National Quality Forum
Measure Applications Partnership (MAP)
Coordinating Committee
Measure Set Review
Wednesday, September 8, 2021

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

Committee Members Present:

Charles (Chip) Kahn III, MPH, Co-Chair
Misty Roberts, MSN, Co-Chair
Arif Kamal, American Academy of Hospice and Palliative Medicine
Clarke Ross, American Association on Health and Disability
Sam Tierney, American College of Physicians
David Gifford, American Health Care Association
Heidi Bossley, American Medical Association
Katie Boston-Leary, American Nurses Association
Elizabeth (Liz) Goodman, America's Health Insurance Plans
Andrea Gelzer, AmeriHealth Caritas
Carol Peden, Blue Cross Blue Shield Association
Margareta Brandt, Covered California
Kacie Kleja, HCA Healthcare
David Baker, The Joint Commission
Leah Binder, The Leapfrog Group
Mary Barton, National Committee for Quality Assurance
Rebecca Kirch, National Patient Advocate Foundation
Liz Cinqueonce, Network for Regional Healthcare Improvement
Libby Hoy, Patient & Family Centered Care Partners
Emma Hoo, Purchaser Business Group on Health
Dan Culica, MD, PhD, Individual Subject Matter Expert
Janice Tufte, Individual Subject Matter Expert
Ronald Walters, MD, MBA, MHA, Individual Subject Matter Expert

NQF Staff:

Dana Gelb Safran, President and CEO
Katie Berryman, MPAP, PMP, Senior Project Manager
Tricia Elliot, Senior Managing Director, Quality Measurement
Victoria Freire, MPH, CHES, Analyst
Ivory Harding, MS, Manager
Joelencia Leflore, Coordinator
Becky Payne, MPH, Senior Analyst
Udara Perera, DrPH, MPH, Senior Manager
Ashlan Ruth, BS IE, Project Manager
Susanne Young, MPH, Manager
Gus Zimmerman, MPP, Coordinator

Also Present:

Anita Bhatia, Program Lead, Hospital Outpatient and ASC Quality Reporting
Lauren Lowenstein, Program Lead, Inpatient Psychiatric Facility Quality Reporting Program, CMS
Michelle Schreiber, Deputy Director for Quality and Value, CMS
Susan Yendro, The Joint Commission

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Proceedings

(10:02 a.m.)

Welcome and Introduction

Ms. Elliot: Good morning, everyone. This is Tricia Elliot from NQF, and we're going to kick off and start the MAP measure set review meeting.

So, welcome, everyone. Before we get into the meat of the meeting here, we're going to go through a few housekeeping reminders. Please mute your computer or your headset when not speaking. The system will allow you to mute and unmute yourself and turn your video on and off throughout the event.

We encourage you to keep the video on throughout the event, and please ensure your first and last name is listed correctly in your video when you logged in. We will do a full roll call once the meeting begins in just a minute here, and feel free to use the chat feature to communicate with the NQF staff if you're having any issues. We will be using the raising hand feature during the open discussion of the meeting.

So, once again, welcome to our Day 1 of the Measure Application Partnership measure set review meeting. I'll take just a minute here to review the agenda. We're going to do some welcome, introductions, and disclosures of interest. CMS will provide some opening remarks. We will then review the measure set review process and measure review criteria. And then we'll be starting into some of the categories of measures. We'll be starting with the inpatient psychiatric facility quality reporting measures, and one grouping of those measures.

We will have a break for lunch, we will then do more of the inpatient psych facility measures, focusing on tobacco and alcohol. This afternoon we'll continue with ambulatory surgical center quality reporting

measures. We will have an opportunity for public comment, and then a Coordinating Committee discussion at the end of the day.

Okay, with that, I would like to hand things over to Dana Gelb Safran, our CEO here at NQF, for some opening remarks.

Dr. Safran: Thank you very much Tricia. And with apologies in advance, my dog appears to be very excited about something going on outside, so I hope I don't have any competition for your ears. But it's truly my pleasure to welcome all of you today to this very first meeting of its kind, the measure set review meeting for the 2021-2022 Measure Application Partnership cycle. As I think everyone here knows, it's been 20-plus years at NQF, and our members have been at the forefront of advancing healthcare quality with a particular focus on establishing and maintaining our nation's portfolio of quality measures.

And this year NQF has partnered with the centers for Medicare, and Medicaid services, and the MAP Coordinating Committee to pass out a new process for measure set review. CMS's goal for this process is to offer a holistic review of quality measures with input from diverse, and multi stakeholder groups. This is a first ever formal process for considering which measures might be appropriate to remove from use in federal programs.

And there are so many important reasons to consider measure removal, as we all know. There's increasing important emphasis on alignment across programs, reduction of burden for those being measured, moving toward parsimony, particularly with value-based payment programs. Moving towards a narrower, more outcome-oriented measure set.

And so this is a really important opportunity that we've had to look at measures to consider their appropriateness for recommended removal. But

also, very importantly, to do a trial run of the criteria by which measures can be evaluated for such a process.

So, later this year, NQF will produce a final report that includes the recommendations and rationale from this 2021 process and the MAP Coordinating Committee's work. In 2022, a report will come forward that will include input from the setting specific MAP work groups, as well as the rural health and brand new health equity advisory groups.

So, I would just like to take this moment to thank everyone for being here. For those of you here from the public, we thank you for your time and interest in this process. For those of you on the MAP Coordinating Committee, thank you for the time and energy and commitment that you've brought to this process. I'd also like to acknowledge members of the MAP Hospital Work Group who are joining us today to observe and think about how this process might affect their program.

Finally, and very importantly, really want to offer my thanks and appreciation to Chip Kahn from the Federation of American Hospitals and Misty Roberts from Humana for serving as the Co-Chairs for the MAP Coordinating Committee. Thank you both so much for your leadership and your willingness to help oversee this process. We are looking forward to working with you on this.

And with that, let me hand it to you, Chip.

Co-Chair Kahn: Thank you, Dana. Thanks for the kind words. And I'll say a few words, and then pass it to my Co-Chair, Misty. First, I'd like to thank CMS for providing this opportunity to us. Up to this point, all of you on the phone and on the air have gone through many years of process regarding looking at the measures that were to be proposed. And now I guess we get to step back and take a more strategic view.

And I hope that, as we have our discussions, that, in a sense, obviously, our task is removal, but that, rather than think about it as removal, we think sort of strategically as where in each of these programs the measures ought to be. And we think of this as an assessment, and we consider issues as gaps, gap issues, and other issues, as well as simply what we might remove, because we can make whatever recommendations that we want.

And the process that we went through, albeit short, because of the nature of this demonstration, it, I think, did give you an opportunity to think big picture and not simply about whether this measure worked or didn't work from your perspective. So, that's what I think we should think about as we go through the day. And clearly this is a demonstration. In the future we will have a more normal MAP process with advice and guidance from our work groups, and then taking that work.

But because of the nature of the timing we had with the legislation, and trying to get this finished, we sort of short circuited it, and I just want to express my appreciation for all the work, and patience from the Coordinating Committee for taking sort of this short circuit process, and playing it out over the next two days. So, with that I look forward to our discussions.

But I look forward mostly to the learning process that we'll go through, that hopefully we'll set in place a set of assessments and processes that we'll do every year in league with our already assigned task of reviewing measures that CMS is considering for inclusion in the regulations. So, with that, I'll pass it off to Misty.

Co-Chair Roberts: Thanks, Chip. Thanks, Dana. Well, welcome, good morning, everyone. I'd like to also iterate my thanks to CMS for really allowing us this opportunity. I think that this is a huge opportunity for this committee to really expand our

scope and do more for the program. Also, the NQF, there's so much behind the scenes work that happens to get us to today. It is going to be a long couple days, so thanks to you, the Coordinating Committee members, for kind of bearing with us and taking this extra time. We know that this is kind of above and beyond your normal work day. So thank you for that.

I'll also iterate what Chip said: let's think about this as really more of high level strategic, but more holistic approach at looking at the measure sets. It's not just about removing measures, this is about thinking about the whole picture. And I don't think that -- I have this vision that in the future we're really going to get there, to have that holistic picture.

This is an iterative process. We are going to be learning as we go. We will be kind of rolling in our typical process with some of those work groups in the future, but with this short timeline, we're kind of going with the flow. But it is an iterative process; we will continue to improve on this. So bear with us as we learn together, and thanks for your time today.

Disclosures of Interest for Organizations

Ms. Elliot: Excellent. Thank you, everyone, for those warm welcomes to kick off the meeting. I will now begin with the disclosures of interest and roll call. As a reminder, NQF is a nonpartisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendos, or humor related to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting. While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others.

We'll combine disclosures with introductions. We'll

divide the disclosures of interest into two parts because we have two types of MAP members: organizational members and subject matter experts. I'll start with organizational members.

Organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests. Because of your status as an organizational representative, we ask only one question specific to you as an individual, we ask that you disclose if you have an interest of 10000 dollars, or greater in an entity that is related to the work of this committee.

Let's go around the table beginning with the organizational members only. I will call on anyone on the meeting who is an organizational member. When I call your organization's name, please unmute your line, state your name, your role at the organization, and anything that you wish to disclose. If you did not identify any conflicts of interest after stating your name and title, you may add "I have nothing to disclose."

First up is the American Academy of Hospice and Palliative Medicine.

Member Kamal: Good morning. I'm Arif Kamal, an outpatient palliative care physician and member of the board of directors of AHPM, and I've got nothing to disclose.

Ms. Elliot: Thank you. And actually I forgot to do our Co-Chairs first. So, Chip, if I could circle back to you.

Co-Chair Kahn: I have nothing to disclose.

Ms. Elliot: Thank you. And Misty?

Co-Chair Roberts: Nothing to disclose.

Ms. Elliot: Excellent, thank you, appreciate that. Next up, the American Association on Health and Disability.

Member Ross: Hi, this is Clarke Ross. I'm the public policy director for the American Association on Health and Disability in my 50th year working for my 6th national disability organization in D.C., and I have nothing to disclose.

Ms. Elliot: Thank you very much. The American College of Physicians.

Member Tierney: Good morning, hi. I'm Sam Tierney, I work at the American College of Physicians, and I'm representing them on this call. Typically, it's Amir Qaseem who represents ACP, but he was unable to join. I have nothing to disclose, and my work really relates to performance measures and leading the work at the College within that realm.

Ms. Elliot: Excellent. Thank you. Sam. American Healthcare Association.

Member Gifford: My name is David Gifford, and I'm the chief medical officer. My alternate, Marsida Domi, will cover for me briefly tomorrow. The only thing we have to disclose is that we are measure stewards of, I think, about ten different measures in the long-term care sector for NQF measures, and a couple are used by CMS in rulemaking. But none of them are for discussion today.

Ms. Elliot: Excellent, thank you. American Medical Association.

Member Bossley: Hi, it's Heidi Bossley. I'm a consultant to AMA. Unfortunately, Koryn Rubin and Dr. Suk had conflicts, so will not be on, and I'll be representing. I have no disclosures to disclose.

Ms. Elliot: Thank you, Heidi. American Nurses Association.

Member Boston-Leary: Hi, I'm Katie Boston-Leary. I'm the director of nursing programs, overseeing nursing practice and work environment at the

American Nurses Association. Also co-lead for a grant that's a CDC health Project Firstline, and I have nothing to disclose.

Ms. Elliot: Thank you, Katie. America's Health Insurance Plans.

Member Goodman: I'm Liz Goodman. I'm the vice president of government affairs and innovation at AHIP.

Ms. Elliot: Liz, you're a little bit hard to hear.

Member Goodman: Sorry. I have nothing to disclose.

Ms. Elliot: Okay, thank you, I heard you better that time. AmeriHealth Caritas. Is Andrea Gelzer on the line?

Okay, we'll circle back. Blue Cross Blue Shield Association.

Member Peden: Good morning, everybody, my name is Carol Peden. I'm the new executive director for clinical quality for Blue Cross Blue Shield Association, and I've only just started, so I'm new to this meeting today. So, I look forward to joining you all, and I have nothing to disclose.

Ms. Elliot: Thank you very much. Covered California. Is Margareta Brandt on the call?

Okay, we'll circle back. Next we have HCA Healthcare.

Member Kleja: Hi, good morning. Kacie Kleja, I'm the AVP of analytics and reporting at HCA Healthcare. I do have more than $10,000 in stock of HCA Healthcare.

Ms. Elliot: Okay, Kacie Kleja, are you on the call?

Member Kleja: Could you not just hear my introduction?

Ms. Elliot: If you're speaking, we can't hear you.

Co-Chair Roberts: We could hear her.

Member Kleja: Hi, can you still not hear me?

Ms. Elliot: Try to get your audio working, Kacie. We can see you fine, but we unfortunately cannot hear you.

The Joint Commission. I don't see David Baker on the call yet; we'll circle back with the Joint Commission. The Leapfrog Group.

Member Binder: Hi, this is Leah Binder. I am president and CEO of Leapfrog, and I have nothing --

Ms. Elliot: Okay, something has happened to my audio. I can't hear people, so hold on one second.

Member Binder: Can anyone else hear me?

Ms. Payne: Good morning, everyone, this is Becky Payne from NQF. I just wanted to note we were able to hear that -- I believe we had HCA Healthcare present, and the Joint Commission, I believe, was also present. And then Leah Binder for the Leapfrog Group is present, and I see that in the chat, Andrea Gelzer is present as well. Have I accounted for everyone so far? Okay, great, we'll give Tricia just one more moment to see if she's able to connect her audio again.

Tricia, we cannot hear you, but we can see you still.

Ms. Elliot: There we go, now I think I'm reconnected. Can you hear me now?

Ms. Payne: Yes, can you hear us? Yes.

Ms. Elliot: Yes, okay, sorry about that. The joys of virtual meetings. Clicked too many places, I think. So, we left off with the Leapfrog Group, and they checked in, yeah, okay. National Committee for

Quality Assurance.

Member Barton: Good morning. This is Mary Barton. I'm the vice president for performance measurement at NCQA, and look forward to participating, and I guess if I had a conflict, it would be that we develop measures that are used in health plan accreditation, and measures that are used in a lot of other spaces as well, thank you.

Ms. Elliot: Great, thank you very much. National Patient Advocate Foundation.

Member Kirch: Good morning. Rebecca Kirch, executive vice president of healthcare policy, and programs with NPAF. I have nothing to disclose.

Ms. Elliot: Thank you very much. Network for Regional Healthcare Improvement. Okay, we'll circle back on that. Patient and Family Center Care Partners.

Member Hoy: Morning everybody, Libby Hoy, founder, and CEO of PFCC Partners, and I have nothing to disclose.

Ms. Elliot: Thank you very much. Purchaser Business Group on Health.

Member Hoo: Good morning. Emma Hoo at the Purchaser Business Group on Health. I'm director of value purchasing. I have no conflicts to disclose.

Disclosures of Interest for Subject Matter Experts

Ms. Elliot: Okay. Is there anyone who has joined that didn't have a chance to introduce and disclose? Okay, so thank you for those disclosures, now we'll move on to disclosures for our subject matter experts --

Co-Chair Roberts: Tricia --

Ms. Elliot: Sorry, go ahead.

Co-Chair Roberts: Sorry, I should maybe modify my disclosure, I don't -- maybe it's relevant. I do have more than $10000 in stock with Humana, the company I work for. I don't think any measures we're discussing impact that, but I should disclose that.

Ms. Elliot: Okay, thank you, Misty. I appreciate that.

Ms. Joseph: Hi, this is Vilma Joseph. I represent the American Society of Anesthesiologists, and I'm just listening in to comment.

Ms. Elliot: Okay, very good. Becky, for folks that are just listening in, we don't require disclosures, correct?

Ms. Payne: That is correct. If you're joining us as a member of the public today, you do not need to make any disclosures, and we look forward to your comments during the opportunity. Thank you.

Ms. Elliot: Thanks, Becky. So, we've completed the disclosures for the organizational members, so we're going to move on to disclosures for our subject matter experts. Because subject matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of today's work group meeting. We are especially interested in your disclosure of grants, consulting, or speaking arrangements, but only if relevant to the work group's work.

Just a few reminders, you sit on this group as an individual. You do not represent the interests of your employer, or anyone who may have nominated you for this committee.

I also want to mention that we are not only interested in your disclosure of activities where you were paid. You may have participated as a

volunteer on a committee where the work is relevant to the measures reviewed by MAP. We are looking for you to disclose those types of activities as well.

Finally, just because you disclosed, does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency, so please tell us your name, what organization you're with, and if you have anything to disclose. I'll call your name so that you can disclose. First, we have Dan Culica.

Member Culica: Good morning everyone, you pronounced my name very, very well.

Ms. Elliot: Thank you.

Member Culica: So, thank you for having me on the committee. I am with the Health and Human Services Commission of Texas, I am with the Medicaid program, and I might say that I am the leader of better base payment reform in the state, and for the quality measurement effort throughout the program and the agency, and I have nothing to disclose.

Ms. Elliot: Thank you very much. Janice Tufte.

Member Tufte: Hi, I'm Janice Tufte. I'm sorry, I have my camera off, I'm getting up and walking a lot. I am considered a patient partner collaborator in health systems work, and I've served on multiple NQF expert panels and in work groups, and I have nothing to disclose that's directly related to the measurements as I've seen them, thank you.

Ms. Elliot: Excellent, thank you. Ronald Walters.

Member Walters: Ron Walters, I'm an oncologist with MD Anderson in Houston, where I've been for 42 years. I have no conflicts of interest and nothing to disclose, no financial interest, et cetera at all. Thank you.

Ms. Elliot: Great, thank you very much. We're going to circle back on two organizational representatives. Liz is representing NRHI, and has stated in the chat that she has no conflicts to disclose. And we also have Susan Yendro from the Joint Commission. Susan, can you -- you're representing Dr. Baker until he's able to join?

Ms. Yendro: Correct, yes.

Ms. Elliot: And no disclosures?

Ms. Yendro: We are measure stewards, I just wanted to point that out.

Ms. Elliot: Okay, great. Thanks Susan, appreciate you joining the call. Excellent. So, thank you all for taking the time to do this. And at this time, I'd like to invite our federal government participants to introduce themselves. They are nonvoting liaisons of this work group. First up, I believe Jeff Brady is representing the Agency for Healthcare Research and Quality, and has stepped away from the meeting.

Next up, the CDC. Do we have a representative from the CDC? Okay. And Michelle Schreiber is on from CMS.

Dr. Schreiber: Yes, thank you, and we have a number of staff on from CMS, thank you.

Ms. Elliot: Okay, thank you. Should we go through introductions, Michelle, or are we good?

Dr. Schreiber: No, we're good.

Ms. Elliot: Okay, thank you. And then the Office of National Coordinator of Health Information Technology, we have potentially David Hunt on the line. I don't see him joining yet. Okay. So, thank you. I'd like to remind you that if you believe that you have a conflict of interest at any time during the meeting, please speak up. You may do so in real time at the meeting, you can message your chair,

who will go to NQF staff, or you can directly message the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting, approach the chair, or go directly to the NQF staff. Do I have any questions, or anything you'd like to discuss based upon the disclosures made today? Okay. Thank you for your cooperation, and we're going to proceed with the meeting.

I'd also like, on the next slide, just to introduce the NQF staff that are on the call today and here to help support. Myself, Tricia Elliot, Katie Berryman is the senior project manager, Udara Perera, senior manager, Ivy Harding, and Susanne Young as managers. Ashland Ruth is our project manager. Becky Payne, senior analyst. Victoria Fraire is analyst, Joelencia Leflore is coordinator, and Gus Zimmerman is a coordinator.

So, they are available through chat if you have any issues, or challenges during the call today. With that, I'd like to transition and introduce Dr. Michelle Schreiber, deputy director for quality and value at CMS, to offer some opening remarks.

Dr. Schreiber: Thank you Tricia. Let me do a sound check; can you hear me okay?

Ms. Elliot: Yes, we can hear you great.

CMS Opening Remarks

Dr. Schreiber: I think all of us have gotten used to these virtual calls, and all of us still make mistakes, and have issues with the various recordings, and video, and that. So, thank you, and good morning to everybody. Well, many thanks to be extended on behalf of CMS. First of all, to NQF, for all the work that they have put in in getting this ready. To the co-chairs, Chip and Misty, yeah, you guys have been behind a lot of this work, in organizing it.

On behalf of CMS, we'd like to formally welcome Dana Safran to her new role, so congratulations, we look forward to working with you. We have a number of staff on the call today from CMS. We will try very hard to answer your questions wherever possible. But again, as Chip pointed out, this was done in a fairly rapid turnaround, shall we say? We won't always have measure stewards on the phone. We won't always be able to answer all of the questions, but we'll try very hard to do so, and would really like to make this an open dialogue as much as possible.

For those of you who don't know me, I'm Michelle Schreiber. I'm a former practicing general internal medicine physician from the City of Detroit, and several years ago as a former chief quality officer, came to CMS as the group director for the quality measures and value based incentives group, and am now a deputy director of the Center for Clinical Standards and Quality. I've known many of you, and have really valued these relationships over the past several years.

To those of you who are new, thank you for participating in this. We're really looking forward to this opportunity. We have sat together over the last several years talking about measures to be recommended, that you have recommended to be put into programs, or recommended not to be placed into programs, but in many ways this closes the loop. This helps really shape what the value based purchasing programs from CMS can look like when we talk about not only measures for inclusion, but the measures that perhaps should be removed as well.

And as several have already noted, there are many reasons for doing this. Priorities change, we're looking at different impacts, there are gaps that we're trying to fill, there are measures that become topped out. There are measures that are no longer clinically relevant, or perhaps as impactful as they

were. And so every year, we shape and reshape these programs on an iterative basis to try and not only reduce burden, but really provide the most impact to all beneficiaries, and all who participate in healthcare, which is pretty much everybody.

Because at the end of the day, what's most important is improving outcomes, and ensuring that all patients have informed information that is useful to them in making their clinical decisions around their care. The process for measure inclusion and measure exclusion is a long process, and we try from CMS to be as open and transparent as possible, not only through the measure application partnership, but also there are multiple rounds of review, both at CMS and for the federal partners on the call, they are very familiar with the review across all of HHS and the government. So, many people have a stake, and a say in these.

In addition, we do the changes to most all of these programs through rule writing, so there are formal proposals with a 60 day comment period by the public. I will promise you, we read every single comment, and you can see that sometimes we propose a measure, and it doesn't get finalized. That happened this year. As a matter of fact it happens every year. So there are multiple opportunities for comment, and at the same time, there are multiple people and agencies who are commenting.

This I think will be a very important voice to have a consensus at the NQF MAP level of what your committee feels is important for removal, and then of course for inclusion as well. As Chip pointed out, I would actually encourage everybody to think a little bit more broadly.

It's not just an individual measure that maybe should be included or excluded, but what are these programs, what should they do? What is their impact? What are the most meaningful areas where

we could make impact? Ensuring that we have measures in those areas, ensuring that we are shining a spotlight in those areas. And it's not just gaps, but it's trends of what's important, it's themes of what is important.

For example, many of us will be speaking about equity, and that clearly has become a top priority agenda item for the Biden administration. The continuation of safety, something that's also extremely important, that we need to make sure that we're always attending to and paying attention to these. So we look forward to all of the comments, and the deliberations of this committee today.

As Chip and others have pointed out, this is a pilot process, and there are, I'm sure, lessons to be learned and kinks to be worked out. But we really appreciate the partnership. We very much value everybody's comments, and look forward to the discussion. So, thank you, Tricia. I will turn it back to you.

Review of MSR Process and Measure Review Criteria

Ms. Elliot: Excellent, thank you. I appreciate your comments very much, Dr. Schreiber. Next slide please.

So, the next part of the meeting, we're going to review the measure set review process and the measure review criteria. So, after the measure set review education meeting on August 9th, Coordinating Committee members selected measures for review at this meeting.

The NQF staff compiled the results, and the top 22 measures selected for review are included in the slides today that we'll be reviewing. Additional information on these measures remain available in the measure summary document distributed through the meeting invite. Next slide please.

NQF staff will provide an overview of each program

to give context for the discussion. Measures are grouped on the agenda by program and topic area for ease of discussion. Co-chairs will begin discussion by asking lead discussants to share rationales for selecting measures for removal, referencing any relevant measure removal criteria. Co-chairs will continue the discussion, calling on committee members in a round robin manner. Committee members should share their opinions and thoughts on their support for removing the measures, referencing any relevant measure removal criteria.

After the discussion, the co-chair will open a vote on each individual measure. Committee members will vote indicating support for removal from the program, a yes, or no for do not remove. The measure review criteria that were used during this pilot year are listed here in the slide one through eight.

So, number one, measure does not contribute to the overall goals, and objectives of the program. Performance, or improvement on the measure does not result in better patient outcomes. Measure is not NQF endorsed. Evidence base for the measure has changed, and the measure no longer reflects current evidence. Measure performance is uniformly high, and lacks variation in performance overall and by subpopulation. The measure is not feasible to implement. The measure is duplicative of other measures in the program, or the measure has negative unintended consequences.

So please keep these criteria in mind during the discussion. We would like feedback as to which measure criteria were most meaningful as you were making some of the decisions that you provided.

Questions on the measure set review process, or the measure review criteria? Okay, hearing none. Feel free to ask questions along the way, and at this point I am going to hand things over -- let's see,

let's go to the next slide please. We are going to look at the IPFQR measures.

Co-Chair Roberts: Hey, Tricia, can I just add one thing? I just want to iterate quickly kind of the two objectives, and you may have stated them, but I know this was something that people were a little confused about last time, but the two objectives that we're really trying to do is get feedback and recommendations on the measures themselves, but also the feedback on the criteria that was used to select the measures. And not just which criteria you used for the measures, but what you felt worked and didn't work. So, I just want to reiterate that there's two objectives to this meeting, and make sure that we're keeping that in mind throughout the day.

Ms. Elliot: Excellent. Thanks, Misty. And we did put those objectives on the meeting agenda, so if folks want to reflect back on that. I appreciate you calling that out, Misty. Okay, any other questions? Was there any hand raised? The team, I know they're checking.

Ms. Perera: Sam Tierney has a hand that's raised.

Ms. Elliot: Thanks Udara. Sam, did you have a question?

Member Tierney: Yeah, I did. I was just wondering how the voting will work. I know that I think the CQMC typically looks at 66 percent of voting members, and maybe it's even 60 percent. I guess I was just wondering will that be the process here in terms of measures recommended for removal, or will there be alternatives considered?

Ms. Elliot: Yeah, for this process, this isn't an official vote, it's more like a poll so that we can have some kind of indication in terms of the flow, because this is a pilot. We are just kind of testing the process. So it's a great question Sam. We won't be looking to achieve quorum, or actual percentages, it's more

just to gauge the process, and how comfortable folks felt with the process.

Co-Chair Kahn: Tricia, can I raise a question about that?

Ms. Elliot: Sure.

Co-Chair Kahn: I guess I'm a little bit, I mean unless we're, I think we ought to go with the 60 that we do normally, because the question is is it a recommendation or not, even if this experiment, it's still a recommendation. If we don't go with it, and we stay sort of neutral, then people don't really, then the vote doesn't mean anything, because it'll just be sort of smushed together in some sort of broad recommendation.

So, I hate to break from the company line here, but I really think that we ought to just stick with our normal process, because otherwise what does a vote mean?

Ms. Elliot: And that's fine, Chip. We can hear from the team, we'll be able to calculate the yes/no totals, and the percentages, so we should be able to do that real time.

Co-Chair Kahn: Okay. Whether or not we have a quorum, I mean I understand that, but I think at least in terms of that.

Ms. Elliot: Okay, but we'll try for the 60 percent, okay.

Co-Chair Kahn: People ought to feel like the vote's meaningful when they're making them.

Ms. Elliot: Sounds good. We will capture that as we go, because we're going to be using PollEverywhere, which folks should have received the link to be able to do that.

Co-Chair Kahn: Great, thank you.

Ms. Elliot: Yeah. Okay, I'm seeing some agreement in the chat, so we'll move forward with that process. Okay, any other questions before we move on? Udara, were there any other hand raising that we need to address?

Ms. Perera: No other hands raised.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Measures - Miscellaneous

Ms. Elliot: Okay, so we'll move forward into the inpatient psychiatric facility quality reporting program, and miscellaneous measures here. So, highlighting the measures, there's three measures that we'll be looking at here. We used the CMIT ID, as you can see on the left hand side, the program name, the measures, the first one is a Transition Record with Specified Elements Received by Discharged Patients. The second, Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification and Screening for Metabolic Disorders.

The MSR selection count is reflective of the number of committee members that had selected this measure as for potential removal. And with that, Misty, can I hand things over for you to start the discussion?

Co-Chair Roberts: Yeah, and refresh my memory, are we going to start with the lead discussants, is that what we decided on?

Ms. Elliot: Yes.

Co-Chair Kahn: Yeah, and then go around to members.

Ms. Elliot: Yeah, and then do the round robin.

Co-Chair Roberts: And then do the round robin, okay. Let me pull up my list of lead discussants here.

Ms. Elliot: And we can do it, if we go to the next slide, it gives more detail on each of the measures. So, this is, let's see, I'm sorry, I was supposed to cover this slide before I handed things off to you, Misty, my apologies. So, this is just referring to the inpatient psychiatric facility quality reporting program. The program type, it is a pay for reporting, and public reporting.

The incentive structure includes states that they do not submit data and all required measures receive a two percent reduction in the annual payment update, and then the program goals are listed here, provide consumers with quality of care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of care for this population, ensuring providers are aware of reporting, and best practices.

And then the next slide please. So this is the first measure that was listed on the table. So this is CMIT 2584, the transition record with specified elements. Okay, so we can call on the lead discussants. Misty, do you want to review all three measures, and then open it up? I think that was our intent.

Co-Chair Roberts: Yeah, I think that makes sense, yeah.

Ms. Elliot: Okay. So slide 18 has the first measure. If it's reported at the facility level, endorsement is removed on this measure. The selection counsel for committee members had recommended this measure for removal. We have the lead discussants listed here, and the criteria or rationale for removing this measure, NQF endorsement has been reviewed, measure is a process measure that does not ensure care coordination with PCP, or post discharge behavioral health provider.

On the next slide, the next measure is 1645, so this is Patients Discharged on Multiple Antipsychotic

Medications with Appropriate Justification. The reporting level is facility, the endorsement status is removed. Three committee members had selected this measure for removal. The lead discussants are listed there. And the criteria reflected or rationale was NQF endorsement removed, the data may be burdensome to collect, and there has been a change in standard of care.

And then the third measure in this grouping is 2725, Screening for Metabolic Disorders. Reporting level is at the facility level. It is not endorsed. Three committee members had chosen this measure. The lead discussants are listed there. And the criteria or rationale is it is not an NQF endorsed measure, measure evidence base is absent, measure does not ensure that routine metabolic screening is occurring. So now, Misty, I'll turn things over to you to coordinate with the lead discussants, please.

Co-Chair Roberts: Thanks, Tricia. So, it looks like the lead discussants that we have here are from AmeriHealth Caritas, Leapfrog, National Patient Applicant Foundation, and NRHI. So we'll start first with AmeriHealth Caritas. I think we have Andrea on the line. Andrea, would you like to kick us off? It looks like she was having connectivity issues earlier, so she may still be having issues.

Let's move on to the Leapfrog Group. Is that Leah that's on?

Member Binder: Okay, I'm unmuted now, can you hear me?

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

Member Binder: This is the mantra of 2020 and 2021, you're on mute, that's it. Okay, so the criteria that we used in recommending this measure for removal, one, it's not endorsed, which we do think is a relevant factor, not always, but we think most of the time it should be considered an extremely important factor. And also it's a process measure,

and it also really fundamentally for us, addresses a criteria for measure review that we actually think could be added, which is it doesn't differentiate excellence from good enough.

We think that needs to be one of the criteria. The purpose of quality measurement should be achievement of excellence, of the highest possible achievement, and that is different from adequacy, or okay, and we'll see in some of these other measures, if you could just go forward to the next one.

Co-Chair Kahn: Okay, do you have Debby Jenkins?

Member Binder: Patients discharged --

Co-Chair Kahn: I can send you the email.

Member Binder: Chip, you need to mute. Patients discharged on multiple antipsychotic medications, I have a similar feeling that this, in addition not being endorsed, having some issues with the evidence base leading to outcomes. We also are concerned about the fact that it is not a -- there really isn't a capacity to differentiate excellence in this.

And then if you go to the next slide, transition record with specified elements received by discharged patients. Similarly, we are concerned about the endorsement, we're concerned about excellence, and we're concerned about generally, for all three of these as well, we were concerned about the burden of collection not exceeding the relevance to outcomes. So that was the perspective we had come from.

Member Gelzer: Excuse me, hi, this is Andrea Gelzer. Can you hear me?

Ms. Elliot: We can hear you now, Andrea.

Member Gelzer: Okay, great. Yeah, and I would echo all of those comments. I mean the primary reason for selecting these measures was

endorsement was removed. Having been at this for quite some time, the reporting level of the facility, again, it's just a process measure. It doesn't ensure that the results were acted on. There is no integration with the receiving or outpatient provider. I do not believe that this measure, as Leah said, is one of excellence, and I think we can do better.

Co-Chair Roberts: Great, thanks, Andrea. From the National Patient Advocate Foundation, do we have Rebecca?

Member Kirch: This is Rebecca, hi, thank you. Agreeing with all the comments so far, very influential that it was not endorsed, but also I think leaving room from the patient care giver perspective for measures that really matter to them, which can still be process measures, but not that substitute for the quality care that we all, as was just said, we can do better. And these measures don't promote that sort of excellence.

Co-Chair Roberts: Thanks Rebecca. I think from NHRI we have Liz on the line?

Member Cinqueonce: Yes, are you able to hear me now?

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

Member Cinqueonce: Okay, great. So, I would just echo the other comments, again, looking at the endorsement status of each of these measures, that was top of mind for us. The other, the only new point that I would bring, is that on the metabolic screening measure, we were concerned that the annual cholesterol level is not aligned with clinical guidelines of looking for that to occur every four to six years unless there is heart disease, diabetes, or a family history of high cholesterol.

But again, I would agree with the comments made by the other lead discussants, thank you.

Co-Chair Roberts: Thanks Liz. Michelle, I think you have your hand raised.

Dr. Schreiber: Thanks, yes, I was on mute. A question for the reviewers, especially the transition record and the discharge on multiple antipsychotics, do you see those as safety issues, if you want to have measures on antipsychotics in particular, but even the transition record to ensure that there are -- I think someone needs to go on mute.

Co-Chair Roberts: Ron, can you go on mute?

Dr. Schreiber: But even the transition record to ensure that patients, and frankly others, are receiving the records. So I'm curious if you see these as patient safety measures, or if you don't think that they fill that role, either?

Member Cinqueonce: So, this is Liz Cinqueonce with NHRI, that's actually not one of the measures that our organization had flagged as a candidate for removal. We do see that as a standard of care, and noted that the endorsement was removed, but the national rate on that one was at 68 percent, so we did still feel like there was some room for improvement on that measure.

Co-Chair Roberts: Leah, any thoughts on Michelle's question? Leah, are you on mute?

Member Binder: Off mute, sorry about that. This was a conundrum for us, Michelle, and I think you bring up a good point. Obviously we see the safety value of this, and everything about this is critically important from a safety perspective, but it's also pass-fail, it's not going to tell us anything about great agents of quality. It's like if you don't do this, it's poor quality, it's bad safety.

If you do do it, check the box, you're doing an adequate level of safety, but it's not going to give us enough information to tell us that there's excellence in there. And I think that's important,

because it's a measure that's hard to collect, and it seems to us that we should have high value measures, where we are able to differentiate among providers in really meaningful ways, and so I mean this is a standard of care that should be looked at for accreditation, and for all other forms of sort of basic surveillance to assure safety. But it's not quality, it doesn't give us enough accreditation for quality, I think that was our thinking.

Dr. Schreiber: Okay, thank you.

Member Tufte: This is Janice, I've had my hand raised, can you see it?

Co-Chair Roberts: Yeah, okay, Janice, go ahead.

Member Tufte: Nobody called on me. Yeah, I see this can go either way, but I think transitions is so important, and the multiple antipsychotic medications, I just want to say, I live near a safety net hospital, and I can find these medications and these papers along the streets where people literally leave the hospital and just dump them. So, this is not uncommon in reality, but the point is at least there's some record for it.

But I do appreciate what others have mentioned about, that it's a quality issue, and excellence, and how provider reporting should be noted. And if it's burdensome, that might be why it's not, 68 percent is pretty high, but it seems like there probably could be a better measure.

Member Ross: Hi, this is Clarke Ross, I had my hand raised too, so I'm not sure if my function is working. I wanted to ask a question about multiple antipsychotic medications. Can someone share with me other discharge medications, documentation which may, or may not include antipsychotic medications, other measures that are endorsed in the portfolio.

Co-Chair Roberts: Who would be the best person to

answer that?

Co-Chair Kahn: Let me just, Michelle, do you have somebody?

Co-Chair Roberts: Michelle, yeah.

Dr. Schreiber: I'm not sure, so we have several experts from the IPF team, Lauren Lowenstein, who leads the IPF work, Tim Jackson, Grace Snyder, and Tamyra Garcia, who is the deputy of QMVIG. I'll ask if any of them want to comment, otherwise we may have to take your question and get back to you. Lauren, did you want to comment?

Ms. Lowenstein: This is Lauren, and before I say anything, I'm just wondering, could you maybe ask your question again? You're wondering whether there are other NQF endorsed measures that include antipsychotic medication?

Member Ross: Well, medications in general, and antipsychotic medications in particular in discharged individuals. We know that the combination of medications is a significant element in the health and wellness of people with serious mental illness. Being discharged from an inpatient facility means serious mental illness, and if there is another existing measure that addresses medications, antipsychotic medications at discharge, then I'm very comfortable. If there is no similar measure, then I'm very uncomfortable removing this.

Ms. Lowenstein: Thank you. So, I think the most similar measure that we have in the IPFQR measure set is the medication continuation measure, which looks at whether patients filled a prescription for their medication, it would include antipsychotic medications, as well as other medications after their discharge. So, that --

Co-Chair Roberts: Lauren, can you repeat, which measure did you say that was?

Ms. Lowenstein: It's the medication continuation measure, medication continuation following discharge.

Co-Chair Roberts: So, it's broader than just the antipsychotic medications.

Ms. Lowenstein: And the measure doesn't, the reporting of the measure doesn't identify what types of medications were filled. So, this measure looks at patients who were discharged with either major depressive disorders, schizophrenia, or bipolar disorder, who had filled at least one evidence-based medication through 30 days post discharge, and the public reporting of this measure sort of aggregates all of those diagnoses and medications.

Dr. Schreiber: And this is Michelle again. As Lauren points out, those measures are meant for two somewhat different intents. So the one that Lauren is talking about is really for patients who are discharged on whatever medications that they're discharged on, but in particular maybe their anti-schizophrenic medication, or their bipolar medication, are they actually continuing those after they leave? Do they have evidence of those medications being refilled?

The one on multiple antipsychotics actually is different, it is truly meant to be a safety issue around taking multiple antipsychotic medications, and so the intent is different. So, really to get at your question, do we have another measure that specifically address antipsychotic medications, or multiple antipsychotic medications? And I believe the answer is no, although we'll verify. This is also a measure that is used across nursing home facilities, discharged, or use of multiple antipsychotics. And so it's a measure that is similarly used in other programs.

Co-Chair Roberts: Thanks for that. So, I know we had originally discussed after the lead discussants that we would do a round robin at some -- it looks

like we've had a couple of hands raised, a couple of others who have shared their thought.

Do we think it makes sense to do a round robin? Or just -- maybe just ask if anyone else any other thoughts?

I'm open either way. It just might get a little long doing the round robin.

Member Bossley: Misty, this is Heidi. I don't have a problem if you just open it up for discussion.

But, I will admit, I'm finding it confusing to try to talk about three measures at one time.

Co-Chair Roberts: Right.

Member Bossley: So, I'm just wondering, I don't know if that's the process we're going to have for the rest of the meeting.

But, the flipping back and forth between the three is a little challenging for me.

Co-Chair Roberts: Thank you. Do others agree with that? I was thinking the same thing.

Because I'm thinking okay, we're talking about the multiple antipsychotic, but, what were the other two we were discussing?

So, I do agree. It looks like we have some others that are agreeing as well. So, Tricia, I know we had originally discussed just all of them at the same time.

But I think --

Ms. Elliot: Okay. We'll break it apart.

Co-Chair Roberts: Yeah. I think that makes more sense.

Ms. Elliot: Okay. Do we want to circle back then to Slide 18 real quick, I think, there we go. So, Misty,

do we want to do a quick call for comment on this particular measure?

So we'll do that through each of these measures. And then we'll move forward that way.

Co-Chair Roberts: Yeah. I think that makes sense. And I know a lot of Leah's comments, and Liz's comments, were similar for all three measures.

But, there could be -- could be some differences to point out in terms of the criteria rationale.

So, let's start with this one, the transition of record. Anybody else have any additional comments on this measure?

It looks like the criteria again, was the NQF endorsement removed. The process, the fact that it's a process measure.

And then of course, Leah voices concerns just around, you know, thinking about it, more around the excellence piece of it.

So, any other comments on this measure?

Member Ross: Hi, this is Clarke Ross again. I would ask the same question I asked before.

Is there another endorsed measure dealing with transition, the process of transition? And the record across the name, the transition?

Dr. Schreiber: I don't have the entire inventory in front of me, but I believe the answer is no.

This measure was meant to get at whether or not information is transmitted to the ne -- to the patient as well as the next level of care.

Member Ross: In that case I'll do a commentary. That I have a family member, a person with mental illness and worked for NAMI, the National Alliance of Mental Illness.

There are so many crisis and screw ups in transition from one level of care to the other with lack of communication.

And typically the receiving facility or organization says, oh, we don't have the record and we can't get it.

So, I'm trying to think what message this sends, that we don't care -- if we remove the measure, we don't care about the medical record accompanying the transition.

I'm not wedded to any particular measures, just the concept of a transition record to the next place. And this is where we have casualties, is failure to have complete information from one setting to another.

Co-Chair Roberts: So Clarke, I think you're bringing up a good point as we are kind of looking through the measure criterion that was put together originally.

I think that one of those was looking at whether or not the measure is duplicative. But, on the other hand, if it's not duplicative, do we have other, if we're voting to remove not necessarily because it's duplicative?

But, because of the other criteria, then a second question that we might need to ask ourselves is whether not there are similar measures?

Will this create a measure gap if we -- if we were to remove it? So, not sure exactly how to think about that in the process, Tricia.

But, I think that it is a great question.

Dr. Schreiber: Yep.

Co-Chair Roberts: Any other -- are there any other comments on the transition record measure?

Member Bossley: Misty, this is Heidi. This may be a

question for CMS. But, I know that this measure, it actually was a suite of measures, was in the inpatient program at one point and then removed because of concerns around privacy issues.

I guess a question would be, have you had a similar scenario happen in the inpatient site setting? Or is it not an issue?

Because that would be another thing, I think worthwhile knowing.

Dr. Schreiber: Heidi, Michelle. Thank you. I don't think that it has come up as an issue around privacy.

I think to Clarke's point what we were really trying to drive at, was making sure that people did have information so that care doesn't fall through the gaps.

Member Bossley: Okay. Thank you.

Co-Chair Roberts: Any other comments on this one?

Co-Chair Kahn: Can I ask a process question? So, do we then what to vote now?

Or do we want to go through all three and then vote as a package? Or no, or I assume we're voting individually.

But, voting for them together, I'm just asking the question from a process standpoint. Which way do you want to do it?

Ms. Elliot: Chip, it's Tricia. I was thinking we'd get through the discussion on the three. And then we can bring up the poll and do each -- we would do each measure individually.

But, we are ready if you would like to do that.

Co-Chair Kahn: No. That's great. I just wanted to know.

Ms. Elliot: Okay. Okay.

Co-Chair Roberts: Okay. So, discuss all three. But then vote on each individually.

Co-Chair Kahn: Right.

Co-Chair Roberts: After we're done.

Co-Chair Kahn: It's just so I wanted to make sure it was clear to everyone.

Co-Chair Roberts: Okay.

Ms. Elliot: Thank you.

Co-Chair Roberts: So, I think this is the one that we have a lot of discussion on. Let me open it up to anybody else on the committee that would like to add any additional comments for this one.

(No audible response.)

Co-Chair Roberts: Okay. I think we can go to the next one. Okay. Screening for metabolic disorders. Any comments on this one?

(No audible response.)

Co-Chair Roberts: Okay. So, do we want to go back to the first one and vote on that? Is that the plan?

Ms. Elliot: Correct.

Co-Chair Roberts: Okay. And that's in the poll, the poll everywhere.

Ms. Elliot: Yep. So, we'll give folks a minute to pull that up.

Co-Chair Kahn: So, Tricia, I'm still -- I pulled it up, and I still am sort of with, test what time zone you're in.

Ms. Elliot: Okay. They have to initiate the poll anywhere. So, the new question will come up.

Co-Chair Kahn: Okay.

Ms. Elliot: Okay. It's activating and folks should be able to see it on the screen as well as we walk through this.

Ms. Young: So, you should be able to see the test question.

Ms. Elliot: Correct. And then we'll initiate the first question.

Ms. Young: Okay. So, polling is now open for Measure 2584, Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).

Do you support the removal of this measure from the IPFQR Program?

Co-Chair Kahn: How do you get this to work? I really don't understand. I'm sorry.

Co-Chair Roberts: Chip, did it not automatically pop up, the next section?

Co-Chair Kahn: No. No, and then I -- it just -- and now I'm back in the join presentation and I can't get it. What do I do?

Co-Chair Roberts: Go back to the original link. Click on that again.

Co-Chair Kahn: Oh yeah. I got it now. I got it now.

Ms. Elliot: Okay. I think we have a hand raised. Sam, did you have your hand raised for a question?

Member Tierney: Yeah. I was just wondering, and I don't know if this is a possibility, but could there be an abstain option? I don't know if any other organizations would like that. But I feel as though we need that, because, like, our performance measure committee hasn't reviewed this particular

measure.

Ms. Elliot: We don't currently have that option.

Member Tierney: Okay.

Ms. Elliot: In a normal -- when we do a mock process, there is an abstention option.

Member Tierney: Mm-hmm.

Ms. Elliot: So, we don't have that here today. But, we'll take that feedback to integrate that into the process for the future.

So, thank you.

Member Tierney: Thanks.

Co-Chair Roberts: Do we know how many votes we should expect? It looks like we've got 15 right now.

Ms. Elliot: Sixteen.

Co-Chair Roberts: Is that how many we should look -- it looks like we're at 16 now. Is that how many we should expect?

Ms. Elliot: That's close to it. We're double-checking right now.

Co-Chair Kahn: Well, has everybody online who is an official member voting?

Member Peden: I cannot find the link. So, if I just have Tricia, or somebody could send it to me? Thank you.

Ms. Elliot: Yes. So, I'll ask the NQF team. Can you send Carol Peden the link for poll?

Co-Chair Roberts: And maybe in the chat in case anybody else is having issues.

Ms. Payne: I can resent an email to everyone. We would like to not put this in the chat. It is a private

link for Coordinating Committee members only. And this is a public meeting.

Ms. Elliot: We're at 16. If everyone who is voting -- it is 21. But I think we're waiting for a couple more folks to get into the poll everywhere.

Ms. Young: It looks like we have 17.

Ms. Elliot: Okay.

Member Tufte: That was probably mine. I didn't realize. What happened was I clicked the bottom button. I mean, I had voted. And then when I did like try to vote again, then it was added evidently.

Ms. Elliot: Okay. So, we're up to 17. And I think we have at least two abstentions. So, that's 19.

Ms. Young: It looks like the -- so that's maybe a few, I think.

Ms. Elliot: Just to check in. Is anybody else having any issues with voting?

Member Tufte: Can you tell who's voted? And you can chat right to them secretly?

Ms. Elliot: Yeah. The first time we go through this, is always the biggest hurdle just to get everybody connected.

So, we're checking some things behind the scenes here.

Co-Chair Roberts: Everyone's going to have to be -- be patient and bear with us. And we'll work through this today.

Ms. Elliot: Yep. We are running ahead of schedule. So, that's the good news.

Co-Chair Roberts: And we do appreciate the feedback throughout the process as well. To, you know, for instance someone brought up, well, this is confusing to me.

So, please continue to give us that feedback. That helps it, helps us make it a better process for the future.

Ms. Elliot: Exactly. Thank you.

Member Walters: I also might add that I do respect those whose vote is not counted yet and should be allowed.

But, I don't think it's going to change the results.

Co-Chair Roberts: That's a good point, Ron.

Ms. Elliot: Duly noted. We're -- with the current results we're at 82 percent for yes to remove.

Co-Chair Kahn: Yeah. I think for NQF work, that's a consensus by any other name.

(Laughter.)

Ms. Elliot: Okay.

Co-Chair Roberts: I think the main thing though is just to make sure that everybody who can vote, is able to vote.

So, I don't know if we want to, if there's anybody that still has not been able to access the Poll Everywhere. If we want someone to work with them on the side? Or how we should proceed?

Ms. Elliot: Okay. I think if folks are comfortable, we can proceed. Unless -- let's see. I think we'll go ahead and read the results.

Ms. Young: Okay. As Tricia mentioned, 82 percent. So, 14 yes and three no. The polling is now closed.

So, we're going to go to the next measure. The polling is now open for Measure 1645: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification from the IPFQR Program.

Do you support the removal of this measure from the IPFQR Program? Yes or no?

And again, let us know if you're having any problems polling.

Co-Chair Roberts: Could we move onto the results?

Ms. Elliot: Yes. Susanne, can you go ahead and move onto the results?

Ms. Young: Yes. Polling is now closed for Measure 1645. The results are 16 yes, two no. That is 88 percent.

So, the next measure, the third and final measure in this section. Polling is now open for Measure 2725: Screening for Metabolic Disorders from the IPFQR Program.

Do you support the removal of this measure from the IPFQR Program? Yes or no?

And let us know if you're having any issues with Polling Everywhere.

Voting has slowed down. Polling has now closed for Measure 2725. The results, 13 yes, no three. And that is 81 percent.

So, those are the three measures in this section. So, I'm going to turn it back over to Misty.

Opportunity for Public Comment on the IPFQR Measures

Co-Chair Roberts: Great. So, looks like a consensus for all three to be removed.

I think the next step in the process, NQF staff, correct me if I'm wrong, is to open it up now for public commenting for these three specific measures.

Is that right?

Ms. Elliot: Yep.

Co-Chair Roberts: Good. All right. So, at this point I'm going to open it up. Just a few reminders for public comment.

Please limit your comments just to the IPFQR measures that we just reviewed. And also, limit your comments to two minutes.

And I'm trying to look to see if we have any hands raised for public comment. I'm not seeing any hands.

Udara, do you see any hands?

Ms. Perera: I don't see any hands, Misty.

Co-Chair Roberts: Nope.

Member Ross: May I ask, this is Clarke Ross, a process question? Wouldn't it be more helpful to have public comment before we vote?

There may be some authority, personal experience affected by whatever the measure is that we're talking about.

I just think it's odd that now that the vote is here, please comment on whether you like it or not. And I would prefer to hear that before I vote.

Co-Chair Roberts: I think that's a good -- a good thought Clarke. And I'm trying to think back of how we historically do it with the MUC.

Co-Chair Kahn: We usually do it this way. But I -- I mean, it's a good suggestion then.

Co-Chair Roberts: Yeah. Is there any reason that we do have it like this, Tricia? Do you know? Or others that may know?

Ms. Elliot: Yeah. We'll have to double check on the order of things. But, typically voting does come first, and then public comment.

Co-Chair Kahn: Yeah.

Ms. Elliot: So, I think sometimes public comment is influenced by how the Committee has voted. So, if their comments align with the voting, then they may not comment.

But, I'll get the additional reasoning behind that. But, historically public commenting goes last after a series of measures like this.

Co-Chair Roberts: Yeah. So, -- so maybe we can --

Ms. Elliot: Yeah.

Co-Chair Roberts: We can discuss that if that makes the most sense or not.

Ms. Elliot: Exactly.

Co-Chair Roberts: And I do --

(Simultaneous speaking.)

Ms. Perera: And we do have a few hands raised. First is Sam Tierney.

Member Tierney: Yeah, hi. I just wanted to offer a suggestion for why it's like that. I know that's how the consensus development process works.

So, maybe there was an attempt to align those two processes. But, I appreciate Clarke's comment, and I think it's a good one.

But, that's just my speculation as to why that's the way it is.

Ms. Perera: We also have David Gifford.

Member Gifford: Yeah. I was just echoing the other comment. If the com -- the public comment is after we vote, do we get a chance to revote if we feel compelled and moved by the public comment?

Co-Chair Kahn: Usually we have little public

comment. So, it -- I think not.

Member Gifford: No. No, I understand, yeah. I think -- I think the thrust that I'm hearing from all the committee members is, if public -- if there was public comment, which is rare, but if there's public comment that was compelling that none of us considered, how do we incorporate that into our voting process?

If we have it before the voting, that's helpful. But, I understand that someone may not what to comment if they, you know, if the vote goes this way, they don't want, you know, to take up our time.

If they comment afterwards and we feel it compelling, can we go back and revote? It's just, how do we make sure we incorporate that? That's all.

Co-Chair Kahn: I think we could do it after we have our discussions, before we vote. I mean, we don't usually have that many other people on the line.

I don't think -- it's not going to take up a lot of time probably.

Ms. Elliot: Great. I think we can incorporate that into this process. Because it is pilot and it's MSR.

But, typically if we rely on the history with the MUC process, that we don't revote after pub -- we do the voting, public comment, and then we do not revote after public comment, because there's specified voting members.

But, I understand the nature of this discussion in terms of hearing the public comment, so.

Ms. Perera: Leah Binder also has her hand next.

Member Binder: Yeah. I was just going to echo the -- Clarke's point that also said, and I think you just said this, but part of the purpose of these two days

is to really like test the process for this.

So, I think we should test that for sure. And see right away, and see how that goes to hear from the public prior to the vote.

Co-Chair Roberts: Yeah. I think that makes sense. I think we should do it that way for the next set.

Any -- and again, we do usually get limited public comment. I don't see any other hands raised.

Member Walters: Well Misty, this is Ron. My hand --

Co-Chair Roberts: Hey Ron.

Member Walters: Sorry. I wanted to thank and congratulate the group for getting through the first round of this.

It is a pilot process. And I think what I heard was sometimes it's more painful recommending to remove a measure than it is to approve it in the first place.

It is a valuable process though. Look at the kinds of things we talked about, the issues about each of the measure.

We gave criterion rationale for the kinds of considerations. And that is -- that's what we're asked to do in a pilot project, is to provide that sort of feedback to Dr. Schreiber and others as to what might be the reasons to remove a measure.

And I think the group did an excellent job. And again, we're advisory to other people. So, thank you again.

Co-Chair Roberts: Thanks for that Ron. We sometimes forget to kind of celebrate accomplishments, right?

Co-Chair Kahn: Well, thank you, Ron, that's --

Co-Chair Roberts: Yeah. Okay. Well, if we have no

public comment, I know we are at -- we are way ahead of schedule, which I probably should not say out loud.

I'm going to -- let's see, do we -- what do we want to do here? Do we want to proceed with the next set?

This was a miscellaneous set for the Psych Program. I think the alcohol and tobacco is next.

But, I think we had originally planned for a break before that, if I'm looking at the agenda right. Yeah.

Co-Chair Kahn: Yeah, let's -- since we were going to go until 1:00 and some of us may have scheduled things at 1:00, I wonder whether we should plow forward and continue to use our time?

But Tricia, what do you want to do?

Ms. Elliot: Let me just check in with the team. I think we're fine with that. We may be making a few adjustments on the fly here based on the feedback we just received.

So, if you bear with us as we, you know, move, you know, public comment ahead of voting and things like that. We won't have a chance to fix any slides or do anything.

But, if you bear with us through that, then I think we can just keep moving forward. Because we're quite a bit ahead of schedule, because it's -- yeah.

So, then the -- we'll kind of -- maybe that -- I won't say it, that we'll have some time at the end of the day. But well, I don't want to jinx ourselves here.

So, yeah. I think the team, if I'm seeing that they're all good to go. So, I think we can go to the next slide, which will say lunch break.

But, we'll defer that until after the next section, which is a continuation of the IPFQR measures.

Co-Chair Roberts: May I ask? May I suggest maybe just a quick five minute bio break before we -- since we have time?

Ms. Elliot: Sure.

Co-Chair Kahn: Okay. Well, why don't we reconvene about 11:40? How about that?

Ms. Elliot: That is good.

Co-Chair Roberts: Yes.

Ms. Elliot: Okay.

Co-Chair Kahn: Okay. Good.

Ms. Elliot: Okay, fine. Thanks Misty.

Co-Chair Kahn: Take it myself.

Co-Chair Roberts: Back at 11:40.

(Whereupon, the above-entitled matter went off the record at 11:32 a.m. and resumed at 11:40 a.m.)

Ms. Elliot: Okay. Chip and we're ready to go. This is Tricia, I'm back.

Co-Chair Kahn: Okay. Great.

Ms. Elliot: Before we go onto the next section, I just wanted to recap a couple of adjustments that we're making, if that's okay.

And I want to make sure we're on the same page. Particularly Chip then to see as we navigate forward.

So, as we move into the next section, we'll have the co-chairs will call on the lead discussants first. Similar to what you had started, Misty.

Then we will open it up to raising of hands. That seems to be working better than trying to do the round robin. If that's okay?

And so, with a call of hands, because we have the team monitoring the raising of hands, and we'll ask members to wait until we recognize them with the hand raising.

And they may also use the chat if they want to give us a heads up that they want to speak.

We will discuss one measure per set at a time. So, we'll pause after introducing each measure.

Get through the grouping of measures before we do the public comment. And then we will conduct polling.

Does that kind of recap some of the adjustments we wanted to make?

Co-Chair Kahn: I think so, yes.

Ms. Elliot: Okay.

Co-Chair Kahn: So, you're going to -- but you're going to open -- we open up though with you going through the whole thing, right?

Ms. Elliot: Correct. I'll walk through each of the measures. And then we'll circle back to the initial measure and then start the discussion.

Co-Chair Kahn: Okay.

Ms. Elliot: Okay. So, the next --

(Simultaneous speaking.)

Co-Chair Kahn: Okay. So, we're ready, I guess.

IPFQR Measures - Tobacco and Alcohol

Ms. Elliot: Okay. So, the next set of measures are also in the IPFQR Program. And they're tobacco and alcohol measures.

So, page -- or I'm sorry, slide 24, please. Next slide. There's eight measures in this grouping.

And once again, it's an Inpatient Psychiatric Facility Quality Reporting Program. The measures are tobacco use treatment provided or offered with eight committee members selecting that; tobacco use treatment, also with eight members selecting; tobacco use treatment at discharge with eight members selecting; tobacco use treatment provided or offered at discharge, seven measure -- or seven members; alcohol use brief intervention; alcohol use brief intervention provided or offered, with six members selecting that; and then SUB-3 alcohol and drug use disorder treatment provided or offered at discharge, along with SUB-3a alcohol and other drug use disorder treatment at discharge.

So, we'll walk through slides -- and it might be more efficient, should I -- I'm thinking I can walk through one slide, we'll pause for comment.

Then we've got the -- let's see, the background. I'm just looking ahead real quick. Yeah. I think we'll pause -- we'll walk through the description of what's on the slide. And then open up for comment, if that's okay, Misty?

Co-Chair Kahn: Hold on.

Ms. Elliot: Okay. So, the first one --

Co-Chair Kahn: I think I'm doing -- I think I'm doing this one.

Ms. Elliot: Oh, are you on this section, Chip?

Co-Chair Kahn: Yes.

Ms. Elliot: Thank you. Sorry about that. Okay.

So, this first one, CMIT 1677: Tobacco Use Treatment Provided or Offered. It is reported at the facility level.

Endorsement status is removed at this point. As mentioned, eight members had selected this. The lead discussants are listed on the slide.

And the criteria/rationale are removal with NQF endorsement has been removed, specifications are flawed, further clarification needed for definition of "inpatient", measure of compliance with standard of care.

With that Chip, I'll hand things over to you for the lead discussants.

Co-Chair Kahn: Okay. So, was it Sam Tierney with the America College of Physicians?

Member Tierney: Yes. That's right.

Co-Chair Kahn: Go ahead.

Member Tierney: Okay.

Co-Chair Kahn: If you have comments.

Member Tierney: Oh, yeah. For sure. So, as I mentioned earlier, the ACP has a performance measurement committee that reviews measures.

And this was one of the measures that was reviewed and not supported. A couple of the reasons for not supporting the measure relate to the specifications, the evidence, and the ability to implement the measure.

In terms of specification, I would say the results of the measure, or we would say the results of the measure would not easily identify opportunities for improvement.

So, if you look at the numerator, patients receiving counseling and/or pharmacotherapy, are equal to patients receiving -- refusing either or both.

So I, you know, you can't really get to the point of knowing which one was -- was noted with a particular patient.

And so, we also think that the measure doesn't allow for alternatives, such as contraindications

from medication. So, if a patient has one of those contraindications, how would that be classified?

Presumably it would be a refusal. But, it's not actually the case. So, I think we need some at least modifications to the specification.

We believe the specifications are missing fee exclusion criteria, including patients who expire during hospitalization.

And as I mentioned above, possibly maybe the exclusions to incorporate the patients who have contraindications to pharmacotherapy.

We also felt that some of the data elements require more clarification with particularly practical counseling and then cognitive impairment. When practical counseling is in the numerator, the same cognitive impairment is listed on there.

So, you know, in looking at the specifications, I understand that each of these are designed better. But, it seems like at least in the description or the numerator statement or denominator statement that those would be -- those at least should be, you know, better defined at a high level.

And the denominator specification should fairly define what constitutes inpatient status. You know, I don't -- it doesn't necessarily describe it.

I know there's an exclusion related to length of stay. But, I don't know if that's the full description of inpatient status.

With regards to evidence, you know, the developers present evidence to support the benefit of performing these interventions. But, those -- or the evidence is in the outpatient setting.

And so, it's not in the hospital setting. So, you know, I think we would need some level of evidence or some evidence to support the interventions in the hospital setting.

And finally, physicians -- facilities and individual physicians have faced challenges with implementation. Particularly in identifying the counseling interventions.

So, this may lead them to spend a disproportionate time on -- to a phased treatment, when other conditions should take practices.

So, those are kind of what we see. And I'll, you know, turn it over back to you, Chip. So, we'll get the take of the rest of the lead discussants.

Co-Chair Kahn: Yeah. It sounds like a strong letter to follow on that one. Okay. Let's go to Covered California, Margareta?

Member Brandt: Hi, this is Margareta Brandt with Covered California. I think we -- we would agree with many of the previous comments.

Our main rationale here was NQF's endorsement was removed. Again, you know, looking at the measure specifications and the inclusion of offered and refused, is a little confusing and concerning about how to be able to assess, you know, progress and outcomes using this measure.

Again, this measure is more process focused. And there maybe better measures or -- that look at outcomes.

And then also again, similarly thought that this tobacco cessation generally might be better addressed in outpatient setting and/or with -- in coordination with outpatient settings.

Co-Chair Kahn: Okay, thanks. Leah, do you have anything on -- from Leapfrog to add?

Member Binder: We don't have anything to add. I agree with what the others have said already.

Co-Chair Kahn: Okay. Emma from Purchaser Group, do you have anything?

(No audible response.)

Co-Chair Kahn: Okay. So, we're going to go through the whole group and then come back to the public. Do we have anybody -- I mean, any -- should we do any comments now from our group?

Any other comments beyond the discussants?

Ms. Elliot: Yes. If anybody has any additional comments to make?

Co-Chair Kahn: So, any hands raised?

Ms. Perera: Michelle Schreiber has her hand raised.

Co-Chair Kahn: Okay. Michelle?

Dr. Schreiber: Thank you. I just want to remind the group that we had in rule writing this year, a proposal to remove many of these measures.

In particular, the first two for tobac -- the first ones for tobacco we had left in the treatment at discharge. And the same thing for alcohol, we left in the ones for discharge.

And there was significant public comment. And there was significant comment across HHSs. This went into clearance.

And then if you'll see, we did not finalize removal, because of the significant comment that we received back.

In particular, there is evidence that these particular topics, tobacco use and alcohol use, are problems, particularly in the psychiatric patient population.

And it feels that it was felt by many, including SAMHSA and others that these are important interventions for patients while they're in a psychiatric facility.

So, I am just sharing with you that we actually did propose for these measures to be removed. And I

think if we were to re-propose that, I think we need to have broader conversations across -- to gain consensus.

Co-Chair Kahn: Michelle, at least in terms of what we heard from our comments, did you go -- did you include most of the kinds of rationale that was already expressed?

Or did we give you some -- anything new?

Dr. Schreiber: We did include most of what was already expressed. I must say, some of Sam's comments about measure specification changes, we didn't.

But, in terms of other things, and why to use these measures, we did. And so, you know, I just share with you that these weren't finalized as proposed.

And so we tried removing them.

Co-Chair Kahn: Okay. Well, I think, I guess my assumption here is we've got to sort of call it as we see it. And see what happens.

Dr. Schreiber: No, I agree with you, Chip. And I think my -- my conversation is that if -- if the committee feels strongly about having these removed, we need to somehow be able to voice that and to get consensus with others as well.

Co-Chair Kahn: Okay.

Dr. Schreiber: So, thanks.

Co-Chair Kahn: Thanks. So, we'll see when we go through the process here with these.

Are there other comments or questions, Tricia?

Ms. Elliot: I see Libby Hoy has her hand raised.

Member Hoy: Yes, hi. I think -- I guess what jumps out at me as a reason for removal is the age cutoff.

I think younger, our younger kids are experiencing and very vulnerable to tobacco use. So, I'm not sure why we're cutting off at 18.

It seems like we should be much -- if we're going to address this, that we address it for a broader audience age wise.

Co-Chair Kahn: Good comment. Any other?

Ms. Elliot: Leah, did you -- you had your hand raised?

Member Binder: Yeah. I think this also might be a moment when we should, for the purpose of understanding this pilot we're in, think about an option for us to recommend that a better measure be developed, or recommend that there be a better measure worked on.

Because the topic is obviously interesting. I had -- the issue of tobacco counseling related to psychiatric discharge is actually a really, really important issue.

I can see now why that was based on some very important issues. I think measures are a problem.

And you know, to my earlier remarks, I don't think it differentiates excellence from just adequacy. And so, I think a better measure would do that. And would, -- there's lots of ways it can be better measured.

But, I wonder if we could incorporate that into this process somewhat? Instead of simply saying, remove the measure, we could say, improve. And start to work to improvement the measure and replace it.

Ms. Elliot: So noted, Leah. Thank you. Sam, did you have additional comments?

Member Tierney: Yeah. I just wanted to comment that our committee reviewed this in general for the

inpatient settings.

So, some of the comments that Michelle raised about the importance of this, and Leah supported in the psychiatric community, or psychiatric discharge, I don't think that -- we reviewed it just overall for inpatient settings.

So, I think that some of those comments may alter some, you know, at least the overall concerns. Although I don't think many of the concerns related to the specifications would be addressed by that.

Co-Chair Kahn: Well, let me suggest, in terms of meeting Leah's mandate there, that we'll go through the discussion, we'll hear from the public and everything else, and then we're going to have a vote. And if, let's just say on this one, for conversation, if we voted to drop it, then we do have a lot of commentary that came from our discussion and, obviously, the staff is taking notes and maybe we should, if there is a recommendation, then all the discussion about the reinforcing issues around that should probably be recorded and passed on with the recommendation. So it's not simply a vote; it would be a summary, and we depend on the staff, I think, to make the summary of the points we made as to how we feel about it.

Does that make sense?

Ms. Elliot: Yes. And the discussion and the qualitative feedback is being captured, and the meeting is recorded and everything, so we will capture those key points, Chip. Thank you.

Opportunity for Public Comment on the Tobacco and Alcohol Measures

Co-Chair Kahn: Okay. So I think we're going to do the public, unless there's any other hands, I think we're going to do the public comment at the end of our discussion of all the measures. So I guess let's

go, are we ready to go to the tobacco use treatment?

Ms. Elliot: Correct. Next slide, please. Slide 26 is where we should be. So this is CMIT ID 2588, tobacco use treatment. This is a subset of Measure 2. It's reporting at the facility level. It's endorsement was removed. We had MSR selection count of eight committee members. Lead discussants are listed there, and the criteria or rationale for removal: NQF endorsement removed, challenging to collect as part of a set, treatment may be better addressed in an outpatient behavioral health primary care setting or through outcome-focused measures in an inpatient setting.

Co-Chair Kahn: Okay. So I guess we go to Sam again.

Member Tierney: Yes. So the committee that I referenced did not actually review this measure, so I can't comment on whether they would support or not support it. But I do think many of the items that I mentioned with the last measure are relevant here. I know that there are additional exclusions for patients who expired, so, obviously, that would be relevant.

But I would say we would echo a lot of the comments that I made last time, although we couldn't vote one way or the other.

Co-Chair Kahn: Okay. Margareta, any comment?

Member Brandt: Yes, we had many similar feedback as to the previous measure, since this is a subset measure. So I think we looked at these measures as, kind of as a group since they, these three measures go together. So we don't have any further feedback or comment.

Co-Chair Kahn: Leah, any --

Member Binder: Same as Margareta.

Co-Chair Kahn: And then Emma. Okay. Not hearing anything, do we have any hands up?

Ms. Elliot: I'm not seeing any.

Co-Chair Kahn: Okay. So going once, going twice. Hopefully, I think when we're looking at this particular set, I mean it is still inpatient sites. Hopefully, we don't have too many deaths in this area.

Anyway, let's go to the next slide.

Ms. Elliot: Sure. The next measure is CMIT 2589, and this is tobacco use treatment at discharge subset of TOB-3a. It is reported at the facility level, endorsement status has been removed. The measure set review selection count from the committee is eight. Similarly, discussant's criteria or rationale for removal: NQF endorsement removed, challenging to collect as part of a set, treatment may be better addressed in an outpatient behavioral healthcare setting. So very similar to the other measures. Or through an outcome-focused measure in an inpatient setting.

Co-Chair Kahn: Okay. Sam.

Member Tierney: Same comments as with the last measure. ACP didn't review it.

Co-Chair Kahn: Okay. Margareta, anything?

Member Brandt: Yes, same comment as with the previous measure.

Co-Chair Kahn: Leah.

Member Binder: Same comment, but I want to add one thing, just another one of the pilot questions, like this process as a pilot. I wonder if the lead discussants in some of these, we might want to consider at least recruiting members of the committee who might support having these measures. I think the folks that you identified as

lead discussants are those who voted in the spreadsheet vote to, you know, that these should be removed.

And so it might be valuable to ask maybe at that period of time after the vote, the spreadsheet vote I'll call it. If there's anyone who would like to be a lead discussant defending one of the 22 measures so that we have kind of more diversity of perspective among the lead discussants.

Co-Chair Kahn: Okay. I'll do that. Let me say that I hope in the future, I mean, if we look to the next model and we have the workgroups, then, presumably, it would be the leads on the workgroups describing the recommendation. But I think, for our purposes here, yes, we really do need to see whether anyone who voted the other way. So I'll bring it up.

Emma, anything to add? Okay. Well, along the lines of what Leah just asked, I guess I'll ask for hands. Particularly, if there are any hands of people who have any comments who didn't vote to remove, could you give us the reason that you felt that way? Any hands, Trish?

Ms. Elliot: Not seeing any, Chip.

Co-Chair Kahn: Okay. Any other hands or comments? Okay. Let's move on to the next one then.

Ms. Elliot: Okay. So we are on slide 28, which is CMIT 2590, also part of the tobacco use grouping of measures, so tobacco use treatment provided or offered at discharge. And this measure is reported as an overall rate. It is at the facility level. Endorsement status is currently removed. There is seven members that selected this for removal, and very similar criteria or rationale as we've heard with the other measures, including the measure endorsement, challenging to collect, and treatment may be better addressed in other settings.

Co-Chair Kahn: Okay. Let's start with Sam. Anything?

Member Tierney: No, just the same comments as for the last two.

Co-Chair Kahn: Okay. Margareta, anything?

Member Brandt: No, nothing to add.

Co-Chair Kahn: Okay. Leah or Emma? Okay. Do we have any hands of this of anybody that, particularly anybody that didn't suggest that it be removed?

Ms. Elliot: I am not seeing any raised hands.

Co-Chair Kahn: Okay. So this is, so let's go -- okay. So I'm sorry. That's the last, is that the last --

Ms. Elliot: The last of the --

Co-Chair Kahn: Tobacco.

Ms. Elliot: Yes.

Co-Chair Kahn: Okay.

Ms. Elliot: And quick lesson learned here, Chip, since it sounds like most of the discussion is with kind of the lead measure that we introduced, I will review the three alcohol measures, and then we'll open it up for comment, if that's okay.

Co-Chair Kahn: Yes, I think that would be good, I think that would be good.

Ms. Elliot: Okay, great. So we are now on slide 29, which is CMIT 2591, which is alcohol use brief intervention. This measure is reported an overall rate. It's at the facility level. Endorsement has been removed. Seven members picked this for removal. Lead discussants are similar with the American College of Physicians, Covered California, Leapfrog Group, and Purchaser Business Group on Health. Criteria or rationale for removal: NQF endorsement has been removed, little room for improvement,

high burden due to chart abstraction, and may penalize rule providers where patients have limited access to counseling services.

CMIT 2592, alcohol use brief intervention provided or offered is on slide 30. We can advance the slides. Thank you. This measure is reported overall rate and includes all hospitalized patients 18 years or older. Reporting level was not available. The endorsement status is removed. Six members select this for removal. Same lead discussants and similar comments for criteria rationale with NQF endorsement factoring in, little room for improvement, high burden for chart abstraction, treatment may be addressed in other settings, such as in outpatient behavioral health or primary care setting through outcome or through outcome-focused measures in the inpatient setting.

And then the third measure in this subgrouping is alcohol and other drug disorder treatment provided or offered at discharge and SUB-3a alcohol and other drug use disorder treatment at discharge. Reported at the facility level, endorsement removed. Three members had selected this measure. Same discussants, lead discussants. And criteria: NQF endorsement removed, difficult for hospitals to collect data, evidence-based supports, alternative treatment, rural health providers may be unfairly penalized due to lack of access.

So with that, I believe we do, Chip, maybe before we transition to the lead discussants, we do have a hand that was raised. Janice, did you have a comment?

Member Tufte: Through all three? No, I'm just, yes, you finished the third one, too?

Ms. Elliot: Yes.

Member Tufte: I was reading it through, so I wasn't totally listening. I found this interesting in the first two that their chart related, so I'm a little bit

curious if, you know, and this last one, too, is very interesting and it's important. But the way it's worded and what the comments are, the criteria and rationale below it, like it mentions rural health providers may be unfairly penalized due to lack of access for treatment.

The same goes in the urban area. Where I live, it's very hard to get treatment. I mean, it can take months and months, but it doesn't sound like that's how, actually, the measure is. It says who receive or refuse, you know. If it's not there, it doesn't really make a difference if it's not offered.

But in the first two, my issue is that they're chart related, and I'm curious if those are going to be, like, if some of these are going to be electronic, you know, quality measures that are, you know, derived from codeine. So it's kind of odd that this doesn't come from, like, ICD codes or whatever or, I don't know, rather than charting. So that's just, you know, I guess I would affirm that they should be removed without these. But on the third one, I think some of the rationale behind it, I'm not sure if that's really correct.

Co-Chair Kahn: Okay. Do we have any, I guess, technical views on it from CMS to sort of respond to Janice's questions?

Dr. Schreiber: No, I don't think so. We'll take the concerns back, however.

Member Tufte: If they're talked out, it sounds like the first two are very high, which is, you know, people do recognize alcohol. But in the third one, since we're addressing opioids, it looks like, you know, they're penalized because, perhaps, I don't know, if they're unable to refer somebody, that's different than refusing. So that's all on that one.

Co-Chair Kahn: Okay.

Ms. Elliot: Thank you.

Co-Chair Kahn: Any other hands before we go to Sam?

Ms. Elliot: No, no other hands raised.

Co-Chair Kahn: Okay. Sam, any comments on these?

Member Tierney: Yes. So for the first one, CMIT 2591, our committee did review this measure and did not support it. While they felt that the measure represented an important clinical concept, they highlighted that the developers didn't present evidence to support the benefit of performing this intervention in the outpatient setting and particularly related to improvements in consumption rates.

They also had some concerns about the referral to Alcoholics Anonymous not being included in the measure specifications and that this and, I think to Janice's point, the overall comment was that this could unfairly penalize clinicians who practice in rural areas where patients have limited access to counseling, but it sounds like that also could be a challenge in the urban environment, as well.

And I think, you know, similarly, to the construction of the alcohol or the tobacco measure where it's, you know, referral or refusal, so I think that's also a problem that we would highlight, as well, although that wasn't officially discussed by our group.

Co-Chair Kahn: Margareta, anything?

Member Brandt: Yes. We had fairly similar comments about this measure. I think, yes, just mainly focused on NQF endorsement being removed and that, you know, the need to develop more outcomes-focused measures for both tobacco use and alcohol use intervention and that these could potentially be better addressed or better coordinated with outpatient settings.

Co-Chair Kahn: Okay. Leah, anything?

Member Binder: We have a different reason for voting that we thought this should be removed. We thought it should be removed, going back to my own self-made criteria that I want to recommend we consider as part of the criteria list, which is that this is a baseline standard. It's not a standard that allows for us to differentiate excellence, which we believe all quality measurements should allow us to do.

So we think it's a baseline measure. We do not agree that it penalizes rural providers because, recognizing that it is more difficult in rural communities to offer a full range of services, this is an essential service and, if it's not available, then that itself is something to report. And it's still not an adequate level of care, given the seriousness of alcohol use as a problem.

So recognizing it's harder in rural areas, it's actually essential and it should be considered a baseline standard. So, again, we did not, we think it should be removed because it's a box check and not a quality measure.

Co-Chair Kahn: Emma, anything to add? Okay. Let's go to the next one. Why don't we go through all of them, and then I'll open it up.

Sam, do you have anything on this one?

Member Tierney: Yes. I think, you know, our committee did not support this measure and for many of the reasons that have been discussed. But, particularly, there was a feeling that implementation may encourage overuse of medically-assisted therapies, while the best evidence for treating drug and alcohol use disorders includes pharmacotherapy coupled to counseling.

And, similarly, related to the evidence, it's mostly referring to outpatient settings and not inpatient

settings. And then, finally, the referrals to Alcoholics Anonymous or the primary care clinician do not currently, or at least when the measure was reviewed by our committee, fulfill the numerator requirements, which I think is concerning.

And then, actually, there is one finally; I know I just said finally. There's another point that our committee identified. The numerator specifies FDA-approved medications. There is limited evidence to support those FDA-approved medications, but there's also some off-label use that occurs. And I understand you couldn't incorporate that into a measure because it's, you know, the FDA hasn't approved it, but I think just to maybe be aware of that and, you know, recognize that in some way in the measure.

So those are our comments.

Co-Chair Kahn: Okay. Margareta, anything?

Member Brandt: Our rationale is very similar to the previous measure, so I don't have anything else to add.

Co-Chair Kahn: Okay. Leah, anything?

Member Binder: Similar, except we do think that there should be evidence base that any measure leads to outcomes regardless.

Co-Chair Kahn: Okay. Emma. Okay. Trish, are there any hands?

Ms. Elliot: I'll look real quick. I don't see any other hands.

Co-Chair Kahn: Okay. No one who didn't recommend. Okay. Let's go to the next one. Sam.

Member Tierney: Yes. So, actually, my comments related to the last measure are actually related to this measure. So ignore what I said last time and replace it with this one. The other measure was

actually not reviewed by our committee, but I think it would have similar concerns as the 2591. But the comments I made last time are related to the 5555. So apologies for that.

Co-Chair Kahn: Okay. Margareta.

Member Brandt: Again, we looked at these measures as a whole set and so very similar rationale to the previous two measures.

Co-Chair Kahn: Okay. Leah.

Member Binder: Same.

Co-Chair Kahn: Emma. Anybody have concerns with dropping it that didn't -- okay. Are there any hands, Trish?

Ms. Elliot: No hands raised.

Co-Chair Kahn: Okay. So I think we're at a point where we could go to the public then if we're going to change the style. So the committee now will get the advice and guidance of the public prior to voting. So does anybody in the public want to make comment? Trish, do we have anybody?

Ms. Elliot: Looking. I don't see any hand raised or anything in the chat just yet. Give it another minute or so. Susan Yendro has her hand raised. Susan, did you have a comment?

Ms. Yendro: Hi, yes. This is on behalf of us, as the measure steward. You know, recognizing that these are not perfect measures, however, I think, kind of related to what Michelle brought up earlier in that, you know, I think right now, for alcohol and tobacco use, we've seen an uptake in the use of alcohol and tobacco, especially through the pandemic. We feel this would be a bad timing to remove these measures.

You know, I think we agree with looking at what better measures we could develop in the future. But

to have a measure that helps to recognize and keep the focus on these very important areas, these topics need to be addressed particularly, I think we talked about, in the psychiatric setting. I think it's particularly important for those areas.

And, you know, so we would support continuing to have these measures while other measures that are perhaps better measures of outcomes could be developed.

It is a very difficult setting to develop measures. I think it was brought up, some of the issues, with the chart abstraction being burdensome. Electronic health records in this setting are still evolving and very much underutilized compared to the hospital, inpatient hospital setting. And so I think that needs to be taken into consideration, as well, as we move forward.

Thank you.

Co-Chair Kahn: Okay, good. Other comments? Trish, anybody else?

Ms. Elliot: I'm not seeing any other hands raised. Let me just double-check.

Co-Chair Kahn: You know, before we vote, I guess I'd like to make a comment. I'm troubled. I guess we've dealt with this same issue over the years, which is we have measures that clearly, according to what we've heard from the commentary, are lacking in many ways; but then we feel compelled to make sure we keep them on the agenda, even if we don't have better measures. And the idea, I guess, is it will be front of mind with the providers and clinicians if the measures are there.

But I guess I'm really torn because Leah has pointed out that, without striving for excellence, a lot of these measures are just checking the box. And I guess I find it hard to believe, in terms of, you know, what are the three things we're worried

about? Improvement, accountability, and transparency. Well, I guess, in terms of transparency, the measures tell you something maybe; but, in terms of improvement, I don't necessarily see, particularly in some settings, as has been pointed out, that these drive that. And in terms of accountability, I don't think they necessarily measure up there either because they're not outcomes oriented.

So I don't know. I think, at some point, we have to fish or cut bait and say, if we need something better, let's get something better and not stick with something just because it's the right topic. But that's my two cents.

Any other questions, Trish, or --

Ms. Elliot: Yes. Clarke Ross has his hand raised.

Co-Chair Kahn: Okay.

Member Ross: Hi. So I'll respond with my two cents to Chip's two cents. This entire endeavor reflected by the National Quality Forum and all its members and stakeholders, there's a credibility test with people who depend on these varieties of treatment services and supports. And if we eliminate entire categories of measures because they're not perfect. And I'm very frustrated with these measures that have little age bans and only apply to one setting and only two diagnoses. What we do sometimes is eliminate an entire category of measures when alcohol abuse, for example, and tobacco use and abuse by people with severe and persistent mental illness is documented in all the SAMHSA studies as a very serious issue. It sends a message that, you know, the National Quality Forum just eliminated an entire category of measures.

And so I think these are very important public health topics and, as inadequate as a measure is, we need a proxy for these overwhelming public health problems: tobacco, alcohol, opiates, et

cetera. And that's not defending six or eight measures and it means a difficult process of trying to find one. Dr. Schreiber already said that treatment at discharge was something CMS supported in the alcohol and tobacco area.

So trying to have something that sends a message that the entire quality measurement endeavor recognizes in an effort to address quality measurement in these overwhelming public health areas is important. And it is hard to defend a lot of little items in these variety of measures.

So from a consumer point of view, that's a perspective I have. I have to go back and explain to lots of people with disabilities across the country, including mental illnesses. Yes, they eliminated this entire category because each of the measures was inadequate; and they are inadequate. But waiting for the perfect, you'd spend your whole life waiting for the perfect.

So that's my maybe one cent to Chip's two cents.

Co-Chair Kahn: Thanks.

Ms. Elliot: We have a few more hands, Chip. Yes, next up is Sam.

Member Tierney: Yes, hi. I'd like to add another set to the discussion, and this is not representing ACP. It's just based on my past experience as a measure developer. You know, I think Leah's point about recognizing, you know, excellence is a good one. However, I might disagree with it a bit because I feel like, you know, when you're developing measures, you either talk about the floor or the ceiling. And I think if the floor isn't even met and you have data that says, you know, there's a huge gap in just meeting the floor, then you can't possibly set the measure at meeting the ceiling.

And so I think that that's one challenge that developers face.

And I think, Clarke, to your point, we have a phrase in measure development and I'm sure in other, many of you would recognize this and maybe it's a common phrase that you would say, but we can't let perfect be the enemy of good enough. And so I do think when people review measures, there's lots of things you could say are wrong with them. But you have to focus on, you know, is this reasonable and can we live with it?

And so, again, not ACP's perspective, but I just wanted to share that as a former measure developer.

Co-Chair Kahn: Thanks. Trish, anybody else?

Ms. Elliot: Yes. Next up, we have Ron Walters.

Co-Chair Kahn: Okay, great.

Member Walters: I'm probably the most predictable person on the call. So I agree completely with what Chip said. I mean, yes, let's not let perfect be the enemy of good, but how are you classifying these as good is because they're present and they're continuing. They don't accomplish what they're supposed to be accomplishing, as Chip said. You haven't seen they've improved processes scores or anything like that.

They're important issues; we can't forget that. But what is going to drive the next development of better measures if not so good measures are left around for a number of years? We need to send a message. The message may not be accepted. The message may not be totally adopted. But I think the work that this group is doing is to send a message: get better measures. We've been playing with these for a long time; and, yes, they need to be more outcome oriented and process, which is an argument that started when NQF first got this authority to become this agency for CMS. We haven't, we are moving the needle towards outcome measures, when appropriate, at a snail's pace, and

the work that we're doing on this committee is to try to influence that.

Thank you.

Ms. Elliot: Okay, Chip. Next up is Michelle Schreiber.

Co-Chair Kahn: Okay. Thanks. Michelle.

Dr. Schreiber: Thanks. I just want to emphasize the comment that Clarke made before. This really is a public health emergency almost. Mental health disorders during the COVID pandemic have gotten worse, as has the use of alcohol and tobacco. We know that in this particular population with mental health, alcohol and tobacco are actually even more problematic than they are, say, in the generalized hospitalized population.

And so it, again, based on a lot of feedback that we had, but it didn't seem like a good time to send a message that this wasn't important when, point of fact, this is very important and getting worse.

Chip, to your point about what measures can do, I mean, I think all of us agree with that. But is there transparency? There is transparency. Is there accountability? This does hold organizations accountable, and we all know the cycle of measures. They may start with a structural measure. They may then go to a process measure. They may then go to an outcome measure, and none of us would disagree to get to an outcome measure. But, frankly, there's still a lot of opportunity to improve in the process measure where we haven't talked these measures out.

And, finally, are they moving the needle? We think they are moving the needle. They gradually have shown improvement. I grant you all probably not great, not enough. We're not there yet with what we need to do. But I think these are huge public health issues that to not have any measures on them at all would be difficult and really a disservice

to patients.

Co-Chair Kahn: Thanks. Other comments?

Ms. Elliot: Yes, we've got quite a few hands. So next up is Leah.

Member Binder: I want to echo, I think Ron made the point that I think is really important: get better measures. I kind of want to go back to my earlier recommendation that we actually have a way to vote that, when we say that we want to remove measures, that there's also a way to vote to say, and in a clear way, not just as a qualitative notes to the meeting but actually in a clear way that this is a high priority gap that has to be filled and we'd like it to, you know, be filled because I just think that recommending that this measure be removed is not a statement that it's not an urgent problem. It's just a statement that this measure isn't going to get us there. And so I think that I'd like us to have a formal way of making that clear as a group.

Co-Chair Kahn: I mean, as we make our way through this, Trish, I guess we've got our voting. Is there -- I mean, I think this is a really good point because these are forward-looking recommendations. I mean, these are action recommendations really. I'm not sure, I don't know when -- we obviously have a lot of different alternatives at the MAP, at our conventional MAP meetings. Is there anything we can do? I'm not sure, Leah, just because -- can you suggest anything?

Ms. Elliot: I think we can capture, you know, future processes and how we can influence how this is going forward with those types of comments. I think we've captured, you know, we're capturing the essence of these discussions, but I'm not sure if there's an immediate thing we can do right now.

Co-Chair Kahn: Let me suggest this because I think that, in the future, in the vote we really need

something, you know, if we have yes -- and maybe we can work this out in process after because we'll have later discussion of this -- but, you know, yes, no, yes but gap must be filled, or something like that because I think we're, when we vote on this, I'm not exactly sure on the yes/no what the vote means. Maybe it's really a vote on whether something is good or not good in terms of this perfect versus the good.

But I think we're going to need to recognize this when we come back, and I think I brought this up at the beginning. I think one of the things we need to recognize here is this is a chance for us to recognize gaps, and these things, this points to one type of gap, which is we have measures that are, by everybody's agreement, insufficient, as important as the topic the measure covers is. And we've got to figure out a way to quantify that so that that would be the signal we send because I don't think anybody here disagrees with Michelle's point about these things being at a crisis level, particularly for the mentally ill.

Co-Chair Roberts: And I see that as, like, an input as the information that we need as part of the decision-making process. So before we vote to remove something, we need to know are there other similar measures? And if the vote is we still think that this is not the right measure, then it's like there's an output of, okay, there's a high-priority gap that needs to be filled after decisions are made. And I see the first up as an input into the decision-making process.

Member Tufte: This is Janice. I'd just like to add something. This came up when I worked on a MAC scorecard, and it was, you know, for pre- and postpartum health. And because it had not been maintained, it was rolling off, and there was three of us that were really adamant about this needs to stay on; it's the only one you have in the MAC scorecard that's addressing this issue. And it was

when it was really coming to light, you know, some years ago. We still have many issues in that area.

It had to do with maintenance in that situation, right? So I just looked. It is still on there. You know, there was a lot of discussion. And what I see here is, you know, it's a mess; I agree. This should be measured, these should be measured. I think alcohol is noted, but, with substance use, you know, we also have the innovative accelerator project that's mostly for Medicaid, and I'm not sure why we can't transfer that over, you know, to some of the substance use disorder measures and beneficiaries or context needs. You know, there's measures in there that could perhaps go over.

But when we did look over these, which was a big job, if you went to each one that you looked at, you could see where the comparable, you know, measures were. And there were some where I really noted where the e-quality measures were really better, I felt, and that they shouldn't roll off, but perhaps they weren't used as much.

So we are moving, you know, to the electronic quality measures; and, I don't know, it seems to me that we should have some sort of major transition discussion with developers on this and how we can help to keep these, like these public health measures that are so big, into it but have it not be such a large burden for the providers. It is important to the people.

Co-Chair Kahn: Well, presumably, in the history, at the beginning, a lot of this is going to be in the history; it's got to be. So this should be in the record one way or another.

Trish, are there other questions?

Ms. Elliot: Yes. David Gifford has had his hand raised for a bit. David.

Co-Chair Kahn: David.

Ms. Elliot: I think he removed his hand-raising so maybe --

Co-Chair Kahn: Okay. Anybody else, Trish?

Ms. Elliot: Yes. Heidi Bossley.

Member Gifford: Can you hear me now? Sorry.

Ms. Elliot: Oh, David, yes, we can hear you now.

Co-Chair Kahn: Yes, go ahead, David. Go ahead, David.

Member Gifford: Yes, I agree with everyone else, you know, about the high priority issue. But, you know, part of our criteria was unintended consequences and, you know, moving the needles that fit with the program. And, you know, Michelle didn't give a resounding endorsement that this is moving the needle very much, and, you know, there's an opportunity cost for us to have measures out there that everyone is spending time following, if not helping us move the needle on, an incredibly important public health crisis in the country.

You know, working with NQF over the years, I've just watched the face validity of the topic drive endorsement and drive the measures when there's some really bad measures that get out there and they have unintended consequences, including opportunity costs, of focusing on stuff that's not going to help move the needle.

So for me, in deciding this, you know, while no measure is perfect, is this measure really going to help move the needle, or is it bad enough that, despite this being a huge public health thing, we shouldn't let it go forward. I mean, it's lost NQF endorsement. That's a bad sign to start off right off the bat.

So, to me, I guess, understanding the opportunity costs. And I agree. I think, because this is a pilot discussion, we've always had discussions at the end

of our voting on the MUC list of what other gaps should be there, but we've never really spent a lot of time on it. This is, I think, a real opportunity to talk about it, especially if we're going to remove measures that we need to address.

I mean, if we need them on, then everyone says, oh, well, we still have the measure, we don't have to do anything, and they focus somewhere else. So, to me, I'm almost worried about the opportunity costs that create by leaving this measure on.

Co-Chair Kahn: Trish.

Ms. Elliot: Yes. Next up is Heidi Bossley.

Member Bossley: Thanks. I was going to bring up some of this later, but, since it's kind of being discussed now, I thought I would bring it up. I'm struggling over a few things, and I think I don't know the right answer. But I feel like there's degrees of priority on perhaps how quickly a measure might need to be removed, for example. Like Dave just mentioned, if there's unintended consequences, that's something that should be moved off quickly, regardless of whether there's a replacement or not. Perhaps there are other ones where we know there's a measure either in the set already or under development that could replace a measure, and, again, that to me is maybe you don't move quickly on removal but you think about this a little bit more and prioritize it sooner rather than later.

So those are the things I'm struggling with.

The other thing that I keep thinking about, too, is, for example, these measures had endorsement removed, but I don't think the measures were used in the inpatient facilities at that time. And I don't know, I think, I'm assuming some of the reason why it was removed was because the measures were topped out. NQF staff may have that. I didn't get a chance to go back and look at the history.

They're not topped out here, so I don't know if I can prioritize removal if that was the reason why they were.

So those are just things that I keep thinking about. And then my overall question, knowing where we may be headed, we may be recommending a removal of a lot of measures from this set for this program. What kind of message are we sending with a yes on nine, however many measures it might be, and would it help at some point to create some prioritization so that CMS understands why we think things may or may not be important to move sooner rather than later.

Co-Chair Kahn: Okay. I think you made, you know, a number of good points we need to discuss later in terms of increments of our recommendations.

Trish.

Ms. Elliot: David, you still had your hand up. Did you have additional comments or are you good? I'm thinking he might --

Member Gifford: I'm sorry. I'm good. Sorry.

Ms. Elliot: Oh, okay. No problem. Just wanted to double-check.

Co-Chair Kahn: Other comments.

Ms. Elliot: Michelle Schreiber raised her hand.

Co-Chair Kahn: Michelle.

Dr. Schreiber: I just wanted to get back and give you guys some data on the alcohol measure, SUB-3. The performance was 65 percent in fiscal year '19 and 73 percent in fiscal year '21, so that's an 8 percent improvement in three years. On tobacco, TOB-3, 40 percent adopted in fiscal year '18, moving to 60 percent in fiscal year '21. So we actually do think that there's been improvement.

Co-Chair Kahn: Okay. Other comments, Trish? Because we need to really move here.

Ms. Elliot: No other hands raised. Liz Goodman had a comment in the chat about the enemy of good, so folks can catch up on that. And then I just want to give the opportunity, if there's anybody that's on phone line-only and not able to raise their hand, if there's any questions, we'll pause for a moment to see if there's anybody on the phone lines.

Co-Chair Kahn: Okay.

Ms. Elliot: Not hearing any.

Co-Chair Kahn: So then we go to the public, and then we vote?

Ms. Elliot: Correct, correct.

Co-Chair Kahn: Is there anybody from the public that has any comment? Please make, you know, let us know and Trish will --

Ms. Elliot: I'm not hearing or seeing any at this time, Chip.

Co-Chair Kahn: Okay. Well, let's go to the vote then, and I think we can finish right before, I mean, right on schedule for the next section. So why don't we --

Ms. Elliot: Yes. So the team is pulling up the Poll Everywhere. If everyone can get that pulled up and ready to go. Okay.

Ms. Young: Okay. We have seven measures to do in this section.

Co-Chair Kahn: I guess we'll take each one individually?

Ms. Young: We will. We're going to start with, the polling is now open for Measure 1677. This is tobacco use treatment provided or offered. Do you

support the removal of this measure from the IPFQR program? And, again, please let us know if you're having any problem with Poll Everywhere. Thank you.

Member Binder: I'm sorry to ask this question, but how do you vote?

Ms. Elliot: You should have received a link to Poll Anywhere, Leah.

Member Binder: In my email?

Ms. Elliot: In your email, yes. There should be a link, and then you can log in.

Member Binder: I don't see it. Oh, wait.

Ms. Elliot: Did you find it? Yes, we resent it this morning, as well as yesterday.

Co-Chair Kahn: You may want to use it on your phone. Then you can keep the computer in.

Ms. Elliot: Another message was sent at 11:17 this morning with the link, if that helps you find the email. Okay. We'll just wait another minute. Were you able to get in, Leah?

Member Binder: I did, but it's not -- I voted, and then what do I do? It doesn't do anything.

Co-Chair Kahn: Once you vote, then you just wait for the next one. They'll put it up.

Member Binder: No, it didn't send me the next one.

Ms. Elliot: Yes, we have to --

Co-Chair Kahn: They haven't gotten to it yet.

Member Binder: Oh, I'm sorry. Okay.

Ms. Elliot: Yes, we'll do one at a time. So I think we're good. We're at --

Co-Chair Kahn: 18 to 1.

Ms. Elliot: Yes, 19 votes.

Co-Chair Kahn: Let's go to the next one.

Ms. Elliot: Susanne will read the results first, and then we'll move on, Chip.

Ms. Young: The poll is now closed for Measure 1677. Results are 18 yes, 1 no. That's 94 percent.

So we will go on to the next one. Polling is now open for Measure 2588, tobacco use treatment. Do you support the removal of this measure from the IPFQR program? Yes or no.

Co-Chair Kahn: Is that our number?

Ms. Elliot: I think we're at 19. If you want to go ahead and close, Susanne.

Ms. Young: Polling is now closed for Measure 2588. The results are yes 14, no 5. And that is 74 percent.

Co-Chair Kahn: Okay. Let's go to the next one.

Ms. Elliot: Next one.

Ms. Young: Moving on to our next measure, polling is now open for Measure 2589, tobacco use treatment at discharge. Do you support the removal of this measure from the IPFQR program? Yes or no.

Co-Chair Kahn: I guess we're at 18. Is there one person outlying? I think we should give it ten more seconds.

Ms. Elliot: Then we'll close it.

Co-Chair Kahn: Let's close it.

Ms. Elliot: Okay. I'm good with that. Susanne, if you can close it. Thank you.

Ms. Young: Polling is now closed for Measure 2589.

The results are yes 7, no 11. And that is 64 percent.

Moving on to our next measure, polling is now open for Measure 2590, tobacco use treatment provided or offered at discharge. Do you support the removal of this measure from the IPFQR program? Yes or no.

Co-Chair Kahn: Okay. We're at 17. I think we were at 18 last time.

Ms. Elliot: Go ahead and close it?

Co-Chair Kahn: Yes.

Ms. Elliot: Okay. Go ahead and close it, Susanne.

Ms. Young: Polling is now closed for Measure 2590. The results are yes 8 and no 9. And that is 47 percent.

And moving on to our next measure, polling is now open for Measure 2591, alcohol use brief intervention. Do you support the removal of this measure from the IPFQR program? Yes or no.

Ms. Elliot: Okay. I think we're at 19, if you want to go ahead and close, Susanne.

Co-Chair Kahn: Okay.

Ms. Young: Polling is now closed for Measure 2591. The results are yes 14, no 5. And that is 74 percent.

Moving on to our next measure, polling is now open for Measure 2592, alcohol use brief intervention provided or offered. Do you support the removal of this measure from the IPFQR program? Yes or no.

Ms. Elliot: Okay. We're at 19. I think we can go ahead and close.

Co-Chair Kahn: Okay.

Ms. Young: Polling is closed for Measure 2592. The results are yes 15, no 4. And that is 79 percent.

And the last and final measure in this section, polling is now open for Measure 5555, SUB-3, alcohol and other drug use disorder treatment provided or offered at discharge; and SUB-3a, alcohol and other drug use disorder treatment at discharge. Do you support the removal of this measure from the IPFQR program? Yes or no.

Co-Chair Kahn: Okay. Well, that's 18. One more vote, one more vote. Oh, there we go.

Ms. Elliot: Nineteen. We can close it.

Co-Chair Kahn: I guess I can't make a joke.

Ms. Elliot: Okay. I think we'll close. We have 20.

Ms. Young: Yes, polling is now closed for Measure 5555. The results are yes 10, no 10. Fifty percent.

That's the end of this polling section. Thank you.

Co-Chair Kahn: Okay. Well, let me suggest that we have some interesting findings here, and it's just too bad we can't gradiate it, but we clearly have a lot of qualitative comments that I think should be taken into account.

Let me suggest this. We're at 12:53, Trish and Misty. If we, you know, came back at our scheduled 1:35, we're giving ourselves a few extra minutes. But then we get back on, I mean, we'd be back on what you've got written as the schedule, and then we move to the next section.

Co-Chair Roberts: Correct.

Co-Chair Kahn: And we'll be ahead of the game.

Ms. Elliot: I was going to suggest that, as well.

Co-Chair Kahn: Okay. So we'll come back at 1:35 then and take the next section. I want to really think everybody. This has been, I think, great commentary, as well as the voting has gone

smoothly, too.

Ms. Elliot: Excellent. So as Chip mentioned, we'll take a lunch break until 1:35, and when we come back we'll be starting with the ambulatory surgical center quality reporting measures.

So thanks, everyone. See you after lunch.

(Whereupon, the above-entitled matter went off the record at 12:54 p.m. and resumed at 1:36 p.m.)

Ambulatory Surgical Center Quality Reporting (ASCQR) Measures

Co-Chair Roberts: At this point, we're going to discuss the ambulatory surgical center quality reporting measures. And Tricia, I'll hand it over to you to talk about the measures in detail, right?

Ms. Elliot: We'll get started, welcome back from lunch break everybody, we are on Slide 34 and we'll move quickly to Slide 35, please.

There are three measures that we'll be discussing in the ambulatory surgical center quality reporting program.

The first is CMIT ID Number 1049, which is cataracts improvement in patients' visual function within 90 days following cataract surgery.

There were seven members that selected this measure for removal, 1061, appropriate follow-up interval for normal colonoscopy in average-age patients.

Three members had selected this for removal and 2639, normothermia outcome, and three members had selected that for removal. Next slide, please.

The ambulatory surgical center quality reporting program is a pay-for-reporting and public reporting program.

The incentive structure includes ASEs that do not participate or fail to meet program requirements receive a two percent reduction in the annual payment update.

The program goals of this quality reporting program are to promote higher quality, more efficient healthcare for Medicare beneficiaries through measurement and allow consumers to find and compare the quality given at ASEs to important decisions on where to get care.

Misty, I think these measures are different enough. I'll do the first description in pods for discussion, if that's okay?

Okay, the first measure we'll discuss is 1049, which is cataracts improvement in patients' visual function within 90 days following cataract surgery.

It's the percentage of patients aged 18 and older with the rest of the description there. The reporting level is clinician-individual, endorsement status is that endorsement has been removed.

And as mentioned, seven members recommended this measure for removal. For this section, the lead discussants are HCA Healthcare, National Patient Advocate Foundation, Network for Regional Healthcare Improvement, and Purchaser Business Group on Health.

The criteria or rationale stated for removal, the NQF endorsement being removed designed for physician use and not tested for current level of measurement and setting.

Measure performance is uniformly high and there is a similar measure. With that, Misty, I'll hand things back to you to start the discussion.

Co-Chair Roberts: So, we'll start out with HCA and I think, Kacie, are you on the line?

Member Kleja: Hi, good afternoon, thank you. I

actually reviewed these measures with our ambulatory surgery division and the quality people that are part of that division within our organization.

They had a couple of specific comments on this particular measure. Obviously, as Tricia already measured, the NQF endorsement was removed for this measure. The big one is this is currently a voluntary measure and very few ACSs are actually reporting on it.

So, if you look at the most recent data that are available on Care Compare, there's only 46 ASCs nationally that even reported on this measure.

There's also difficulty for ASCs to actually collect and report on this measure due to the burden of the survey collection, and so it is a very cumbersome measure for them to collect, which is probably why so few are voluntarily reporting.

Previously, there was a similar measure like this in the physician quality reporting program and there were a low number of physicians that also reported on this measure from that perspective as well.

Those were all their comments.

Co-Chair Roberts: Thanks, Kacie. From the National Patient Advocate Foundation, we have Rebecca.

Member Kirch: I'll just be responding on each of these from the patient caregiver perspective and I think what was most influential in our decision-making is the lack of uptake on this one is concerning.

Because if it's not a meaningful measure for the providers, it's not going to deliver the good outcomes for patients and families. So, that was the most influential among the many of the criteria.

Co-Chair Roberts: Thanks, Rebecca. From ENRI we have Liz.

Member Cinqueonce: Our observations were very similar. I think the other thing that came in play is the uniformly high performance on this measure for those that are selecting it.

Co-Chair Roberts: Emma from the Purchaser Group.

Member Hoo: One of our perspectives on this was that there is a similar measure that sets a particular target of 1020 visual function. And it made sense to consolidate and use a common measure that also had a specific outcome target.

Co-Chair Roberts: I have a question just briefly, I don't know if Michelle or someone else can answer, maybe even the lead discussants.

In terms of the criteria where it says it's designed for physician use, not tested for current level of measurement and setting. What is the current level of measurement and setting?

Dr. Schreiber: This is Michelle, you're correct. It is at the moment used, as is it's voluntary. Anita Bhatia is on the phone, who is the lead for ASCQR for this measure so I'm going to ask her to comment.

But I do want to make one other comment at the moment. Most of you have probably seen in rule-writing that this is proposed actually as a mandatory measure, no longer a voluntary measure.

That is in part because of the comments we just heard a few minutes ago that there hasn't been enough reporting quite honestly and so this is one of the ways to try to get comment.

This really is trying to get at CMS's commitment to look at functional status improvement and that's really what the measure aims to do.

Anita, I know you're on the phone, do you want to provide further comment, please?

Ms. Bhatia: Thank you, Michelle, can you guys hear me? I just want to check before I start talking. The visual function survey measure, as everyone has pointed out and rightfully so, has been reported by few facilities.

We do have a core group of facilities who strongly believe in this measure and so they have reported and continue to report. I would be cautious in looking at the latest data that is reported in that.

There was a blanket exception due to the public health emergency so essentially, a lot of ASCs were closed during the time when reporting would have happened.

So, you do have to be careful when you look at those numbers but they have been low overall. We think this is a valuable measure. The functional survey measure is a very nice measure because it actually measures how well the patient function.

It's not visual acuity, it's actually visual functioning, which is something separate. That is why it is more work to collect the information and so as has been pointed out, very few have pointed out this out to date.

But we would like people to report on this measure. We think that it builds more continuity so the facility can know how well their patients are performing after they have surgery done at their facility.

So, that is why we really like this measure for the program.

Dr. Schreiber: Anita, do you have any comments to the question about at what level this has been tested?

Ms. Bhatia: What level it has been tested?

Dr. Schreiber: It's a question, you guys can correct me if I'm wrong.

Co-Chair Roberts: It looks like one of the criteria that was used to select this measure for removal is it says it's designed for physician use and not tested for current level of measurement and setting.

I just wanted to clarify what is it? What level of measurement and setting was it tested for?

Ms. Bhatia: I believe it actually was tested at the facility level but I have to verify that. I know for certain it is tested for the clinician level, that's why it was part of the physician reporting program.

Co-Chair Roberts: I will open it up to the rest of the Committee to see what additional comments we have. It looks like we do have a few hands raised. Leah?

Member Binder: I would strongly recommend and I believe this should be a mandatory measure. I just want to put a little context around this too that I think is important which is that there are very few measures on ASC performance.

Certainly very, very, very few that are looking at outcomes for ambulatory or outpatient surgery. We also are always looking for measures that look at outcomes other than mortality.

This one is looking at I think a very important measure to consumers certainly. I think when we're looking at outpatient surgery or ambulatory surgery, we're always going to have to look at days following the surgery.

It's going to be a little more difficult sometimes to collect it because of that because it's not like an inpatient setting where you can track the outcomes right there in the hospital.

Most of the time you're not going to be able to do that in an ambulatory situation because they left. By definition, they've gone. So, they do need to be tracked later.

I think this is actually has some great strength to it and given the paucity of measures in this category, it is particularly important to preserve it.

I would add one other comment which is cataracts surgery is by far the number-one most commonly performed surgery in ACSs and for Medicare beneficiaries.

So, that is another reason why I think it is important to preserve what we can of outcome measures in that area.

Co-Chair Roberts: Thanks, Leah. David?

Member Gifford: I'll add to Leah's comment.

As a geriatrician, this is not only a great outcome measure, it's also an inappropriateness measure because the success of cataract surgery is based on the visual function impairment, not how bad cataracts is or the visual acuity part of the surgery.

We know that a lot of people get operated on not because of visual function but because of how ripe the cataracts is. So, I think this actually picks up both function and appropriateness for the surgery.

I think it's the main reason for it being added to this discussion today was that it was voluntary and no one was using it. That's going to be made mandatory. I think that takes a lot of it away.

And then I would just echo and double-down on everything Leah just said.

Co-Chair Roberts: Any other comment? It looks like Dan?

Member Culica: It was me, I'm sorry. I think actual question is, and I think somebody addressed it already and I apologize, I didn't know the name about the competing measure.

There is a similar measure, so the questions would

be how similar it is and whether the other one would be endorsed by NQF.

Co-Chair Roberts: Anita, do you know the answer to that? I think it might have been Kacie that brought it up if I recall.

Ms. Bhatia: I don't know what measure they're referring to, I would be interested to know what it is.

Member Hoo: It's the one that sets the improvement measurement at 2010 vision that's used in MIPs.

Ms. Bhatia: Again, that sounds like a visual acuity measure whereas this is a visual function measure and it is a patient-reported outcome measure as was pointed out.

Member Culica: It's way different, thank you.

Co-Chair Roberts: That's helpful because I actually had the same question around the similar measure. I'm looking at some of the other criteria rationale with the measure performance being uniformly high.

And this could be an incorrect assumption but if it is a voluntary measure, I'm guessing that those who are voluntarily reporting on it probably are reporting on it because they are doing well.

So, again, that could be an incorrect assumption but I wonder if that's the case.

Ms. Bhatia: That's what we think, what we believe. The people who are reporting on this measure love this measure and they do put the work into reporting.

Co-Chair Roberts: I do agree with everything that Leah said. As I look at this one, I know my thought was this is an outcomes measure, this is looking at the visual function. Why would we want to get rid of

it?

And then walking through some of the criteria in the discussion that we just had, it seems like we might have rebutted some of that criteria.

I don't see any other hands raised. I want to still open it up to see if anybody else has any discussion items on this.

Member Hoo: Anita, can you speak to the length of the survey?

I do think it makes sense per Michelle's comment that as a mandatory measure, we would see greater spread and we wholly support the use of PROMs in this space.

Ms. Bhatia: When you say the length, are you referring to the length of the survey itself or something else?

Member Hoo: The survey, there are multiple versions of the survey.

There is, I believe, an original version of the survey that has 32 questions and then there are other versions of that survey which scale down the number of questions but still get to the same outcome measure.

It's basically a Cliff Notes version, different grades from the larger survey. And that's just to make it an easier survey to administer, but the surveys are scientifically validated.

We do have a discussion regarding the different -- or not a discussion, but we do have mention of the number of surveys, differing in the number of questions and that they're scientifically valid with references in the proposed rule.

Was that the question?

Ms. Bhatia: Yes, thank you.

Co-Chair Roberts: Any other thoughts on this one? Let's move to the next one.

Ms. Elliot: The next slide is Slide 38 and it is CMIT Measure 1061, appropriate follow-up interval for normal colonoscopy in average-risk patients.

And just to call out in the description patients' age, patients aged 50 to 75, the reporting level is facility, the measure is endorsed, and three members requested this measure for removal.

Lead discussants are listed here and then the criteria or rationale for removal was the measure was designed for physician use and it has not been tested for this level of measurement and setting.

There's a need for more robust measures for ASCs. Measure has unintended consequences of increased frequency of screening with provider outreach reminders issued at five years.

Misty, if you want to lead the discussion?

Co-Chair Roberts: Yes, we'll go to Kacie, we'll kick it off with you again.

Member Kleja: Our group actually did not have any additional comments on this specific measure so no questions or concerns.

Co-Chair Roberts: Rebecca? Rebecca, you might be on mute. Let me switch over to Liz.

Member Cinqueonce: Actually, this is not one of the measures that we put forward as a candidate for removal. Our observation was that there still does seem to be some room for improvement so we do not recommend it.

Co-Chair Roberts: Emma?

Member Hoo: One of the concerns we had was the frequency in terms of provider outreach occurring at five years or we've heard of cases of even fewer.

And while recognizing that there is a dearth of measures in the outpatient space, one of the areas that we'd like to see more focus on would be the outcomes and the safety aspects of the care as opposed to this procedural aspect of follow-up.

Co-Chair Roberts: Thanks, Emma. I'm going to go back to Rebecca just to see if she was having any audio issues. Let me open it up to the rest of the Committee. Any other comments on this one?

Member Baker: I had one comment, Misty.

Co-Chair Roberts: David?

Member Baker: Yes.

Co-Chair Roberts: Go ahead, David.

Member Baker: I always viewed this as the title suggests, that it's appropriate follow-up.

The problem that this I thought was addressing is that many patients who have a completely normal screening colonoscopy should not have colonoscopy repeated for ten years.

But nevertheless, there's a big problem with patients being screened far more frequently or at shorter intervals than that. So, I didn't understand, this said this measure has unintended consequences of increasing the frequency of screening.

So, could somebody explain that because I thought this was designed to address the problem of increased frequency of screening.

Dr. Schreiber: David, this is Michelle, you're right, this is designed to address the increased frequency that was seen. In other words, we're looking for ten years and trying to discourage organizations from doing it earlier than that.

So, you are correct.

Member Baker: To my knowledge, this is still a significant problem and I would advocate for keeping this measure. I completely agree there are other measures particularly around safety and even the quality, looking at the proportion.

But these are provider levels that are tricky to measure, the polyp detection rate, for example. But in terms of appropriateness and addressing one of the big problems of overscreening, I would advocate keeping this.

Co-Chair Roberts: Thanks, David. Any other comments on this one?

Co-Chair Kahn: I just want to ask a clarifying question.

Co-Chair Roberts: Go ahead, Chip.

Co-Chair Kahn: If you have a polyp and that's the polyp, I assume that means then that wouldn't be marked against you if the doctor suggested five years, is that right?

Member Baker: That's correct. If you look at this, it's the percentage of patients who received the screening colonoscopy without biopsy or polyp.

So, the patients who have a polyp removed, to determine the correct interval you need to look at the number of polyps and the pathology. So, it's a very tricky thing to measure.

But still we know that if we did not have a biopsy or a polypectomy, the vast majority of patients should wait ten years before the next, unless they have got something very unusual in their familial history or something.

Co-Chair Roberts: Does anybody else have a comment?

Ms. Elliot: I'm sorry, Misty, did you call out Sam Tierney?

Co-Chair Roberts: Yes, it looks like her hand is raised.

Member Tierney: Sorry, I didn't hear what you said, I was waiting, no problem. I was just curious about this provider outreach reminder at five years. I didn't necessarily see that in the specification.

So, I was just wondering if whoever commented on that could provide some additional detail.

Co-Chair Roberts: Does anyone want to speak up as calling that out?

Dr. Schreiber: Anita, is there anything in the measure specification that you want to bring up for that? I'm just not aware.

Ms. Bhatia: I'm not aware of anything regarding outreach reminders for this measure. I'm wondering if someone may be thinking of the measure -- we did have an appropriate follow-up interval for patients with polyps.

And perhaps that outreach reminder at five years was for that measure or related to that measure.

Co-Chair Roberts: So, as far as you know there's nothing in the specs around the reaching out at five years?

Ms. Bhatia: No.

Co-Chair Roberts: Janice?

Member Tufte: Hello, I wanted to mention that there's now competing guidance on this regarding 45, starting at 45, and I just wanted to add that.

Co-Chair Roberts: Thanks for that. Any other thoughts on this one? Let's go ahead and move to the next.

Ms. Elliot: The next slide is Slide 39 and this is measure I.D. 2936, normothermia outcome,

description is listed here in the slide, the report level's facility.

The measurement status is not endorsed. Three Committee Members recommended this for removal, the lead discussants are listed, and the criteria or rationale for removal is that it's not NQF endorsed.

Chart observation creates burden, measure captures compliance with standard of care. Part of surgical care improvement measures that were retired in 2015 due to high performance and MIPS average performance rate for this measure is 98 percent.

Co-Chair Roberts: I'm going to switch it up with the lead discussant so why don't we start with Emma first this time?

Member Hoo: I don't think I had specific comment on this measure, though I think the criteria and rationale listed at the bottom of this makes sense in terms of the removal of the measure.

Co-Chair Roberts: And Liz?

Member Cinqueonce: I agree, I don't know there's a lot more to add other than what's shown there in terms of the criteria and rationale.

Co-Chair Roberts: Rebecca?

Member Kirch: Agreed, the top out was most influential on this end and just making room for measures that will matter more to people.

Co-Chair Roberts: Kacie?

Member Kleja: Agreed, we didn't really have many comments outside of the criteria and rationale that were already listed.

The one question that I had is just curious about, and Michelle might be best to address this, is about

the initiative to move to digital quality measurement.

I know the ASCs are definitely behind in that space compared to the hospital setting. But I'm curious if there's been any future thinking about migrating some of these burdensome chart-abstracted measures to something in a more electronic digital format.

Dr. Schreiber: This is Michelle. If you want me to take that one, the answer is yes because we're always thinking of migrating to digital measures.

And frankly, something like this that you can get from the chart would be something that we would consider.

I want to just answer a couple of other points as well. We recognize that the MIPS average performance rate was high and it was in the SKIP program too.

For the ASCs this is a more stringent measure than the MIPs one and the mean is currently at 86 percent. So, there is currently room for improvement in this area.

And it is tested at the facility level for ASCs.

Co-Chair Roberts: I was going to ask you about that performance rate, I'm glad you addressed that.

Ms. Bhatia: Just to note, on the normothermia outcome measure, this is an ASC quality collaboration measure. They developed it and tested it.

They have not gone through the endorsement process due to the effort that's involved. So, I would be cautious on striking it because it's not NQF-endorsed.

Co-Chair Roberts: That's good to know. I'm going to open it up to the rest of the Committee for

questions, thoughts? Leah, I think I saw your hand raised.

Member Binder: I just wanted to point out that I think we have a paucity of measures for ASCs, particularly the outcome measures but even just any kind of measures.

So, in this area I would strongly encourage us not to be removing measures. There just aren't enough of them and this clearly has some significant safety implications.

Co-Chair Roberts: Michelle, how many measures do we have for ASCs, do you know?

Dr. Schreiber: Anita, do you have that off the top of your head? I don't. We'll look and we'll get it to you.

It isn't a huge number and one of our concerns is the same that Leah has raised actually, especially as Medicare starts cutting back on the inpatient-only surgical procedures and other procedures.

We think there's going to be a rise in procedures done in ASCs. There's a relative paucity of measures there and we think this is a very important area to continue to build.

I'll ask Anita if she has the exact number of measures in the ASC program?

Ms. Bhatia: There are currently five measures in the program, one of which is a claims-based measure. We have some other claims-based measures that are going to be coming online but that is it for this program.

Co-Chair Roberts: Five measures?

Ms. Bhatia: Yes, and I would also add a note that we have not received any complaints that this measure is burdensome in terms of the chart abstraction.

We have never received that comment and we have not received any complaints about it so I think that's interesting. Not that the absence of things means it doesn't exist, I understand that.

Co-Chair Roberts: David, you have your hand raised.

Member Baker: I was going to comment on that. I'm not very familiar with this but it seems like a very straightforward abstraction, right?

You're looking to see whether a patient is normothermic within 15 minutes of arrival in the PACU. You look at one sheet that has all of their vital signs documented.

So, I was curious about that same question and what do people know about why this would be burdensome? I wouldn't think capturing the denominator would be very burdensome either.

Co-Chair Roberts: Does anyone have any comments or thoughts around the burden?

It does seem to be straightforward but as I was trying to think of what might create the burden, I wonder if it's the combination of capturing the temperature within the 15 minutes, the combination of the temperature and the time of the temperature.

I wonder if that's what is maybe creating some burden, or could be.

Member Peden: Carol Peden. I've done some work on this not in the U.S., but a lot of work on this in the U.K. and it can be the numbers of patients going through.

I think almost everybody will have their observations done immediately after surgery but if you're not abstracting it, then there can be very large numbers of patients going through. And often, when you start working in this area you do it by sampling. So, that might be part of the problem.

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

Member Culica: I do and I think I'm a little bit intrigued by the measure and I'm surprised as to why it's not endorsed by NQF. I think that in my opinion, it's not just a measure for the sake of measure and capturing it into the chart.

But I'm thinking of the evidence behind it in terms of -- I guess what I'm trying to say is I'm thinking of what is the impact on the patient if he's having surgery and anesthesia within the 60 minutes after a previous point.

I think that this is what the merit of the measure is. I would ask NQF to revisit this and go back to the Committee.

Dr. Schreiber: I'm not sure it's been brought before the Committee yet. As Anita outlined, I think they were in the process of considering it.

Co-Chair Roberts: I think Anita mentioned that the process to get NQF endorsement is quite lengthy so that's why they haven't pursued it yet. It's not that it was not endorsed, the tests weren't brought forth.

Member Culica: I see, thank you.

Ms. Bhatia: Just to second the thought, the literature is fairly extensive on the importance of the normothermia following surgery. So, we did discuss some of that when we proposed this measure.

Member Peden: I would agree the evidence is strong but it's important.

Co-Chair Roberts: Emma, I see your hand raised.

Member Hoo: I was wondering if you could confirm the earlier statement that although the MIPS performance rate was 90 percent, the current reporting on this, the mean is 85.

Did I understand that correctly?

Dr. Schreiber: 86 and you're correct.

Member Hoo: So, there is definitely room from a facility perspective?

Dr. Schreiber: Correct.

Co-Chair Roberts: I think Libby asked a question in the chat around are there other measures in development and if there are more in the pipeline that may increase burden?

Dr. Schreiber: Libby, can you just clarify measure and development for what? There's always measures in the pipeline for development, that's what we bring forward to the MAP every year.

For what? For normothermia? For ASCs in general? For which?

Member Hoy: I apologize, Michelle, I wasn't more specific.

I was just looking at the criteria that we're having this discussion based on and looking at the burden question, I was curious if there are more measures on the table for this particular program in this arena given the paucity of measures that have been discussed.

For me that was just a balancing factor.

Did we need to make room in this arena for measures that maybe would do more to create better outcomes and better information for patients and families to make decisions on? Or is this where we are?

Maybe that whole question is out of line or out of scope for this meeting but I was just trying to get my head around that burden question.

Dr. Schreiber: Thanks for clarifying that, I just

didn't understand the question. There are always measures in the pipeline for ASCs, as I pointed out, and as Leah spoke to earlier, we think this is an area that frankly needs more measures.

There's only five in there now. I think we can expect looking at some of the hospital measures that have traditionally been hospital ambulatory procedural measures about testing those for an ASC facility setting, and extending those.

Especially some of those procedures that are going to move into the ASC space like orthopedic procedures or others.

And I think you can probably anticipate that will be a future direction as well as a future direction of looking at complications and others from procedures done in ASCs.

But I'm trying to remember if there's something that's coming forward this year. Off the top of my head I actually don't remember but I think we can all anticipate this is an area of great interest to build measures.

Or to test those that we already have and re-specify them for this facility.

Member Hoy: Thank you so much, that's really helpful to my thinking.

Ms. Bhatia: Just to add, we did ask for comment on some areas for measure development for ASCs which include, as Michelle said, for the orthopedic procedures as well as for the possibility of a pain management measure.

So, if you have some time, we would love to have your comments.

Dr. Schreiber: Send us your written comments.

Member Hoy: Great, thank you.

Co-Chair Roberts: Any other thoughts on this one? Is that the last one we're going to discuss?

Opportunity for Public Comment on the ASCQR Measures

Ms. Elliot: Yes, that was the last one. We're open for public comment?

Co-Chair Roberts: Yes, I think we decided on public comment now. Just a reminder, limit your comments to two minutes and focus specifically on the ASCQR measures.

It looks like we do have a hand raised from Vilma?

Ms. Joseph: Yes, I'm an advocate of the normothermia measure. I think it's important because there aren't that many outcome measures. In terms of ease of obtaining the data, pretty much anytime you're in the PACU with a patient, the first thing that happens is that the vital signs are taken and the patient is assessed.

Part of the assessment is to take the temperature so it's easy for the nurses to do that and you can just imagine that even if the information is on paper, it's on one piece of paper, that PACU note.

Because usually patients are in the recovery room for about an hour to two hours in the ambulatory surgery center. So, overall, the data is out there saying that it's beneficial.

Even when it was at 98 percent I was saying this is such an important measure that it should really be a never event if possible. So, I'm happy to see that you've re-stratified based on a facility that ambulatory centers have room for improvements.

So, again, overall, I'm in favor of keeping the measure.

Co-Chair Roberts: Any other public comments? I think we are now going to vote on the first one. Do we want to go back to that one?

Ms. Young: Bear with me a moment while I share my screen. Polling is now open for Measure 1049, cataracts improvement in patients' visual function within 90 days following cataracts surgery.

Do you support the removal of this measure from the ASCQR program? Please let us know if you're having any problems with the poll.

Co-Chair Roberts: 21 is the magic number, right?

Ms. Elliot: Correct, I think we're ready to close, Susanne.

Ms. Young: Polling is now closed for Measure 1049. The results are yes, 6, no, 14. That is 28 percent. Moving onto our next measure.

Polling is now open for Measure 1061, appropriate follow-up interval for normal colonoscopy in average-risk patients. Do you support the removal of this measure from the ASCQR program?

Ms. Elliot: We were at 21, I thought. There might be an abstention so we'll go ahead and close.

Ms. Young: Polling is now closed for Measure 1061. The results are yes, 3, no, 17, or 15 percent.

Our last measure, polling is now open for Measure 2936, normothermia outcome. Do you support the removal of this measure from the ASCQR program? We'll go ahead and close with the 20 votes. We ended up at 21.

Polling is now closed for Measure 2936. The results are yes, 1, no, 20, for roughly 5 percent and that's it, that was our last measure of the day.

Co-Chair Roberts: I don't know that we have this necessarily incorporated into our agenda but do we want to pause and maybe open it up for some general comments on how the day went before we get into --

I think the last discussion item is something that CMS had requested feedback on. What do you all think?

Ms. Elliot: I think that's a great idea, Misty, we're ahead of schedule for today and we do have that as an agenda item for tomorrow but I think it's maybe good to get feedback today and tomorrow, because we can evaluate the process.

So, based on our overall, as Misty shared at the beginning of the meeting, the meeting objectives for this measure set review is to provide feedback and recommendations on measures selected for the measure set review pilot.

And then review and provide feedback on the measure review process and the criteria that we're using. So, I think, Misty, could I call upon you to help us navigate the discussion related to that and how the process has worked so far today?

Co-Chair Roberts: Sure, I will say a couple things, I'll just start out with a couple things that I had in my notes, one of them being really having the information available around how removing the measure might create a gap.

That was one big thing overall. So, I don't know if that's something we can come prepared with tomorrow with additional information on that, if there's anybody that would be able to speak to that?

Because that does seem to be a common question that's asked that I think is important for us to make decisions.

Ms. Elliot: If we're not able to get that for tomorrow, definitely for the next cycle, we're hearing that consistently from the discussants and the feedback.

Co-Chair Roberts: Any other comments on the day? I think we've had great feedback throughout the day. We've been able to take everything on the fly, change things up to make the process a little bit better, switch the order and the timing of things.

But any other comments or anything we might be able to do differently tomorrow to help facilitate the conversation a little bit better?

Member Hoo: This is Emma.

One of the comments I would have is that given the short time we had to review the measures originally during that voting process, it's helpful to have some of the summary information that you've provided today to better understand which measures have a track record in MIPS versus the alternative site for unit of reporting that is being discussed here.

For example, just the most recent measure we discussed and understanding also the pipeline, not only if it leaves gaps but what potentially might be forthcoming that would be a richer measure or has been further tested in a similar environment.

Co-Chair Roberts: I see a few hands raised. ECG, is that Liz Goodman?

Member Goodman: I just want to echo what Katie said. I think the context is good and so on these ambulatory surgery measures, there aren't many and that, as the pipeline was building, was really helpful context.

So, as much color you can give us around the program itself and where the measure fits, because it really needs it.

Co-Chair Roberts: I agree. Michelle?

Dr. Schreiber: I think this has been really helpful. I just have a couple of points. One is I think both NQF and CMS can be helpful with providing more of the background so thank you all for asking about that.

Including how the measure has been performing, how the measure has been performing over time, where it stands in the pipeline, does it create a gap?

But I think one of the things that I feel a little bit is missing is these all come forward as proposals for removal and the conversation has been supporting removal.

I feel like we could enhance a little bit more the opposite point of view. So, sometimes in the MAP or in the other Committee meetings, there's a program and there's a con.

I kind of didn't feel like we always had both points of view here.

Whether or not that means we have to bring measure stewards forward or you assign people on the Committee to do a program and a con, I guess I'd like to see a little bit more of both sides.

Co-Chair Roberts: Thanks for that Michelle. Carol?

Member Peden: Yes, I think this has been a good discussion, I've learned a lot. For me, the takeaways are that we have agreed that some areas, some topics are important but measures need improved and our ability to recommend on that.

Also, the illusion that there are some very major up and coming areas, the ambulatory surgery centers being the most obvious one where we really need more measures evolved.

So, our ability to take that forward.

Co-Chair Roberts: Chip?

Co-Chair Kahn: To answer Michelle, I think first we do miss here the richness of the Work Groups, their expert in each of the areas doing the drill-down. Not that we don't have experts on this Committee.

But second, I think part of the dilemma in terms of this experiment to me was the way the question was asked and the question the pre-assignment was given.

So, I think it's not surprising we came out with the configuration we did for this meeting, but I think we can fix that next time. But the next time we're going to have a more thorough process.

I think the information we discussed that you and NQF can provide would be really, really helpful upfront for the Work Groups. I also think -- and maybe we can discuss this a bit tomorrow.

I guess we have another meeting, we can talk about it. We do need a different voting process, more choices.

Obviously, abstentions should be an option but I think that Leah raised a really important point that just like we have some gradation in our other voting, we need some here too.

We're making recommendations anyway so the question would be no with provision, which is no but we still need this measure or some measure in this area.

I think we need to have that kind of option because I think we need to be able to quantify that as well as have it be qualified out of the discussion.

So, I don't know what the categories are to be at, I think that will take some thought.

But I think we probably would end up with two or three different categories and a voting process like we have for the regular MAP consideration of the recommendations of CMS.

Co-Chair Roberts: I agree. David?

Member Gifford: One area I think would be helpful to include and it's good that we organized it this way as we talked more about how these measures are used in the programs.

We are advisory to CMS on these programs. I am struck because we're actually assigning a lead discussant tomorrow on a measure that's not used by CMS.

So, I'm not sure why we're even talking about it since really, the role of MAP is advising CMS on pediatric measures. I'm not sure why we're talking about removing measures that aren't in a program.

Maybe I mistook it but it doesn't appear to be in the program.

Co-Chair Kahn: It's where the list came from, it's got to be --

Co-Chair Roberts: Yes, I was going to say I don't think we have any that aren't in a program or it shouldn't be on the list.

Co-Chair Kahn: It all came out of that 500 or 600 list that was narrowed down to the programs. It all came from CMS.

Member Gifford: It says it's in the hospital inpatient quality program but I couldn't really find it.

I do think one thing that would bolster our discussion as a map, both when we were endorsing and removing, is talking a little bit more about the programs they're in with what it is.

Because we sort of just talked about the measures in general from a quality improvement standpoint and other issues. There's multiple hospital programs.

I know that on the post-acute side there's a couple

different programs, I know there's going to be a measure that we've already endorsed for one other program coming through on a different program for the same measure in December.

So, understanding why CMS feels they need to improve, I understand and support it but I think we don't always tackle that and that's just one area of my comment.

Dr. Schreiber: Can I just answer someone's question about a pediatric measure? Because I was looking through tomorrow's agenda. There is in the IQR program exclusive breast milk feeding.

Somebody may think that's a pediatric measure. Yes, it's a pediatric measure but it's also meant to be a safety and maternal care measure. That is why it's in the IQR program.

Member Gifford: So, I'm understanding the program and what you're trying to capture with it. Now it makes sense. I could have picked mom or I could have picked a kid when I said it's a pediatric measure.

Co-Chair Roberts: So, David, it sounds like more information around the specific program that we're talking about. I think I also heard you say how the measures are used in the program.

Did I hear you say that as well?

Member Gifford: Yes.

Co-Chair Roberts: Any other comments for the day?

Co-Chair Kahn: I have one more. I think, and it comes from David where I think David may have been going. I think whether something is in a payment program versus just reported is really, really important.

I think the standard for the payment program has to be a little bit higher in terms of what the role of

that measure is. Because in a sense, having placeholder measures is fine if we need it for sending messages or symbolism.

But when you're talking about payment, I think you've got to be very clear that message plays an improvement in accountability role that's really well defined. That's my view anyway.

Co-Chair Roberts: Any other comments before we get into one final discussion? I think I'm going to hand it over to Chip now.

Co-Chair Kahn: Why don't we go to Slide...is it 42, Tricia?

Ms. Elliot: Yes.

Co-Chair Kahn: And we'll put up a question. This came from CMS so do you want to give us the background on the question?

Dr. Schreiber: I'll be happy to, thank you.

Given the timeline for these changes is getting shorter and shorter, I think it's hard for everybody, as a matter of fact, to sometimes process these annual changes.

And systems have to respond to annual changes and if they built their quality program around measure and we change it around and they have to do another one, that's work for the systems, it's work for providers.

Frankly, it's work for us, we have to change the IT systems to be able to support that and the months of clearance that these proposals go through is getting longer and longer.

So, it was actually our IT group that was asking us if there was any opportunity to extend the timeframe of changing measures and changing these programs instead annually to every other year.

It could look like something that the hospital programs one year change and the next year the MIPS programs change, and so we kind of go back and forth between the two.

I'm really just here to ask your opinion as people who are very familiar with these programs and stakeholders who use these programs what the pros and cons might be of extending that cycle of change.

I can tell you from our point of view the program is we would actually have time to do what is becoming, as you can see, a tremendous amount of work, a tremendous amount of work around rule-writing, a tremendous amount of work around changing and testing the IT systems, and going through the MUC list and the MAP.

There's a lot of work that goes behind both these measures and these programs, and so that would allow a little bit more room for thought and to get that done.

The other pro is, as I pointed out, it would allow systems and opportunity to get a little bit more experience with the new measure that they have and to not have to change their systems on an annual basis.

The con of course is that changing the systems on an annual basis keeps it most current, keeps the most important measures at the forefront, keeps the pipeline going, and is able to respond to, say, changes in administration priority or changes for pandemic, not that wouldn't have superseded going evolved year anyhow.

There are ways around that such as interim final love rules with comments where we can make changes.

But I just wanted to really hear from the group what they think is the best pace of change and what the

pros and cons are from your point of view.

So, thank you for the potential to discuss this today.

Co-Chair Kahn: Yes, that really is very clear, Michelle. I have some comments but I'll wait. So, do we have any hands up?

Ms. Perera: Sam?

Member Tierney: Yes, thanks for the opportunity to weigh in on this, Michelle. I completely appreciate the struggle because especially for implementers, it's helpful to have a spec that's not going to change from year to year.

Having been on the other side of this as a measure developer, people will bring up implementation challenges that you'd really like to incorporate right away.

But because of long time period to institute changes, you have to note that's just not possible this year but we can consider that in future years.

And so I guess I would wry that the longer the time period between changes, the less flexible measures can be to either those implementation challenges, changes in evidence, and those sorts of things.

So, I completely appreciate the challenges and I guess I just raised that I faced when I was developing measures and would receive feedback and we would essentially just have to say we can't incorporate that right now but we can incorporate it next year.

And again, if you're considering two years, that's extending it even further. Thanks.

Dr. Schreiber: Sam, I really appreciate what you're saying because right now you're right, if a measure is in development and for some reason it misses the MUC deadline that is in May, it doesn't get on the MAP for discussion.

It can't be proposed the following year, you have to wait an entire another year to even get it on the MUC list, you're absolutely correct. The timeline for some of this work is really quite long.

We were actually hoping that an every-other-year cycle might to some degree improve that because we could have submissions all along rather than just a one time a year deadline drop-dead date, can't get it on the MAP otherwise.

But I hear your concern, this is long as it is, we understand that.

Co-Chair Kahn: Other hands?

Ms. Perera: There are, the next one is David Baker.

Member Baker: This is a really good question, Michelle. Most of what I was going to say I think you've already said.

I think the pros for doing this is ironically, a lot of the electronic clinical quality measures, it is more work for the systems to do the programming to generate that and more work on the receiving end.

So, even though we talk about chart-abstracted measures being so burdensome, there's real challenges for the EXQMs and the digital measures.

But on the other hand, as you've said, they are the measures that miss the deadline but also, when we review measures we talk about -- Chip, this gets back to the issue about the multiple categories.

So, we'll say that a measure requires...I'm blanking on the term now, but with caveats. We'll approve something but they need to make some changes. Would you wait two years to re-review that?

If there's some sort of a hybrid like you were talking about, Michelle, where you're able to do some things, interim reviews to keep the pipeline going, or to even re-review some of those measures that

were given conditional endorsement, I think that would be helpful.

Maybe you can get the best of both worlds. Other hands?

Ms. Perera: Ron Walters?

Member Walters: I think there is a way to change things and it got me thinking about how often is care changing in the different programs that you have?

And so, of course, a long experience in the IQR program.

An IQR is essentially mortality, safety, negative outcomes, cost, and readmission-type stuff.

So, those don't change terribly frequently, drivers of that can change but the actual kinds of things you're going to measure really haven't changed that much since the beginning of the IQR.

You mentioned earlier OQR, which may well change significantly given what's going on and is certainly a broader category of stuff in one respect than inpatient is.

And then you get into the different programs. Of course, I live in the PCHQR world, which you blink and there's different drugs and all sorts of things.

But the core things are still pretty steady and kind of similar to some other programs. Ambulatory surgery is another area that's probably going to change a lot as you alluded to, and you might want to keep a closer eye on what's changing there.

Psych ward, I'll speak rather naively, to me the same issues in psych are the same issues that were in psych five years ago. We talked about a lot of them earlier today.

That might be one that may not require annual

changes by the rules. I think you do have to view this from a program perspective. MIPS is one that changes every year too.

MIPS, measures come, measures go, et cetera, and practice changes and so MIPS is not enough to look at.

I think you have to look at it from a program perspective and you modify any changes you make in the rule and the timing of the rules and submission of majors based on what you monitor as changes in the healthcare system itself.

Dr. Schreiber: Thanks.

Member Baker: Can I make a comment on what Ron just said? I think that's a really interesting idea, Ron.

One thing would be to say for certain high priorities, let's say it's every two years but you go off cycle and you say we really need more measures for ambulatory surgery centers, there's a lot of shift and care to ambulatory surgery centers, we think it's a high-risk area so we're going to annually proposed measures for ambulatory surgery centers.

That's been historically a very short list so not a heavy lift. But it may be that the routine review happens every other year.

But for certain high priorities you allow that to happen annually, that would take some of the burden off staff in healthcare organizations.

Mr. Ross: This is Clark Ross, I had raised my hand but it's not functioning I guess. I wanted to react to the idea that nothing's happened in psychiatry and mental illness and behavioral health.

And we can wait every cluster of years.

There is significant change in integrating behavioral health into primary care and general health and

significant activity in integrating general health and primary care into certified community health centers, which is a SAMSA CMS national program.

These changes are happening all the time and the role of social workers in each kind of setting.

This is very fluid, making incremental but important progress in whole health and whole-person health and getting mental health professionals to deal with general health and vice versa.

So, this idea that psychiatry and behavioral health is static and could wait for clusters of years is just really not accurate. What's accurate is the change is happening all the time, we have 50 state mental health authorities, we have 50 state substance abuse authorities, Medicaid financing, tinkering, which then results in practice change.

This is a very fluid and exciting area of change, it's not static.

Member Walters: Thank you, I knew it was going to catch it from somebody.

Co-Chair Kahn: Are there other hands up?

Ms. Perera: Next is Leah.

Co-Chair Kahn: Leah?

Member Binder: I think it's a really good question but I would say we want medicine and healthcare to evolve quickly.

We want change to be happening rapidly so if that is not occurring, and therefore, we think that measures don't need to change that much, actually, the measures need to change more.

I think it's a catch 22 but it is the fact that we want to see change and that will result in more change to make sure that measures are continually keeping up with the evolution of the healthcare system and the

improvement, hopefully, of that healthcare system.

So, as much as I would love to agree that we should remove some of the burden from CMS, because I do know this is an intense production each year.

At the same time, I think we want healthcare to change rapidly, therefore, we're going to need to continually evolve the measures that are out there and used to facilitate that.

So, I would say it's probably a good idea, the pro in my mind would be to stay with the annual improvement.

Co-Chair Kahn: Are there other hands?

Ms. Perera: Yes, Janice and then David.

Member Tufte: Thank you for calling on me. I am a patient engaged so it is so cumbersome I agree but I think it's important to stay on top of what's happening, where there is some accountability.

But I do agree with what Dr. Ron said, that tell me a little bit about some that do necessarily have to go every year.

I don't know if we can move into a space where some are not annual and some are, especially the ones perhaps that don't change much and have high rates of accountability or whatever.

But I do think because we're moving into the meaningful measure world and PROMs, a lot more stuff is coming on, I would like to see more, I don't know how you say it, bundling or score cards per either episode or along the lines somewhat of where the society input could be.

And also, it might be beneficial if Work Groups themselves decide what look at the measures that pertain to their special area and, Steve, what may be up for removal.

That might be another opportunity there.

Co-Chair Kahn: Who's next?

Ms. Perera: David.

Member Baker: I think Leah brings up another really interesting question and as she was talking I was thinking about some of the places where we've seen the most changes.

One I know very well which is stroke. Five years ago, a mechanical thrombectomy came out and turned the whole system of stroke care on its head and we've had to develop new measures and new programs.

Yet if you look at where CMS is for the measurement program, it doesn't tend to be those deep-dive niche areas. So, would CMS ever consider one of the even outcome measures from mechanical thrombectomy? That's only 5 percent or so of stroke patients.

So, I think you're right, Leah, that we do need to have continuing measure development to support quality improvement in some of these rapidly changing areas, which is one of the places where a lot of quality and safety issues are.

But I'm not sure that for the typical measures that we're using for the hospital programs and these other large programs that those things that are changing the most are going to be relevant, just because they're such niche areas.

I could say similar things about joint replacement and similar things about atrial fibrillation, ablation, and these others, but that's just not where CMS has been going from the measurement perspective.

Michelle, do I have that right?

Dr. Schreiber: You do but I think those are topics that we are certainly interested in exploring at some

point in time. Those same new technologies you're talking about become major expense to CMS and major patient safety issues and need to be I think examined and measured.

Member Baker: We have the measures for those in our certification programs, which tend to be the service lines that it's quite different than looking across all hospitals.

Dr. Schreiber: By the way, David raises interesting an interesting question too. We'll get to it I think tomorrow when we talk about individual disease readmission and mortality versus total.

It gets to this product line versus total hospital picture, but you're right.

Co-Chair Kahn: Other questions?

Ms. Perera: We don't have any additional hands raised.

Co-Chair Kahn: So, I guess my conclusion, Michelle, from listening to this is that it doesn't maybe fit a binary result in terms of the two years.

So, it wouldn't just be the hospital programs one year and the physician programs the next year and that would be the pattern.

It seems to me, at least what I'm hearing, that we need to go through some kind of priority-setting process if you want to lengthen in times.

And the priority-setting process and agenda-setting process for let's say a two or four-year period might help define stretching some things out or keeping some things at the year.

Obviously, there are limits to how short you can make some of these things. But I think without that kind of more dynamic scheme, you're almost stuck with the year to year.

What I think you need to really recognize is the issue that Leah says, you don't want to get behind the eight ball. On the other hand, at any given time if you had a priority-setting process, you could probably identify the areas.

What we know from some of these other areas, we could identify at least on a 12-month basis where you should be spending time, 1 year versus the next, that would be my observation.

Dr. Schreiber: I think that's a really good comment to Chip and actually, to all of you, thank you for the comments. By the way, it wasn't just the work of CMS, it's really the work that systems and providers put in to changing their processes as well.

David, your point is really a key one as we transition to electronic, digital quality measures, those take time for systems to build. At some point in time we'll get to where they're standard and maybe they're not as difficult to build and standardized data elements will all be defined and they'll be kind of modular, but that isn't the process that we're in now.

We hear back from hospitals and other organizations that they can't keep up either. So, this issue of prioritization, Chip, I think you're right, and we try to do that.

You guys can see even an annual rollout, there are some areas that get a lot of focus and a lot of change and some areas that it's basically maintaining things more or less the status quo from year to year.

I think that's probably what we'll need to continue to do. Just to be clear because there were a lot of comments on this from mental health, I want to put my plug in for mental health being a very dynamic, changing area right now that is a very high priority for the Biden Administration.

What I took back from today's conversation is that many of you think we should pretty much rework the inpatient site program if you basically are looking to remove what I think is more than half of the measures.

And so we will take that back as very good input but it is a high priority area that I think people are going to start seeing a lot more of around mental health in general.

So, thank you, and really to the Committee, thank you for the opportunity to talk about these kinds of ideas really that we talk about internally.

It's nice to be able to ask the question and hear very good feedback.

Thank you.

Co-Chair Kahn: Are there any other comments or thoughts before I pass it back to Tricia? I think we've completed our tasks for today and I want to thank everyone for the time and effort.

We're finishing earlier than the agenda sketched out, which is a good thing because this medium is great for processes but it also is difficult to stay too many hours.

So, I think we're probably getting to our limit of Zoom or whatever the system is as it is.

With that, I'll pass back to Tricia and she'll give us instructions for tomorrow.

Ms. Elliot: Thanks, Chip, I just want to call on Vilma. We saw that you raised your hand, did you have a comment before we wrap up?

Ms. Joseph: I'll be really, really brief. I was just curious, we're always thinking about the MIPS program and MVPs.

When are we going to expand it beyond Medicare to

the Medicaid population so we can do more measures for the OB patient who isn't Medicare-eligible but is on Medicaid.

Dr. Schreiber: I think you're already reading into CMS and some of the internal conversations about how we can align this more.

There are certainly a lot of conversations about aligning these but there are also conversations on how can we look more at all-payer data and make sure that we are capturing all patients, certainly all CMS patients, across that continuum.

Because care really should be the care and there are pockets of areas like maternal safety, for one, mental health actually for another, where Medicaid is one of the leading payers in the country in those areas.

We really need to make sure we're focused on those two.

Adjourn

Ms. Elliot: Thank you so much. With that, I will wrap things up for today and I want to remind all the Coordinating Committee Members that the access information for Day 2 is different from today, Day 1.

It can be found on the agenda or on the calendar invite that was sent for Day 2.

We will start promptly at 10:00 a.m., we will start off with a roll call and then get things rolling into the hospital readmission reduction program early on in the agenda.

Thank you, everybody, for your time and attention today and we're able to give people a couple hours back in their day. So, enjoy the rest of the afternoon and we'll reconvene tomorrow morning at 10:00 a.m.

Thank you, everyone.

(Whereupon, the above-entitled matter went off the record at 3:00 p.m.)