, and the 3493, which is the one with falls, was conditional support to remove, and I'm also looking at the notes here.

Okay, I think what the MAP Committee suggested is that it is an important concept and that we were hoping for a different measure that really addressed some of the questions and limitations of this, mostly because of the issue that this measure comes from a different long-term care system and the concern being that the context for home care is quite different, and so there was a desire for a measure related to falls that was more specific to home care and also didn't have unintended consequences.

Member Ross: Thank you. I read that and I know those of you who administer programs have to deal with the reality of the context and that sort of thing.

I'm concerned about a message the National Quality Forum recommends dropping falls prevention from a home health program. That's how a whole bunch of advocates around the country are going to interpret this, but I recognize that the measure came from a different context. Almost every measure has all of these serious limitations and gaps.

So, that's my concern. It's also my concern with the

other measure is the message that the National Quality Forum recommends to CMS dropping falls prevention and functional assessment in planning from home health. And I realize, you know, these aren't great-fitting measures.

Ms. Williams-Bader: So, before we take additional hands, thank you for those points, Clarke. I do want to clarify a couple of things though.

I mean, again, there is conditional support for removal, which means that the MAP does think that the topic is important and that removing the measure would create a gap in measurement.

I don't want us to forget that there is that option because that would allow MAP to indicate that the topic itself is important, but the measure is not the right measure, so please do keep that in mind.

And then just a smaller point of clarification, it's not NQF. Just semantics, from a semantics point of view, it's not saying it's NQF recommending removal. It would be MAP recommending removal, so.

Ms. Lamb: Jenna, can I just add two --

Member Ross: I just want to say that's technically correct, but that's not what the health, disability, mental illness community will interpret because it will be a National Quality Forum report for public comment, and then there will be a final National Quality Forum recommendation and people won't differentiate between little components. They'll just say the National Quality Forum, but sorry. I'll be quiet now.

Ms. Lamb: Jenna, can I add two things --

Ms. Williams-Bader: Yes.

Ms. Lamb: -- related to 5853? Because I think Clarke also raised that one. The reason for removal of 5853, and I'm sure you also read this, was this

one was topped out.

Both are mandated measures in CMS and the committee did look at that as well, and so, and I will leave the discussion of the messaging related to decisions. Our decisions were based on the criteria.

Co-chair Kahn: And let me -- and they were overwhelming recommendations obviously, because they wouldn't be on this list otherwise. Are there other hands, Jenna?

Ms. Williams-Bader: Yes, so we have Janice, then Amir, then Michelle.

Co-chair Kahn: Janice?

Member Tufte: Thank you. I'm sorry. Yeah, so I appreciate everybody sharing today and my thoughts were though about 3493, that it was home care, not LTCH, and so now I'm understanding there might be a better measure, but to be sure that it's still, you know, a measure in long-term, and then the 5853 topped out answered that question, so thank you.

Co-chair Kahn: Okay, you had somebody before Amir, I think, Jenna?

Ms. Williams-Bader: Amir is next, yes.

Co-chair Kahn: Amir, Amir.

Member Qaseem: This discussion gives me an opportunity to go over the measures. That's not good ever, right? So, is this a good time, Misty and Chip? I wanted to strike a couple of more measures or I'm not allowed to?

Co-chair Kahn: Oh, you mean from the list?

Member Qaseem: Yeah.

Ms. Williams-Bader: So, Amir, you can provide your rationale for why you'd like to pull and then the

committee can discuss, and at the end of this discussion, we expect to -- we would want to know from the committee which ones they want to pull.

Co-chair Kahn: Yeah, let me say this before you start this. At the end of the meeting, we'll get a chance to talk about process. I think that you have a consent calendar. You've got 80 to 100 percent vote on it.

I think people, if they do want to pull, we have to have some process where we do it before the consent calendar is presented itself because I know that there's public comment, but it seems to me that it does disrupt the whole reason to have a consent calendar.

And to be able in the midst of the discussion of it to pull things, I think is not appropriate, but we'll see how you all feel when we have our process discussion at the end and we didn't set that as a rule, but anyway, proceed, Amir.

Member Qaseem: All right, sorry, guys. So, one is a blood pressure measure. It's the, what is the number of it, 01246. My summary of it is I totally, whole-heartedly agree that treating patients appropriate blood pressure goal, as we all know, it decreases heart rate and stroke, so many of us are clinicians here.

The issue always comes around and I start thinking about the measure is the operationalization of it. The strict blood pressure control across the whole patient population does not work.

We all know, those of us who are geriatricians on the call, that's not the reality of the things that we're dealing with in the practice of medicine. You do not want 120/80 for an 80-year-old. It just -- that's dangerous for them as we all know.

And then if there is -- I think this issue came up in the past as well, the age range. If it was like 18 to

60, that's one thing, but after that, I think there is definitely a stratification or something that needs to be accounted for.

So, that's one issue because that's fundamentally bad medicine we are going to be pushing for if we're going to go in the direction of 120/80, and I'd love to hear if anyone disagrees with that.

The second issue there is the most recent blood pressure. That again is not the reality as you all know. You don't go with the most recent blood pressure. It is supposed to be either you have to see a range, you need to see what's happening at home, what's the blood pressure at home.

That's not clinical medicine. You're not supposed to take if someone has driven on Interstate 95 and they come see your doctor at Hopkins, and we're going to take their blood pressure and go with that. That's actually again bad clinical care.

And the third argument over here is I think to a certain degree, the risk adjustment and all of that, again, has not been taken into account.

So, that's the summary of it, Jenna. If you guys have discussed the folks who took this into account, I respect their opinion, but we are pushing for bad clinical care, I mean, fundamentally.

Co-chair Kahn: So, I'm sorry, you're arguing that these should not be conditionally retained. You're arguing these should be dropped because --

Member Qaseem: Yeah, yeah, because the issue for that, Chip, the reason I'm pushing for it -- and I'd love to hear from Michelle. I mean, she's treated patients in Detroit. The thing over here is these issues keep on coming on. This is not the first time they have been brought up, but I haven't seen the change in the measure, right? The conditions, conditions, conditions continue.

So, at some point, Chip and Misty, my request is when do we say that it has been out there for long enough and the conditions have continued to be long enough that it's time to change?

Co-chair Kahn: Well, I know from personal experience, I always get my blood pressure taken at the doctor, and if we followed what my blood pressure was at the doctor, I would be on blood pressure medicine right now.

Member Qaseem: Exactly, right?

Co-chair Kahn: And then when I go home at night and over a week period and take my blood pressure every night, I come back and I'm 123/75 and there's no reason I should take blood pressure medicine.

Member Qaseem: There you go. I mean, that's exactly what I'm talking about, so I rest my case. I respect all of you guys. You guys are very smart. You know what's happening out there. I struggle with this one, guys, every time.

So, sorry to pull this, Jenna. I didn't want to. It's just when I read it, my blood pressure goes up.

Ms. Williams-Bader: So, thanks for those comments, Amir. I would like to remind people, because it's not presented on this slide here, about the conditions for retaining, and that is having --

So, the workgroup said to have multiple encounters for the denominator, change the last reading requirement to an average or a therapeutic window, and to allow ambulatory or at-home blood pressure readings to be included in the measure. So, there are conditions attached to this.

Member Qaseem: But Jenna, my point was those conditions have been in existence for a while now. I'm thinking at least six or seven years we have been talking about this. At some point, my request

was when do those conditions get operationalized where we pull the plug?

Ms. Williams-Bader: Thanks, Amir.

Member Qaseem: Did you want me to talk about the second one or just shut up for now? How do you want to do that?

Ms. Williams-Bader: I think it's best to get all of the measures on the table and then we will circle back and see how the rest of the committee feels about pulling those. Does that work for you, Chip?

Co-chair Kahn: Yeah.

Member Qaseem: All right, so the second one is the CAHPS measure. I'm trying to find the number and I lost it. You'll know which one I'm talking about though, the CAHPS for MIPS survey, something like that. So, I think it's -- anyway.

Ms. Williams-Bader: Yeah, it just didn't have a number. It's on this slide here.

Member Qaseem: Okay, all right, so I couldn't find it. So, this is again patients are our north star absolutely. Again, I just fundamentally believe that we need to do whatever patients, is best for our patients. That absolutely is right.

The couple of points that comes to my mind over here when it comes to this CAHPS measure, one, we know that some of these things have led to unnecessary treatment that have harmed many of the patients. The biggest one is the opioid prescriptions that's out there.

We are very well aware of that issue, so we need to be cognizant if we are heading towards -- and I know the struggle of we don't have any alternate mechanism in place at this point in time and this is the best we've got, but the best we've got is leading to harm. So, keep the whole opioid crisis in mind when we are talking about CAHPS.

The second one is I think that it comes down to it's not a good gauge. The reason it comes down to it with some of this survey that, again, you guys are already well aware of these issues, is that either most or all patients who are participating, you can't go with the small minority that's participating that can lead to change. I think that becomes a problem.

The third one from my end is going to be we need to hold organizations perhaps responsible, not physicians. So, because there is a wait time that's happening, or if they mess up your front desk staff, that sort of is not in the physician's control, and I don't think anyone is going to disagree with some of this issue.

And the final one is -- I forget. It's slipping my mind. I'll shut up.

Ms. Williams-Bader: Amir, to the -- sorry, Chip, go ahead.

Co-chair Kahn: So, well, I mean, he's now raised the issues, Jenna. How are we going to arbitrate this?

Ms. Williams-Bader: I guess I think I, if you're okay with it, Chip, I'd like to get all of the measures on the table so we have a sense, and then we can circle back. Is that okay?

Co-chair Kahn: Yeah, because I have some questions to CMS on this when we come around.

Ms. Williams-Bader: Okay, so, yeah, if we could keep track of those questions and comments. I see Michelle has her hand raised and I would just -- if anyone else would like to recommend pulling any measures, please raise your hand now so you can get those on the table.

Ms. Dardis: This is Michelle. Actually, I wasn't recommending to pull any measures. We just hopped to that conversation before we could close

out the comment I had on the falls measure for the home health program.

I just wanted to acknowledge for this group that when we met for the MUC List in the fall, we spent a lot of time discussing how difficult it is to evaluate a measure that hasn't been tested for the program it's proposed for.

So, I'm in complete agreement with the working group that recommended conditional support for removal for the falls measure on the condition it wasn't tested for the program.

I just wanted to call that out as a systems thing where this measure was implemented in the program, and now on the back end, we're recommending removal.

Co-chair Kahn: Okay, so are there other -- is there interest in pulling anything else other than what Amir put on the table?

Ms. Binder: Can I just ask a question? The falls measure has come up a number of times. Are we pulling that one?

Co-chair Kahn: No, I don't think Clarke asked it be pulled. He just wanted the discussion, I think. It's up to Clarke.

Member Ross: Well, I wanted to see the sense of the group. I don't want to waste time, but I also feel strongly that an alternative would be retaining the measure until a more appropriate measure is in place personally.

Co-chair Kahn: What was our -- I'm sorry. Could you go back to that sheet, Jenna, on the falls measure? I don't remember. I'm blocking on which --

Ms. Williams-Bader: Sorry, what was your question?

Co-chair Kahn: Could we go back to the slide with

the falls measure?

Ms. Williams-Bader: I think it's here. It's the second one down. So, that one -- and again, this one was more conditional.

Co-chair Kahn: Yeah, but it says conditional support for removal. When it says conditional, then we're placing conditions on it, so that means I guess it wouldn't be removed, right, unless the, I mean, unless the conditions were met to remove it. Is that correct, Jenna?

Ms. Williams-Bader: Right, so conditional support for removal carries with that this measure should only be removed once a better measure is in place, that removing it would create a measurement gap.

Co-chair Kahn: Right, so I think with that criteria, we're not -- we're being careful when we're qualifying our recommendation. And I think in terms of your criteria, we're not saying it should -- we're saying we have to have that, but we just think in this case, this isn't the right one to have, so is that okay, Clarke?

Member Ross: Yes, now that it's explained because I was going to propose conditional support and the condition would be find a replacement.

So, unless other members want to pursue this further, I'm fine with noting in the report that we discussed this and describing some of the discussion, but not going further with a vote.

Co-chair Kahn: Okay, anybody else, any comments? Okay, so I think, Jenna, we have our list then of the ones that Amir brought up.

Ms. Williams-Bader: Right, yes, the blood pressure. And there are two versions of the blood pressure, but I think Amir was referring to -- I guess you should clarify, Amir. If we could go back to that slide?

There's the web interface version of this measure as well as the ECQM, so do you want to -- are you suggesting to pull both or just the web interface version?

Member Qaseem: I mean, the details would apply to probably both, right? I was looking at 01246, but the ECQM is pretty much very similar to 01246, right, Jenna?

Ms. Williams-Bader: I believe they are fairly similar, yes.

Member Qaseem: Yeah, I mean, so it's going to apply to the same.

Ms. Gomez: Yeah, this is Lisa Marie Gomez. The measures are the exact same. It's just how the data is reported to CMS. That's the only difference. The measures are the same. You are correct.

Co-chair Kahn: Okay, so, but now let's go to adjudication, Jenna. How do we determine whether there's a preponderance of, I mean, whether he's met the criteria or whether there's a preponderance of feeling that we need to move these out of here?

Ms. Williams-Bader: So, we do -- again, this is the pilot year of implementing our consent calendar, right, so I think we are allowing for a little bit more flexibility this time around and then I think we'd like to tighten it up in the future.

I guess it would be good to hear -- we're not having a full-blown discussion of the measures right now. If we decide to pull them, then we do have a time slot later in the day for having the actual full discussion and vote, but it would be good to hear if there are others who support pulling these from the consent calendar at this time.

Co-chair Kahn: Okay, I'm not hearing a lot of comments. Well, let me suggest that we note in the record -- I mean, I'll suggest that we not pull them

then unless we get, I mean, more support for further discussion. Is that fair, Jenna?

Ms. Williams-Bader: Yeah, but I do see Heidi has her hand raised, and then Liz Goodman says I support. Liz, are you saying you support pulling those three measures?

Ms. Goodman: I think wherever there is a question, measures should not be rolled up into a consent calendar.

Ms. Williams-Bader: Thank you for clarifying that. Heidi?

Member Bossley: Yeah, I feel like I'm having a little deja vu because I think we had a consent calendar before and we're --

Co-chair Kahn: Right.

Member Bossley: -- doing the same exact thing that happened last time. I think at a minimum -- I completely agree with the issues that Amir has raised, and one of the things that I struggle with every time we look at both recommending a measure for inclusion versus removing it is if we don't, for example, remove this measure because we don't think it meets what we want, where is the process to get the new measure?

Because I'm not seeing those new measures to replace, and so at a minimum, I think the issues he raised, I think some are in the conditions, but to have that further fleshed out really would be helpful.

I don't know that we need to pull it and have a vote unless, I think, Amir, you're asking for them to be removed completely, and if that's the case, then I'm going to say, Jenna, sorry, where is the MIPS EQM measure?

Because there is a third version type, the registry type, that should be a part of this conversation as

well. So, if we're going to do that, we should be complete and it should include every iteration of this measure as well.

So, I'm on the fence. I don't really want to take any more time today because I think we've got a lot still left, but I do think Amir raises some really good points.

Co-chair Kahn: Let me say this though about his points. So, Amir, you would be for, on these items, conditional support probably for removal. I mean, you're going to want to do something different than conditional support for retaining, right?

Member Qaseem: Yeah.

Co-chair Kahn: Otherwise, there's no reason to --

Member Qaseem: Yeah, that's the condition of the -- yeah, I agree with you, Chip, because for some of them, we need to start going in the direction of removal unless someone starts changing these measures, something Heidi just said, because a change is not happening, right?

And again, I don't want to derail the conversation, Jenna, Chip, and Misty, and these are big. I mean, the hypertension is a bit ticket item, and Chip, you said it very well. That's not clinical medicine, so why do we have a measure that's not reflective of how medicine works?

Co-chair Kahn: Okay, well, I guess we should -- I don't know. I mean, we've got enough support. I think it -- Jenna, I mean, we ought to put them in the other discussion then.

Ms. Williams-Bader: Okay.

Co-chair Kahn: Okay, so are there any objections to anything else on here where they would want a recommendation different from the one we've got? Okay, let's see, so can we proceed? I mean, actually can we just proceed to a vote then, Jenna, if we

don't --

Ms. Williams-Bader: We don't actually vote on the consent calendar.

Co-chair Kahn: Okay.

Ms. Williams-Bader: We just, if there -- so to be -- let me try to be really clear. I'm putting this in the chat. We are pulling -- let me get these numbers right.

So, we're pulling 01246-C-MSSP, CMS 165, Version 10, and CAHPS, sorry, I'm typing as well, CAHPS for MIPS Survey from the consent calendar. So, then we just ask if there are -- oh, I didn't send that to everyone. Hold on.

So, then we ask are there objections from anyone for the remainder of the measures? And if there are no objections, then the workgroup recommendations become the Coordinating Committee recommendations for these.

Co-chair Kahn: Great, so let me ask that when we get to those at the end, we just had a pretty full discussion, that we try to limit our discussion and pretty much go straight to what I think is going to be the recommendation, I mean, of conditional support for removal rather than retaining, and then we can see what happens on the vote.

Ms. Williams-Bader: Clarke does have his hand raised, so Clarke?

Co-chair Kahn: Okay, Clarke?

Member Ross: No, I just wanted clarification on what we're doing. I fully support the CAHPS measure. I don't agree with Amir's characterization of the consumer/patient.

Co-chair Kahn: No, you'll have an opportunity --

Member Ross: So, I just wanted to clarify we're

pulling it because we're going to vote to remove it?

Co-chair Kahn: Well, no, we're pulling it -- yeah, we're going to have a vote when we get -- a full vote on it, so you'll have an opportunity both to discuss it and to then have a vote. Yeah, we just moved it --

Ms. Williams-Bader: Right, we --

Co-chair Kahn: -- away from the consent calendar, which is a consensus calendar, so it will have full consideration. This doesn't dictate what will happen. This only just says we now will have more discussion. Is that okay?

Ms. Williams-Bader: Misty has her hand raised.

Co-chair Roberts: Yeah, can you just clarify again? I think you said the consent calendar, there will be no voting at all. Essentially we are agreeing with the workgroup recommendations except for those measures which Amir has suggested pulling from the consent calendar. Is that correct?

Co-chair Kahn: Right.

Ms. Williams-Bader: Right.

Co-chair Kahn: That's correct.

Co-chair Roberts: Okay, can you give any -- I guess I feel like I need just a little bit more information on some of these and the rationale, and maybe I didn't do my due diligence beforehand, but it seems like a lot to just say yeah, I'm good with that.

Co-chair Kahn: A little bit. Remember, these had 80 percent to 100 percent vote on them.

Co-chair Roberts: Within the workgroups.

Co-chair Kahn: Within the workgroups. Everybody had an opportunity to review them. I mean, the whole point of this is that we, you know, clear the

low-hanging fruit as it were, and then people have an opportunity to pull things if they think they don't fit this definition of low-hanging fruit in terms of the recommendation.

Co-chair Roberts: I'm just going to look back through over here quietly.

Co-chair Kahn: Okay.

Ms. Williams-Bader: I know we like the -- if we are able to end ten minutes early, that's great, but I do -- since we do, after this point, will not have an opportunity to discuss these measures, other than the three that were pulled, I just want to make sure there is nothing else. And Chip, thank you for helping us move this along as well.

Co-chair Kahn: So, with -- if I hear no objection, then we will proceed, okay, no further objection. Okay, so we're supposed to break at noon, but we're about ten minutes before that, but I know that we then review -- on the measures that we review, Jenna, at 12:20, do we have public -- we already had public comment on them or, I mean, do we have a public comment?

Ms. Williams-Bader: No, the three Hospital Outpatient Quality Reporting Program measures we're discussing at 12:20 did have a public comment yesterday, so --

Co-chair Kahn: Okay.

Ms. Williams-Bader: -- we're not doing an additional one today.

Co-chair Kahn: Okay, so then let me propose that we come back at, you know, between 12:15 and 12:20, maybe save ourselves, and get started promptly since we're ending about nine minutes early. Does that --

Ms. Williams-Bader: I'm sorry, and are we -- so no one -- we're saying no other objections to the

consent calendar, so --

(Simultaneous speaking.)

Co-chair Kahn: I just asked and nobody objected. That's what I just said. I said are there any other objections and nobody said anything. I think we're good, Jenna. Let's just --

Ms. Williams-Bader: Okay.

Co-chair Kahn: -- move, okay.

Ms. Williams-Bader: And you were suggesting coming back at what time, Chip?

Co-chair Kahn: Well, maybe 15 after or 18 after. Let's try to get back a little bit before 20 after and we'll get started, so we can keep things rolling.

Ms. Williams-Bader: Okay, why don't we say 12:15 Eastern Time?

Co-chair Kahn: Okay, good.

Ms. Williams-Bader: Thank you all so much. We'll see you at 12:15.

Co-chair Kahn: Thanks a lot. Bye-bye.

Ms. Williams-Bader: Thanks, Bye.

(Whereupon, the above-entitled matter went off the record at 11:52 a.m. and resumed at 12:16 p.m.)

Measure Set Review Recommendations for the Hospital OQR Program

Ms. Williams-Bader: Okay, if we could go to the next slide, please? So, we are going to pick up the discussion with the three Hospital Outpatient Quality Reporting Program measures that we did not get to yesterday. If we could go to the next slide, please?

00930-C-HOQR: Median time for ED Arrival to ED Departure for Discharged ED Patients

Ms. Williams-Bader: The first one is 00930-C-HOQR, Median Time from ED Arrival to ED Departure for Discharged ED Patients. This measure calculates the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.

The measure is calculated using chart extracted data on a rolling quarterly basis and is publicly reported an aggregate for one calendar year.

The measure has been publicly reported since 2013 as part of the ED throughput measure set of the CMS Hospital Outpatient Quality Reporting Program.

Endorsement was removed for this measure and five advisory group and workgroup members selected this for discussion initially in the survey in April. If we could move to the next slide, please?

And then I will pause here to see if there is a CMS program lead who has any contextual comments to make about this measure?

Ms. Patel: Hi, yes, this is Shaili Patel. I will start off saying that this measure calculates the median time from emergency department arrival to the time of departure as you just covered.

The endorsement was removed. The overall feedback we received from NQF stated that it requires some specification and algorithm changes.

This may be because the abstraction of these data elements are primarily focused on case-specific documentation where there is unclear or conflicting documentation in the medical record about the discharge time itself.

I do want to mention that this measure collects data for overall rate, also for psych and mental health

patients, and transfer patients. It is publicly reported since 2013 and it has been in the program since 2012.

Now, the rationale is that based on evidence, ED throughput is an indicator of hospital quality of care and shows that shorter length of stays in the ED led to improved clinical outcomes.

Significant ED overcrowding has numerous downstream effects, including prolonged patient waiting times, increased suffering for those who wait, rushed or/and unpleasant treatment environments, and potentially poor patient outcomes.

The quality improvement efforts aimed at reducing ED overcrowding and length of stay have been associated with increase in ED patient volume, but decrease in number of patients who leave without being seen, a reduction in costs, and an increase in overall patient satisfaction.

The study also demonstrated that the need for dedicated emergency mental health services, that's an indication that the clinical needs for these patients substantially differ from the non-psychiatric population.

With that being said, the measure again is public reported and used to calculate overall star ratings.

We also provide facilities with their reports, which allow facilities to really review their performance and compare to their peers, and promote quality of care provided in their facilities, and lastly, this measure also allow facilities for effective communication and coordination of care.

In terms of performance, it is an inverse measure, meaning the lower the number, the better. The average for the overall rate is 149 minutes.

For the psych/mental health patients, however, it's

quite high, which is 304 minutes, and lastly, for the transfer patient, it is 294 minutes, so again, high compared to overall rate.

Based on our topped out methodology, this measure is not topped out as the TBC is greater than ten percent, and based on the current data, 90th and the 75th percentiles are still statistically distinguishable.

For this measure, we currently have 4,688 facilities that submitted data for the calendar year 2021. Note the number of facilities are based on CMS' certification number or CCN, and a CCN can have multiple facilities under one CCN, meaning the individual, the number of individual facilities are much higher, and this also includes COTS, which are not required to participate in the OQR program. Thank you.

Ms. Williams-Bader: Thank you. So, Chip, I'll turn it over to you. I believe we'll take comments from the workgroup co-chair first and then the lead discussants.

Co-chair Kahn: You want the workgroup and then the discussants or --

Ms. Williams-Bader: Yes.

Co-chair Kahn: Okay, comments from the workgroup?

Ms. Williams-Bader: I believe we have Akin on today as well. Akin, would you like to introduce yourself and then give a summary of what the workgroup discussion was about this measure?

Mr. Demehin: Sure, thanks. My name is Akin Demehin. I'm a co-chair of the MAP hospital workgroup, and in my day job, I'm senior director for quality and patient safety policy at the American Hospital Association. Thanks for the chance to be with you again today.

So, on this measure, we had quite a wide-ranging conversation at the workgroup. I think it weighted heavily on folks' minds that this information is something that patients often are very interested in seeing to understand what their experience in an emergency department might look like.

We also noted the comments from the equity workgroup around some of the potential disparities in these rates.

I think what tilted the group towards at least starting with a voting recommendation of conditional support for removal were a couple of things. The first was the loss of NQF endorsement, which certainly is a major consideration for us.

The second was brought up by a few folks on the group and that is the measure has been in the program for quite a long time. We're not seeing a whole lot of change in the rates that are publicly reported.

Now, change does sometimes take time, but in the minds of some folks at the table, if we're not seeing change after having a measure in the program for approaching ten years, maybe there's something in the measure itself that is not helping to generate that change.

And then finally, there was conversation around the lack of risk adjustment and the fear that this measure wasn't adequately accounting for the differences in patient complexity and facility type that could potentially influence wait times in facilities.

The reason why folks, I think, gravitated towards conditional support for removal as opposed to outright support for removal was the recognition that these are data that are helpful context that patients are interested in.

I think it was really a signal from the group that we

would like to see a better measure than what we have in front of us. So, I think that sort of summarizes it and I'm glad to take any questions the group may have while you have this conversation.

Ms. Williams-Bader: Chip, I think you're on mute.

Co-chair Kahn: Jenna, do you want to go to the lead discussants?

Ms. Williams-Bader: Yes, so we have the Joint Commission and HCA Healthcare, and I guess we can start with the Joint Commission.

Ms. Dardis: Thanks, Jenna. Hi, this is Michelle from the Joint Commission. So, we noted there were no public comments received on this measure. In the MAP rural health group, one voted to retain and seven voted to remove.

The MAP health equity workgroup was pretty split, but favored retention noting health equity implications as Akin mentioned. However, the Joint Commission would support removal, not conditional support, but outright support for removal.

To support our consideration, we reviewed both the measure data shared by NQF as well as data we have at the Joint Commission. In addition to CMS collecting this measure, it is used in a number of programs, including HRSA's MBQIP program, and the Joint Commission includes it in our hospital accreditation program as an optional measure for reporting.

We have about 610 hospitals on average that report it per year, which is far smaller than the CMS OQR population, but still significant enough to look at the data.

And over time, while median rates have varied slightly, there really is no clear trend either at the median or the 25th or 75th percentile, and

performance skews far to the right, which could suggest room for improvement, but when you don't see improvement or any significant change over a period of ten years, it leads you to question whether this measure is targeting what it intends to measure.

We also noted that the MAP coordinating committee actually originally voted for phased removal of this measure back in 2013, shortly after it was launched.

When it went through NQF endorsement in 2018, the committee voted to not endorse stating it did not meet the criteria for importance, noting that they didn't think there was a performance gap because there is not significant evidence to support that there is a rate that truly is a rate that is good. Lower is better, but what is good?

So, for these reasons and given we haven't seen change over time, we agree with the original committee that reviewed the measure in 2018 and recommend removal from OQR based on the criteria that it no longer meets program priorities and does not leave a gap given a lack of a direct relationship to outcome, the degree of variation in performance, and a lack of improvement over time.

Co-chair Kahn: Okay, HCA? Do we have any -- Jenna, are we -- I don't hear from --

Ms. Williams-Bader: I'm not either. I think it's okay to go ahead and move onto discussion.

Co-chair Kahn: Okay, so let's have a discussion. We've got concerns out and how many hands? Do we have any hands?

Ms. Williams-Bader: Clarke has his hand raised.

Member Ross: Yes, it's a question. So, yesterday, the group voted 12 to seven to eliminate a measure on people who were never seen clinically who go to

the emergency department. Now we're proposing eliminating a measure on the median time.

What measures exist around emergency room performance, precisely emergency room? Again, many low-income folks in urban areas, the emergency room is their primary care setting, and for people with serious mental illness, it is a predominant location for service and support, particularly on Friday and Saturday nights.

So, in order to try to explain this to the disability, and mental illness, and substance use disorder communities and the advocates, what emergency room measure, precise measure similar to consumer responsiveness can we say exists when we're eliminating these two?

Ms. Patel: I -- this is Shaili Patel. I suppose this is for CMS. If we eliminate the two measures that we have currently on the list, then we would be left with having neither two ED measures we have in our program currently.

Member Ross: Thank you.

Co-chair Kahn: Can I ask CMS whether there's been any investigation of other measures or the Joint Commission, whether they have looked for other measures? Because in both these cases, we get this very -- I'm completely sympathetic with Clarke's concern. But we get these -- this description of the deficits of these measures other than they're ED measures. So we need measures that are useful, both in improvement and in terms of transparency for consumers. Is there other work going on so that if we ask -- if we did a conditional, we know that there's something on the horizon?

Ms. Schreiber: There's nothing currently on the specific horizon that I'm aware of, although we can go back and check except the American College of Emergency Physicians sometimes does have measures in the pipeline. The one thing that we

have been specifically looking at is a subset of this particular measure which is for mental health patients because you can see that the numbers, the wait times for mental health patients are dramatically different and extremely long in many cases. But the answer is no, at least for quite a while, Chip, there wouldn't be anything.

Co-chair Kahn: Okay.

Ms. Dardis: And this is Michelle for the Joint Commission. I have a comment. We align with CMS for the most part.

There is an ED throughput measure for admitted patients which we feel is more closely tied to clinical outcomes. And that's looking at the admin decision time to ED departure time for patients. So it addresses the issue of ED boarding.

As far as ED measures go, there are no other throughput measures. But there are clinical process of care measures for the ED. There's measures around stroke care and time to PCI and other clinical timing measures.

(Simultaneous speaking.)

Co-chair Kahn: That you use, I mean, that's used by the Joint Commission.

Ms. Dardis: And also used -- I won't speak for CMS. But I know that there's a semi-composite measure for OQR that includes some of the timing measures, I believe.

Ms. Patel: This is Shaili from CMS.

Co-chair Kahn: Yes.

Ms. Patel: Yes, we have the semi-eCQM measure which will be replacing our current chart objective. Two chart objective measures were acute coronary and intervention.

Co-chair Kahn: Okay.

Ms. Williams-Bader: Janice has her hand raised.

Co-chair Kahn: Janice?

Member Tufte: Thank you. I have an echo. It's scary. I do see this is something that could be noted. But the reality is, especially, like, on the weekend that was mentioned, if somebody has to see a specialist, it could be an ophthalmologist or ortho or whatever. It can take a long time.

And so I recently was 12 hours myself in a emergent care which might be considered ED until I could get into a bed. And so that's a huge issue at our local hospital. They're not even able to discharge people to the hospital except for the trauma, their Trauma 1 hospital.

So they've actually announced that they're not accepting patients because they have over 100 patients waiting for long-term care that there is no availability. So I mean, there's a lot behind this. And I'm glad to hear there's a mental health related component of this. And I appreciate who just mentioned the composite measure that has a time involved.

Co-chair Kahn: Okay. Any other comments or questions?

Ms. Williams-Bader: I'm not seeing any other hands raised or comments in the chat.

Co-chair Kahn: So I guess the question on this one, if we proceed, Jenna, to take action, obviously we have four alternatives: support for retaining, conditional support for retaining, conditional support for removal, support for removal. Just from the discussion, though, it seems to me two things have popped out. One is that there is a lot of concern that we have measures in this area and we don't have a lot of alternatives right now.

And two, that this measure, though, it is unclear what it really tells us because -- and it's been out there a long time. And then I guess we do have the issue of whether it's endorsed or not. But it seems to me that we -- so I think in terms of the extremes, support for retaining and support for removal, that it probably doesn't fit in terms of starting out our process on that.

So why don't I suggest that we do conditional support. And it wasn't a consensus at the workgroup. So if we did conditional support for retaining and then had the staff note the issues that were brought up, would we want to do that as a -- and have a vote on that to see where we go? Would that be acceptable to the group? Jenna --

Ms. Williams-Bader: Let me just ask -- I'm not -- other than the CBE endorsement, I'm not sure I caught what the condition -- like, what needs to be changed about the measure.

Co-chair Kahn: Well, I mean, I think it was -- well, first, one condition -- I'm sorry. So you're arguing that we might want a condition -- I mean, conditional support for removal. But the condition basically being there has to be viable alternatives to it. Is that what you're suggesting?

Ms. Williams-Bader: Yes, I think so.

Co-chair Kahn: Okay. Well --

Ms. Williams-Bader: So just quickly, we do have a couple of hands raised. Bob Dickerson, do you have -- is there something that you need to say just because we are moving to a vote? And then Misty has her hand raised.

Mr. Dickerson: Yeah, the only thing I wanted to mention is in terms of how the measures are worded. CMS has more recently started reporting that breakdown. But in addition to the average time in the ED and the 90th percentile for patients with

mental health psychiatric diagnosis, they've also started breaking that down by the ED volume. So they've got categories for average times for high volume EDs, low volume EDs, medium. So I just wanted to add that.

Co-chair Kahn: Okay. Misty?

Co-chair Roberts: Yeah, I'm just going to suggest maybe starting with what the workgroup agreed to start with which is conditional support for removal based on essentially that support being against other measures that would close that gap, unless, Chip, you had thoughts on other conditions for retention.

Co-chair Kahn: No. I mean, I think we can start with that. So Jenna, let's then -- we want to move on. So let's start with conditional support for removal but the conditions that have been mentioned. And let's vote on it and see where we go -- see where we come out.

Ms. Williams-Bader: Sounds good. We'll pull that up.

Ms. Harding: Voting is now open for 00930-C-HOQR, Median Time from ED arrival to ED departure for discharge ED patients. Do you vote conditional support for removal?

Co-chair Kahn: We got 16, we got 17, we got 18. That may be the top because I don't think we've got -- oh, 19, great. Well, we made 20. We have 20. Let's give it another 30 seconds.

Ms. Harding: Okay.

Co-chair Kahn: Okay. Let's call it because we need move.

Ms. Harding: Voting is now closed. The results are 16 for yes, 3 for no.

Co-chair Kahn: Okay.

Ms. Harding: That gives us a percentage of 84 percent.

Co-chair Kahn: Okay. Well, then that's a recommendation that met the criteria for consensus. Okay. Jenna, let's go to Abdomen CT, right?

02599-C-HOQR: Abdomen Computed Tomography - Use of Contrast Material

Ms. Williams-Bader: Yeah. So the next measure is 02599-C-HOQR, Abdomen Computed Tomography, CT, Use of Contrast Material. This measure calculates the percentage of abdomen and abdominal pelvic CT studies that are performed without and with contrast out of all abdomen and abdominal pelvic CT studies performed, those without contrast, those with contrast, and those with both. In each facility, the measure is calculated based on a one-year window of Medicare claims.

The measure has been publicly reported annually by the measure steward, CMS, since 2009 as a component of its HOQR program. The measure is not endorsed, and six advisory group and workgroup members selected this measure for discussion. We will turn over --

(Simultaneous speaking.)

Ms. Williams-Bader: -- to our CMS program leads to make brief comments about any contextual comments they'd like to make.

Co-chair Kahn: Oh, I'm sorry. Yes, CMS.

Ms. Patel: Hi. This is Shaili Patel again. Yes, this measure is calculated based on a one-year window of Medicare claims. So since this measure is a claims-based measure, the facilities are not faced with data collection burden.

In terms of some rationale, the CT performed with and without contrast doubles the radiation dose to

the beneficiary. It exposes the beneficiary to potential harmful side effects of the contrast materials itself, reducing the unnecessary use of combined CT abdomen studies defined as those that are performed both without and with contrast agents for the evaluation of solid organs. And body cavities represent an important opportunity to improve practice and patient safety.

The measure promotes high quality efficient care and is intended to reduce unnecessary exposure to contrast materials and/or radiation. It also ensures adherence to evidence-based medicine and practice guidelines and provides data to consumers and other stakeholders about facilities imaging use. In terms of performance, this is also an inverse measure.

The average for this measure is about 7.6 percent of patients, again, based on our topped out methodology. This measure is not topped out as the TBC is greater than 10 percent. And based on the data, 90th and the 75th percentiles are still statistically distinguishable.

For this measure, we currently have, based on, again, CCN, about 3,636 facilities report being on this measure. This includes COTS, which are not required to participate in this program. Thank you.

Co-chair Kahn: Thanks. Let's go to Akin.

Mr. Demehin: Thanks, Chip. So this was an interesting conversation for us. And I think you may sense a theme here from a lot of our discussion around our concern around the lack of endorsement with some of these measures as well as how long some of these measures have been in the programs. In the case of this measure, I think initially when we had a conversation about it, our concern about the lack of endorsement was really sort of pushing us towards potentially one of the removal categories.

We then had some conversation with CMS -- and Shaili, you may want to elaborate on this after giving this quick summary -- around some of the changes that have been made to this measure since it was initially adopted and since it went through the NQF endorsement process a long time ago. And I think the folks around the table recognize that the importance of the topic in trying to avoid excessive radiation from CT scans, I think the lack of endorsement made them concerned about whether the measure was functioning in the way that it should.

But with some of the changes that had been made, I believe it was to some of the inclusion and exclusion criteria. Folks felt a little bit more comfortable with keeping the measure but asking that it go through the NQF review process again to make sure that it is working in the way that it's intended. So that in broad brush strokes is why we landed where we did.

Co-chair Kahn: So I'm sorry. So you're saying that the recommendation which didn't get a consensus was retained -- conditional retention?

Mr. Demehin: That's right. That's where we recommended starting the voting.

Co-chair Kahn: Okay. And then Jenna, do you have discussants?

Ms. Williams-Bader: Yes, we do. So the discussants for this are American Health Care Association who I don't believe is on and Civitas Networks for Health.

Member Sonier: This is Julie. I'm here representing Civitas. It's very helpful to me that we have the chair of the hospital workgroup to explain the workgroup's conversation because I was looking at this measure. And the overall performance -- the median performance is about 5 percent of patients. And to me, that really seemed like it was topped out. So understanding the conversation that they

had about some of the changes to the measures that made the workgroup more comfortable with keeping the measures with the condition of endorsement has been helpful to me.

I was initially leaning towards suggesting removal or conditional support for removal just based on what appears to me to be very high and unvarying performance on this measure which I'm still concerned about. I don't know enough about the methodology that CMS uses to determine whether a measure is topped out. But to me, it seemed like this was as close to a topped out measure that I'd ever seen. But hearing from the workgroup chair, I think it seems reasonable to have conditional support for retaining the measure but still to keep an eye on when this measures becomes topped out because I think it inevitably will.

Co-chair Kahn: Okay. Do we have questions from the committee?

Ms. Williams-Bader: Sorry. Let me just -- is the American Health Care Association on?

Co-chair Kahn: I thought you said they weren't.

Ms. Williams-Bader: Just I thought they were, but they might be. Go ahead.

Member Sreenivas: Yeah, this is Kiran Sreenivas from American Health Care association.

Co-chair Kahn: Oh, great.

(Simultaneous speaking.)

Member Sreenivas: Yeah, no. I think everyone said kind of what we agree with as well. I think the only additional thing or comment I'll make is with the disparity. I think that was the other interesting thing we saw with the Black Americans having a higher rate than White. And I think that kind of also led us to believe support for retaining.

Co-chair Kahn: Okay. Do we have any questions or comments from the committee? Going once. So I think the proposition then that Akin and the other commenters are suggesting is conditional retention with a recommendation that they seek endorsement.

Is that correct? And if it is, no other comments? Then Jenna, I think we can go to a vote if you'd like. It sounds like we're ready to vote.

Ms. Williams-Bader: Yeah, I'm not seeing any other hands raised or comments in the chat. So --

Co-chair Kahn: Let's go to a vote.

Ms. Harding: Voting is now open for 02599-C-HOQR, Abdomen Computer Tomography Use of Contrast Material. Do you vote conditional support for retaining? Okay. We are at 19. I'll give it a few more seconds. We're at 20. Okay. We can close the vote.

Co-chair Kahn: Wow, great vote, 20.

Ms. Harding: The vote is now closed with the following results, 19 votes for yes, 1 for no. And that gives us a percentage of 95 percent.

02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery

Co-chair Kahn: Great, and a recommendation. And so let's proceed to hospital visits after outpatient surgery. Jenna, will you give us an introduction and invite CMS for comment?

Ms. Williams-Bader: Yes, so we are on 02930-C-HOQR, Hospital Visits after Hospital Outpatient Surgery. This measure assesses facility level post-surgical risks standardized hospital risk visit ratio, the predicted to expected number of all cause unplanned hospital visits within seven days of a same-day surgery at a hospital outpatient department among Medicare fee for service patients

aged 65 years and older. This measure is endorsed, and five advisory group and workgroup members selected it initially for discussion. We can go to the next slide, and I'll invite CMS to make brief contextual comments about the measure.

Ms. Patel: This is Shaili Patel again from CMS. Our rationale for this measure is, again, outpatient same-day surgery is exceedingly common in the U.S. Nearly 70 percent of all surgeries in the U.S. are now performed in the outpatient setting with most performed as same-day surgeries at HODs.

And this is sort of expected to increase as the procedures continue to move from inpatient only. While most outpatient surgery is safe, there are well described and potentially preventable adverse events that occur after outpatient surgery which can result in an unanticipated hospital visits. In terms of performance, this is also an inverse measure.

So the average for this measure is 1.1. Again, based on our topped out methodology, this measure is not considered to be topped out as the TBC is greater than 10 percent. And based on our data, 90th and some 5th percentiles are still statistically distinguishable.

We have total of about 4,690 facilities reporting on this measure. This also includes COTS, which are not required to report for our program. Thank you.

Co-chair Kahn: I'm sorry, Jenna. Just for clarification, this is endorsed as I understand by NQF?

Ms. Williams-Bader: Yes, that is right. So we are just looking into this as far as the rationale goes for the workgroup. So if you can give us a minute perhaps in the meantime we can turn it over to Akin for the workgroup summary.

Mr. Demehin: Sure. So I will say there was a little bit of confusion on this point as well at the

workgroup around what the endorsement status of this measure was. I also think there was a little bit of confusion on the workgroup on this measure versus the hospital visits after colonoscopy measure that is also part of the OQR but was not up for discussion as a part of this conversation. I think most folks at the table were fairly supportive of retaining this measure. And I think given some of the uncertainty around its endorsement status wanted to make sure to add that condition.

There was some conversation too about the need for ongoing examination of the influence of social risk factors on performance. I am not entirely sure whether that worked its way into a condition for its support because, again, I think there was some broader confusion about what the endorsement status of this particular measure was. But overall, I would say the sentiment about this measure at the workgroup was fairly positive.

Co-chair Kahn: Okay. Do we have any discussants?

Ms. Binder: I think I'm one of them.

Ms. Williams-Bader: Go ahead.

Ms. Binder: So I think also a discussion that I saw in the literature is that -- or the materials that were sent was something about reporting this out as a ratio. And, like, the sterilized infection ratios are reported as ratios. And that can be confusing.

And so I definitely sympathize with that point. But overall, I would strongly support this measure. This is one of those measures that CMS is best positioned to collect on.

This is very, very difficult information for others to obtain such as even a health clinic. It's very hard because you're tracking -- you're coming to link the patient in two different settings. So it is extremely important to -- I know the purchasers, the point made earlier, 70 percent of surgeries are done in

these outpatient settings.

So we do need to find new ways to track outcomes. They can't be the same as inpatient where you can see the outcome. The patient is right there in the bed.

That's not the case with ASCs and with hospital outpatient units like this. So it's very important to be able to look at the visits for the ED. It's important to lots of folks.

And I would also add that I think for consumers it's also really helpful for them to understand and be able to compare, especially among outpatient surgical units, especially. So I agree with the comments again that were raised about the ratios. It would be nice if it were also all-payer. Would love for CMS to consider that.

But I have a couple things I'd love them to add. But having said that, it's an extraordinarily important measure to 70 percent of all the surgeries that are done in this country. So it's extraordinarily important to be endorsed, and we strongly support it.

Co-chair Kahn: Okay. Questions or other points to make? So I --

Ms. Williams-Bader: We do have -- sorry, there is another lead discussant as well. So do we have Blue Cross/Blue Shield Association on?

Member Peden: Yes, yes.

Ms. Williams-Bader: Okay. Go ahead.

Co-chair Kahn: Carol, go ahead.

Member Peden: Yes, I mean, we've been strongly supportive of maintaining this measure. I think not only are 70 percent of surgeries done, but the complexity and the scale of surgery done is moving rapidly. So we need to be tracking this.

I think the comment that the other -- it overlaps with other measures. And the other measure was outpatient colonoscopy. And that is a totally different procedure to something compared to a major hip replacement in a 75-year-old.

So we need to track this. And I know there were some issues around it's clustering around the mean. But this is one case where we want to find the outliers, the local center that is not doing well and is having really high cases of admissions. So I think those are all very important reasons to keep this.

Co-chair Kahn: Okay. If I -- any other comments?

Ms. Williams-Bader: Chip, you want to -- yeah, so we've had a lot of back and forth with CMS about the endorsement status of some of these measures because --

Co-chair Kahn: Right.

Ms. Williams-Bader: -- there is a version of the measure that is endorsed that is not always considered by CMS to be the same version of the measure in a program. So for this one, I do think that's a place where we have had some confusion. So I would ask CMS to speak to whether or not CMS considers the version of this measure that's in the HOQR program to be endorsed because at points, we've heard that it's considered to be not endorsed, even though there is an endorsed version of the measure.

Co-chair Kahn: Okay. CMS, can you give us some clarification?

Ms. Patel: Yes, this is Shaili Patel. It is endorsed.

Our colleague, Doris Peter, actually provided the NQF number. Yes, we did have back and forth. But the version we currently have is considered to be endorsed, NQF-26887.

Co-chair Kahn: Okay. Is there any other discussion and clarification there?

Okay. I would suggest that we start with considering the discussion, considering that it is endorsed that we start with support for retaining as our first vote and see where we go from there, Jenna. Is that okay with everyone? And if it is, why don't we go ahead and have a vote?

Ms. Binder: Sounds good to me.

Ms. Williams-Bader: Okay. We'll go ahead and pull that up.

Co-chair Kahn: Okay, great. Thank you very much.

Ms. Harding: Voting is now open for 02930-C-HOQR, Hospital Visits after Hospital Outpatient Surgery. Do you vote support for retaining?

Co-chair Kahn: 16, 17, 18, 19. We had 20. Let's give it another -- now we're at 20. So I think we can go ahead and look at the vote. Oh, 21.

Ms. Harding: Okay. We will close the vote. And the results are 20 votes for yes, 1 vote for no. And that gives us a percentage of 95 percent.

Discussion and Recommendations of Measures Pulled from the Consent Calendar

Co-chair Kahn: Okay, great. And I think with that, we will now go to a discussion and recommendations of the measures that were pulled from the consent calendar. And I think I'm supposed to hand the reins of the chair over to Misty for that discussion. Is that correct, Jenna?

Ms. Williams-Bader: Yes, that is right. So as a

reminder, we have two groups of measures that we'll be discussing in this section. The first will be the measures that were pulled prior to the meeting by Coordinating Committee members, and then we will talk -- we'll turn to the measures that were pulled earlier today.

02936-C-ASCQR: Normothermia Outcome

Ms. Williams-Bader: So if we could go to this next slide. So the first measure is 02936-C-ASCQR, Normothermia Outcome. And we will -- okay. So our lead discussant here will be the Coordinating Committee member who requested pulling the measure. That is Janice. So Misty, I'll turn it over to you and to Janice.

Co-chair Roberts: Okay, thanks. So do we want to start with Janice? Or do we want CMS to provide any contextual comments or our workgroup lead, or just start with Janice?

Member Tufte: I'd like to hear what you have to say first. Thank you.

Co-chair Roberts: Maybe we ask CMS to provide some contextual information.

Ms. Bhatia: Hello, this is Anita Bhatia. This measure is simply the percentage of patients that have undergone surgery that ends up at least 60 minutes in length that measures the length of the surgery. But after surgery, attain normothermia which is at least 96.8 degrees Fahrenheit.

I'm not sure why this measure is up for discussion. This is an ASC quality collaboration development measure. I believe that there's some concern about the measure only addressing hypothermia rather than hyperthermia. I leave it up to you to share your thoughts and why you wanted it.

Member Tufte: Yeah, I recently had surgery, major day hip surgery. And I have a low body temperature

to begin with. And so they couldn't even detect my temperature.

So when patients age, they have a lower -- a large percent of patients have a lower body temperature between 94 and 98.6 usually. But I guess my concern was that the reason it was voted yes is because things can happen with hypothermia. But they also happen with hyperthermia.

So I wasn't sure if there is a measurement when it's 100 and above or if we have a number for that. And it was also discussed in the workgroup that this is really pretty much a standard of care and that I believe it had performance utilization was 95.11 in 2020. So I question is that's topped out.

And I think that in my opinion it's probably standard of care that they do take the temperature. But if it is documented or not is questionable. But they also said it was highly impactful and meaningful to patients.

And I think that hyperthermia, like, a balanced low, hyper and hypo, might be better. It has not been tested for feasibility. And I was thinking possible or conditional. So anyway, that's my thoughts. Thank you.

Ms. Bhatia: And that's helps. There were several points in there. So let get them out. So one on the temperature range, first, I did take a look at the measure and the definition.

Hyperthermia is not addressed. Hyperthermia does occur, but it occurs much more rarely. It is a rare occurrence, and hypothermia is relatively common. The percentage that I saw in the literature ranges quite a bit, but at least 20 percent can experience hypothermia.

And hypothermia is linked to greater risk of complication. So that's the origin of the measure. That said, I do agree that the hyperthermia might

want to be considered with this measure. And that's something that I would like to take to the measure developer which is the ASCQC.

But thank you for that comment. I think that is something that might need to be included with the measure to address normothermia on both ends of the spectrum. And also this is the first I've heard about the age consideration, so I'll take that to them as well.

Member Tufte: Yeah, I looked it up in research papers where people have looked at this. So it does happen quite often in the elderly, but it doesn't mean that they need to still be watched. I was kind of surprised that the low was 94 degrees.

Ms. Bhatia: Okay. So I'm going to take this to the ACCQC. I'm just an epidemiologist. So I'm going to take that to them.

Regarding testing, the ASCQC did test this measure. And they do have testing data. It was tested in a group of ASCs. So it's not an untested measure.

But regarding the standard of care, this level temperature where they set it, at least at the time that it was done, is actually a relatively stringent standard. So in other measures especially on the physician side, they have actually had a higher and a lower level of temperature to attain normothermia. So I think this might be one of those measures that does need a relook, and I'll take that to the ASCQC.

Regarding performance, the measure of performance is relatively high. If one looks at the quality reporting center site, you can actually look at that measure and see how it's performing in terms of ASCs reporting on it. Again, there are still some outliers.

There's a number that are -- there's a whole bunch of facilities that are at the 99 to 100 percent level.

It does fall off into 88, 85 percent range. So there is still some room for improvement.

So just because the measure might be considered topped out does not mean that we necessarily want to remove it from the program. There is still room for improvement. And you can change the specification.

Member Tufte: I just want to say too that it was feasibility and the eCQM. So that was what was not tested.

Ms. Bhatia: Oh, I'm sorry.

(Simultaneous speaking.)

Ms. Bhatia: Well, the level of eCQMs right now is kind of up in the air for this particular study. We in our request for comment this year did ask for feedback on the use of eCQMs and interoperability in the ASC study. So we are looking forward to receiving comment on that because typically when we ask the question, people say, oh, well, ASCs don't have that capability.

But that's been the same answer for a number of years. I do see a comment that normothermia is not tested for eCQM feasibility. In general, eCQM feasibility hasn't been tested for a while in ASCs completely. And so we are embarking on getting that information now, that topic across the board.

Co-chair Roberts: Thank you.

(Simultaneous speaking.)

Member Tufte: Yes, thank you for that. And I just wanted to say I mailed my comments to NQF. And they can forward to you or I could forward them to you, so --

Ms. Bhatia: Yeah, that would be useful when I go talk to -- in terms of working with the ASCQC.

Member Tufte: Okay.

Member Peden: Can I make a comment?

Co-chair Roberts: Yeah, this is Carol. I was getting ready to call on you. Go ahead.

Member Peden: Yeah, thank you. I'm an anesthesiologist. And basically anesthesia induces vasodilation. So your body temperature drops. So maintaining temperature against normothermia is the measure because it requires -- anything other than a very short procedure requires active maintenance which is a good part of patient care.

So the fact that we've got a group of centers that are not doing that I think is worth -- this is an important measure in anesthesia quality. The hypothermia issue in anesthesia, hypothermia can be an emergency because it came be malignant hypothermia or it could be sepsis. But there's a really kind of medical emergencies or medical situations that are different than maintenance of normothermia for high quality care. So they're slightly different things.

Ms. Bhatia: Yeah, that's probably why the ASCQC formulated this measure the way they did. But if anything, you might want to include some exclusions in this measure, like, for malignant hypothermia. Or apparently, I'm not -- again, I'm not an anesthesiologist at all or a physician. Apparently, hyperthermia can occur for other various reasons. But again, they're rare. But again, that might something --

Member Peden: Extremely rare.

Ms. Bhatia: At least --

Member Peden: Extremely rare.

Ms. Bhatia: -- get excluded from the denominator. Or maybe the numerator needs to be fine tuned. I think the specifications could be looked at just

based on the way they're written now.

Member Tufte: There's a timed entry, I believe, on when the body temperature should go to normal, right? So it should be documented, individuals that have lower body temperatures to begin with.

Ms. Bhatia: Yeah, I believe that's the point was at the beginning. Some people don't even have that body temperature normally. So again, specifications sometimes do need to be looked at, and I will take that to the measure developer.

Co-chair Roberts: Okay. I'll throw it out to anybody else. Is there anyone else from the Coordinating Committee have other thoughts?

Ms. Williams-Bader: I'm not seeing any other hands raised.

Co-chair Roberts: Should we move forward to vote? I don't know. Help me with this one for these that are pulled from the consent. Are we voting on the workgroup recommendation?

Ms. Williams-Bader: I think that's a good place to start, yes.

Co-chair Kahn: Yeah, that's where you'll start.

Co-chair Roberts: Okay. Let's do that which is support for retaining.

Ms. Harding: Voting is now open for 02936-C-ASCQR, Normothermia Outcome. Do you vote to support the workgroup recommendation as the Coordinating Committee recommendation? We are at 18. I'll give it a few more seconds.

Okay. I think we can close. Voting is now closed and the results are 17 votes for yes, 1 vote for no for a percentage of 94 percent.

05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report

Ms. Williams-Bader: Okay. So we can move -- oh, sorry. Yeah, so the next measure is in the Merit-based Incentive Payment System. This is 05826-E-MIPS, M-I-P-S, closing the referral receipt specialist report, eCQM. So I'll first turn it over to the CMS program lead to see if they'd like to make any contextual remarks.

Ms. Gomez: Hi, this is Lisa Marie Gomez with CMS. So this measure meets MIPS objectives. Particularly, it's a high priority measure. It's broadly applicable. The measure is not topped out and shows room for improvement, and it's a digital quality measure.

I also want to highlight that communication coordination -- sorry, give me one moment. Sorry. I just want to highlight that communication coordination of care is a priority and a program that worked towards this goal have been found to improve quality of care for patients and reduce hospitalization. I just want to also highlight that the MIPS program offers different collection types, so for example, Medicare Part B claims, clinical quality measures, and electronic clinical quality measures based upon a clinician or a group's preference.

Each of these collection types have different measure analytics in order to communicate how to abstract data from the data sources available to the clinician. Therefore, having this as an eCQM does not penalize those clinicians who do not utilize an EHR but allow those that do utilize one for the capture of data to report this measure. I also just want to note that MIPS allows choice measure selection.

So right now, clinicians or groups have an option to report six measures. So this is one of 200 measures that are available within the program. So if they find that this measure is too burdensome, they can pick

a different measure. So that's all that I have for this particular component for this measure.

Co-chair Roberts: Thanks. So I think we'll open it up to Amir. I think you recommended, I believe, from the consent calendar. Can you share your rationale for that?

Member Qaseem: Sure. Thanks, Misty. And I appreciate CMS' response. By the way, one comment caught my eye, that you can select any measure. That applies to all MIPS measures, right? That doesn't matter, the selection. That is not how we justify a measure.

So this measure, I had more time to think about it. Let me just go over the criteria that Jenna talked about. The first one is measure does not contribute to the overall goal.

So I was just thinking about what they were saying. And I may have shared -- you may have already seen it. The intent of this measure is to provide seamless care coordination.

But there are two things over here. There is no way to know if the report was read, right? The second one is it does not hold a specialist responsible for closing the loop, but they actually completed the referral.

It's one-way operation that's happening, not the two-way. A referral needs to be the report needs to be closed by the specialist to whom the patient went to see. The specialist is not held accountable for this one.

This measure in terms of your criteria, the measure not endorsed by consensus based entity, this measure has come up in the past. And this is -- please correct me if I'm wrong. When it was in the 2011-2012 Medicare/Medicaid EHR incentive program, we didn't support it as MAP.

2013-14, physician compare, we did not support it under MAP. 2013-14, value-based payment modifier physician feedback program, we did not support this program. So there's a history of this measure not getting the support.

In terms of your criteria for performance and improvement on the measure does not result in better patient outcomes, did you guys notice non-validity, reliability data? You just have raw data over here, what I'm seeing is what's getting reported. You don't know if the measure is reliable or valid. And that's a major component that's missing.

The Criteria 8 in terms of the burden part, and that's why on that one that you can always select another measure. Of course it applies with any measure. But that doesn't mean we should have a measure that's a problematic measure because over here as you all know many of the providers were not part of the big network and not in the university places and some rural providers. They cannot -- they don't have system built, the technology to pull the referral.

So some of them are based on criteria that I want to -- just picking apart, like, specifically that it does not meet some of the criteria beyond one. It fails across many criteria. So going back to my general comments, as I'm looking at this measure, I mean, it is an important clinical concept. Don't take me wrong.

Just take the hypertension issue. I'm saying it's a good concept. But it can encourage -- there's some practical problems. The specification, as I said, not defined the time intervals. There's some practical issues that come up.

You may refer a patient. But what you're referring a patient for, that issue might get resolved before you see a specialist. That's one. Or you may not even get a chance to see the specialist.

We all know the time gap for some of the subspecialty. But you have to wait for six to eight months. That's real world that we are again dealing with.

So if you don't have a measurement here and you can't even see the specialist, it doesn't make sense. And that happens a lot in a lot of subspecialties as we all know. And then many times patients may get better and they may not even see the subspecialist, right?

In terms of the operationalization of this measure, again, if it's a well integrated system, I think this works out very well. But there are plenty of systems that are not. I have dealt with it.

The patient may decide to go -- I'm in Philadelphia, Penn, Jefferson. The patient may go to -- even if you take, for example, Virginia. You do not get the -- our EHR systems do not get the -- I have to click find.

It doesn't just show up. It's not as simple as that. I'll just stop over there, Misty. I know you guys are running behind and all that. So that's about it. Those were the things from my end. One, I went through the criteria and how it fails multiple criteria, not just one, and the second, some of these other issues that I highlighted.

Co-chair Roberts: Thanks, Amir. I'll just say this. Lisa, do you have anything else to add based on Amir's comments?

Member Qaseem: And again, I will stand corrected. But I pulled up the MAP, past history of MAP and this measure and how we have given it to not support in the past.

Mr. Green: So this is Dan Green from CMS. Can you guys hear me okay?

Member Qaseem: Sure, yes.

Co-chair Roberts: We can.

Mr. Green: Yeah, thanks. I work with Lisa Marie. I would just -- I respect the comments that were just made and agree with some of them in terms of -- and we're trying to poll to see what testing we do have available for this. But in the meantime, this is -- as was pointed out, this measure does not have to be reported.

So if you're in a rural setting and you don't have the ability to report it, certainly there's close to 200 other measures you can select from. I would argue, however, that the concept her is so critical to good care. As a physician myself and I'm sure there are many clinicians on the line, I'm an OBGYN. And for example, if I found a lump doing a breast exam, I would want to make sure that patient had the appropriate imaging and if need be followed up a general surgeon.

It's too -- it's not good care just to leave something out there and hope that patient ended up getting the -- or went to the referral or the test or whatever as he or she was instructed. It's too much to chance. And I will say quite a few -- it has a huge cost to the healthcare system, not just in terms of obviously patient's health which of course is paramount but also in terms of malpractice cases delayed care, et cetera.

So I would -- I'm strongly obviously campaigning that I think this measure really needs to be retained. It may not be perfect, but the concept is too important to discard. Thank you.

Co-chair Roberts: Thanks, Dan. I'll open it up to others from the Coordinating Committee. Any other comments on this?

Member Qaseem: And just to respond to that, the fundamental, I fully agree. First of all, something we have discussed and you guys have heard me say. Just because it's good clinical care doesn't mean

everything needs to be measures in clinical care.

I mean, that's just not how we can do it. You have to have the right measurement in place. But shouldn't that be measuring all physicians?

So if I refer a patient to the person -- sorry, I didn't catch your name, Dan, I think, you're an OBGYN -- to you, I should get measured. But so should you, right? Do you agree with that?

Mr. Green: I don't disagree with that. But you can appreciate there are so many things that could happen between your referral to me and me actually seeing the patient. So in other words, if I'm referring -- let's say you're the breast surgeon in the example I gave before.

And if I had a suspicious mask that I referred the patient to see you, she may never contact your office to be seen. She may just say, oh, well, he's a worry wart or whatever. I'm not going or I'm too busy or I'll go here and they forget.

So you would have no way of knowing that the patient was even necessarily directed to come to see you. I on the other hand would never get a letter back from you and say, hey, Mrs. Jones, this record is still coming up as incomplete and would reach out to the patient again and say, hey, whatever happened? I never got a note from Dr. Amir. You know what? And I know that's your first name. I'm sorry. I didn't see your last name.

Member Qaseem: That's fine. That's fine.

Mr. Green: But I never got a note back. What did you think about this mass I sent you for? So again, it's another check to make sure that the patient actually had the test or the consultation or whatever it was that was requested. And if not, again, call the patient.

I may send the patient a letter. But this is -- I think

you and I both would agree that's good care. It doesn't mean that there's not a little bit of a lift here. But especially an important referral, it's critical.

Co-chair Roberts: Clarke, I see you have your hand raised.

Member Ross: Yes, I just wanted to reinforcement Dr. Green's observations. Coordination, communication is essential. Every measure we consider has gaps.

And from the consumer/patient point of view, we're always asking, why doesn't the measure include X, Y, and Z? That's not a sufficient reason in my mind for rejecting a measure because other parties should be part of the communication and coordination process. I agree ideally with that.

And as Chip has reminded us, these are workgroup recommendations where 80 or 90 percent of the workgroup supported this. And I bet there are physicians on the workgroup. So I just wanted to reinforce Dr. Green's observations. Thank you.

Co-chair Roberts: Thanks. Leah?

Ms. Binder: I think Clarke just covered what I was going to say. I just support the measure because it's just such an important issue since that's the biggest weakness in our health system is this handoff. And so I think a measure that tracks that in very important settings is important.

Co-chair Roberts: Thanks. Michelle?

Ms. Dardis: I was just going back to the question of testing data. Do we know when this measure was last endorsed or if it achieve endorsement? Because I do think the concept is definitely important. But is the measure measuring what it's intended to measure is my current question.

Ms. Gomez: So this measure is not endorsed, and I

just want to highlight that. For a measure to be included in this, it does not have to have a particular endorsement, like, for example, NQF endorsement. As long as the measure had evidence based -- its focus was evidence based and that's as required by statute.

And I just want to highlight that we're currently researching the testing of these measures. So we will provide. For the measurements, we are able to pull that. So I just want to highlight that we're pulling this information right now.

Ms. Dardis: Thanks, Lisa Marie. I just wanted to underscore I agree with Amir's concern that if this measure isn't intending what it's intended to measure, then it may not be a useful comparison for consumer purposes. And so I do think that's a really important factor here.

Member Qaseem: And that exactly was my point. And again, the issue of evidence has come up. I didn't want to go. They're looking at it. The developers do not cite any evidence to form the basis of this measure.

I mean, I'm getting a lot of verbal things. And I think, as I said, hands down, clinically, conceptually, it makes sense. But that information is not here, what I have in front of me, even the evidence piece.

Co-chair Roberts: So let me ask the question. Are there other measures that capture the referral process?

Ms. Gomez: Hi, this is Lisa Marie, CMS. I'm going to ask Colleen Jeffrey to answer that question.

Ms. Jeffrey: Hi, Lisa Marie. This is Colleen Jeffrey. We were just looking up all of the other measures we have. So we do have a couple other measures which are specifically looking at the specialty communication with the physician who's doing the ongoing care. So it doesn't look at that full loop

where it goes from the referring physician back to the referring physician. So some of the measures that we have that look at this are diabetic retinopathy, communication with the physician managing ongoing diabetes care.

So this is looking at communication between the clinician that is look at that macular from this exam and communicating that with a physician who's continuing the care for diabetes. In addition, we have a measure like that for ongoing care for post-fracture for men and women. But again, the kind of unique thing about this particular measure is that it is looking at that full loop, that full circle of going from if a clinician refers someone to a specialist to ensuring that they receive a report from that specialist.

Member Hoy: This is Libby. Thank you so much for that additional information. As has been said, this is a critical area when it comes to patient safety. So thank you for the explanation.

Co-chair Roberts: I'm not seeing any hands. I think we should probably move forward for voting. I would like to propose that we do move forward with voting on the workgroup recommendation to support for retaining and go from there.

Ms. Harding: Okay. Voting is now open for 05826-E-MIPS, Closing the Referral Loop, Recipient or Specialist Report. Do you vote to support the workgroup recommendation as the committee recommendation? We're at 19. I'll give it a few more seconds.

Okay. I think we can close the vote. Now we're at 21. Okay. And the results are 18 votes for yes, 3 votes for no. And that gives us a percentage of 86 percent.

Ms. Williams-Bader: All right. Thank you all so much. So now we are going to move to the measures that were pulled earlier today. As a note,

we have about 20 minutes per measure, I believe, in order for us to stay within the agenda slot for this. So I wanted to raise that.

01246-C-MSSP: Controlling High Blood Pressure

Ms. Williams-Bader: And if we go to the first measure, this is 01246-C-MSSP, Controlling High Blood Pressure. I'm just going to summarize quickly the points that Amir made earlier when pulling this. So he had raised the concern about strict controlling across a whole population and said that that could work for those 18 to 60 years of age.

But I was concerned about a lack of stratification, particularly I think for older adults. The other issue is using the most recent blood pressure. He'd prefer to see a range or to see a measurement and also to see measurement at home and then also brought up the topic of risk adjustment and then also raised that there have been concerns about this measure for a while. And he's not seen changes to the measure. So Amir, did I miss anything?

Member Qaseem: No, that'll about summarize things, Jenna.

Ms. Williams-Bader: So I believe I'm turning it over to Chip, yeah.

Co-chair Kahn: Yeah, let me say I don't think -- we already did spend time discussing this. So hopefully we can take less than 20 minutes and not keep everyone as long. But Amir has made a number of important points about this. So I guess is there a discussion, questions from the -- or actually, I think CMS commented before. Does CMS have anything to say before we get into the committee?

Ms. Gomez: Yes, this is Lisa Marie Gomez with CMS.

So, I just want to highlight that this measure is a high-priority measure and it's also an intermediate outcome measure. And one of the goals in our

program is to include those test measures within our program.

And this measure also, it actually does not show low adoption, based upon ability to benchmark in MIPS. And we do show that, within MIPS, within the MIPS benchmark, there is a performance gap. So, it's not topped-out, which shows that there is room for improvement.

And this is part of the Core Quality Measures Collaborative and aligned across multiple CMS programs. And I just want to highlight that this measure, this particular version of the measure, is not NQF-endorsed, but the MIPS version of the measure, it has a slight, little modification, which is why we removed the NQF endorsement ID for this measure.

So, when a measure is updated, we may not get re-endorsement from -- the measure may not have re-endorsement, but the measure may be similar, but because it's not the exact same that was submitted for NQF endorsement, we remove the NQF ID. So, I just wanted to highlight that dynamic there.

That's all I have with regard to this measure.

Mr. Green: Lisa Marie, did you all cover No. 3 that's on the screen, the ambulatory at home blood pressures?

Ms. Gomez: No, we didn't address that particular dynamic. Do you want to?

Mr. Green: Yes. Thanks. This is Dan Green again. Sorry to interrupt.

But we do allow for at-home blood pressures to be included, assuming the clinician is using those pressures and documenting them in the record.

Co-chair Kahn: Yes. Because I'm just concerned with what Amir described and, actually, going back from personal experience. I could see, without the

third one, this actually drives bad practice.

Mr. Green: Yes. No, we felt the same way. Again, I wouldn't swear to it, but I think that may have been the modification that we made which Lisa Marie was referring to in terms of not 100 percent lining up with the original NQF-endorsed measure.

So, yes, I agree with you completely. I mean, insult to injury, you know, with the pandemic, folks were afraid to come into their doctor's office; doctors were afraid to see patients for non-emergent situations. I mean, you know, this plays right into allowing these blood pressures. I agree with you, it's an important concept for good care.

Co-chair Kahn: Well, no, I mean, I can give you three examples of my own personal experience where, if I hadn't said I wanted to do it at home, they would have given me blood pressure medicine --

Mr. Green: Yes.

Co-chair Kahn: -- just from the blood pressure in the doctor's office, because it is so frequently --

Mr. Green: "White coat syndrome."

Co-chair Kahn: Yes.

Mr. Green: Yes. That's a great point. Thank you.

Co-chair Kahn: Yes.

Well, other comments?

Or, Amir, where do you want to take this?

Member Qaseem: I mean, so the information that I was quickly looking at, and that I have in front of me, I'm not seeing this, but I do trust CMS has made this change somewhere. Nothing from the information that I'm finding. So, that's one.

The issue of the ages would still stay. I mean, as I

said, it still is there, the 18 to 60 versus the geriatric population. You just cannot have 120 blood pressure for many of the elderly. That is considered bad care. As a matter of fact, hypertension leads to bigger problems, as we are all very well aware of.

And so, on this, as I said, I'm happy to hear someone who disagrees with me on this. We are providing care out there. So, having the tight blood pressure controls for all the population, we're going to lead harm, and significant harms. Sixty-five and above is where this issue is the bigger issue, right? That's where hypertension and multiple medications, and all, and the falls start. So, including that population in this group, that's bad clinical care.

Co-chair Kahn: I'm sorry, CMS said this wasn't endorsed, but --

Ms. Gomez: So, the original measure was NQF-endorsed, but when we make the same modification to the measure, like a slight modification, and the exact language is not the same that we submitted for NQF endorsement, we remove that ID just to ensure that there is no confusion or discrepancy in terms of what is considered endorsed versus not endorsed.

So, in this case, we did make some changes to the measure. And as a result of those changes, we did not identify that this measure was NQF-endorsed.

Co-chair Kahn: Okay. Considering some of the things that Amir said -- I'll recognize the question in a second -- and considering the changes you made, do you anticipate seeking endorsement and putting it through the process?

Mr. Green: That's a great question. If I'm not mistaken -- and, Colleen, if you're unmuted, please chime in here -- but this is an NCQA measure.

Ms. Jeffrey: That's correct.

Mr. Green: Right. So, I don't know that it would be our place to take their measure --

Co-chair Kahn: Okay.

Mr. Green: -- for endorsement with the change again.

Our big change -- and again, please weigh in here, guys -- was allowing the ambulatory blood pressures, is that -- am I on target?

Co-chair Kahn: Got you. Got you.

Member Qaseem: So, just to chime in on that NCQA measure, that's a plan level. The issue isn't the individual physician level, right? I mean, if you're going to talk about plan level, I will withdraw many of my concerns. It's the individual physician level that's a problem.

Mr. Green: Right. Respectfully, many of our NCQA measures -- and we have well over a dozen, and I'm sure considerably more than that in the program -- are NCQA HEDIS measures that have been modified or adapted for the program.

Co-chair Kahn: Okay. I think I saw Leah.

Ms. Binder: Yes, I think that Amir's raising really important issues. It's just I think that we should ask that this go through the endorsement process, as part of the process of obtaining it. I mean, it's obviously an incredibly important measure. So, I would suggest that still the condition support for retaining still would make sense.

Ms. Schreiber: Amir, hey, it's Michelle.

Let me ask you a question. I'm seeing the control at 140/90. Where are you seeing it at 120/80?

Member Qaseem: Let me -- I'll pull it up again. Let me find that.

Ms. Schreiber: I have it from page 71 from the clinician meeting.

Member Qaseem: Yes.

Ms. Schreiber: But the description is 140/90.

Member Qaseem: Yes, and I can look it --

Ms. Schreiber: Which what you'll ask for in some populations to have a blood pressure that is higher than 120/80.

Member Qaseem: So, let me look at Michelle, if I could go through that again, but let me do that.

But, I mean, I would argue -- well, that's not going to do the specific case and the scenarios, but you know what I'm based on. I'm talking about 85-year-olds --

Ms. Schreiber: I understand your point; believe me, I do.

Member Qaseem: Yes.

Ms. Schreiber: But I wanted to make sure I wasn't missing something. You keep talking about 120/80. That's what this measure is specifying. It's 140/90.

Co-chair Kahn: Other questions or points?

Okay. The --

Member Barton: Oh, this is Mary Barton from NCQA.

Co-chair Kahn: Yes?

Member Barton: I just wanted to confirm that, in fact, this is a HEDIS measure that has been specified for the eCQM program, and the parent HEDIS measure does permit blood pressure readings. And to be honest, I am not -- I'm flummoxed by the differing deadlines for updating eCQMs that happen. And so, I don't know if that has already been put into the eCQM or if it's about to be

put into the eCQM. But I just wanted to confirm that that's the case.

Ms. Jeffrey: Hi. Sorry. Real quick, this is Colleen.

I just wanted to note that it has been put into the eCQM. So, the difference, in every single buy we remove the NQF number for the MIPS program. It was due to the number of encounters that are required for the different denominator eligibilities. So, the NQF-endorsed version does require multiple visits on different dates in order to be denominator-eligible; whereas, the MIPS measure is only looking for one encounter.

Member Qaseem: So, Chip, what I'm hearing, I mean, that's a big difference, right? Is it possible -- I think Leah brought this issue up; someone did. We need to ask for NQF endorsement, not whether we go in the route of conditional support for retaining or not retaining. It comes down to how strong of a match, which is a process issue that we have talked about in the past many times, right?

Co-chair Kahn: Yes. I guess I will ask the question then. CMS sort of brought it up. If this is an NCQA measure that you're using, but you're crosswalking it, it sounds like, from the plan level to the individual, I guess to get this endorsed -- and I don't remember how NCQA deals with endorsement -- you would have to go back to the manager of the measure to ask them to go through the process, if they even would? Is that the issue?

Ms. Schreiber: I'm trying to think through your logic.

Co-chair Kahn: I'm sorry?

Ms. Schreiber: Go ahead. Was someone else going to answer? I was just trying to walk through Chip's logic in my mind.

Member Barton: Yes, Michelle, this is Mary.

Co-chair Roberts: Go ahead, Mary.

Member Barton: I was just going to say, typically, when we bring a measure, we try to bring all of the implementation children of the measure. So, we would come with a recommendation for getting a plan-level measure endorsed, and we would also include the specification for the physician-level measurement. But I just don't know how our work lines up with NQF's work plan, and then, how that lines up with the requirements for updating measures through the eCQM program. So, it's just three different schedules that have to line up just right to get this, you know, to get this moving forward.

Co-chair Roberts: Well, we're not going to -- yes, thank you, Mary -- we're not going to resolve this today, Amir, I don't think.

Why don't we do the following? Let me suggest the following to see if it's a path forward.

And also, I think, if I'm right, Jenna, we have really two blood pressure measures here which are both the same measures, but one is a digital and the other is not? Is that correct?

Ms. Williams-Bader: Yes, that's right. Yes.

Co-chair Kahn: So, I would ask this recommendation: I would pair the two together for this recommendation. So, the recommendation would be that we do conditional support for retention, our condition being that we ask the various parties involved to consider conferring with NQF to see whether there's some path towards endorsement that would get this all cleared up, so that we'd be moving in the right direction.

Is that fair? And, Amir, does that respond to your concerns, at least partially? And would that get us a vote? I mean, the ability, a consensus here to vote on this?

Member Qaseem: Yes, that's reasonable. We can vote on that. Let's keep it moving.

Co-chair Kahn: Okay. Any other comments from the Committee on this or thoughts before I --

Ms. Williams-Bader: Michelle has her hand raised.

Ms. Dardis: Thank you. Just one question for clarification.

Is it that both measures we're considering are not currently endorsed? Because that would make a difference on the condition.

Co-chair Kahn: I think both measures are not currently endorsed. Is that correct? That was the working assumption of mine, but that is a factual question.

Ms. Williams-Bader: That's correct.

Co-chair Kahn: Okay. It is correct that neither measure is currently endorsed.

Ms. Dardis: Thanks.

Co-chair Kahn: Are there any other comments from the Committee?

Ms. Williams-Bader: I think we need to take separate votes. These are separate measures. They've been voted on.

Co-chair Kahn: Oh, okay. No problem, but let's just roll the votes though.

Ms. Williams-Bader: Yes.

Co-chair Kahn: So, we're not --

Ms. Williams-Bader: Sure. And then, my follow-up question is, does the Coordinating Committee feel comfortable with the conditions already stated here? And we just are adding CBE endorsement? Or are you removing the ones here and replacing with CBE

endorsement?

Co-chair Kahn: I would assume we leave all that in there, and then, add that. But is there any objection to that?

Member Qaseem: I mean, I think it's going to come in handy when NQF is going to -- it's good for memory sake than anything, right? It's such a huge discussion that's happening. Hopefully, someone will read it one day. I don't know what happens to this.

Co-chair Kahn: Okay. So, Jenna, let's go ahead with the vote on each one separately, but let's roll the vote. We'll do one, and then, the next vote.

Ms. Williams-Bader: I think someone has been trying to say something. Go ahead.

Co-chair Kahn: I'm sorry, who was that?

Ms. Gomez: This is Lisa Marie Gomez with CMS. I just want to highlight the context for why the measures are separated out.

So, as I noted during the other Shared Savings Program measure, I indicated the web interface. So, this measure here is a web interface measure. The web interface under the Shared Savings Program is set to sunset starting with the 2025 performance period. So, this measure will be available for 2023 and 2024. So, after that, this measure will sunset and no longer be available as an option under the web interface.

And then, the other version of the measure, the eCQM version, that is a measure that's part of the Shared Savings Program that is available even now for stakeholders or, actually, ACOs to report on.

I just want to highlight why they're separate measures and provide context relative to their availability in the program. So, the eCQM version will continue to be a measure, even after 2025. But I just want to highlight that differentiation there.

Co-chair Kahn: Well, I guess I would propose that we continue to go ahead as we are. Because it's only 2022, and then, we just have everything being consistent in terms of them going forward, since the measures really measure the same thing, even if they play out in different venues.

Is that fair? I mean, if anybody has a problem, please let us know.

Ms. Williams-Bader: Julie does have her hand raised.

Co-chair Kahn: Okay. Julie?

Member Sonier: It's a question about the conditional support for retaining. I thought that we clarified that ambulatory or at-home blood pressure readings are allowed to be included in the measure? So, if that's the case, then we would remove that from our condition?

Ms. Williams-Bader: So, it looks like --

Co-chair Kahn: Well --

Ms. Williams-Bader: Can I clarify? What it looks like in the chat is that it's remote home monitoring devices. So, I don't know if there are broader or other types of ambulatory -- or sorry -- at-home blood pressure readings that people would want included.

Sorry, Chip, is that what you were going to say?

Member Sonier: I sort of read that to include anything that's acceptable to the clinician is allowed to be used.

Mr. Green: That's the intent.

Ms. Jeffrey: Just to clarify, yes, so blood pressure readings taken by a remote monitoring device and are conveyed by the patient to the clinician are acceptable. What is not acceptable within this

measure are readings that are taken with a manual blood pressure cup and a stethoscope. So, that specific incident is called out as being an exclusatory BP, any electronic device, and then, a patient conveys it to the clinician is acceptable.

Co-chair Kahn: Okay. I don't think we should get into -- I mean, do we need to get into the detail of that? Or do we just go with that as our understanding, Jenna?

Ms. Williams-Bader: I think we just need to know whether you all want to keep Condition No. 3 here, not whether or not you think -- if they're already in there, then in some ways -- I guess I'll just leave it at that.

Ms. Jeffrey: Okay.

Ms. Williams-Bader: We can submit whether --

Co-chair Kahn: Let's just move forward with the vote. I think we have enough information out there that everybody gets it. These are the components of it, and let's get it. Hopefully, we can work out between the parties getting it endorsed, because, presumably, this clearly is important and probably could lead to endorsement.

Ms. Williams-Bader: So, just to be clear, we're taking No. 3 out and adding CBE endorsement of the third --

Co-chair Kahn: When you say taking out No. 3, you mean allowing --

Ms. Williams-Bader: The Workgroup rationale that will go, or the rationale that will go into the final recommendation spreadsheet we share with CMS right now will have these three conditions listed on the screen, plus the CBE endorsement, unless you all would like to remove No. 3, which I think we've already covered.

Co-chair Kahn: No, I think we do the plus.

Ms. Williams-Bader: Okay.

Co-chair Kahn: I think we do the plus that we just covered.

Okay. Let's have a vote then, whenever you're ready, Jenna.

Ms. Harding: Okay. The vote is now open for 01246-C-MSSP: Controlling High Blood Pressure.

Do you vote to support the Workgroup recommendation as the Coordinating Committee recommendation?

Co-chair Kahn: Well, I think it's as amended by the Coordinating Committee.

Ms. Harding: It looks like the poll is still open, Katie. Do you want to try again? Did you get it in? I see we're at 20, 21.

Member Boston-Leary: Yes, I got it in. I'm sorry.

Ms. Harding: Okay.

Member Boston-Leary: I had an issue initially. I didn't know what was going on. Sorry about that.

Ms. Harding: No problem.

Okay, I think we can close the vote now.

Voting is closed and the results are 20 votes for yes and 1 vote for no.

That gives us a percentage of 95 percent.

CMS eCQM ID: CMS165v10: Controlling High Blood Pressure

Co-chair Kahn: Okay. And now, we go to the next vote on the other version of this.

Ms. Williams-Bader: Yes, I just think we want to make sure that, yes, the conditions are all the

same, the same Workgroup recommendation. So, we can go ahead and move to the vote.

Ms. Harding: Voting is now open for the eCQM version of CMS165v10: Controlling High Blood Pressure.

Do you vote to support the Workgroup recommendation as the Coordinating Committee recommendation?

Ms. Goodman: Can you just repeat what the Workgroup recommendation specifically is?

Ms. Williams-Bader: So, it's conditional support for retaining with the three conditions -- hold on, I just want to say this correctly. Okay. Sorry. So, it is that the Workgroup supports -- okay.

Having multiple encounters is important. So, that's Condition No. 1.

Two is change the last reading requirement to an average or a therapeutic window.

And three, allow ambulatory or at-home blood pressure readings to be included in the measure.

And the Coordinating Committee has added a fourth, which is CBE endorsement.

Ms. Goodman: Great. Thank you very much.

Ms. Williams-Bader: Sure.

Ms. Harding: Okay. It looks like we have received two additional votes. We'll give it a few more seconds.

(Pause.)

Okay, I think we can close the vote.

Voting is now closed and the results are 18 votes for yes and 1 vote for no.

And that gives us a percentage of 95 percent.

Co-chair Kahn: Great. So, we've got an action. I think we have one more measure?

Ms. Williams-Bader: Actually, Chip, before we move to that, quickly, as Heidi pointed out earlier, there is a registry-based version of this measure as well in the Shared Savings Program. We did not have a vote for it separately, but if the Workgroup supports -- or sorry -- if the Committee supports this, we can say that the comments for the eCQM apply to the registry-based measure, if all are comfortable, if folks are comfortable with that.

Co-chair Kahn: So, is there any objection to that? Do I hear any objection?

Okay, let's move forward with that.

Ms. Gomez: Hi. This is Lisa Marie Gomez with CMS.

I just want to clarify that it's correct that the measure is available in multiple means, but, in terms of what the Committee identified, it was just those two measures as being removed. So, it's fine that you all highlight that, but the MIPS version of the measure was not identified, but it's the same measure as discussed previously.

Co-chair Kahn: Well, these are just recommendations, anyway. So --

Ms. Schreiber: We'll take the recommendations for the eCQM also, Chip.

Co-chair Kahn: Okay.

Okay. So now, we go to the final one, and, Jenna, do you want to describe it?

Consumer Assessment of Healthcare Providers and Systems, or CAHPS, for MIPS survey

Ms. Williams-Bader: Yes. So, this is a Consumer

Assessment of Healthcare Providers and Systems, or CAHPS, for MIPS survey.

Amir requested to pull this earlier. The reasons why being that we need to do an assess for patients, and that certain types of questions have led to unnecessary treatment; for example, opioids. And he recognizes that there is not a good alternative right now, but doesn't think that this particular measure is a good gauge of quality, and that it's important to hold organizations responsible for this type of quality action, not physicians.

So, Amir, did I miss anything.

Member Qaseem: No. I think you covered it all. I mean, I think the issue we're dealing with, we still don't have an alternate, right? It's a chronic struggle. Within NQF, we have talked about it and CMS. I really hope we can come up something since this is such an important topic area.

Co-chair Kahn: Okay. Jenna, do we want to go to CMS before we --

Ms. Williams-Bader: Sure, we can go to CMS.

Co-chair Kahn: Does CMS have any comments about --

Ms. Binder: Thank you, Chip. This is Leah, and I would like to comment.

First of all, there are no pain questions in the MIPS CAHPS survey. I recognize that had been a concern of Amir's because of the question of opioid overuse. There is no such pain question in this particular survey. There was at one point in time in the Hospital HCAHPS Survey, but those questions were actually removed.

We think that the questions that are asked of patients around their patient experience with their providers is actually extremely important, and hearing the viewpoint of experience from the

patient's point of view is extremely important. And actually, we think in the MMSP program it is mandatory; in MIPS it is currently voluntary, but we're very supportive of really keeping this, because we have a fundamental commitment to hearing the voice of the patient around experience.

Co-chair Kahn: Okay. That's the same as -- Amir, any further comments? And then, I'll open it up to the Committee.

Member Qaseem: No, nothing, Chip. I think we can just roll.

Co-chair Kahn: Okay. Anybody else have any other comments before we --

Ms. Williams-Bader: Clarke has his hand raised.

Member Ross: Hi. During lunch, I heard from an academic medical center researcher who made the points that Michelle made; that pain question was something some years back in a different survey, but was taken out, and it's not a relevant item.

And I wanted to reinforce Michelle's point about the overall importance of the consumer/patient/recipient experience being built into the process. So, I reinforce what CMS said.

Co-chair Kahn: Okay. Any other comments before we go to a vote?

Member Qaseem: The only thing, I mean I hear you, Clarke, too, and Michelle. I mean, they should look at the appointment wait time and the staff at the front desk. You can't believe a physician's job. In my healthcare system, I'm responsible for everything. If you believe so, so be it.

Member Ross: Well, I've worked for three national family organizations over 25 years -- United Cerebral Palsy; CHADD, Children and Adults with ADHD, and NAMI, National Alliance on Mental Illness. And thousands of family members have had

experiences with practices who are headed by physicians that are not ideal, and that's what CAHPS is trying to get at.

And I'm not going to entertain the physician versus the receptionist. But families all over this country are concerned with the responsiveness and respect to each and every individual patient, and the CAHPS is a national methodology, trademark, AHRQ, all that sort of thing, that tries to get a piece of that.

And so, rejecting this in a way would send a signal of rejecting the CAHPS approach itself, and then, based on a flawed assumption about the pain question.

So, that's my response. Thank you.

Co-chair Kahn: Yes. Anybody else have any comments?

I'll sort of endorse that, and go beyond that and say that I think, Amir, actually, I do think it is the physician's responsibility, because when you talk to that person who answers the phone, the receptivity, the ability to fetal trust that that person is going to get your message at the right level to the doctor, is really the doctor's responsibility. Because if the patient feels like they can't get through, then that can affect the health care that the doctor is providing. So, I think the doctor is just as responsible for making sure that that entry into the office or the clinic is as important as literally walking in through the threshold of the doctor's office. I mean, that's just my own view, but I find it hard to separate that.

Ms. Williams-Bader: So, Parul has had her hand raised, and then, Emma.

Co-chair Kahn: Okay.

Member Mistry: Hey, Sorry, I'm having problems with video.

But I have a question for CMS. First of all, I agree this is a very, very important measure to capture the voice of the consumer. However, the question I have is, as I'm looking through all the numbers, are you folks seeing a decrease in response rate across the board; i.e., are we getting enough on the number of Participants that are completing the survey, so we have a pretty good gauge of where are the opportunities for improvement?

Ms. Schreiber: Well, again, Parul, in the HGL programs and MMSP, this is mandatory. So, we do get a lot of reporting; on the MIPS side, perhaps less so. And I will say both CAHPS and HCAHPS fell off during the pandemic, but I think that we have enough reporting.

Member Mistry: Okay.

Ms. Schreiber: The other thing I want to comment on is, Amir, to your question. There are actually very few questions about, you know, the receptionist and the staff in the office. There are largely questions -- I have the survey in front of me -- there are largely questions directly about the provider.

Co-chair Kahn: Okay. Any other points?

Ms. Williams-Bader: Yes, Emma has her hand raised.

Co-chair Kahn: Emma?

Member Hoo: Yes, I would just echo that things like communications and the composite measures that come off CAHPS really cut across the entire office. And it should be a common responsibility around having the responsiveness, accessibility, and so forth, with the patient.

Co-chair Kahn: Okay. Other comments?

Okay. Hearing none, Jenna, I think we can --

Ms. Williams-Bader: Yes, sorry, Chip, Rebecca has her hand raised.

Co-chair Kahn: Okay. Rebecca?

Member Kirch: The last comment here, but this is the type of place where, from the patient/caregiver perspective, we'd love to see eventually what was endorsed as a palliative care measure around patients reporting on being heard and understood, and the opportunity of CAHPS as well. So, future directions, big opportunity.

Co-chair Kahn: Okay. Jenna, if there are no other comments -- going once, going twice -- then, we have a support for retaining as the recommendation. So, I think we can vote on that.

Ms. Williams-Bader: Okay. We'll pull that up.

Ms. Harding: Voting is now open for Consumer Assessment of Healthcare Providers in Systems for MIPS Survey.

Do you vote to support the Workgroup recommendation as the Coordinating Committee recommendation?

We're at 19. We'll give it a few more seconds.

(Pause.)

Okay, I think we can close the vote.

The vote is closed and the results are 18 votes for yes, 1 vote for no.

And that gives us a percentage of 95 percent.

Co-chair Kahn: Okay. So, that's affirmed.

And then, Jenna, if I read my agenda right, do I hand it back off to you, and then, you give it back to me? I mean, we're finished? Have we finished all of the measures?

Ms. Williams-Bader: Yes. So, we have finished all the measures that were pulled from the consent calendar today. And thank you all for keeping these discussions concise, so we could get, actually, a little bit ahead of schedule today.

So, we are now going to do a -- this is the final opportunity for public comment on the day.

And, Chip, I will turn it over to you.

Opportunity for Public Comment

Co-chair Kahn: Okay. Well, I'm going to remind the public to limit their comments to no more than two minutes, and we'll take the comments of those who raised their hands on the web platform first, and then, go to the phone lines. And we'll proceed then, and Jenna will announce the order.

And then, when we conclude these comments, which I'll chair, then I'll hand off to Misty.

So, let's see if there's anybody that has any comments, Jenna.

Ms. Williams-Bader: Okay. At this time, I am seeing no hands raised and I am seeing nothing in the chat.

And I just would like to see if there's anyone on the phone line who would like to speak. Give it a few seconds.

(Pause.)

I'm still not seeing anything. So, I think we can -- last chance.

Co-chair Kahn: Okay. Assuming that we're moving on, then I guess it's I hand it off to Misty to discuss gaps.

Ms. Williams-Bader: I think, actually, we've taken that out of the agenda.

Co-chair Kahn: Oh, okay. Okay.

Ms. Williams-Bader: So, we were going to move to the feedback on the measure set review process next.

Co-chair Kahn: Okay.

Coordinating Committee Feedback on MSR Process

Ms. Williams-Bader: And just take a deep breath, everyone. That was a lot that we got through yesterday and today. And again, we know that there were a lot of changes to the process, some planned ahead of time and some a little bit more last minute that we've had to adjust to over the past two days. So, really appreciate you sticking with us and staying engaged throughout these discussions.

We definitely want to hear your feedback on the process. And so, we'll have that opportunity here. We did shorten it, the amount of time for this discussion, based on the needing to get through some of the measures today. So, we can spend a couple of extra minutes if people are still making comments.

But if we go to the next slide, we do have a couple of poll questions first. And then, we have some discussion questions to work through.

So, if we could move over to the poll questions first, just so we can get a sense for where the Committee is?

So, our first question is, "The Coordinating Committee review of the measures under review worked well?" So, thinking about the materials that we provided you ahead of the meeting; the discussion we had yesterday and today, how did that go?

We have a separate question about the consent calendar, I believe. So, you can hold off on that. Just thinking about, as I said, the information NQF

provided and the discussion, how did that go?

Looks like we're still getting votes in.

Okay. I think we can -- oh, yes, I think we can go ahead and close.

Okay. So, about two-thirds thought it went well, but a little more than a third of you think that it didn't. So, definitely want to dive into that.

And then, if we can go to the next question, which is, "The use of the consent calendar for the Coordinating Committee meeting worked well?"

We'll wait for those last couple of votes to come in.

I think we can go ahead and close it.

All right. So, definitely sort of a split opinion here. So, we'll get your verbal feedback on this as well.

Okay. If we could switch back to the slide, then?

So, starting with the first poll question, and thinking about and asking for your feedback for this, what worked well during the discussion and review and what would help the process be even better?

And I see, Chip, you've got your hand raised. So, I'll go to you.

Co-chair Kahn: Yes. I think the Committee did a great job under the circumstances, and I appreciate deeply both what the staff did and what CMS did.

But I think, for us to do our work, we are a coordinating committee and we have a lot of expertise and very smart people on this Committee. But we really pulled together what Workgroups do, and I don't know how we can effect this, but we have to have, I think, for our process to work, the committees, I mean the Workgroups that have the context, the complete context. Because it was something Leah brought up, rightfully, a number of

times -- they have to have quorum, and they have to give us, I think, firm recommendations.

That doesn't say that we can't bring up issues and maybe a change a decision, but, basically, at the end of day, we're probably going to affirm most of what they offer us.

And second, on the consent calendar, I think if people want to pull things out of the consent calendar, obviously, the Committee can do that, but I think we have to have some time limitation on that prior to the meeting, or at least prior to the consideration of the consent calendar.

Because, remember, 80 to 100 percent, considering my experience with Workgroups and this Committee, I mean, is an incredible consensus. And so, to make the consent calendar, you've really got a really high bar. And so, I think for us to overcome that bar, and say we need to spend time talking about it, it's got to be something that pops out. And I think it's difficult to have us, then, have to adjudicate that on the same, you know, I mean, sort of popping up. I think we need to know in advance when somebody on the Committee thinks that we could potentially overrule a Workgroup that was at 80 or 90, 80 to 100 percent.

Those are my two points. Oh, well, one more.

And I think that, at the end of the day, in terms of our criteria, either we believe in a multi-stakeholder expertise of NQF or we don't. And, yes, there are a lot of measures that may go forward from the MUC or from here that are endorsed. But I think endorsement has to be one of our highest, I mean, maybe even our highest criteria; that, yes, we can find exceptions to, but we have to really have a strong rationale to have an exception to it.

Those are the three points I'd like to make.

Ms. Williams-Bader: Thank you very much, Chip.

Julie, I see your hand is raised.

Member Sonier: Yes. I completely agree with everything that Chip just said, and I wanted to add a couple of additional comments.

So, one is that, in the advance materials -- so, the advance materials were great and somebody made a comment about the summary forms being very helpful. And I totally agree, those were extremely useful.

One thing, a suggestion, to make it even easier from a Committee perspective in the future, if there was like one, like, one-page summary in the beginning that said, you know, "These are the measures. This is the Workgroup recommendation, and even like, "Here's what the Rural Group said and here's what the Equity Group said," just so that -- because I found myself digging for a lot of that. And even on the consent calendar, we looked at all the measures, and it was like, well, what exactly is the recommendation, right? Because sometimes it lists to retain and sometimes it lists to remove. So, just to have a little bit more like visual cues in like a one-page summary would be extremely helpful.

I did notice in the digging that I did that it seems very, very frequent that the Workgroup recommendation was different from the Rural Workgroup's recommendation. The Equity Workgroup, it seemed, didn't take a vote on everything. And I was curious about why that was the case. So, the votes that I did see from there were very mixed, but there were lots of measures that they didn't vote on. And so, I was left scratching my head a little bit about kind of what their input was.

But, overall, I think I voted "yes" on the two, like, poll questions that you just had. But I also wanted more nuanced as their categories, right? It was like, "Yes, but," right, because like, yes, it worked overall pretty well, but there definitely are areas, including

the sort of people recognizing the commitment that they're making when they want to be on these Workgroups, that they have to show up for meetings and they have to prepare in advance, is very important.

Ms. Williams-Bader: Yes, thank you for those comments.

And to address what happened with the Health Equity Advisory Group, so we've been trying to right-size the questions we ask the advisory groups about measures we used. I think even with the MUC process, we've noticed that the question we ask, which is, I think, is a 1-to-5 Likert scale, that a lot of the votes end up being around 3, 3.5, which wasn't really differentiating between measures,

And so, this time we tried something else, asking them a yes/no question which aligned more with the Workgroup. What we asked the Workgroups, which was, did they support retaining the measure in the program, yes or no? Which worked okay with the Rural Health Advisory Group, but the Health Equity Advisory Group found it challenging because there were some measures that did have a health -- they were thinking more about, does the measure have a health equity impact?

And some might have an impact, but would not, are still not good for the program, and others might have an impact, but are good for the program and should stay in. So, they found it challenging, and we ended up pulling the poll question a few measures in for that meeting.

So, I think there's still more for us to think about there as far as what's the best way to collect feedback from the advisory groups; does polling work; what would be the right poll questions? But that is what happened there.

And I appreciate all of the other comments.

Leah, I see your hand is raised. And then, Michelle.

Ms. Binder: Thanks. Yes, I wanted to thank everyone and thank Chip, in particular, because I know I was difficult. So, I appreciate that you were responsive.

I think yesterday's meeting was a lot -- today's meeting was a lot better; put it that way. And I appreciated hearing from CMS at the opening comments for each of these measures. I think that did help put it in much more context. At least, I think they spoke yesterday, but somehow I didn't get the same sense from them of understanding why these measures exist and what they're about, and et cetera. So, that was helpful.

I think I'll go back to my earlier issue just to put it on the table. I still think, when we're talking about removing measures, that is a different kind of recommendation than adding them, which is what we used to do with the MUC process. But when we try to remove a measure, we do need to look at how it's being used; if it's being used effectively. If not, then it should be removed. But if it is being used effectively, we need to consider that as part of the other considerations that we bring to the table around whether a measure should be removed. It's a very important piece of it, and I think that's probably something that should be added to the criteria in some way.

Thank you.

Ms. Williams-Bader: Thank you, Leah.

Could you expand on that a little bit with what you mean by "added to the criteria"? Because we do have questions about use. Let me just pull it up for myself, so I can reference.

Is there anything, in particular? Or if you want to think about it, and send us an email later, that's also fine.

Ms. Binder: Yes, let me see what wording of what I would want to say, but I do think there's an element that -- it's not only that that criteria is considered, but that we have information to apply to consideration of that criteria. So, that it's sort of formally added to our previewing -- which, by the way, I also thought the materials were excellent.

Ms. Williams-Bader: All right. Thank you for those comments, Leah. Appreciate that.

Michelle?

Ms. Dardis: Thanks, Jenna.

I would second that the materials were extremely helpful. Or I'm probably "fifthing" or "sixthing" that at this point.

I am a measure developer by background. So, my comments are going to be a little technical.

I think where I could see opportunities for improvement would be around the sharing of performance data and sharing of testing data.

I wanted to ask whether the Workgroups had performance data when they reviewed the measures for the current use in programs. Because I noted that the materials we reviewed, it was present for some measures, but not all.

Ms. Williams-Bader: So, this is we gave them what's available publicly. And we've worked with CMS to pull that. So, there's -- sorry, I just muted myself in the middle there -- there is not always data available, for a number of different reasons. So, we provided them what's available.

And I think the other challenge to keep in mind is that we did not have a source of information for these measures the way that we do for the MUC list. For the MUC list, a measure developer filled out a very long application or submission, which I'm sure you're familiar with, and that's where we go to as

the source of truth for information about the measure. We might supplement it with information from NQF, from our own systems, for example, about whether the measure is endorsed or what those reviews have been like. But a lot of that information is coming from the submission.

Here, we have nothing like that, and we don't have a clear set of measures at the beginning of the process that we're even focused on. We have to whittle it down within the programs we're looking at, and then, try to pull information together for those measures.

So, we had to use a process where we search for some information in our systems ourselves. We worked with CMS program leads to really try to pull together other information.

So, no, we did not have testing information available. And again, the performance data we pulled and worked with CMS to present what was available. But, for some measures, there just isn't information available for different reasons.

Ms. Dardis: Thanks, Jenna.

Then, what I would say about that is somewhat conceptual, and also concrete, I guess. I think we had a lot of conversations today that focused on the importance of a measure. If we were talking about the consensus development process criteria, we talked a lot about the evidence. We talked a lot about patient perception and patient experience.

But we didn't get into many conversations around performance data or reliability and validity. And I think those are two different factors that, for many of these measures, we just said, is it endorsed or not? Measures can lose endorsement for multiple reasons. Only one of them is testing. The other could have been importance or feasibility.

So, I do think that, where possible, if we would

have been able to refer to past endorsement summaries -- I know, for my own preparation for the measure I was the lead discussant for, I went back to look at the 2018 Standing Committee's recommendations and the submission by the measure developer, so that I could look at some performance data, as well as testing data.

I, personally, find that really helpful because I think in some cases the measure developer, there's a lot of reasons we don't pursue endorsement. You know, it could be off-cycle measure changes. It could be needing to have a bigger sample size before we can take a measure for endorsement, and that might mean piloting a measure in a quality improvement program before moving it to accountability. As a measure has been in use, it may be a financial decision not to continue to pursue endorsement.

So, while I agree with the comments that have been made that endorsement is so important, I do think that, if there is a way we can refer to past endorsement submission data, it might help address some of the concerns we faced where we were assessing measures that were no longer endorsed.

Ms. Williams-Bader: Thank you for that, Michelle.

At the moment, I don't see any other hands raised. So, I might ask you a follow-up question.

And I see Dan's raised his hand.

Dan, go ahead.

Member Culica: So, thank you. It might not be in the context, but I think that a lot of the bumps that we faced yesterday were because of the lack of a quorum coming from the Workgroups.

And I think that when you are on a group, there is issues of responsibility and accountability. So, I don't know if we can reinforce them in any manner. I think that's what impeded our process yesterday a

lot, if we didn't have patience.

Ms. Williams-Bader: Thank you for that.

Carol?

Member Peden: Oh, yes, and I'd echo the comments. I found the rating (audio interference) very, very helpful.

One thing about the quorum as well is, particularly with the Hospital Workgroups, we have very, very few surgical measures. And I just wonder if they're not getting to quorum, do they have -- you know, on the measure, for example, when colonoscopy was suggested as comparable for a return after ambulatory re-surgery, I just wonder if there were members of the group who were surgeons or anesthesiologists, you know, some balance. And I don't know whether we consider that. I mean, it may be too difficult, but I just wondered. It's something to think about.

My other comment was the public comment, because BCBSA, we commented on a couple of them where I think we were the only people. And I'm just wondering, you know, if that's unusual and what you expect to get out of that, or how we encourage it, if it's seen as important.

Ms. Williams-Bader: Yes. So, we had several opportunities for public comment during this process. There is the initial public comment on the measures that were identified, sort of rose to the top after we surveyed Advisory Group and Workgroup members on which measures they would like to discuss in this year's measure set review. There are public comment opportunities at every meeting, and then, we had the public comment on the draft recommendations spreadsheet.

So, across all of those public comments, we've seen a relatively low number of comments, I think. Again, this is a brand-new process that everyone is

getting used to at a time of year where people are not expecting the MAP to be particularly active.

So, I think in the future, as we're able to establish the timeline more, that, potentially, more people will be expecting the review to happen and could be commenting.

But we have had a relatively low number across as well. So, we've tried to provide as many opportunities as we could for there to be comments. I don't know if others at NQF have anything to add.

Okay. Well, thank you all so much, and I've seen there's a lot of comments in the chat as well, and I appreciate that.

I did have one follow-up for both Michelle, but anyone else as well. Again, one of the challenges we have for these measures -- because they are in use in programs and, potentially, in use in other places, and then, there is the crossover with the endorsement -- is, if a measure is similar to, but not exactly the same as a measure that's endorsed or that's been endorsed in the past, do you think it is helpful to have information about that measure that's been endorsed, or could it be potentially confusing to have that, if CMS does not consider them to be the same measure? I think that was the place we struggled as far as, like, how much information to provide.

Ms. Dardis: That's a really good question. And I think when it comes to the evidence for the measure, if the measures are parallel in intent and measure description, I think the evidence discussion definitely is important. The performance gap discussion is probably the same.

I think where this group was adamant during the MUC process was that the data source does change the measure reliability and validity and feasibility. So, for those components, I wouldn't personally consider the two forms comparable, but on the

evidence front I would, personally,

Ms. Williams-Bader: Thank you for that, Michelle. It's something for us to consider in the future.

Okay. Any last comments?

Really appreciate you all staying here, staying to provide this feedback.

Emma, go ahead.

Member Hoo: I would also just add, too, that it's helpful to really understand the context of voluntary measurement reporting and the potential versus the actual. In the discussion of the cataracts, for example, there were comments about the narrow range of performance, but, in fact, because it was really a subset of organizations that voluntarily report, the variation in reality is probably much larger. And so, having that broader understanding is helpful.

Next Steps

Ms. Williams-Bader: Thank you.

Okay. Well, it seems as though we are drawing to a close here. Unless anyone on my team has any follow-up questions to ask, I will go ahead and I think we've got maybe one or two slides on next steps. And then, I want to give Misty and Chip a chance to provide any closing comments.

So, our next steps will be taking -- if we can go to the next slide -- will be taking these final recommendations and creating our final recommendation spreadsheet and report, and sharing those with CMS, which will be published later in September. And that's really it for this MSR cycle.

Let me turn it over to Chip and Misty for their final comments.

Co-chair Kahn: Well, thanks. I think I've said everything, at least in terms of the work, other than to say this Committee I think did a terrific job.

It's always a difficult task for us, whether it's this or the MUC, because we don't meet that frequently. And unfortunately, for the last many years, we haven't been meeting in person. And I think it's so much easier when you're all in the same room.

So, I just want to express my appreciation on it, and obviously, appreciation to the staff that I think, you know, put up with us over the last many hours and really helped navigate a meeting that I think, obviously, had its rocky beginning, but we always seem to have that, sort of finding our way. And then, we proceed really well through the process.

So, I'd like to thank the staff and thank CMS for their work, and particularly, my Co-Chair, Misty, for her leadership.

And with that, I'll pass the baton to Misty.

Co-chair Roberts: Thanks, Chip. Appreciate your partnership as well.

Yes, I would just say thanks to everyone for kind of hanging in there. I know these are long days, again, with some deep discussions and, certainly, a lot of information to digest, not only pre-meeting, but, then, also during the meeting. So, we definitely appreciate it.

We appreciate the hard work that NQF puts into this. Appreciate the CMS, our Workgroup Co-Chairs, everybody's participation.

I do think there are, certainly, still some opportunities. We are learning. It seems like every meeting we're kind of implementing something just a little bit new. So, I do think there are certainly some opportunities, and we appreciate this

feedback at the end.

I think this is really important to help us improve the process. So, I think there is definitely a way that we can kind of summarize some of the information that ends up -- I feel like it often gets asked, if it's not provided. So, if we can kind of think through what are those key things that are important for us to make a decision, but also still leverage a lot on, you know, the decision that's made by the Workgroup, because they put a lot of effort into it prior to everything coming to us.

So, again, I appreciate everyone's time and look forward to our next one.

Co-chair Kahn: Great.

Jenna, take it away.

Ms. Williams-Bader: Yes, sure.

Oh, I see a hand raised.

Kim?

Ms. Rawlings: Hi. Good afternoon, everyone.

Like Michelle put in chat, unfortunately, she had to run to another engagement and couldn't hear the feedback and kind of close out the meeting with you all.

But just wanted to, again, thank you all for not only your feedback on the individual measures, but, really, your engagement and your commitment to the process and to providing us important feedback.

Again, the votes and the consensus and the quorum, all of that is, of course, very, very important, but it's really your lively discussions that give us the information that we need to really incorporate your feedback into our decisionmaking processes. So, thank you for that.

And again, like everyone said, thank you so much for your patience and your flexibility. I know some of you are new; some of you have been around for a while. It took us a really long time to kind of iron out the kinks of pre-rulemaking. I think it finally settled after like four or five years.

And so, you know, just like that process, this process is going to take a few years. But, thanks to your honesty and direct feedback, that will, hopefully, get us there quicker.

So, thank you so much and have a good rest of your afternoon.

Ms. Williams-Bader: Thank you all very much. I really appreciate the conversations we've had and the feedback.

We hope you enjoy the rest of your afternoon. Look at that: we were behind and we're ending early now. So, thank you all so much for that.

And, yes, thank you to Chip and Misty for guiding us through as well.

(Whereupon, the above-entitled matter went off the record at 2:38 p.m.)