National Quality Forum

Measure Applications Partnership (MAP)

Hospital Workgroup 2022 Measure Set Review (MSR) Meeting

Wednesday

June 22, 2022

The Workgroup met via Video Teleconference, at 10:00 a.m. EDT, Akin Demehin and Cristie Upshaw Travis, Co-Chairs, presiding.

Present:

Akin Demehin, MPH, Co-Chair
Cristie Upshaw Travis, MSHA, Acting Co-Chair
Donna Bednarski, RN, MSN, ANP-BC, CNN, Kidney Care Partners
Hilary Dempsey, Press Ganey
Janice Donis, RN, UPMC Health Plan
Frank Ghinassi, PhD, ABPP, National Association for Behavioral Healthcare
Maryellen Guinan, JD, America's Essential Hospitals
Marty Hatlie, JD, Project Patient Care
Vilma Joseph, MD, American Society of Anesthesiologists
Anna Legreid Dopp, PharmD, American Society of Health-System Pharmacists
Jennifer Lundblad, PhD, MBA, Stratis Health
Denise Morse, MBA, City of Hope
Santosh Mudiraj, MPH, Henry Ford Health System
Sarah Nolan, PhD, MPA, Service Employees International Union
Phoebe Ramsey, JD, Association of American Medical Colleges
Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB, Individual Subject Matter Expert
Karen Shehade, MBA, Medtronic
Zeynep Sumer, MS, Greater New York Hospital Association
Jackson Williams, JD, MPA, Dialysis Patient Citizens
Lindsey Wisham, MPA, Individual Subject Matter Expert

Non-Voting Federal Liaisons:

Andrea Benin, MD, Centers for Disease Control and Prevention (CDC)

Alan Levitt, MD, Centers for Medicare and Medicaid Services (CMS)

Michelle Schreiber, MD, CMS

NQF Staff:

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

Also Present:

Anita Bhatia, MPH, PhD, CMS
Ora Dawedeit, CMS
Leah Domino, CMS
Beth Godsey, MSPA, MBA, Health Equity Advisory Group
Colleen McKiernan, The Lewin Group
Shaili Patel, Hospital Outpatient Quality Reporting Program, CMS
Doris Peter, PhD, Center for Outcomes Research and Evaluation (CORE)
Gequincia Polk, Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), Interim TO COR, CCSQ, CMS
Kimberly Rawlings, Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
Melony Sorbero, PhD, MPH, Health Equity Advisory Group
Kingsley Weaver, Mathematica
Laurie Zephyrin, MD, MPH, MBA, Co-Chair, Health Equity Advisory Group

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Proceedings

(10:04 a.m.)

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

Ms. Williams-Bader: Good morning, everyone. My name is Jenna Williams-Bader. And today we'll be talking about the hospital workgroup review of measures. Thank you so much for joining us this morning.

A couple of housekeeping reminders. Please remember to mute and unmute yourself throughout the event and you're welcome to have your video on. You may raise your hand if you'd like to speak. And if you're a call-in user, we ask you to please state your first and last name when speaking. You may also use the chat feature throughout to communicate with NQF staff if you have any questions or issues.

Next slide please. We also have some ground rules that we ask you to keep in mind. So we'd really like you to please respect all voices, remain engaged and actively participate, keep your comments concise and focused, and be respectful of others -- and allow others to contribute. We are here to learn from all of you, so please share your experiences and we really look forward to the discussion today.

Next slide please. Also, I'm sure many of you are familiar with the Webex platform, but we wanted to run through a couple of quick reminders. You may mute and unmute yourself using the mute button along the bottom portion of the screen. You may also click on the participants list on the lower right-hand corner in order to see the participant list. And there's also a chat. That's where you'll find the chat button as well. And then to raise your hand, you can use the reactions tab or there's a little raised hands icon as well along the bottom.

Next slide please. So as I said, I'm Jenna Williams-Bader. I'm a Senior Director at the National Quality Forum here. We truly appreciate that you're all joining us today and taking time out of your busy schedules, especially as we are -- as we are entering the summer here. We'd also like to thank CMS for funding this work. And we are really excited to be kicking off the Measure Set Review for the first time with all of our MAP advisory and workgroups.

Next slide please. So brief review of the agenda. We'll start with welcome, introductions, disclosures of interest, and a review of the meeting objectives. We'll then give CMS the opportunity to make some opening remarks. I will then review the Measure Set Review process and the Measure Review Criteria that we'll be using today. And then we'll spend the majority of the meeting running through three programs and the measures that were pulled within those three programs for discussion.

We are taking public comment at the beginning of each program. But there will also be an opportunity for public comment at the end of the meeting. And then before we sign off today, we will have a discussion of gaps in the hospital Measure Set Review Program, as well as we'd really like to take the opportunity to ask for your feedback on this Measure Set Review Process as it is new. And we definitely would like to hear your feedback on how we can improve the process in the future. And then we'll close out with next steps and closing comments.

Next slide please. And one more if you can. Great. So now I'd like to turn it over to Elizabeth Drye, our Chief Scientific Officer for some opening remarks.

Dr. Drye: Good morning, everybody. It's my pleasure to welcome you to today's MAP Measure Set Review Hospital Workgroup Meeting and guests honored to partner with CMS to convene the MAP

and bringing together this Office Stakeholder Group representatives from Quality Measurement, Research, Body Improvement, purchasers, community health agencies, health professionals, health plans, consumers, suppliers. As you all know, we tried to bring all the relevant stakeholders to the table.

Last year we collaborated with CMS and piloted this Measure Set Review process, which is an attempt to offer a holistic review of quality measures within specific programs. We focused on the hospital setting in the pilot only. The 2021 pilot, we were able to review 22 measures and we generated a final set of recommendations and rationale for specific measures for removal. The process was a learning experience for us. And as Jenna said, this is -- we're expanding to, you know, the broader set of measures and the broader set of MAP workgroups. And so we want to be learning from this experience as well.

This year we'll be building on that pilot. Brining the three setting specific workgroups, including hospitals and the two advisory groups, the Equity and Rural Advisory Groups into the process. The MAP members will review the measures from a hospital clinician PAC and LTS settings, as well as the hospital settings. It will be the first year we involve the full team. So again, we welcome your feedback. You can keep notes as we go through. We got some really good feedback from our advisory groups and are looking forward to how you experienced this -- it's a complex process.

Today's meeting will focus on discussing the measures under review as we mentioned from the hospital setting. And as Jenna mentioned, including that PPS-Exempt Cancer Hospital's Ambulatory Surgical Center Quality Reporting Program and the Hospital Quality Reporting Programs.

During today's meeting, we'll consider each measures particular challenges and how those

challenges contribute to a case for either retaining or removing the measure. Examples are, you know, issues with data collection reporting, methodical issues, or any potential unintended consequences of either retaining or removing the measure.

None of this is possible, none of this examination of the measure sets without your participation, so we want to thank you, all the workgroup members and federal liaisons for their time and effort. And also thanks to our colleagues at CMS and the program leads who have joined today's call. You've been extremely helpful during this process. They are able to provide, you know, specific context about why measures are currently used in programs. That's really helped round out the discussion. And we want to again, thank you in advance for providing your feedback that we'll hear at the end of the day.

Finally, I want to extend a special thank you to our Co-Chair Akin Demehin and also our Acting Co-Chair Cristie Upshaw Travis for their leadership and time today. We're going to recognize as well the Committee's Co-Chair Dr. Sean Morrison who was not available for today's meeting. So we look forward to engaging with you in the process. I'm going to hand it back off to the steady hands of Jenna Williams-Bader who will introduce the Co-Chairs for their welcoming remarks.

Ms. Williams-Bader: Thank you so much, Elizabeth. Yes, if we could go to the next slide then. We'll have some welcoming remarks from our workgroup Co-Chairs. Akin, I'll go ahead and turn it over to you.

Co-Chair Demehin: Thank so much, Jenna. Good morning, everyone. Thanks for taking time out of your busy schedules to participate in this inaugural round of Measure Set Review. And I think it's incredibly important that we as a workgroup and the

other workgroups get the opportunity to participate in this process. And it's really sort of the other piece -- complimentary piece of our usual MUC review process where we really have the chance to reflect on measures that are in programs and give CMS some sound advice on whether those measures are still up to par and remaining in those programs.

So really looking forward to the conversation today. Because this is the first time that we are doing this as a group, I would also ask for your grace and for your patience as we navigate this process. And we look forward to not only doing it, but making it even better going forward. So thanks so much.

Ms. Williams-Bader: Thank you so much, Akin. And then as Elizabeth mentioned, we have Cristie Upshaw Travis who is our Acting Co-Chair for today. Cristie, would you like to make some opening remarks?

Co-Chair Upshaw Travis: Definitely. Thank you so much. And I'm really pleased to be able to be part of this process. I've been on the MAP Hospital Workgroup from its inception. And this has always been on our agenda to be able to take a holistic look at the measure sets and think about those measures that might need to be removed, as well as those measures that could be added.

So I just join with the team at NQF and CMS and Akin in thanking all of you for being part of this important process and just reiterate Akin's request for grace today because this is the first time the Co-Chairs have been through this process too. And I'm sure that as we move throughout the day, we will -- we will be improving as we go along. So thank you all so much for taking all the time in advance to review these measures and to participate today.

Ms. Williams-Bader: Thank you very much, Cristie. And yes, thank you, Akin and Cristie for being open and flexible and willing to navigate this new process with us.

All right, if we could go to the next slide please. I'll now turn it over to Tricia Elliott who's going to run us through the disclosures of interest today.

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

We'll combine disclosures and 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. We'll start with the organizational members.

Organizational members represent the interest of a particular organization. We expect you to come to the table representing those interests. Because or your status as an organizational representative, we ask you only one question specific to you as an individual. We ask you to disclose if you have any interest of $10,000 or more in an entity that is related to the work of this committee.

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

If you represent an organization that is a measure steward or developer and if your organization developed and/or stewarded a measure under

discussion today in the past five years, please disclose that now. And then we ask you to recuse yourself from the discussion and pole for that measure during the day.

Next slide please. So as mentioned, I'll go through each organization. If you can state your name and your title and if you have any disclosures. We'll start with America's Essential Hospitals.

Member Guinan: Hi. This is Maryellen Guinan. Hopefully you can hear me. I'm Policy Manager at America's Essential Hospitals and I have nothing to disclose. But I would like to note I'm only on the phone and unfortunately can only be with you all til about noon. We're at our annual conference in Boston. But I'm happy to be on the line. Thanks.

Ms. Elliott: Great. Thank you, Maryellen. American Case Management Association. American Society of the Anaesthesiologists.

Member Joseph: Hello. This is Vilma Joseph. I am the Vice Chair of the Committee on Performance and Outcomes Measurement and I have nothing to disclose.

Ms. Elliott: Thank you. American Society of Health-System Pharmacists.

Member Legreid Dopp: Good morning. My name is Anna Legreid Dopp. I'm a pharmacist with the American Society of Health-System Pharmacists. We're a member of the hospital MAP working group and I have nothing to disclose.

Ms. Elliott: Thank you. Association of American Medical Colleges.

Member Ramsey: Good morning. Phoebe Ramsey with the AAMC where I am a Manager of Regulatory Policy and I have nothing to disclose.

Ms. Elliott: Thank you. City of Hope.

Member Morse: Hi. Good morning. My name is Denise Morse, Director of Quality and Value Analytics at City of Hope and I have nothing to disclose.

Ms. Elliott: Thank you. Dialysis Patient Citizens.

Member Williams: Good morning. Jackson Williams, Vice President of Public Policy and the Staff of Dialysis Patient Citizens. I have nothing to disclose.

Ms. Elliott: Thank you. Greater New York Hospital Association.

Member Sumer: Hi. My name is Zeynep Sumer. I'm the Senior Vice President for Regulatory and Professional Affairs at Greater New York Hospital Association and I have nothing to disclose.

Ms. Elliott: Thank you. Henry Ford Health System.

Member Mudiraj: Hi. This is Santosh Mudiraj. I'm the Quality Manager for Performance Improvement and Data Analytics and I have nothing to disclose.

Ms. Elliott: Thank you. Kidney Care Partners.

Member Bednarski: Good morning. I'm Donna Bednarski. I'm a Nurse Practitioner at a dialysis access center in Detroit. And I'm representing Kidney Care Partners and I have nothing to disclose.

Ms. Elliott: Thank you. Medtronic.

Member Shehade: Hi. I'm Karen Shehade, Senior Director in Medical Affairs at Medtronic. And because I have stock in the company, I do have potential conflicts, which I would refrain from any topics that may pose a potential conflict.

Ms. Elliott: Okay. Thank you for that disclosure. I am going to be skipping Memphis Business Group on Health. That is Christie Upshaw Travis' organization. And as a Co-Chair, she'll be representing herself as a subject matter expert as a

Co-Chair.

National Association for Behavioral Healthcare.

Member Ghinassi: Good morning. This is Frank Ghinassi. I'm a Board Member for NABH and I'm also President and CEO of Rutgers University Behavioral Health and I have nothing to disclose.

Ms. Elliott: Thank you. Premier Healthcare Alliance. Press Ganey. Project Patient Care.

Member Hatlie: Good morning. Marty Hatlie, I'm President for Project Patient Care. I have nothing to disclose.

Ms. Elliott: Thank you. Service Employees International Union.

Member Nolan: Hi. I'm Sarah Nolan. I'm Deputy Policy Director at SEIU and I have nothing to disclose. I would also add that unfortunately I also have to leave around noon for a root canal. I wish I were in Boston. Does that sound fun.

Ms. Elliott: Thank you for letting us know. Society for Maternal-Fetal Medicine. Stratis Health.

Member Lundblad: Good morning. I'm Jennifer Lundblad, President and CEO at Stratis Health. I'm glad to be with all of you today and I have nothing to disclose.

Ms. Elliott: Thank you. UPMC Health Plan.

Member Donis: Hi. Good morning. This is Jan Donis. I'm the Senior Director of Pro Value Based Care Program at UPMC and I have nothing to disclose. I also have to sign off a little bit earlier this afternoon, probably around 1:30 or 2 o'clock.

Ms. Elliott: Okay. Thank you. And I'm going to circle back. We received a chat message from Hillary Dempsey who is the Senior Policy Analyst of Press Ganey. And Tejai Gandhi will be also on later and

she is the Chief Safety and Transformation Officer. So Press Ganey does have representation today.

And then just wanted to -- Let's see. Okay, so I think Sean Morrison dropped off. So I just wanted to call him out if he was still on the line.

So we have completed that section of the disclosures. Now we'll 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 the workgroup's work. We are especially interested in your disclosure of grants, consulting, or speaking arrangements, but only if relevant to the workgroups work in front of us today.

If you are a measure steward or developer and if you've developed and/or stewarded a measure under discussion today or in the past five years, please disclose that now. And then we ask you to recuse yourself from the discussion and pole for that measure later in the day.

So a few reminders, you sit on this group as an individual. You do not represent the interest 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 the MAP. We are looking for you to disclose those types of activities as well.

Finally, just because you disclose, does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency. Please tell us your name, what organization you're with, and if you have anything

to disclose. I'll call your name so that you can disclose.

I'll begin with our Co-Chairs. Akin Demehin.

Co-Chair Demehin: Thanks, Tricia. Akin Demehin, Senior Director for Quality and Patient Safety Policy at the American Hospital Association. Nothing to disclose.

Ms. Elliott: Thank you. Cristie Upshaw Travis.

Co-Chair Upshaw Travis: Hi. I'm Cristie Upshaw Travis. I'm the CEO of the Memphis Business Group on Health. I have nothing to disclose that I think is related to today's activities. But in the full disclosure category, I am on the National Quality Forum Board of Directors and serve as their Chair. I'm also on the LeapFrog Board of Directors and serve on the NCQA Employer Advisory Committee. But none of that is related to today's work. I just wanted to be sure I was disclosing everything I needed to disclose. So thank you.

Ms. Elliott: Thank you, Cristie. Next slide please. Lindsey Wisham. Lindsey, if you're speaking, you're on mute.

Member Wisham: Okay. It's the double mute -- it's the dreaded double mute. It got me already this morning. Can you hear me okay?

Ms. Elliott: Yes.

Member Wisham: Okay. Sorry about that guys. We had to kick it off with someone. Right? So I'm Lindsey Wisham, Director of Federal Health Solutions with Telligen. I am here as an individual subject matter expert having worked with electronic clinical quality measures for over a decade. I would also like to note I have served as a patient advocate and received honoraria on measure development and research for CMS, DoD, and SBA, but none of those for the measures under discussion today. And

I would also like to note that my employer, Telligen does hold CMS contracts, but not related to the development or stewardship of again the measures under discussion today.

Ms. Elliott: Next slide. Thank you so much, Lindsey. Richard Gelb. Suellen Shea.

Member Shea: Yes. My name is Suellen Shea and I am a Senior Clinical Consultant at Oracle Cerner on the VA/DoD side where I do consulting work with our clients around data and process improvement. I have extensive experience with eMeasures and some development of indicators, but that in no way impact today.

Ms. Elliott: Great. Thank you, Suellen. Before I move on to our next step, I just want to circle back to see if there's anyone that I have missed, either an organizational rep or a subject matter expert that wasn't able to speak up. Okay. Thank you.

At this time, I'd like to invite our federal government participants to introduce themselves. They are non-voting liaisons of the workgroup. I think we have Alan.

Dr. Levitt: Yes, hi. This is Alan Levitt. I'm the Medical Officer in the Division of Chronic and Post-Acute Care at CMS. Dr. Schreiber should be here soon. She had a conflict currently and she asked if I would join early on to welcome you.

Ms. Elliott: Excellent. Thank you, Alan. And is there anyone on the call from the CDC, the Centers for Disease Control and Prevention?

Dr. Benin: Yes. Hi. Can you hear me?

Ms. Elliott: Yes.

Dr. Benin: Okay. This is Andrea Benin. Sorry. My computer disconnected, but I'm on the phone. I am the Branch Chief in the Surveillance Branch in the Division of Healthcare Quality Promotion at the

Centers for Disease Control and Prevention. And you know, we handle NHSN -- the National Healthcare Safety Network.

Ms. Elliott: Excellent. Thank you. And at this point, I'm handing things back to Jenna. It's all yours.

One more thing before I completely hand it off. So a big thank you to all to get through our disclosure of interest process. I'd like to remind you that if you believe you might have a conflict of interest at any time during the meeting, please speak up. You may do so in real time during the meetings. You can message your Co-Chair who will go to the 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.

Does anyone have any questions or anything you'd like to discuss based upon the disclosures made today? Okay. Once again, thank you for your cooperation and we're ready to proceed with the meeting. And I'll hand things off to Jenna.

Ms. Williams-Bader: Great. Thank you so much, Tricia. If we could go to the next slide please. I wanted to take a moment to introduce the MAP workgroup staff. You've just heard from Tricia and I'm Jenna. So you've heard from the two of us. We also have Katie Berryman who is Director of Project Management, Ivory Harding and Suzanne Young who are managers on the project, Ashlan Ruth who is our project manager, and Joelencia LeFlore and Gus Zimmerman who are the associates supporting this work. So a big thanks to our team here.

And the next slide please. I'd also like to introduce the CMS staff that we work closely with. We have Kim Rawlings who is our task

order contracting officer's representative or COR from CMS, as well as Gequincia Polk who is the IDIQ COR for this work.

All right. Next slide please. So for today's meeting, we have three main objectives. First if we're going to do, as I mentioned, a quick overview of the Measure Set Review process and the measure review criteria that we'll be using today. We'll then give you the opportunity to discuss and recommend measures for potential removal or for retaining in programs. And at the end of the day, we'll be seeking your feedback on the process so far.

All right, next slide please. I'll now turn it over to CMS for welcoming remarks. Then Alan, I believe that you are stepping in for CMS today.

Dr. Levitt: That's right. Thanks so much. My name is Alan Levitt. As I said, I'm the Medical Officer in the Division of Chronic and Post-Acute Care at CMS. And for the past nine years was the CMS representative on the PAC/LVC workgroup here for the MAP.

As I said, Dr. Schreiber had a conflict early this morning. And so she asked me this morning if I would just come and welcome you, but she should be joining soon. On behalf of the Agency and on behalf of CMS leadership, we do want to thank all of you for convening today. This is a lot of work for you to do and we really do appreciate that. With a special thank you as well for the Committee Co-Chairs and also for the NQF staff.

As I've said here before, I think one of the lessons that we've learned during the public health emergency is the importance of this public/private partnership. And the NQF is an excellent example that this partnership successfully works. This Measure Set Removal or Measure Set Review, I should say, meeting is really just another step in that partnership on top of what's already done in

terms of the review of the measures under consideration that's done by this workgroup later this year.

Our leadership participated and listened to the Rural Health Workgroup and the Advisory Group in the Health Equity Advisory Group meetings that occurred last week. They heard a lot of thought provoking feedback. And we're excited to hear the feedback and the recommendations that are going to be made today by this workgroup.

As a reminder, as this is the next steps, we may trip a little, which is okay. We're all in the quality world. We're all used to tripping a little and learning from those trips to keep making things better. And that's -- you know, that's what we're trying to do here, you know, as we keep building four a better future together. So thank you once again and Michelle should be here soon. And I'll turn it back to Jenna's steady hand.

Ms. Williams-Bader: Thank you so much, Alan. And we are very grateful that you were able to join us today and to give those welcoming remarks.

Review of MSR Process and Measure Review Criteria (MRC)

All right, if we could go to the next slide then. So I will be giving a review of the process -- how we've gotten where we are today, and what we'll be doing today at this meeting.

So if we could go to next slide. For those of you who attended our education meeting back in April, this slide will look familiar to you. I just wanted to run through some key points here though and important context for today's discussion.

So as a reminder, CMS and NQF prioritize the programs that would be included in the 2022 Measure Set Review. There are a number of programs that fall under MAPs purview. And it was

too many to discuss all at once, so we've divided them into groups and are discussing several today.

NQF then refined the list of measures by program and created a survey that our workgroup and advisory group members were invited to participate in. These MAP members nominated measures for removal via the survey. And used the measure review criteria as rationale for nomination.

One important thing to keep in mind though is that our MAP members who responded to this survey had very basic information available about the measures at the time they completed the survey. Really mostly information about the measures specifications and whether or not the measure was endorsed. But we were really asking them to use their knowledge of the measures in order to nominate measures for discussion.

Once we had the survey results, NQF staff selected measures with the most votes for the advisory group and workgroup discussions. And then we posted that narrowed list of measures for public comment. It was once we had this narrow list that NQF staff prepared the measure summary sheets. And that's when we were able to provide MAP members with more detailed information about the measures, including things like reporting and performance data, more information about the measures endorsement history and whether it had been reviewed by MAP before.

So that's something to keep in mind as we talk about the measures today. On the slides, we do present the criteria that were used by survey respondents as the reasons why they selected measures for discussion. But it's possible now that we have more detailed information about the measures that we might find that some of those reasons don't really bear out once you have the data in front of you. We have met with the Health Equity and Rural Health Advisory Groups. We might be able to have a

few of those members join us today, but we also -- NQF staff will be providing a summary of the discussions of those measures that the Advisory Groups had, so that you have their feedback as well about these measures.

And then today we'll be discussing the hospital measures. We'll be meeting with the Coordinating Committee in August and they'll be reviewing the workgroup recommendations as they do for MUC. So that's a quick overview of the process. Please feel free to let me know if you have any questions.

In the meantime, we'll go to the next slide. Here's the list of the 2022 MSR Measure Review criteria. We have ten and they group a little bit. The first two -- The first one is really about does the measure contribute to the overall goals and objectives of the program? Second is, is the measure duplicative of other measures within the same program? Also have is the measure not endorsed by a CBE or consensus-based entity or has it lost endorsement?

Fourth is has their performance or improvement on the measure does not result in better patient outcome or does the measure not reflect current evidence? So a couple around evidence and tied -- whether or not the measure is tied to outcomes.

Six and seven are related to performance. So six is, is the measure topped out so that performance is uniformly high and lacks variation and performance overall? And a second is more about does the measure performance not substantially differentiate between high and low performers so that performance is mostly aggregated around the average?

Next slide please. We then also have a couple around usability and what it's like

for reporting entities. So criteria eight is does the measure lead to a high level of reporting burden for reporting entities? Nine is the measure is not reported by entities due to low volume, entities not having data, or entities not selecting to report a voluntary measure. And then the tenth one is around negative unintended consequences including potential negative impacts to the rural population or possible contributions to health disparities.

So these are the review criteria that we'll be using today as part of the discussion and rationale for why measures might be selected for removal or why there might be conditional support for measures.

Let's move on to the next slide then please. These are the decision categories that we'll be using for the Measure Set Review. And I'll walk through each of those -- each of these in a little bit more detail.

If we could go to the next slide. The first is support for retaining. So this is really to be used by MAP. If the workgroup feels that the measure either does not actually meet any of the review criteria after discussion or the measure may still meet at least one of the review criteria that the workgroup thinks the benefits of retaining the measure in the program outweigh the criteria. And in this particular circumstance with support for retaining, it would also mean that MAP does not have any particularly conditions that they want to see the measure meet in order to stay in the program or any changes that the workgroup has about the measure that there are no recommendations.

So a couple of examples of how a measure might fit into this category would be if the measure is a PRO-PM that is associated with reporting burden, but MAP feels it's an

important measure for patients. Or another one could be that the measure is not reported by some entities due to low volume, but it is a meaningful measure for those entities that can report it.

Next slide please. So conditional support for retaining is somewhat similar to the previous category, except for in this case, MAP has some conditions or modifications that they would ideally like to be addressed about the measure. So in this case, it could be a measure that is not endorsed by CBE, but MAP would like to see it be endorsed. Perhaps a new guideline has come out very recently and the measure has not yet been aligned to that new guideline.

MAP might also recommend that the measure be respecified as an electronic clinical quality measure. Or there could be another modification that MAP would like to see. But the main difference between this and the previous category is that there is a condition for obtaining a measure in the program.

Next slide please. So then conditional support for removal would be that MAP would actually like to see the measure be removed from the program. They think that the measure does meet review criteria and that the measure is no longer contributing value to the program. But in this case, MAP might think that there would be a gap created if the measure was removed.

So this category we see really being used for cases where MAP would like a measure to be removed, but thinks that there would be a gap and that the gap needs to be filled first before the measure is removed. So in this case, it could be that there's a process measure that has very high performance and MAP would like to see it be replaced by an outcome or maybe a more

detailed process measure. So that's really where this particular category would get applied.

And then the last category, support for removal would be that the MAP thinks the measure meets at least two of the review criteria and MAP does not think removing the measure will create a measurement gap. So MAP is comfortable if the measure would be removed next year or proposed removal next year, they don't think that there would need to be any replacements suggested first. So an example here could be a measure is topped out and is even perhaps a standard of care and so no longer really needs to be measured.

So again, feel free to let me know if you have any questions. But we'll go ahead and move to the next slide. So the key voting principles here are in line with what we do for MUC, so they'll be familiar to you. We do have quorum to find that 66 percent of the voting members are present virtually for live voting. And then we will be establishing consensus threshold of greater than or equal to 60 percent of voting.

And in this case, we'll be starting with a category that the Co-Chairs feel like the group is -- that is building consensus around. And then we'll work through the voting categories, depending on where the workgroup is starting. Every measure under review today will receive a recommendation.

Next slide please. And then a quick overview of the process for today as we talk about each measure. So NQF staff will describe the program in which the measure is currently included. One of the Co-Chairs will then open public comment for the measures under review within that program. We'll then start working through the individual measures one by one with NQF staff introducing the measure.

We'll also be asking CMS program leads if they have any contextual information about the measure they'd like to share. The lead discussants will then offer initial thoughts about retaining the measure in the program. And we'll have Advisory Group volunteers as I mentioned or NQF staff summarize the Advisory Group discussions of the measure.

Then the Co-Chairs will ask for clarifying questions and open the measure for discussion.

Next slide please. The workgroup will then discuss each measure and provide feedback on whether there are data, collection, and reporting challenges for hospitals. Whether there are methodological problems of calculating performance on that measure. And any potential unintended or negative consequences related to either the removal of the measure or retaining the measure in a specific program.

Then as I said, the Co-Chairs will put forward a decision category based on where they think the workgroup discussion has gone for that particular measure. If there is no -- does not appear to be any consensus, they will start with conditional support for retaining and then move through the categories that's listed here.

Next slide please. And then finally, NQF staff will tally votes. And as a note, if no decision category achieves greater that 60 percent, the measure will be assigned the decision support for retaining as these are measures already in a program. And so we see the burden here really being providing a rationale for removing a measure from a program. And if there's not strong feeling in that direction, then the recommendation will be support for retaining.

Next slide please. All right, so do we have

any questions on the review process we'll be using today? I'll pause here to see if there are any hands raised.

Member Hatlie: This is Marty Hatlie, I've got a question. If members of the Rural Health and Health Equity Advisory Groups don't show up, will there be someone on NQF staff that will summarize any comments that they've got for us?

Ms. Williams-Bader: Yes. I'm prepared. I have my notes and I am ready to summarize the discussions if they're not available.

Member Hatlie: Thank you.

Ms. Williams-Bader: Any other questions? I'm not seeing any in the chat. I don't believe I'm seeing any hands raised. Any questions on the phone? Okay. Well feel free to ask questions as we run through the process as well. I will now turn it over to Joelencia who is going to run our voting test for us.

Polling Test

Ms. Leflore: All right. Thanks, Jenna. So we'll now conduct a polling test utilizing the link that was provided by email yesterday. Please let NQF staff know if you did not receive the link and we can also direct message you. As a reminder, the polling link is reserved for MAP Hospital members. All right, I think we're just pulling up the link right now -- or the question.

All right. So voting is now open for the polling question. Do you like tea? And I'll give everyone about 30 more seconds. I think we should have about 20 people voting.

Member Wisham: Would it be possible for you to post that link in the chat?

Ms. Leflore: I can direct message you cause

it's not available for the public.

Member Wisham: Okay.

Ms. Leflore: Give me one second.

Co-Chair Demehin: And Joelencia, if there are any folks who are on the phone, how should they record their votes?

Ms. Leflore: The link was provided by email, so if possible, they have that email. They can use that.

Co-Chair Demehin: Okay. And then if they don't have the email available, can they just verbally give it to you?

Ms. Leflore: Let me check with my team, give me one second.

Co-Chair Demehin: Okay.

Ms. Elliott: Akin, this is Tricia. The preference would be to private message a vote and that could go to Jenna or Joelencia if they're not able to connect to the Poll Everywhere. Usually with a little bit of troubleshooting, we're able to get everybody connected.

Co-Chair Demehin: Yeah. And I --

(simultaneous speaking)

Ms. Leflore: We have 18 already.

Co-Chair Demehin: Okay, good. I suspect most the people on the phone have access to the link. So I think we're probably okay.

Ms. Leflore: And it can be downloaded as a phone app as well. So we're troubleshooting on two people. We expect to get to 20. So this is a good time to do that troubleshooting, so we'll just give it a minute.

Member Guinan: This is Maryellen. Did mine go through because I am doing it on the phone, but I did use the link.

Ms. Elliott: It does look like it just came through. We're at 19, so we're just waiting on one more.

Member Guinan: Okay. Thank you.

Ms. Leflore: All right. We're just working through logistics on one more vote. All right, I think we can go ahead and close the poll. And we'll just troubleshoot behind the scenes for one -- the last member. So voting is now closed and we're going to go to the count view. Thank you. So 16 members voted yes and three members voted no. And I'll now return it back to Jenna.

Ms. Williams-Bader: Great. Thank you very much, Joelencia. If we could go to the next slide.

All right. So now we will actually start working through the programs and the measures. The three hospital programs that were included in the 2022 Measure Set Review was the Hospital Outpatient Quality Reporting Program, the Ambulatory Surgical Center Quality Reporting Program, and the PPS Exempt Cancer Hospital Quality Reporting Program. We'll be starting with the PPS Exempt Cancer Hospital Quality Reporting Program.

So if we could go to the next slide please and then the next. This is a Quality Reporting Program that is voluntary. Data are reported on the provider data catalog. The program goals are to provide information about the quality of care in cancer hospitals. In particular, the 11 cancer hospitals that are exempt from the In-Patient Perspective Payment System and the In-Patient Quality Reporting Program. And encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's

experiences and best practices.

If we could go to the next slide please and then the next. I will now turn it over to Cristie who will open our public comment.

Opportunity for Public Comment on PPS

[Prospective Payment System]-Exempt

Cancer Hospital Quality Reporting (PCHQR) Program Measures

Co-Chair Upshaw Travis: Thank you, Jenna. I appreciate that. This is the opportunity for us to hear from the public about the PPS Exempt Cancer Hospital quality reporting and the measures that we will be considering. So please raise your hand if you're on the platform and we'll know that you'd like to make a comment. And then we will go to anyone that may be on the phone.

And I'm going to ask my NQF colleagues to let me know the order within which to call on people. Just one reminder, please keep your comments to no more than two minutes. We want to be sure we can hear from everybody who would like to raise a comment at this time. So NQF, can you let us know if anybody has raised their hand?

Ms. Williams-Bader: Yes. It looks like Frank Ghinassi has his hand raised.

Co-Chair Upshaw Travis: Okay, Frank.

Member Ghinassi: Yeah. Thank you very much. I was asked to serve as a lead discussant, I believe. And I have just a few points that I wanted to make. Are you able to hear me okay?

Co-Chair Upshaw Travis: Well Frank -- and Jenna, please correct me. We're begging for grace here already. I think we're going to come to you after we have the public comment.

Member Ghinassi: Got it. Perfect.

Co-Chair Upshaw Travis: Thank you, Frank.

Member Ghinassi: I'll be here. Thank you.

Co-Chair Upshaw Travis: Thank you.

Ms. Williams-Bader: That is correct, Cristie. Thank you.

Co-Chair Upshaw Travis: Thank you. So has anyone from the public raised their hands? I don't see it on my screen.

Ms. Williams-Bader: I don't see any hands raised at this time and I don't see any chats either.

Co-Chair Upshaw Travis: Is there anyone on the phone from the public that would like to make a comment? Okay. Well thank you all. And Jenna, I think we'll move on then.

05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice

Ms. Williams-Bader: Yes. Thank you. If we could go to the next slide then please. So the measure we'll be talking about within this program is 05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice. This measures assesses the proportion of patients who died from cancer, not admitted to hospice. Endorsement was removed for this measure. And five survey respondents selected this measure for discussion.

Before I turn it over to others, I do have a quick statement to read. So 05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice is a new claim space measure developed by the Alliance for Dedicated Cancer Center based on the concept of NQF 0215 with the same measure name, which is a registry measure stewarded by the

American Society of Clinical Oncology. ASCO notified NQF, it would no longer maintain the registry version of the measure in Spring 2022 because the registry version of the measure had not been used in the CMS Merit-Based Incentive Payment System Program since 2019, so no data was available to retain NQF endorsement.

CMS approved this new claims-based version of the measure for the PCHQR Program and is now working to implement the new version of the measure. This will be the first year this measure will be implemented in the PCHQR Program.

The Alliance for Dedicated Cancer Centers and ASCO are in discussions about who will steward this claims-based version of the measure with NQF moving forward. ASCO also has a call scheduled with NQF on June 13th to discuss this measure, along with other ASCO-stewarded End of Life Registry measures, which now have claims-based versions developed by the Alliance for Dedicated Cancer Centers for the PCHQR Program.

So before I turn this over to our lead discussants, would the CMS Program Lead like to provide any contextual comments about this measure?

Ms. Dawedeit: Hi. This is Ora Dawedeit. I'm the Program Lead. Leah Domino is also on. She's the Measure Lead. Leah, would you like to provide any updates?

Ms. Domino: I have no updates. Pretty much, she summarized exactly what we were going to relay to you from ASCO regarding this measure, so thank you.

Ms. Williams-Bader: Any further questions?

Co-Chair Upshaw Travis: Jenna, this is Cristie and I

apologize. So I have to admit, I'm a little confused and I want to be sure that we do what we need to do relative to this measure. And are we looking at the new measure or are we looking at the old measure?

Ms. Williams-Bader: Yeah. That's a great question, Cristie. So the reason we provided that comment is we are looking at the new measure. We need to talk about the measure that's in the program. But I believe quite a bit of the information provided in the measure summary sheet is related to the MIPS version of the measure that uses registry data because that's where this is information available as this is a new measure to the PCHQR Program.

So we just wanted to make that clear to folks that the information provided -- and I think we did try to -- I'm just pulling up the measure summary sheet right now. I think we try to make that as clear as possible in the measure summary sheet, but that's why we wanted to make that statement today.

Co-Chair Upshaw Travis: And just for clarification, is the information that was provided in the measure summary sheet accurate for our discussion that we're about to enter into?

Ms. Williams-Bader: I'm just taking a look at it right now. So as we said, the endorsement is really around -- the endorsement history is really around the MIPS version of the measure that's registry-based. This new claims-based version has not been through NQF yet. Let's see. We have information from the Measure Applications Partnership review. I don't know if CMS can speak to whether that information is applicable to this claim space version or not. We did not have performance data about this. And again, I think the feasability information came from the registry-based version of the measure as well.

So as it is a new measure, we really don't have -- we didn't have much information to share. But let

me turn it over to our CMS program leads to see if they have anything they'd like to add.

Ms. Dawedeit: This is Ora. No, we do not have the performance data. Is that correct, Leah?

Ms. Domino: That is correct. (audio interference). So we do not have the public data.

Co-Chair Upshaw Travis: All right.

Thank you all very much. I mean it does appear to me -- and please someone, correct me if I'm reading this wrong -- that the intent of the measure, although it's a new measure. It's claim space, not registry-based. But the use of the measure and the reason that the measure was put into the program, those aspects have not changed. Is that correct?

Ms. Dawedeit: That's correct.

Co-Chair Upshaw Travis: The importance of hospice for instance, you know, for this population. Okay. Well with that said, Jenna, I didn't mean to interrupt the flow, but it got a little confusing for me and it may have for others.

Ms. Williams-Bader: No. I really appreciate you clarifying, Cristie. That is something to note is again this is -- this is one place where this differs from the MUC process. With MUC, we have a clear list of measures that CMS releases. And measure stewards and developers spend a significant amount of time pulling together information that they put in their MUC application.

In this case, we're talking about measures already in use in programs. So we had to pull this information from a variety of different sources. And we've been working closely with the CMS program leads in order to do this. But there is not one source of information. And sometimes these measures are adjusted or tweaked as they're put into programs,

which is why we need to work with the program leads very carefully on this.

So before we get to our lead discussants -- apologies, let me just -- Okay. Actually so lead discussants will go next. And we have Project Patient Care, The National Association for Behavioral Health, and Stratis Health listed as lead discussants for this measure. And I believe was it Frank, who had started speaking. So maybe we can go to him first.

Member Ghinassi: Thank you very much. And again, just for a clarification point. On Page 48 of the materials that you sent out, the field label says rationed out for removal of consideration. I just want to be clear. Is what we're discussing, the possible removal of this measure -- I just want to -- I want to understand the intent of the discussion. And is there going -- Will this lead to a potential vote on this being retained or removed?

Ms. Williams-Bader: Yes, exactly. You've got it right, Frank. But as you point out, the workgroup can absolutely vote to retain the measure in the program as well.

Member Ghinassi: Got it. Let me just start off by reiterating the bullets that you've got on the slide in front of us. Apparently this measure is duplicative of other measures within the same program. That's a point, I think, for the group to consider. It's not endorsed by a CBE. It looks like what had happened is that it was originally endorsed and then the measure developed was declined to re-endorse. But I'm not exactly sure of the rationale behind that. But that is a point that it was initially endorsed and then was not followed up after that.

There is an indication of these negative, unintended consequences impact those rural

populations. Something to consider. And then as we have the discussion, obviously on Page 50 for those of you who have your materials with you, there are comments from the Alliance of Dedicated Cancer Centers around their strongly wanting to retain it. And they offer a number of reasons about this, including utilizations of these programs by insurance programs even though apparently the data has not yet been made public to these PCHs. But they are indicating that they believe there will be benefit with that.

I just wanted to raise those points. And I'm happy to hear from the other lead discussants. Thank you.

Member Hatlie: This is Marty Hatlie. I can go next or Jennifer, I don't know if you want to. But I'm totally confused about this as well, Cristie, so thank you for --

Member Lundblad: Go for it, Marty.

Member Hatlie: -- softening the crowd there. I can't tell whether there's a measure gap if we pull this out because it sounds like the measure that might be duplicative is still in process. I'm curious if we heard any comments from the Rural or Health Equity Advisory Groups because of that bullet that Frank just recited that suggested that there might be some unfairness there.

I can't tell honestly from the summary whether it's burdensome to report this or whether it's topped out. I think it sounds like it might be on the way to being topped out or burdensome or duplicative, but I just really can't tell. And then you know, there is that comment. So I'll reinforce what Frank said. I mean there was a strong comment from an organization that said the data was very useful and used by pairs. So I'm not sure how I would vote on this or

what I would recommend because I just don't -- don't understand exactly where the gap would be if this is removed. Jennifer.

Member Lundblad: Yeah. Thanks, Marty. Thanks, Frank. Jennifer Lundblad with Stratis Health. Our organization focuses on quality -- Quality of care, quality of health. And I would say from that perspective, who better to be measuring appropriate referrals to hospice then cancer centers? I think they should be doing that the best of anyone across the care continuum. So this feels like such an important measure from that perspective that cancer centers are thinking from that whole person approach, not just about treatment and cure, but when appropriate, thinking about what the end of life and dying process is about. So it seems just so important.

So with that said and with some confusion by myself also around the data collection of methodology, it seems that moving from what has been a registry measure to a claims-based measure is important. So if we are to remove and then encourage the measure developers to resubmit perhaps with a package that includes the other two similar measures, that would be a wise move.

Member Hatlie: If I could add to my comment based on what Jennifer just said. I also would hate to see some measure of this practice go away if it would leave a gap. I think it is very important to patients. I mean I might have a complex here because I've been through two end of life journeys with my parents, both of who we referred to hospice and it was a fantastic experience for my family. So it is information that I think is important to patients to have and to organizations to know. I'd hate to see a gap here.

Co-Chair Travis Upshaw: Thank you, all very

much. Jenna, did you want to give us -- or do we have representatives from the Rural or Health Equity Groups to give us their thoughts on this measure?

Ms. Williams-Bader: Sure. It looks like we have Laurie Zephyrin from the Health Equity Advisory Group. Laurie, have you been able to join? And I think I'm -- Yes. So I can provide a summary for both the Health Equity Advisory Group and the Rural Health Advisory Group.

So we did a poll with the Rural Health Advisory Group. The question we asked them was do you support retaining the measure in the program? So for this particular measure, zero percent of the Rural Health Advisory Group supported retaining the measure in the program. Seven or 100 percent said no, they do not support.

And the reasons they gave was that they surmised from reading the measure description that there is no way to discern why patients declined hospice. The measure discounts patients who declined. They said that it seemed like we would want to know those impacts so that we could determine if rural patients were not being admitted to hospice.

There was also a concern about the availability of services and the ability to distinguish if services are being offered or alternative services are being given that don't count as hospice. And they thought this may be a particular concern in rural areas with a limited number of providers.

Then the Health Equity Advisory Group, we did not end up polling for most of the measures with that group after some discussion with them. We determined that the polling question in their context was not working. But we do have comments from them.

They had quite a bit of discussion about this measure. It was very complex. They acknowledged that there are certainly equity issues related to access to hospice.

However, there's also some concern that the measure assumes that hospice is the right outcome for all patients. And one member in particular raised concern that in its current state, hospice is not appropriate for everyone. And in particular BIPOC communities. There was another concern that there's a challenge for patients whose primary language is not English. And so they might be offered hospice in English or offered in a way they do not understand.

They thought also that cultural aspects need to be taken into account. And that they're not always handled in a sensitive way. And overall, they said if hospice is not designed and responsive to the needs of the whole population, if it falls short on cultural components, the goal should not be a high rate on this measure. And then their hospice might not actually be available in some cases. So again like I said, a complex conversation about this measure from the Health Equity Advisory Group.

Co-Chair Travis Upshaw: Well, those are great examples of why we have a Rural and our Health Equity Advisory Groups. And I really appreciate the time they took to consider this measure.

I think we will go on and I encourage our lead discussants to please continue your thoughts during the workgroup discussion as well. Because I know you now have the benefit of having heard the Rural and Health Equity discussion. But I think we will move on.

You know, I want to be sure that if there are clarifying questions that we have the

opportunity to get those answered through CMS if there are any clarifying questions, if we could start there. Does anybody on the workgroup have a question?

Ms. Williams-Bader: Christie, if I could, I did want to address one of the questions. I think this came from Marty, so about the endorsement. So as I mentioned, the version of the measure that was endorsed up until 2022 was the clinician registry-based version of the measure. And the measure steward, ASCO did not have -- I think the measure stopped being collected in MIPS, perhaps in 2019. I could go back to the statement. So they did not have information -- performance data to submit with their re-application for endorsement. So at that time, they decided to not submit the measure for re-endorsement.

So the measure did not lose endorsement in that it did not go through the process and was determined to no longer meet NQFs endorsement criteria. It was that the measure steward did not have all the data they thought they needed in order to get the measure re-endorsed. So they declined to re-submit the measure for maintenance endorsement.

Co-Chair Travis Upshaw: One more clarifying question around that, Jenna though. For the claims-based measure, which I think is the one that we're really considering here, that has not yet gone through endorsement. Is that correct?

Ms. Williams-Bader: That is my understanding, yes.

Co-Chair Travis Upshaw: Okay.

Ms. Williams-Bader: It has not.

Co-Chair Travis Upshaw: I do have one other clarifying question. And Jenna, you can decide who's best to answer this. There was a statement and it's

kind of in this first bullet point that it's duplicative of other measures that are in the same program. I know that there were -- if I remember correctly, there were some other hospice-related measures in the program. But I don't know if they were more complimentary than duplicative. And perhaps if you could just let us know what other hospice-related measures are in the program and people can kind of put this one in context with the others.

Ms. Williams-Bader: Sure. So I can speak to what we have in the measure summary sheet, but then also welcome the CMS program leads to speak up if they have any feedback as well. We pulled this information from the CMS Measures Inventory Tool. And there are two measures in that tool that are listed as similar to this one in the program. That's the 05736-C-PCHQR: Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days. And then 05734-C-PCHQR: Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life.

Co-Chair Travis Upshaw: So in my mind -- this is just -- I'm trying to draw the distinction. They're not the exact same -- It's not the exact same measure. I think originally the MUC -- when it went through the MUC process, people thought of them as complimentary perhaps, not necessarily duplicative. But that's for everybody to consider for their own. So I apologize, I was kind of taking off my Co-Chair hat with my comment.

So I see that Marty has his hand raised.

Member Hatlie: Yeah. It doesn't sound duplicative to me with those other measures just having read them. I think this is maybe a learning moment that it would be helpful to have to see those measures in print in the summary materials for us, so we can make that judgement perhaps better by actually reading the complimentary or potentially

duplicative ones. But this doesn't sound duplicative. And it does seem like there would be a gap if we were to remove this.

You know, the comments -- I listened carefully to the Health Equity comments too and it sounds like that was more of an editorial sort of setup comments about, you know, how the palliative care process and referral process to hospice could be improved, but not really opposition to keeping this measure. So I'm inclined to now vote or lean into voting in support of keeping this measure and not in support of removing it.

Dr. Zephyrin: I think just to clarify -- This is Laurie Zephyrin from the Health Equity Group. You know, the comments were about -- concerns about the palliative process. But also the comments allude to the fact that for this measure, you know, essentially you would -- you would want a low proportion of patients who died from -- proportion of patients who died from cancer and not admitted to hospice.

I mean there's a risk that with this measure, one can think, you know, things are positive or going well, but not necessarily from an equity standpoint. And so just -- it was just really applying that lens and background around the challenges of hospice and palliative care and nursing home care in Black populations and other populations. And how it could not necessarily be interpreted equally. I just wanted to add that to your comments, Marty. Thanks.

Co-Chair Travis Upshaw: Thank you, Laurie. Akin.

Co-Chair Demehin: Thanks, Cristie. I'll take my Co-Chair hat off for a minute here. You asked several of the same clarifying questions that I had in my head too. So

thank you for doing that. If I'm hearing the conversation and the history of this measure correctly, it sounds like this measure has existed for quite some time, but maybe not quite in the same form as it's being implemented in the PCH Reporting Program. And it sounds like this claims-based version as opposed to the registry-based version maybe hasn't gone through the NQF endorsement process yet.

Reflecting on what Marty said about you know, the importance of potential using hospice services for this patient population, I mean I certainly think it is an important topic. And from my perspective, there's a part of me that feels like it may be a little premature to recommend this get removed from the program. But it does potentially feel like this measure needs another look, whether it be through the endorsement process and examination of some of the incredibly important equity issues that were raised as a part of the conversation. That's kind of where my head is at on this. But really looking forward to hearing the rest of the perspectives from the group.

Co-Chair Travis Upshaw: Thank you, Akin. Jenna, just a technical question. People who have raised their hands will be visible to me. Is that correct? They'd pop into my top line.

Ms. Williams-Bader: They should be. I do see that Jennifer has her hand raised.

Co-Chair Travis Upshaw: Okay. Well, she doesn't show up on mine. So I'm glad -- Jennifer, please share. You know, we may have gotten a note from Jennifer. Let me look in the chat.

Member Hatlie: That was quite long ago, Cristie. I'm seeing it too.

Co-Chair Travis Upshaw: Yeah. I'm just now looking at it. Jennifer, are you on?

Member Lundblad: Can you hear me?

Co-Chair Travis Upshaw: Yes, now we can.

Member Lundblad: Okay. All right. My system decided to do a complete reboot when I was lead discussant. How is that for poor timing?

Ms. Williams-Bader: Perfect. Perfect.

Member Lundblad: So I don't know how much you caught of my earlier comments, but I've been back and I've been listening. And wanted to just pick up the thread of this discussion. I wonder if we as a workgroup are allowed to vote to continue endorsement? And can we also send comments and recommendations back to measure developers about next steps? I do think transitioning and looking at the measure from its claim-based form -- its new form would be really important. And the measure developer should seek endorsement for that.

In the meantime, we want to continue to measure hospice care, I think, in cancer hospitals. I think that's appropriate. And I wonder if as some of the documentation in our pre-materials suggested, is there a way we can package this measure with the other two similar, which I don't think are duplicative -- I agree with you, Marty -- the similar measures. And look at them as perhaps a roll-up or some other way of assessing that most comprehensive use of hospice, ICU, and end of life care. I think that this committee could really benefit down the road from seeing all that even if we agree to continue endorsement. Perhaps it's temporary until we can look at that new package and the new claims-based measure.

Co-Chair Travis Upshaw: Thank you, Jennifer. Jenna, do you see any other hands raised?

Ms. Williams-Bader: Frank, it looks like he's got his hand raised.

Member Ghinassi: Yeah. I just wanted to echo that I think this may be a moment for harmonizing these things. Every chance we get, if we could take something off the table and make this a less complex system while maintaining the important intent. I'm really for that. So if we do vote on this, I'd like it to be with the idea that we're expecting to harmonize these measures going down the road. Just a thought.

Co-Chair Travis Upshaw: Thank you, Frank. Any others, Jenna?

Ms. Williams-Bader: I'm not seeing any others at this time. And I don't believe I see anything in the chat either.

Co-Chair Travis Upshaw: Well let me attempt to summarize what I've heard, but please, you can check me and let me know if I did not capture everything.

I am hearing from those who have participated a general level of support on the support category versus -- support for retaining in some way this measure versus having it removed from the -- from the measure set. So taking the support for retaining, I also am thinking that it may be conditional support for retaining. And a couple of the conditions that I think I've heard that have been shared: One, would be to take the new measure in its claims-based form through the consensus development approval process for the endorsement. So I think that, that would be one of the conditions.

Another condition -- I hate to say condition or suggestion, but it would probably go in as a condition would be to think about how to pair or harmonize this measure with the other similar measures that are in the program related to hospice

in ICU care to really take a comprehensive view of the end of life care that patients are receiving.

I think those were the two primary conditions that I heard. So you know, I guess let me know if you disagree with us perhaps starting the voting process with conditional support for retaining with those two conditions. Is there anyone who disagrees with that as a starting point?

Member Hatlie: Cristie, this is Marty. I don't disagree, but I would maybe add. And that is that the notion of harmonizing and look at the three measures together, I'd like the input on that constellation from the Health Equity and Rural Advisory Group, just so we better understand their -- their process for making their comments.

Co-Chair Travis Upshaw: And is that something you'd like to hear from now, Marty?

Member Hatlie: No. I thought I said condition.

(simultaneous speaking)

Co-Chair Travis Upshaw: Oh, okay. Okay. And Jenna --

Ms. Williams-Bader: Cristie, could I actually ask a question about that if it's possible?

Co-Chair Travis Upshaw: Sure.

Ms. Williams-Bader: So the Rural Health and Health Equity Advisory Groups are part of the MAP process. Right? So they would provide feedback on measures that would be coming through MAP. But would not be involved in measures going through -- either being developed or going through endorsement. So maybe Marty, can you explain a little bit more what you mean about getting their feedback or how

you're picturing involving them?

Member Hatlie: I don't know that I can explain that better. What I would say is that I would welcome their point of view about this measure in connection with the other two that seemed complimentary. Because I didn't understand whether they were opposing this or whether they were just raising concerns in general about equity concerns or unfairness concerns in this program. So I don't know if there's a mechanism, Jenna, to your question about how to engage them. I'm going to have to put that back in your lap to tell me whether there is a mechanism. So if it's problematic to add it as a condition, I can withdraw that suggestion.

Co-Chair Travis Upshaw: Perhaps is there a way, Jenna, to have some commentary that also goes along, maybe not as a condition, but as a strong suggestion?

Member Lundblad: This is Jennifer again. Could we make the condition be that we recommend that the measure developer when bringing this harmonized set of three through the endorsement process, consider the rural and equity implications, rather than specifying the separate workgroups?

Co-Chair Travis Upshaw: I'm going to look to Jenna for some of your thoughts on that, Jenna.

Ms. Williams-Bader: I'm also looking to my team with -- Yes.

Ms. Elliott: I can jump in Jennifer.

Ms. Williams-Bader: Yes. Thank you, Tricia.

Ms. Elliott: Jennifer, I like the way that you worded that. So a condition could be encouraging the measure developer to take those viewpoints into consideration as they either work through, you know, some of the other conditions that were

stated.

Co-Chair Travis Upshaw: Okay. So at this point, we'd have three conditions or actually we could collapse. We have three thoughts. I'm not going to try to wordsmith everything here. But one is it needs to go through the endorsement process in its new form. And we're encouraging the measure developer -- We do want to have the measure ultimately paired or harmonized with the other similar measures. And we're encouraging the measure developers to consider the rural and health equity implications as they take this measure through the endorsement process.

Did I capture that? And I hope somebody's writing this down. I know it's recorded. So let's move to a vote then. We'll start with conditional support for retaining with those conditions that I just stated. And I'll look to the NQF team to help us go through the voting process.

Ms. Leflore: All right. Voting is now open for 05735-C-PCHQR: Proportion of Patients Who Died From Cancer Not Admitted to Hospice. Do you vote conditional support for retaining?

Ms. Elliott: And Joelencia and Jenna, for the record, we do have one recusal on this measure. So we need a minimum of 16 votes.

Ms. Williams-Bader: Thank you, Tricia. I think we are expecting 19 though. Is that right?

Ms. Elliott: Correct. We might have had a couple of the org reps dropped as noted during the DOIs. So we may be at 17, which we are now.

Ms. Leflore: All right. I'll give everyone about ten more seconds. I see it when up to 18. Okay. Voting is now closed. The results are 18 for yes and zero for no. And that will give us a percentage of 100 percent for yes and 0 percent for no.

Ms. Williams-Bader: Great. Thank you very much, Joelencia. So I believe we are now going to break for lunch. And we are almost perfectly on schedule.

(simultaneous speaking)

Ms. Williams-Bader: A good start to the evening -- to the meeting, I mean. Okay. So we will break for lunch and we will come back at -- as a round number, we'll come back at 12:00. We'll go ahead and put that in the chat. And when we come back, we will pick up with the public comment on the Ambulatory Surgical Center Quality Reporting Program Measures. So thank you all so much and looking forward to the afternoon.

Co-Chair Travis Upshaw: Thank you.

Ms. Williams-Bader: Thank you. Bye.

(Whereupon, the above-entitled matter went off the record at 11:33 a.m. and resumed at 12:03 p.m.)

Ms. Williams-Bader: And welcome back from lunch, everyone. I hope you had a nice little break. As promised, we will be talking about the Ambulatory Surgical Center Quality Reporting Program now. So if we can go to the next slide please.

This is a Quality Payment Program and Public Reporting Program. As part of this program, Ambulatory Surgical Centers that do not participate or participate, but fail to meet program requirements received a 2 percentage point reduction of their annual payment update under the ASC Fee Schedule for not meeting program requirements. And the goals of this program are to progress towards paying providers based on the quality, rather than the quantity of care they give patients. And to provide consumers information about ASC qualities so they can make informed choices about their care.

If we could go forward one slide and then one more. We'll go ahead and do public comment for the two measures in this program. And Cristie, I will turn it over to you.

Opportunity for Public Comment on Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures

Co-Chair Upshaw Travis: Thank you, Jenna. So if you're a member of the public and you're on the Webex platform, please raise your hand to let us know that you would like to make a comment. And we'll take people off the platform first and then allow those who are calling in to have an opportunity to provide comment as well. And Jenna, I might need you alls help in knowing if people have raised their hands.

Ms. Williams-Bader: Absolutely. I'm not seeing any yet. I don't see any in the comment yet -- or in the chat.

Co-Chair Upshaw Travis: Is there anyone on the phone that would like to make a public comment? And just as a reminder, we do ask that you keep your comments to no more than two minutes so that we can hear from as many people as possible. Okay. I don't think we have any comments, Jenna, unless you want to give a little bit longer.

Ms. Williams-Bader: I'm just going to give it one more minute to see if anyone raises their hands. I'm not seeing any right now. Okay, I think -- No hands raised and no chats from what I can see.

Co-Chair Upshaw Travis: Okay, thank you.

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

Ms. Williams-Bader: Okay. So I think we're closing the public comment and we can move to the first measure in this program. So that is 01049-C-ASCQR: Cataracts Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery. This measure assesses the percentage of patients age 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery based on completing a preoperative and postoperative visual function survey. Endorsement was removed for this measure and five survey respondents selected this measure for discussion.

I'd like to now see if the CMS program lead has any contextual comments they'd like to make about this measure.

Dr. Bhatia: Hi. This is Anita Bhatia. I'm the program lead for the ASC Quality Reporting Program. Can you hear me?

Co-Chair Upshaw Travis: Yes.

Dr. Bhatia: Yeah. Last time I was on this call, I had some video -- audio problems. Regarding this measure, we do believe this is a usable measure for this program. This is evidenced by the fact that there are a group of ASCs that continue to collect data and report it. The number is small, but that is at least in part reflected due to the fact that it is a voluntary measure. This measure does take some effort to collect, but we do believe it's a very important measure. It's a patient reported outcome measure and it measures an important aspect of outcome -- clinical outcome in that it's how well the person after cataract surgery can actually visually function, not acuity,

but visually function in the world. So that's a bit of context.

Ms. Williams-Bader: Great. Thank you very much, Anita.

Dr. Schreiber: Jenna and Cristie, this is Michelle. Can I just add a couple of comments to what Anita said, which was absolutely accurate? But this is one of the few patient reported functional outcome measures that we have in the ASC Program for a surgery that is probably the most common or certainly one of the most common procedures that is done in an ASC. The negative feedback that we've had about it is that it takes some effort to collect because the ASC has to outreach to the surgeon or the ophthalmologist who follows the patient. But we think that's essential actually in finding out the effectiveness actually of the surgery. And so I just wanted to add a few comments about the background of why we actually not only chose it, but sought to make it mandatory.

Co-Chair Upshaw Travis: Can I ask Michelle and Anita a clarifying question because I think that last statement, Michelle, is very important. Is this measure becoming mandatory and when would that occur?

Dr. Schreiber: To be honest with you, Cristie, it's in a little bit of flux. It was finalized last year that it would become mandatory, but there's some ongoing discussion about that.

Co-Chair Upshaw Travis: Okay. Thank you so much for that update. And I didn't mean to interrupt the flow, Jenna.

Ms. Williams-Bader: No, that's fine asking the clarifying questions. I think that's helpful. Okay.

So now we will go ahead and turn it over to our lead discussants. I have Suellen Shea, Premier Healthcare Alliance, and the Society for Maternal-

Fetal Medicine. I know we have Suellen on the line. I'm not sure about Premier or the Society for Maternal-Fetal Medicine. So we'll start with you, Suellen and then see if others are on the line.

Member Shea: Okay. So some things to note. This measure steward, they're coming up with the new measure. And so that is why they removed or you know, took a step back if you will. And also what they've pointed out that makes it burdensome is the fact that the patient is required to complete the survey prior to and after the surgery.

And considering that it's difficult for the patient to see, this requires the clinical staff or you know, a tech or whomever they designate to assist them through this survey. And there could be a potential for a little bit of bias. And the measure steward said that this was not ever the intent of the measure and have not been researched in that context that it is being used in. And also it was pointed out that this could be bias towards the ASC versus the provider who actually performs the cataract surgery because they're assisting them through the survey, et cetera.

What else did I find? That's really about it I think about the pertinent points that I saw that could be made. And due to the fact that the developer is working on a new instrument to measure visual function from a clinical standpoint, I think is something to really take into account. Did I miss anything, Jenna?

Ms. Williams-Bader: That is up to you, Suellen, but I will see if either of our other lead discussants are on the line. Do we have anyone from Premier or from the Society for Maternal-Fetal Medicine? Okay. I do see a hand raised, but I'm going to quickly summarize the feedback we got from the Rural Health Advisory Group and the Health Equity Advisory Group. And then turn it over to Cristie questions and discussion if that's okay.

So I wanted to see, do we have Beth Godsey on the line from the Health Equity Advisory Group?

Ms. Godsey: Yes.

Ms. Williams-Bader: Okay, great. Hi, Beth.

Ms. Godsey: Hi.

Ms. Williams-Bader: Would you like to summarize the Health Equity Advisory Group's discussion of this measure?

Ms. Godsey: Yeah, absolutely. And thanks for taking the time here. From a health equity perspective, I think there were some discussions about how followup would happen for historically marginalized populations. And that followup care has been a challenge in particular for communities who have been historically marginalized. And so from a health equity perspective, there was concern that this measure might be imbalanced a bit in that the patient population that would be included in the numerator and the denominators would be majority White patients and not your Black, Indigenous, people of color. And so that there was some concern about followup and making sure that, that was occurring.

The second piece was around just overall social needs or the lack of availability to be able to access the survey for the patient reported outcome component of it. And being able to make sure that patients have the ability to respond to this question or these sets of questions and have access to the appropriate materials or electronic frameworks that allow for them to connect to this and respond.

I think the other components were around -- although it's not specifically stated, other aspects around language and making sure that this is available in the pertinent languages that are in that community was also a question that arose. So those were some of the comments that came up related to

the equity component of this measure.

Ms. Williams-Bader: Thank you very much, Beth. And then for the Rural Health Advisory Group, so zero percent or zero Rural Health Advisory Group members supported retaining the measure in the program, six or 100 percent did not. They did not have much discussion about this measure though. Their main point was that it -- They don't actually see a rural health concern here, but they were concerned about the definition of "improvement" and were concerned that there was not a good definition of "improvement" included in the measure.

So Cristie, I will turn it over to you now for discussion. And I see two hands raised. I see Jackson Williams and then Anita B. and Marty.

Co-Chair Upshaw Travis: All righty. Jackson.

Member Williams: Hi. Jackson Williams from Dialysis Patient Citizens. I just had a question for -- I guess a couple of questions for Dr. Schreiber. So I recall back in 2018 when CMS inaugurated the cost benefit analysis for measures that this one of the ones that was tagged as being too burdensome. And so in a proposed rule, it was proposed to be removed. And then I guess there was some opposition to that and then a final rule that was retained. And I'm just curious, were there stakeholders who identified this as burdensome? Is that how it came to CMS's attention in the first place? And I guess my second question is, is CMS still pursuing the cost effectiveness analysis -- or cost benefit analysis on measures?

Dr. Schreiber: So several questions there. And Anita may have to help me out and I know that she's on the line. It is correct and I was transparent about that, that we have heard from stakeholders about this measure being burdensome. And that is one of the challenges from certain points of view about it. On the other hand, from the patient advocate

groups, there's been tremendous support. And again, this is one of the very few true patient reported functional measures that we have in the program.

From the cost analysis point of view, I don't know if this is a measure that has been evaluated from a cost benefit of the measure kind of analysis. There certainly is cost measures regarding this procedure, but I don't know if that answers your question about a cost benefit analysis for the measure. Anita, can you fill in anything more?

Dr. Bhatia: Just a bit. We have not done a formal cost benefit analysis on this measure. We always do burden estimates as part of the Paperwork Reduction Act section -- the burden section and the tax section going into a rule. And since I'm talking, I did want to clarify that were -- we are aware that the measure developer is revising this measure, so that was as Michelle stated. So we look forward to seeing the changes that the measure developer puts forth.

And I also wanted to add that this measure didn't -- doesn't happen in a vacuum. There is actually is an extensive amount of research regarding the usefulness of this survey and assessing function. And it is true, the old surveys don't have a specified difference between the before and after measures. But our understanding is that the measure developer is addressing that aspect of this measure.

Co-Chair Upshaw Travis: Thank you, Anita.

Member Williams: I know I'm not on expert on this. I would just comment that when I looked at the cost benefit analysis in 2018, I ended up writing an article about it. This certainly struck me as yes, this is a measure that is going to be burdensome, but PROMs are by definition going to be burdensome. And I think that, that's a burden that is probably worth -- the benefit probably outweighs the cost. And certainly if I ever have to undergo this surgery,

this would be information that I would want to know about the surgeon and the ASC.

Ms. Williams-Bader: Thanks.

Co-Chair Upshaw Travis: Thank you, Jackson. Any other hands raised NQF team?

Member Hatlie: My hand is raised, Cristie. This is Marty.

Co-Chair Upshaw Travis: Okay, Marty.

Member Hatlie: I'm going to agree with Jackson and with Michelle. I think this is a perfect use of a PROM. I mean there's a lot of options that people who are facing cataract surgery have now in terms of different kinds of lenses. So not only is it important from a public information point of view, but I see this as being really important from a quality improvement feedback point of view to practices that are offering their patients options. I think it's totally worth the burden piece.

And I agree with Jackson's comment that, you know, PROMs in general are going to be burdensome. But that's just the nature of why this measurement is so important is because we go back to the patient to get that feedback after the event. Thank you.

Co-Chair Upshaw Travis: Thank you, Marty.

Ms. Williams-Bader: Suellen has her hand raised.
Co-Chair Upshaw Travis: Suellen.

Member Shea: Yeah. So I think it's probably important to additionally add that those surveys -- I don't know the questions that are being asked on those surveys, so allow me to preface this -- saying that surveys tend to be subjective versus actually I guess testing if the patient's, you know, visual acuity is better following the cataract surgery. So are we wanting the patient's feedback as to how they see it or are we wanting to actually get data on

the true clinical piece and patient outcome? That's my question. What is this measure supposed to serve?

Co-Chair Upshaw Travis: Is there anyone who can address Suellen's question?

Dr. Bhatia: Yeah. This is Anita again. I can address that in that this measure does not look at visual acuity. Visual acuity is a different aspect of vision. I am not -- okay, with the caveat that I am not an ophthalmologist, but this measure is not for acuity. It's for function.

So the questionnaires, which have various claims to them make a more easier and administratable survey ask questions about how the patient is operating in the world. And one of the aspects that the measure developer is addressing is that in their view, some of the questions are outdated and don't address things that people do as much as they used to.

I actually took the questionnaire from my mother -- the short version. And one of them was, you know, playing board games. I don't think my mother played, you know, board games in 50 years. So that didn't apply. So when I looked at the way she would have scored on that survey, she wouldn't have done very well. That's just the little short one. So that's one thing that the measure -- like I said, the measurer developer is addressing. So again, it's not acuity. It's how you're operating, you know, maybe board games, typing, getting things, you know, how you operate in the world.

Member Shea: Right. And so also I think that this is from my perspective strictly. I think that -- I know the burden is placed because they're having to communicate with the provider who did the surgery. But I also think that this would encourage or push us more in the direction of that interoperability that we need to achieve in our electronic health record.

Co-Chair Upshaw Travis: Thank you, Suellen. Akin, is your hand raised?

Co-Chair Demehin: It is. I have both a clarifying question and then maybe just a couple of perspectives to offer on this measure. The clarifying question is I saw I think in one of the public comments that a version of this measure is used in the Merit-Based Incentive Payment System for physicians. And my question -- and this is probably one for our colleagues from CMS is how long has that measure been in the MIPS? And what's kind of the overall level performance? Is there still a performance gap? Can you give a couple of impressions there?

Dr. Schreiber: Akin, it's Michelle and I'll try and take that. I'd have to go back and look at the history of it in MIPS. But recall that MIPS is a voluntary program. Right? And so that those who report measures choose to report these measures. And yes, there is still a performance gap if I'm not mistaken. But I can reach out to the MIPS team and try and get some more clarification for you. I would say that it has been a voluntary measure for the ASCs also, as well as it has been in the MIPS Program. And even within the ASC Program, there is certainly room for improvement.

Co-Chair Upshaw Travis: Anita, did you want to chime in on that?

Dr. Bhatia: No. Michelle answered that.

Co-Chair Upshaw Travis: Oh, sorry. I see your hand up. That's why I was wandering.

Dr. Bhatia: That's up from before.

Co-Chair Upshaw Travis: Okay. Thank you.

Dr. Schreiber: We're a tag team, Cristie.

Co-Chair Travis Upshaw: I believe you. I wanted to be sure she was tagged if she wanted to be.

Dr. Bhatia: Yeah, thanks.

Co-Chair Upshaw Travis: Akin, did you have some other thoughts on this measure?

Co-Chair Demehin: Yeah. So just taking my Chair hat off fora minute and thinking broadly about this measure. I certainly -- I actually have a great deal of agreement with the points that have been made about the importance of patient reported outcome measures. And quite frankly some hesitation in terms of potentially recommending the approval of one that reflects patient reported outcomes. I also think that cataract procedures are common enough that from a measuring and aspect of care that is important, this measure would certainly continue to sort of pass muster.

Where I'm having a lot more trouble with getting behind this measure is number one, is the NQF endorsement question and some of the questions about the survey itself and the instrument that is used to collect information on visual functional improvement. The topic might be right, but if the approach used to measure it needs some work, I think that's a really important thing for us to consider here.

I do worry a little bit too about the level of burden that is required to get that information from the operating clinician who is doing the procedure. I don't want to understate just how important that is, especially at a time like this where the healthcare workforce is under an enormous amount of strain. But I also see in the measure, there's an exclusion for those patients who don't complete the assessment. And there's a part of me that wonders what does that response rate look like? And if it's very -- if the non-response rate is high, are we really measuring something important here?

The level of performance that was shared, I know that it is only voluntary reporting. It struck me as fairly high, which I think in part reflects the relative

success and the relative safety of cataract procedures. So I think where I'm really struggling is are we measuring the right thing here? And it's lack of NQF endorsement and some of the questions are certainly of keen interest to me. And is there enough of a performance gap that remains that we would want to get behind this?

And part of the reason I was asking the question about the MIPS Program to my CMS colleagues is it would certainly influence my thinking in terms of whether the potential temporary removal of something like this would have a gap. And if that gap is being at least partially filled by the MIPS Program, that gives me a little more comfort. So just a few things that are swimming around. This is a challenging one to evaluate for sure.

Co-Chair Upshaw Travis: Thank you, Akin. I'm trying to look and see -- I think Phoebe, do you have (audio interference)

Member Ramsey: I just have a quick question. And I apologize, I missed the beginning of the discussion coming back from lunch. So I may have missed it. But I believe this same measure is in the OQR and had been in a voluntary status, but last year's rulemaking is going to make it mandatory in the future. And I'm wondering about how the measure was included on the list here for the ASCQR and not for the OQR. And whether there should be some thought or discussion around its use across the two programs for comparability purposes for patients or for, you know, consumers to be able to kind of actually one of the few measures where they can really look at the two different settings potentially while they're making care choices. And whether that's something that's been considered?

Co-Chair Upshaw Travis: Anita, would you like to address that?

Dr. Bhatia: Okay. So I don't know that I quite understood that. But this measure is in both

programs. It is in measured in the Hospital Outpatient Quality Reporting Program and in the ASC Quality Reporting Program.

Member Ramsey: Right. I think what I was trying to get at is the idea of considering it for removal from one of the programs, but we're not discussing it for removal from the other. And whether that's something that we should be mindful of in the sense that this is one of those measures that we actually currently have in both programs that does allow for that kind of cross setting comparison. I think that is something that's been discussed when it comes to outpatient quality measurement and the ASC setting of where we can find more synergy between those two programs and allow patients to better compare across the two settings?

(simultaneous speaking)

Member Ramsey: So I think for me, there's a concern about considering removing -- or recommending a removal here, but we're not talking about it for the other.

(simultaneous speaking)

Dr. Schreiber: Phoebe's point is well taken. And I think that the reason that it looks like this is the vote that was taken by all of the MAP members to propose what measures to look at for removal. It may just be -- and I'll ask NQF this -- it may just be that this is the one that rose to the top sort of, you know, in that list and the HOQR one didn't. Which gets back to an earlier conversation about -- and I think this is a future discussion about whether or not we should be looking thematically, in addition to or maybe instead of programmatically.

Co-Chair Upshaw Travis: Very good thought on that, Michelle. I'm looking to see if we have any other hands raised. If not, I do have a comment. Do you see anything, Jenna? I don't see any.

Ms. Williams-Bader: I don't, no.

Co-Chair Upshaw Travis: Okay. I am going to take my Co-Chair hat off. And really I think one of the issues that was raised in the public comment that I want to be sure we at least think through is, you know, it seems that one of the public commenters really stressed that what we really may be measuring here is the surgeon versus the ASC. And I think, you know, putting my experience and endorsement, you know, kind of in front of me, you know, I think it's important to know how does the ASC impact the improvement in functioning? You know, because certainly for a lot of measures, especially surgical ones, the surgeon is always an aspect. But the facility, you know, can have that impact.

So I don't know, maybe this is for the CMS colleagues in terms of thinking about this. You know, are we really measuring the surgeon or are we measuring the ASC? And how does the ASC impact the outcomes here?

Dr. Schreiber: So if this is for CMS, I'll try and take a stab at that. I think in any surgical procedure, the answer is it's both. Right? You know, you clearly need the skill of the surgeon, but you also need the team that generally sits within the ASC. You need the facilities of the ASC. And then the ASC does have some choice about who it allows to operate within its -- you know, within its walls. And so I guess in any of these things, it's both. And I think -- I think that's why you see it as both a physician measure i.e. a MIPS Program and as a facility measure.

Co-Chair Upshaw Travis: Well thank you for that. That's kind of where I was leaning on it, Michelle. But I wanted to kind of hear it from the rationale of it being for you all and what your rationale was for putting it in this program. And yes, you know, certainly where you have the procedure done has an

impact on your outcomes. So are there any other comments?

Ms. Williams-Bader: I'm not seeing any hands or chat messages at this time.

Co-Chair Upshaw Travis: Okay. I'm trying to -- trying to remind myself about -- and maybe Jenna, you can do it faster than I can find it on the -- on the form. But what is the status of endorsement on this measure?

Ms. Williams-Bader: I will look quickly. And while I do that, Michelle has her hand raised.

Co-Chair Upshaw Travis: Oh, yes. Michelle.

Dr. Schreiber: Yeah. Cristie, I just wanted to make the additional point since we were talking about facilities that one of again, the advantages of this being now in the ASC and the Hospital Outpatient Program is the ability to compare then for consumers to look and see what kind of setting they might want to get their surgical procedure in.

Co-Chair Upshaw Travis: Yes, thank you. Thank you very much.

Ms. Williams-Bader: So according to the measure summary sheet, endorsement was removed for this measure in 2018 because the measure was withdrawn due to the developer working on a new instrument to measure visual function. I don't know if CMS has any updates about that since that was back in 2018.

Co-Chair Upshaw Travis: Anita.

Dr. Bhatia: Yeah. Regarding the measure developer, we have been in contact with the measure developer. And they informed us that they were -- as I said, working on revising and updating this measure. Specifically they're addressing two aspects which are they want to update the questions and that

they were going to put a difference between pre and post on it. And that's for the measure which someone had mentioned as a concern. That's the extent of our knowledge on what's going on with this measure. We are hopeful that it will be coming up for review though.

Co-Chair Upshaw Travis: Thank you. Okay. Well my general observations, but please check me on this -- is that although there have been some concerns raised around the measure that there is support for having this type of measure in the program, both from it being a PROM, being able to actually compare to the Outpatient Quality Reporting actually functional assessment versus you know, acuity. Really looking at it from the patient's perspective and how they live in their daily lives.

And the issue I think that I would like to -- for us to think through is whether it seems like retaining is probably where the majority of the people who've commented would be. But there may be some conditions that we would want to consider. And you know, just to put some out there for your feedback to us as to how you would like us to move forward -- how the Committee would like to move forward. One would be around endorsement with the new -- and the new instrument.

So I think at least that's something that I have heard. And that may be the major condition that I have heard that people may want. I mean the question really is whether or not we want to put a condition on it one way or the other. But I do think that the group is for the most part supportive of retaining the measure. And that there would certainly be a gap if it were to be removed.

I'd like to hear a little bit from the Committee around whether you feel a condition is appropriate. And if so, what would that condition be? Or whether you're leaning towards support for retaining without

a condition.

Member Shea: My condition would be based on the fact that the measure steward is coming up with a new measure. And so that -- that's really my condition.

Co-Chair Upshaw Travis: So really focusing on the new instrument.

Member Shea: Yeah because I think that they've seen, you know, the burden from this and the current measure. And so now they're probably, I would assume, doing research or creating a tool that is (audio interference) to use in this area of intent.

Co-Chair Upshaw Travis: Thank you, Suellen. Any other thoughts?

Member Hatlie: Cristie, it's Marty. I'm wondering if this -- if there's any difference in this case about voting to retain versus voting to retain on a condition that there will at some time in the future be a new measure. It seems like it would have the same impact. That we would re-visit it again when the new measure gets into the endorsement process.

Co-Chair Upshaw Travis: So which way would you come down on that, Marty?

Member Hatlie: I'm going to vote to retain just because -- but I would be equally as happy voting the other way. But I'll vote to retain.

Co-Chair Upshaw Travis: Okay.

Member Hatlie: I think it does send a signal for the reasons that Michelle and others have mentioned. I mean this is a very common procedure. You get to -- It's an important piece of information. It's actually something that would be useful to patients and families in choosing where to go. And it's an area where, it's one of the few PROMs we've got. So I

think sending a signal to PROMs is worth the burden because it gives us a new way of measuring not just clinical outcome, but you know, all the things that have been said -- the functional outcome. I can't talk today for some reason.

Co-Chair Upshaw Travis: You're doing great.

Member Hatlie: But in any case, I think it sends an important signal to keep a PROM prominent in our list.

Co-Chair Upshaw Travis: A PROM prominent.

Member Hatlie: Yes, a PROM prominence -- a PROM prominent.

Co-Chair Upshaw Travis: I see Lindsey has her hand raised.

Member Wisham: Yes. Can you hear me? Did I master --

Co-Chair Upshaw Travis: Yes.

Member Wisham: -- the double mute? Okay. You know, I think part of my -- again, maybe this goes back to whether or not there's any kind of alignment with the MIPS measure. So in looking at the MIPS measure specs that we were discussing today, there is an instrument indicated in their specification. So you know, if there is alignment -- I'm just wondering is this 2018 note about endorsement being removed as they're working on a new instrument, is that dated? Right? Do we know that, that hasn't already happened? And that they're using the instrument in alignment with the MIPS measure? Because I guess my thought is in line with Marty's is not to include a condition cause I'm not solid on whether or not they're in the process of doing this new instrument in measure development or if that's already occurred. Cause again in looking at the MIPS measure, which has some alignment into this visual function

assessment is that does actually indicate a specific instrument.

Co-Chair Upshaw Travis: Thank you, Lindsey. I don't know if anyone from CMS can shed any light on that. I think, you know, I know you all have been in touch with the measure developer, but if you have any additional information regarding how it aligns with the MIPS measure, that could be helpful.

Dr. Bhatia: Hi. This is Anita. I had my hand raised.

Co-Chair Upshaw Travis: I'm sorry.

Dr. Bhatia: That's okay. Okay, so the measures are the same. They're just from the same measure developer. I'm not familiar if the MIPS measure specified a specific version of the survey. The way that (audio interference) -- the survey works -- and we actually did include a discussion of that in a rulemaking -- is that they're scaled down.

So I believe the original survey had like 32 questions. Then they made one that was 16 and then they made one that was 8. And they all scale to have the same end measurements. So you multiply it. So for the one that has eight questions, you multiple it times four to get the equivalent to a 32-question questionnaire. And that's how that works.

So for the measure under the Hospital Outpatient Quality Reporting Program and the ANC Quality Reporting Program, we allow flexibility for the facility to choose which one of the surveys they wanted to do. Because at the time, there was more availability of some versions versus others. So they are considered to be equivalent. Some of the surveys are just scaled down for ease of administration.

And regarding the measure developer, they did say to us recently that they were working on updating that measure. But I don't know what their timeline

is going to be in their efforts.

Co-Chair Upshaw Travis: But it does sound like these measures are the same if I heard you correctly in the MIPS Program and in this program.

Dr. Bhatia: Essentially. I just don't know if the MIPS Program specified just one version of the survey or not.

Co-Chair Upshaw Travis: I got you. And they had choices in this program.

Dr. Bhatia: Correct.

Co-Chair Upshaw Travis: Okay. And Akin?

Co-Chair Demehin: Thanks, Cristie. So I think I have a couple of questions. Maybe this is for our NQF team about how we apply the categories here. And then one kind of broader process question for us. You know, as I think about the conversation, I think Cristie is absolutely right that we're sort of trying to weigh the support versus conditional support categories here. Depending on how one views the set of challenges with respect to this measure, one could also plausibly make a case for conditional support for removal.

And I think it really hinges on sort of how you think about the value of retaining the measure in the program. And it's my sense that the value is potentially still there. So it would be a bit of a tricky call between those two categories, but both could plausibly fit.

The question for our NQF Team -- so right now as our colleagues from CMS laid out, this is a measure that's adopted for voluntary reporting. Sort of from my perspective, there is a difference between a measure that's required of everyone versus a measure that is available for reporting. And I think the question is through this process, do we give CMS recommendations on voluntary versus

mandatory reporting? It would be helpful to get a sense of what the boundaries are here in terms of the kinds of recommendations we could make. Cause it may affect either the kinds of conditions that we want to suggest to the Agency and under advise. So what do you advise us there?

Co-Chair Upshaw Travis: Jenna, I think that's for you.

Ms. Williams-Bader: It is. I'm just thinking. We certainly take all of the comments and share them with CMS. I guess Michelle, do you want to speak from CMS' perspective whether it would be helpful to have -- for MAP to also be making recommendations around voluntary versus mandatory reporting? Or do you really feel like that's within CMS' purview to decide? And here, we're just taking recommendations on having measures in the programs or not?

Dr. Schreiber: I think we're happy to take recommendations as people would like to make them. Voluntary, not voluntary in our out, really the most helpful is the conversations around these that we're all having so that we can gain insights into how people are feeling about it. And we're happy to go with the vote however the Committee would like.

Co-Chair Upshaw Travis: Thank you, Michelle. Akin, any followup points that you wanted to make?

Co-Chair Demehin: So that was very helpful. Thanks so much, Michelle. I guess it might make me think of a kind of a conditional support for retention with one of the potential conditions we could consider being while some of this other issues with the instrument and some of the work to bring the measure through the endorsement process is done, maybe it remains a voluntary -- and may be the recommended -- recommendation is to have it as a voluntary measure. That might be one way to approach it. But obviously welcome the thoughts and recommendations of everybody else on the

group.

Ms. Williams-Bader: I see Denise has her hand raised.

Member Morse: Yes, thanks. I'm still having a little bit of trouble squaring away a measure that's in kind of multiple programs and we should really think about this. Is it the measure itself or just the measure being in the program that we're really supposed to be analyzing and speaking to? I have a hard time recommending, you know, a removal or a condition without kind of the context of it being in additional programs as well and evaluating its place in those programs at the same time. So I'm just wondering -- so it's a bit of a comment. But also a question of is it the metric or in the program that we really should be evaluating?

Member Shea: Jenna, I can take a stab at that, but if you want to give NQF's position, I'll give that to you if you'd like.

Ms. Williams-Bader: Yeah. Let me -- Let me start and Cristie, you're welcome to add. So this was one of the challenges we had when thinking about how to structure these conversations. Michelle's absolutely right that the reason why this measure came up for this particular program and why we're discussing it for this program is that it reached the threshold as far as the number of votes. It rose to the top, I guess I should say for the number of votes in this program and it didn't for Hospital OQR.

I think in the interest of time and because as we prepared for these meetings, we did have to try to focus on a certain set of measures, we would ask the conversation to be about the measure in this particular program. But we can -- we can spend a couple of minutes keeping an eye on the time -- if there are comments that folks would like to make about the measure in other programs as well. Those comments would obviously be shared with CMS. And as Michelle said, the feedback is really one of

the things that's most important to CMS.

So we could spend a couple of minutes talking about the measures used in other programs. Again for time and in order to focus the conversation, we'd like most of the conversation to be about the measure in this particular program. Cristie, was that what you were going to say?

Co-Chair Upshaw Travis: You've been more generous than I was going to be. But our job today is to look at it within the Ambulatory Surgery Center Program. But to Jenna's point, you know, if you -- if you have a comment about it in other programs -- I think from -- and I'll take my Co-Chair hat off. From my perspective, the fact that it is in other programs, there is an advantage as Michelle and others have pointed out because you can see the performance across programs who are having an expectation of both facility performance and provider performance. And we've got two different types of facilities that we're measuring it in.

So it seems from my perspective to be good from a continuity and consistency and signaling the importance in all of those settings, you know, I see as something positive when we have the same measure that rolls through different -- different settings and levels of analysis.

We can take one or two comments, but please keep them short if they're relative to any of the other programs and not specifically about the ASC Program. And then I have a -- I have a proposal for you all.

Okay. Well here's what I'm going to propose to do. And you know, I beg forgiveness from Jenna and her team if I don't do -- if I'm not doing this right. Let's start with the support for retaining without any conditions and see where we go on that vote. If we don't reach the threshold, then we'll move to support with conditions. And we'll -- we will outline the specific conditions. So if we could start with a

vote on support for retaining.

Ms. Leflore: Voting is now open for 01049-C-ASCQR: Cataracts Improvement in Patients Visual Function Within 90 Days Following Cataract Surgery. Do you vote support for retaining?

Ms. Elliott: And for this measure, we do not have any recusals and we are anticipating 18 votes.

Ms. Leflore: All right, we'll give everyone about 30 more seconds.

Ms. Elliott: And we need to get 17 more votes -- I'm sorry, two more votes for 17 at a minimum.

Co-Chair Upshaw Travis: Thank you.

Ms. Elliott: Sorry.

Co-Chair Upshaw Travis: Is anyone having difficulty voting? I wonder if we lost a couple of people.

Member Shea: There were some people that said they had to leave the meeting around noon, so you could have lost some.

Ms. Elliott: Yeah. We dropped -- may have dropped. So Cristie, if you're okay with this, we'd like to perhaps while we're waiting for two people to come back that were involved in the beginning of the discussion, so they would have had enough information to make a vote, but were coming back on at 1:00 p.m. So can we hold this vote until we get back to quorum?

Co-Chair Upshaw Travis: Yes. Yes, that would be fine.

Co-Chair Upshaw Travis: Okay. So I think what we'll do then is move to the next ASC measure. And I apologize for how long that took. But I think this was a -- It was a very active and engaged committee around -- around that measure. So thank you for that. And so we'll move to the next

ASC measure.

02936-C-ASCQR: Normothermia Outcome

Ms. Williams-Bader: Great, thank you. So the next measure is 02936-C-ASCQR: Normothermia Outcome. This measure assesses the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the Post-Anesthesia Care Unit. This measure is not endorsed and six survey respondents elected this measure for discussion. I'd like to pause to see if the CMS program lead would like to make any comments about this measure.

Dr. Bhatia: Sure. I can make some comments about this measure. This is Anita Bhatia from CMS. The normothermia measure is a measure that came from the ASC Quality Collaboration. It is not -- was not endorsed because it was not brought to NQF for endorsement. It's not that it was removed or such. At least that's my understanding of why it's not endorsed.

This measure does -- while it does have a high level or overall performance, we do have some outlier facilities. So that seems to be a lot of what we see with ASCs that, you know, generally performance tends to be high on our quality measures, but we do have some low performers that we would like to bring up. So we continue to see value in this measure.

One aspect of this measure is that it is a very stringent measure with the caveat again that I am not a surgeon. But it is very important to not get too cold when one has a surgical procedure. So we find merit in this measure. And I would add that there has been some concerns expressed regarding burden. And we have never heard from our stakeholders or from our ASCs at any time while having this measure that it was overly burdensome. So we're a fan of this measure.

Ms. Williams-Bader: Thank you, Anita. I'll now turn it over to our lead discussants. And I have the City of Hope and Dialysis Patient Citizens as the lead discussants. So we'll start with City of Hope.

Opportunity for Public Comment on Hospital Outpatient Quality Reporting (Hospital OQR) Program Measures

Member Morse: Yes, hi. Thank you. It looks like there was no public comment on this one to go off. I am -- it does appear that it is a for sure a high measure performance on this with the median of 195 percent performance overall. There was not too much -- There was some information about standard deviation, not a lot about range related to the measure, which seems like that might be an important factor.

In terms of the burden, in looking at the measure specs, it does look like they will take a wide variety of different documentation of this, most of which appears to be manual or could be manual in nature. So this is not an eMeasure or claims-based measure by any measures with the significant amount of exclusions, that we require chart audit. It is a measure submitted by web base, which does have a little bit of a burden to its center to continue to report that.

There doesn't -- within just the documentation, there doesn't seem to be a significant amount of reason to continue the measure, I think without that endorsement. Endorsement might be a really good condition here to add, so that the measure goes through that additional scrutiny and especially performance gap analysis.

Ms. Williams-Bader: Thank you. Is there anyone from Dialysis Patient Citizens who wanted to say anything about this measure?

Member Williams: Yeah. It's Jackson Williams. I'm not a clinician, so I don't really feel qualified to

speak on this.

And, if I may, I'll just take this time to suggest that it might be logical to start off -- have one of the people who identified the measures for removal appear and speak first during this process since they essentially have the burden of changing the status quo.

Ms. Bader-Williams: When identifying lead discussants, we did try to go first to individuals who had nominated the measures that did not work for all of the measures.

And there are also -- not everyone had responded to the survey, so we've been trying to spread out lead discussants.

Some people were given the lead discussant role on measures that they did not nominate, but thank you for that feedback.

So, if we have no other lead discussant comments, I will see if we still have Beth on the line from the Health Equity Advisory Group.

Ms. Godsey: Yes, I'm still here.

Ms. Bader-Williams: Great.

Beth, would you like to summarize the Health Equity Advisory Group's --

Ms. Godsey: Yeah. Actually there wasn't a whole lot of discussion from the Health Equity group related to this measure and, in particular, related to implications.

There was some broader comments that were made around potential of the measure related to burden, but not any specific comments or concerns in a health equity lens at this particular moment.

Ms. Bader-Williams: Thank you very much for that, Beth.

And then for the Rural Health Advisory Group, they -- let me just -- so, 0 supported retaining the measure in the program; 6 said they did not support retaining the measure in the program -- that was 86 percent -- and 1 was unsure.

They also did not have a lot of discussion about this measure, but did say that it seems like it could be a standard of care.

So, Cristie, I will turn it over to you now for discussion.

Member Lundblad: Jenna, this is Jennifer.

Could you repeat that what the Rural group said about this? I just didn't lock that in and I was maybe a bit confused about what you just said.

Ms. Bader-Williams: Yeah. Sorry. No problem.

They just said that it seemed like it could be a standard of care. So, something where you would not see -- it's such a standard that you wouldn't see variation. It's just something that is -- it's a standard that everyone does, yeah.

(Pause.)

Ms. Bader-Williams: Any comments or questions from workgroup members?

(Pause.)

Ms. Bader-Williams: While we're seeing if anybody wants to raise their hand or wants to make a comment, I'll take my co-chair hat off and ask -- it does seem that a couple of people have talked about performance gap.

And, Anita, I know that you mentioned that although overall performance appears to be high, there are still outliers.

I was wondering if you had any additional

information that could be helpful to the group to kind of draw this distinction between standard of care that is generally provided or, you know, the outliers that you all have noticed, and I think that could be additional information for us to consider.

Dr. Bhatia: Well, I can a little. So, again, I'm just an epidemiologist, I'm not a clinician, and I have not looked at these studies recently.

When we proposed and then adopted this measure, I did look into it and the -- this measure, as developed by the ASC Quality Collaboration, is more stringent.

It does not allow body temperature to fall quite as far as some other measures of normothermia, but I don't know what the current standards might be if they have change. So, that might be something we could look at.

In terms of outliers, we did just look at this recently. So, again, with the knowledge that this is a stringent threshold for normothermia and how far body temperature can fall, we did see that, as noted, most performers are pretty high.

So, there is -- we have these, you know, these bold bar graphs and most everybody is up at the top with high performance, and then we have a group that clusters down at the bottom.

I don't have the numbers right off the top of my head. At first, I was concerned because some of them were -- these facilities were reporting zero, that none of their cases that they were reporting had achieved the measure, but then I also remembered that this is a stringent level of performance.

So, there is still room for improvement in the data that has been reported to us. And so, we continue to see value in this particular measure.

Co-Chair Travis Upshaw: One thing I noticed, Anita, was that the 2018 performance that is in the measure information provided for our review today was -- the average rate was, like, 85.53. And then by 2020, it had gotten up to 95.11.

One of the questions I guess I had was, that seems like -- it seems like maybe when it started being -- that the measure may have had an impact, you know, because the performance has improved so much over that three-year period of time.

I don't know that I should be looking at the data that way. And so, I definitely want to be checked on this, but it just seemed -- I mean, that's a 10-point difference.

Dr. Bhatia: That is a large improvement. We would like to believe that it was due to the fact that once things are measured, they can get improved because often, you know, it's like with anything. You think you're doing really well at something until you actually measure it. So, as was pointed out, these are reported in aggregate. If I recall when in talking with some of the measure developers, they -- I recall, you know, that there was some mention of that that people didn't realize that they weren't doing this as well as they were.

So, that could be, you know, that could be why this has improved so much.

Co-Chair Travis Upshaw: And take --

Dr. Bhatia: I think we lost connection.

(Pause.)

Co-Chair Travis Upshaw: Can you guys hear me?

Member Shea: Yes, I can hear.

Co-Chair Travis Upshaw: Can you all hear me?

Member Shea: Yes.

Co-Chair Travis Upshaw: Okay. I think -- we are losing people, I think, as well as connection.

I mean, my concern would be if we stopped measuring it, would it fall back down, because that looked like a pretty significant improvement when it was being measured.

And, Suellen, I see you have your hand raised?

Member Shea: You know, I guess my concern in looking at the data element definitions, I am not understanding why those pieces of data are unable to be captured without having to do manual and -- I mean, they should be able to easily pull that data so that data collection burden shouldn't be there.

Co-Chair Travis Upshaw: Any comments to Suellen's point?

(Pause.)

Member Wisham: Cristie, this is Lindsey. I mean, I think to Suellen's point if it hasn't been specified as an eCQM, it probably just hasn't gone through that process of mapping the currently collected elements with the currently used data models for collection and calculation of eCQM.

So, I mean, I don't know if that's our role here to go one step further, again, and actually suggesting changes to the measure.

That's where I get a little squishy as to what, you know, if we're stepping beyond our purview and our purpose on this, but, you know, that could be a suggestion.

I don't know if I want to make it a condition, but that's only a suggestion for how it could meet more of the criteria as determined by the measures that review process.

Member Shea: Yeah, I just -- I had noted that that was one of the things that was mentioned in

reference to this as to why they would not want it, and that's the only reason that I mentioned it.

Co-Chair Travis Upshaw: Well, I will remind everyone this measure has not gone through the endorsement process where a lot of what we're talking about, I think, could be teased out and evaluated because it fits within the criteria that is evaluated for endorsement.

And to the earlier point, certainly I think we'd have more detailed information on performance gap as well as, you know, obviously the testing for reliability and validity.

So, not seeing any other hands raised --

Ms. Bader-Williams: Cristie, I did just want to quickly -- there was a comment in the chat from --

Co-Chair Travis Upshaw: Oh, thank you.

Ms. Bader-Williams: Yeah, from Vilma -- let me scroll back up here -- Vilma Joseph that said, we believe that the burden is not excessive. There is still room for improvement. As of yet, there is no better substitute measure.

And I don't know if Vilma wanted to say anything else related to that, but I agree I don't see any other hands raised at this time.

Co-Chair Travis Upshaw: Well, thank you for sharing that. And if you'd like to go on voice and share any additional context for that, we'd welcome your comments, but we thank you for putting them in chat as well.

So, I'm not hearing anything about removal from anyone. And if I did and just missed it, please let me know.

I do think that if we wanted to consider a condition, I think endorsement could be a condition, you know, for Support for Retaining.

So, I'd like to hear from anybody if they feel like having a condition is important or whether we just want to go with Support for Retaining.

(Pause.)

Member Shea: Support for Retaining is a good way to go.

Co-Chair Travis Upshaw: Okay. Well, why don't we do the same thing and we'll start with Support for Retaining.

And if we don't meet our threshold, I assume we'll go to support -- Conditional Support and then come up with the specific conditions -- name the specific conditions.

So, let's start with Support for Retaining.

(Pause.)

Ms. Leflore: Okay. I believe we're just taking a couple seconds to pull it up. Voting is now open for 02936-C-ASCQR, Normothermia Outcome.

Do you vote Support for Retaining?

(Voting.)

Ms. Leflore: I will give everyone 20 more seconds. We are looking for 17 MAP members to vote.

(Voting.)

Ms. Leflore: And it looks like we might have to go ahead and just lock this --

Co-Chair Travis Upshaw: We've got 17.

Ms. Leflore: Oh, 17, yes. Okay. Great. Awesome. We can go ahead and close the voting.

Co-Chair Travis Upshaw: And don't go anywhere because we've got to come back and vote on the other one.

We need 17 for that vote. So, stay on.

Ms. Leflore: Voting is now closed. The results are 15 yes and 2 no. I'm going to look to my team for percentages. And that is 88 percent for yes.

Co-Chair Travis Upshaw: Great. Okay. Well, thank you for that, and I think we need to come back and vote on the cataracts -- is that -- I'm sorry, is it cataracts? I think it is. Yes.

Ms. Leflore: Yes, that's right.

Co-Chair Travis Upshaw: I've already moved on. So, Jenna, do we just move straight to the vote?

We were going to go with Support for Retaining, I think, first.

Ms. Bader-Williams: We can do that.

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

Do you vote Support for Retaining?

Member Lundblad: We vote even if we voted previously, right? We're starting over on this one?

Ms. Leflore: Yes, please.

Member Lundblad: Okay. Thanks.

Co-Chair Travis Upshaw: Yes. Thank you for asking that question.

Ms. Elliott: Correct. The prior votes were cleared and this is a revote. Thank you.

(Voting.)

Ms. Leflore: It looks like we're at 17 MAP members. So, we can go ahead and lock the vote. Voting is now closed. The results are 10 yes, and 7 no. And

that would give us 59 percent for yes.

It looks like the workgroup did not come to consensus and will continue to the next decision category.

(Pause.)

Ms. Bader-Williams: Cristie's picture has disappeared. I don't know if she's having connection issues. We'll give her a minute.

(Pause.)

Ms. Elliott: So, before -- we'll wait for Cristie to get reconnected here. We just need to outline what the conditions are as we move into the Conditional Support for Retaining if we can get Cristie back online.

(Pause.)

Ms. Elliott: Akin, are you comfortable trying to summarize what some of the conditions were with that measure or should we continue to wait for Cristie?

(Pause.)

Ms. Elliott: While we're waiting, would the group like to propose a condition based on our prior discussion for this measure?

Member Lundblad: This is Jennifer.

One of the things I heard in our prior discussion that I resonated with was wanting to maintain this measure, but knowing that there is a new -- there are instruments coming so that this is a -- we're temporarily extending this conditionally based upon the new instrument to be used.

So, that was one of the conditions I heard.

Member Ghinassi: This is Frank. One I heard was to harmonize this with existing, similar or related

measures as opposed to continuing with multiple ones that overlap or have correlation with one another.

Member Shea: I'm not sure there are other measures that -- there are no other similar measures, but I think the question was around MIPS and, you know, the ASC setting, et cetera.

So, it was across multiple settings more so than an overlap in measures.

Ms. Elliott: Okay. So, thank you for those conditions. So, I heard the instrument piece was mentioned, harmonizing, and then the setting specific or across multiple settings.

Ms. Bader-Williams: Tricia, can I ask a question about -- from what we heard from CMS, it sounds like they are the same.

So, I'm just -- was there a particular thing people heard was not -- is it the issue of being able to select which version of the survey to use? Because other than that I heard they are the same already.

Member Shea: Correct. They are the same.

Member Wisham: I did -- go ahead, Suellen.

Member Shea: I had heard that it was the same survey and the same --

Member Wisham: This is Lindsey. It's -- the short form is the form that's specified in the MIPS measure.

So, if we wanted, you know, the condition was that we ask if the measure developer -- and it sounded like, Anita, you made the comment that this measure has the option to do short or long.

Again, I'm not super familiar with this instrument. So, I don't want to overspeak, but that -- I don't know what the condition would be that we'd ask the

measure developer to perhaps look at or make sure that they were in alignment.

But if we're looking at the burden here, and I know that was a concern, having the measures be in alignment, you would think, would be advantageous since the ASC would have to get this data from the physician.

And if they're collecting it, having the two options align may be beneficial, but --

Member Ghinassi: And there's one other subtlety here -- this is Frank -- and this is more for individuals who looked at the sort of methodology behind the scoring.

I thought I heard, correct me if I'm wrong, that both the short and the long version arrive at the same numerical value, but the shorter one accomplishes that by putting three or four times the emphasis on a subset of each of the questions that you -- you take a shorter one and then you multiply each of those questions in the shorter one by four to get you to the same final scores, the long one.

I haven't seen the insides of that, but that does raise a little bit of concern for me because what it's saying is it's emphasizing four questions which are not emphasized in the same way on the other scale, and it's omitting ones that weigh on the second scale, but are not spoken to in the first.

I don't know the, you know, the intricacies of that, but it raises a flag for me. That's all.

Ms. Elliott: Okay. Akin, are you back online?

Co-Chair Demehin: I seem to be. I had to --

Ms. Elliott: Okay.

Co-Chair Demehin: -- restart my WebEx. I'm not sure what the issue is with my connection. I'm so sorry.

Ms. Elliott: No problem at all. We're trying to reach out to Cristie, too, because it looks like she's lost connection as well. So, we're trying to reach out there.

Co-Chair Travis Upshaw: I've joined by phone, but -- I've just rejoined, but I am on the line.

Ms. Elliott: Okay. Excellent. Thank you, Cristie.

So, we're at the point where we've brought up the cataract surgery. The first votes did not meet the threshold. So, we've moved on to Conditional Support for Retaining.

The group did a great job of restating some of the conditions, and so we propose that you can move the vote forward with the conditions.

One was the instrument-based condition, harmonization, and then -- Jenna, maybe if you can help me summarize this last one, was it just some feedback to the developer on options for the short and long version?

Ms. Bader-Williams: Yeah. I think the two conditions I'm hearing are that -- sorry -- so that the measure developer integrate this new instrument.

And then the second one, that they align across the uses of the measure in different programs to have the same version of the survey be used.

So, I think that's where the harmonization, plus the multiple programs comes in, that there's a suggestion that having the same version be better; is that right?

Member Shea: Yeah. For continuity purposes, uh-huh.

Co-Chair Travis Upshaw: Sounds good.

Ms. Elliott: Okay. So, at this point for the cataract measure, are you comfortable with moving this

forward to a vote, Cristie, with those conditions?

Co-Chair Travis Upshaw: Yes, I am.

Ms. Elliott: Okay. And do you have, Cristie, because it sounds like you're having connection issues, do you have email or text to be able to get us your vote?

Co-Chair Travis Upshaw: Yes, but who should I email it to -- well, I think I do. I don't really know -- I don't really know whether I do or not, quite honestly.

Ms. Elliott: Okay. Okay.

Co-Chair Travis Upshaw: I should be able to do text if you can tell me how to text it.

Ms. Elliott: Okay. You could text it to -- I'll give you my cell phone number. I'll give the whole world here --

Co-Chair Travis Upshaw: Okay.

Ms. Elliott: -- my cell phone number. 847-494-4415. And you can just text me -- this is Tricia. You can text me yes or no.

Co-Chair Travis Upshaw: Okay. I'll do that.

Ms. Elliott: Okay. So, with your permission we're opening the vote, Cristie?

Co-Chair Travis Upshaw: Yes.

Ms. Elliott: Okay. With the conditions as outlined and Jenna summarized. Okay.

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

Do you vote Conditional Support for Retaining?

(Voting.)

Co-Chair Travis Upshaw: Tricia, will you let me know if you got my text?

Ms. Elliott: I did get it. Thank you.

Co-Chair Travis Upshaw: Thank you.

Ms. Elliott: Okay. So, we have 16 there and we're capturing Cristie's behind the scenes. So, hold on one second.

(Pause.)

Ms. Leflore: Voting is now closed. We have 15 for yes, and 2 for no.

Ms. Elliott: Hold on one second. That's 88 percent.

Ms. Leflore: Thank you, Tricia. That would give us 88 percent for yes.

Ms. Bader-Williams: Great. Thank you all so much.

Okay. So, let's go ahead and move to the next program. We are behind schedule, but we'll see if we can catch up here and let's see if we can get through at least one measure before our scheduled break.

So, the Hospital Outpatient Quality Reporting Program. Next slide. This program is pay-for-reporting and public reporting. Hospital outpatient departments that do not participate, or participate but fail to meet program requirements, receive a 2-percentage point reduction of their annual payment update under the OPPS for not meeting program requirements.

The goals are to progress towards paying providers based on the quality, rather than the quantity, of care they give patients, and to provide consumers information about HOPD quality so they can make informed choices about their care.

Next slide, please, and then the next slide. So, I'll now turn it over to Akin for a public comment on these measures within the Hospital Outpatient Quality Reporting Program.

Co-Chair Demehin: Thanks, Jenna.

So, there are a total of five OQR measures that we're going to be talking about this afternoon.

This is your opportunity to provide comment on those. There are two mechanisms to do that.

Let's take the first mechanism first, and that is to raise your hand here in the WebEx platform.

(Pause.)

Co-Chair Demehin: Alright. NQF team, see any hands raised?

Ms. Bader-Williams: I'm not seeing any at this time.

Co-Chair Demehin: Alright. Let's see if there are any public comments over the phone.

(Pause.)

Co-Chair Demehin: Going once. Alright. Let me turn it back over to you, Jenna.

00922-C-HOQR: Left Without Being Seen

Ms. Bader-Williams: Okay. So, we'll go ahead and close public comment and we will move to our first measure, which is 00922-C-HOQR: Left Without Being seen.

This measure assesses the percent of patients who leave the Emergency Department without being evaluated by a physician, advanced practice nurse or physician assistant.

Endorsement was removed for this measure and seven survey respondents selected this measure for discussion.

Let me turn it over to -- or offer for this CMS program lead. Would you like to make any comments about this measure?

Ms. Weaver: Oh, hi. That might be me. No. sorry, I wasn't prepared to speak too much on this measure, but I am available to answer questions.

I think generally we just feel like it's a low-burden measure because most emergency departments are able to easily collect this information, and it is response to quality of care because it encourages emergency departments to have shorter wait times.

Ms. Patel: This is Shaili Patel from CMS, program lead.

I just want to add that this measure, consumers find it useful, helpful because it's publicly displayed.

Also, the facilities find it useful as well because it gives them a comparative value in terms of how they are doing in comparison to their peers and, you know, their perspective geographical location.

And if they are not doing as, you know, ideally speaking, good, then they can -- it gives them an opportunity to review their, you know, internal policies to make adjustments to provide quality of care.

Ms. Bader-Williams: Thank you very much for those comments. So, now I will turn it over to our lead discussants and I have Lindsey Wisham, Stratis Health and UPMC Health Plan.

Happy to start with any, but, Lindsey, would you like to start?

Member Wisham: Sure. I'd be happy to. And I know Jenna just gave us some of the factual nature about the history of the measure, but a couple other things that I noted was that endorsement was removed nine years ago.

Again, it's a longstanding measure. It's been in the program since 2012 and the data's been publicly reported since 2016. So, quite a bit of trending information there.

In the 2012-2013 cycle, NQF did remove endorsement. And so, measure no longer met endorsement criteria.

In the survey it was noted several workgroup members wanted additional information on why it did not retain endorsement and felt that may be helpful in assessing this measure and our recommendation.

As you can see here on this slide, there were four criteria that were identified that this measure did not meet as, I should say, as an opinion of the survey and no public comments were provided. So, no public comments either in favor of keeping the measure or removal.

As it relates to gap areas of measurement in the program, I did go back and just of course refresh my memory and knowledge of the OQR program and what it thinks the measure requirement should be.

It does state it must address an important condition or topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement and desired outcomes, cost or resource utilization.

So, in looking at this measure there's really only two values that they must report, which indicates -- which definitely reiterates what our CMS colleagues stated in that it's a low-burden measure.

So, they're reporting the denominator count of patients signing in to be evaluated in an ED, and then the numerator count of patients who left without being seen.

So, again, while this only has two reporting variables and I don't see an apparent reporting burden, I did want the group's, you know, assessment of how -- the value and to assess the value that this would either give to the provider if it's going to provide information on how to improve quality of care and patient outcomes or to the person making decisions on where to receive care.

So, there is one concern that the measure will be granular enough to provide that valuable information to fill those gaps in the measurement priorities as stated by OQR.

Ms. Bader-Williams: Thank you so much, Lindsey, and -- let me see.

Do we have anyone on the line from Stratis Health?

Member Lundblad: Yes. This is Jennifer again. Thanks for the opportunity.

This is such an interesting measure especially in light of the COVID-19 pandemic and public health emergency over the past two years.

So, when I discussed this measure with my Stratis Health team in preparation for today's meeting, what we talked about was an increase in the rate of patients who left without being seen during COVID.

Why? Well, think about it. People don't want to sit in the waiting room with other sick patients and take the risk of contracting COVID.

ERs have been busier and that means longer wait times. Visitor policies have been restricted off and on over time during COVID. So, that's -- if you really need to have someone there with you, they're not able to sit there or be there.

So, lots of reasons why we've seen an uptick in this, but what we've also seen is some facilities, especially some small rural facilities, have come up with really creative solutions including having

patients wait in their car to avoid unnecessary exposure and be able to wait with someone else and, as appropriate, actually being seen in their cars or out in the parking lot.

So, again, this is really interesting and so a few other points. This is a measure that highlights opportunities for improving access to care outside of the ER.

So, if you think about improvements that can be made to availability of same-day appointments, urgent care, minute clinic, those kinds of things, those would be the improvement strategies to reduce the number of people who left without being seen and really promote some of that as we begin to measure the emergency department experience of care.

I would also note that left without being seen is currently in the MBQIP set of measures, the Medicare Beneficiary Quality Improvement Program, which is what critical access hospitals participate in.

In our Stratis Health National Improvement Work we've seen a pretty significant uptick in interest among critical access hospitals as it relates to this measure and what they're seeing during COVID.

And then sometimes the assumption is made that patients who leave without being seen didn't really need to be seen.

At least a few hospitals that we've heard from and worked with have indicated that, during COVID, patients who left without being seen actually came back later in worse shape than they would have been if they had been seen when they originally presented.

So, I guess I would speak to the third of -- in summary of all that, I would speak to the third of the criteria on this list that's on the slide that, in fact, performance or improvement on a measure

does indeed result in better patient outcomes.

I think we're seeing a lot of creative responses as that increase in the results have been seen.

So, again, a really interesting lens to put it through what's happened over the past two years.

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

I believe the UPMC representative has stepped away. So, we'll move to talking about the Health Equity and Rural Health Advisory Group feedback.

Do we have Rebekah Angove on the phone? No. Okay. So, I will summarize both groups' feedback.

Okay. The Rural Health Advisory Group, 17 percent, or 1 member, supported retaining the measure in the program. 67 percent, or 4 members, did not support retaining. And 1, or 17 percent, was unsure.

The reason why is they saw this as an internal quality improvement metric. They didn't think it was something that would necessarily be useful in the national context for a public reporting program or program of quality.

Although, they did note that they think low-volume hospitals could actually perform well on this measure.

The Health Equity Advisory Group acknowledged that there are a large variety of reasons why patients leave and those are not always related to the healthcare system, but a number of advisory group members thought this measure would highlight inequities.

One member noted that it should be considered that some subpopulations may be more likely to use the ER instead of a primary care doctor, for example.

Another raised a concern that an urban hospital with

a very busy emergency department may not perform as well.

And based on that, there was support for reporting by subpopulation, for example, by language, and this would make the measure stronger than the -- than it is as a general measure.

And they really asked for standardizing or stratifying by population size or even in terms of acuity of the ER or the ER patient population.

So, I think at this point I can turn it over to Akin for the discussion.

Co-Chair Demehin: Thanks so much. And I think as we have during the initial set of conversations around these measures, I think we're going to open it up to the group to ask any clarifying questions of our CMS colleagues.

So, does anybody have any questions for CMS? Lindsey?

Member Wisham: Hi, Akin. Thank you.

I guess the question would be, again, given the feedback especially from the Health Equity Workgroup, has there ever been consideration about reporting this measure at a subpopulation or stratified level so that that granularity could be achieved?

Ms. Patel: Hi. This is Shaili. We have not in the past, but we are looking into stratifying -- potentially stratifying measures in the near future.

Dr. Schreiber: And this is Michelle.

Just to tag onto what Shaili said, part of the problem, when we look at doing that, is the numbers.

So, like, if you want to stratify either by population or you want to stratify by disease state, you know,

how many cardiac patients left versus, you know, a neurology patients, then you start getting into small n's.

Co-Chair Demehin: Thanks for that.

Other questions and -- clarifying questions for CMS?

(Pause.)

Co-Chair Demehin: Alright. How about any clarifying questions for the NQF team?

I know that there was one comment that was raised, and I believe Lindsey touched on it during her summation, around the rationale for removal of endorsement.

Can anybody on the NQF team sort of remind us of exactly what went into that?

Ms. Bader-Williams: Let me look that up quickly. We don't have a rationale here. I believe that means that the measure developer just did not resubmit the measure.

That was back in 2012. So, it didn't go through committee and have endorsement removed. It looks like it just was not resubmitted for endorsement.

Co-Chair Travis Upshaw: If I can just ask clarification on that clarification -- Akin, I'm sorry to interrupt -- on the measure information you said it was retired, which, you know, then made me wonder whether or not it's being, you know, updated, if the measure steward is still, you know, doing what it needs to do with the measure because "retired" makes it sound like, you know, it went away, but it didn't.

Member Shea: And I have a clarifying question also.

I believe CMS is the measure steward of this measure; is that correct?

Co-Chair Demehin: NQF team, is that correct? Looks like -- yeah, looks like it is.

Member Shea: Okay.

Ms. Bader-Williams: Yeah. So, Cristie, to your question, I would wonder if CMS would like to answer about the measure being updated.

Dr. Schreiber: I actually don't have the information. I can try and track it down for you.

Co-Chair Demehin: Just to add a little bit of help, I guess this is in the vein of taking my chair hat off -- my co-chair hat off.

I mean, I guess the retirement of the measure does make me wonder about whether the underlying evidence to support the endorsement and the measure, how that's evolved in the intervening period because we're talking almost 10 years, which is pretty substantial.

Shaili, did you want to jump in here? I see your comment in the chat and I -- if you were speaking, I unfortunately did not hear you.

Do you want to try again?

Ms. Bader-Williams: It looks like she may be having some audio trouble.

Co-Chair Demehin: Shaili, you might want to try -- yeah, you might want to try dialing in to the dial-in number and maybe the NQF team can put that back in the chat just so folks can connect quickly if they do end up losing connection.

Let me pivot to a broader conversation about this measure and what the Committee recommends here.

And, Shaili, when you do have the chance to connect by phone, just say it in the chat and we'll make sure to give you the chance to jump in.

(Pause.)

Co-Chair Demehin: Well, it's a quiet group. Must have a little bit of post-lunch tiredness.

Any thoughts on what category you might recommend for this particular measure?

Member Shea: I mean, this -- and this is me thinking outside the box. This measure combined with others would be beneficial, but the measure in itself I don't believe has proven to be much of a benefit and it's topped out.

So, yeah, taking this data by itself I don't think is probably very beneficial, but that's just me speaking from -- and having been an ED nurse I can tell you there's all kinds of things that go into a patient left without being seen.

Member Lundblad: This is Jennifer again and I think I'm where Suellen is and in alignment with some of what we heard from the Rural Health Group.

If we could say every emergency department should be measuring this for internal purposes, that would be great; but I'm not sure that I think for external reporting and payment that it tells patients very much of anything that's useful and, in fact, could be misleading.

And some of the anecdotal descriptions that I shared when we started off the discussion about this measure leads me to believe that it just -- it's a different situation depending on what's going on in the environment and depending on the ED and depending on the context.

So, again, if we could say every ED should be collecting this and working on it for internal quality improvement, I'd love to have a way to say that, but I know that's not what this forum is all about, but I'm not sure I think it's good for public reporting or payment.

Co-Chair Demehin: That's a very thoughtful comment nonetheless.

Other perspectives on this measure?

Member Wisham: Akin, this is Lindsey.

I -- Suellen and Jennifer, I don't know that the measure, as it stands today, provides enough granularity to actually impact the delivery of the quality of care.

It is a barometer of sorts in that it can measure, you know, the straight numerator and denominator of patients that are left without being seen, but, again, does that give us valuable information to improve the quality of care and to help patients make care decisions?

Again, I think there's other measures, right, in the program, I feel, that are complementary in nature, but it's -- again, I think we're looking at this measure as a standalone measure.

I just don't know if it provides enough granularity, which is why I asked the question about the subpopulation that we started to get into.

Even if that was not a publicly reported stratification, but even, you know, a submitted stratification, that may give a little bit more, you know, value to the measure as far as to the provider and to CMS.

Co-Chair Demehin: Great.

Let me see if Shaili is on the phone because I do want to make sure that she has the opportunity to add additional perspective here.

Are you connected? Okay. Doesn't sound like it. Any other thoughts on this? If not, we may want to --

Ms. Bader-Williams: Akin, sorry. We do have a hand raised.

Co-Chair Demehin: Oh, I'm sorry.

Ms. Bader-Williams: No, that's okay. I will --

Member Sumer: It's Zeynep.

Ms. Bader-Williams: Okay.

Member Sumer: Hi. Yeah, I would agree with the comments made and just add, you know, just again thinking back to our COVID experience, there are hospitals that are, you know, that, in particular, just because of their geographic location and what the communities or the types of areas they're in, the types of communities they serve provide, you know, nonacute care in their EDs and I think that, you know, the variability gets to -- gets at that notion.

I was just thinking during COVID, there was a time when -- especially during the Omicron wave, the -- our EDs here in New York were flooded with people looking to get tested and they didn't have symptoms and they weren't sick. They didn't need care, they just needed testing and, you know, it wasn't available elsewhere.

So, I know that's an anomaly, but it is sort of a really great example of the types of -- the wide range of care EDs provide and I'm not sure this is a great indicator of ED quality of care versus, again, what was said about access to care generally in a region.

Co-Chair Demehin: Thanks so much for that.

Alright. One last opportunity before we open it up, I think, for vote.

(Pause.)

Co-Chair Demehin: Okay. No hands raised, right, Jenna?

Ms. Bader-Williams: I do not see any, no.

Co-Chair Demehin: Alright. So, based on the conversation we just had, I think it may make the most sense to start with the categories for removal and see where the -- see where the Committee is from there.

Does that make sense to folks?

(Pause.)

Co-Chair Demehin: Alright. Let me turn it back to our NQF team to lead us through the voting process.

Ms. Elliott: Great. Before we jump into voting, I just wanted to check to see if there is a representative from Henry Ford Health System still on the call.

(Pause.)

Ms. Elliott: They could go off mute or enter into chat. I wasn't sure if there was someone covering for Santosh.

(Pause.)

Ms. Elliott: Okay.

Dr. Schreiber: Akin, Shaili is back on if you wanted to ask her a question before the vote.

Co-Chair Demehin: Oh, great.

Shaili, I know you were trying to get into the chat earlier. I wasn't sure if you had any other comments to offer on the measure.

Ms. Patel: I do not. I just wanted to make sure I was able to join back on and I'm not -- my apologies.

I did not hear the following, you know, conversations you all were having, but happy to answer any questions.

Co-Chair Demehin: Alright. One last opportunity for

questions for CMS before we launch into the vote.

(Pause.)

Co-Chair Demehin: Okay. Let's do it.

Ms. Elliott: Okay. So, Akin, this is Tricia. We are going to attempt to take a vote, but I do believe we have lost quorum at this point.

And so, if that's the case, if we continue to not have quorum, then we will do offline voting. So, we capture the recording and allow participants to listen.

Those who are participating in the discussion and listening today could just do the vote. Those that need the additional information could listen to the recording and then vote, but we're going to attempt to do the vote and see where we land with the number of votes. We need 17 votes.

Co-Chair Demehin: Okay.

Ms. Elliott: So, Joelencia, do you want to read the vote?

Ms. Leflore: Yes. Voting is now open for 00922-C-HOQR: Left Without Being Seen.

Do you vote Support for Removal?

(Voting.)

Ms. Leflore: I'll give everyone about 20 more seconds.

(Voting.)

Ms. Leflore: I think we can go ahead and lock the vote and we did not meet quorum.

Ms. Elliott: Correct.

So, our next steps will be we do have enough committee members present to continue with the

meeting, but we just do not have enough to complete the voting.

So, we will check occasionally through the participant list to see if we reach quorum, but from this point forward the -- we will get to the point where we recommend a voting category and then the voting will be completed offline.

Co-Chair Demehin: So, Tricia, a question in terms of process.

What sometimes happens with these votes is that if we don't achieve consensus on the first one, we go to another category.

If that happens in the virtual voting phase, could we -- what's the process from there? Does the group have to meet again?

Ms. Elliott: No. What we would do is we'll strategize on the best way to capture the voting, when there's the tiered voting, and capture conditions through comments.

So, if there's, you know, the general consensus in terms of the discussion and the recommendation, then that's what we would put for offline voting.

If we don't achieve consensus there, we will work through the comments that we receive and determine the conditions for the vote, if that makes sense.

Co-Chair Demehin: Great. Alright.

Dr. Schreiber: Akin, just a comment to look in the chat. Shaili put some history of the endorsement in the chat.

Co-Chair Demehin: Very helpful. Thanks so much for offering that up.

Alright. Well, hopefully we can get back to quorum at some point during the meeting to minimize the

amount of offline work, but just to keep the conversation moving, should we move on to the next measure?

Ms. Bader-Williams: Yes. Yes. I think that would be helpful.

And just as a comment as well, Shaili's comments are about, I think, the next measure, not the one we were just discussing.

So, that makes me feel better because her comments were saying the measure lost endorsement, which is contrary to what I had said and she -- this is for the next measure. So, okay.

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

The next measure is 00930-C-HOQR: Median Time From ED Arrival to ED Departure for Discharged ED Patients.

This measure calculates the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.

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

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

The endorsement was removed for this measure and five survey respondents selected the measure for discussion.

If we could go to the next slide, please? Okay. So, let me pause here first and see if our CMS program leads would like to make any comments about this measure.

Ms. Patel: Hi. This is Shaili again.

Ms. Bader-Williams: Yes. Sorry, Shaili, I was -- yeah, go ahead. Actually, go ahead. Sorry.

Ms. Patel: Oh, sorry. Yeah, I just wanted to say similar to the previous measure, low burden, also important for consumers to understand and compare facilities. Also important for facilities to compare their practices amongst their peers.

I do want to note that this measure is stratified based on overall rate of psychiatric mental health patients and also the results are quarterly displayed.

So, I just wanted to point that out that we do stratify this measure and it is publicly reported, including the stratified information.

Ms. Bader-Williams: Thank you very much.

Okay. I will then turn this over to our lead discussants. Let me see if we have anyone from the American Society of Health System Pharmacists or Medtronic on -- oh, I'm sorry. I am on the wrong -- I'm on the wrong measure.

Okay. So, the Greater New York Hospital Association or the Association of American Medical Colleges, anyone online from either of those organizations?

Member Sumer: Greater New York --

Ms. Bader-Williams: Great.

Member Sumer: -- Hospital Association right here.

Yeah. So, as was, I think, alluded to just as we were transitioning, this measure lost its endorsement.

And I would also note it's stratified, but one of the concerns was that it wasn't risk adjusted.

And we've talked a little bit about the fact that there is variation across different types of EDs, you know,

EDs that serve different populations in terms of the types of services they commonly provide to their EDs that serve, you know, that provide a whole lot of trauma, a lot of complex services versus EDs that provide a lot of ambulatory-type care, and the Committee felt that those two types of EDs were the variation across EDs, so great that there would need to be some sort of risk adjustment, which the measure doesn't include for type of ED.

There was also a statement about the burden of measurement. Some said this was somewhat difficult to collect.

I'm not sure that's necessarily the case in terms of the time stamps themselves, but I think the bigger issue might be that there's not enough clarity around when the clock starts and ends, and there might be documentation differences between hospitals in terms of when things are captured in the EHR for reporting.

So, then it's not a helpful measure since it looks like the changes or the improvements were just in terms of, you know, very single-digit minutes and that could just be due to some variations.

I mentioned the variation in performance. It was noted across age, race, a lot of different types of institutions, including differences based on location, facility size, type of teaching versus nonteaching facilities.

And while there was this variation, it didn't seem to convince the Committee that the gap that -- that it was -- it was a difference in quality -- it amounted to a difference in the quality of care. It's very much a patient experience measure rather than a quality of care measure.

Obviously, you can argue that the patient experience is a very important part of quality; however, the measure itself may not be capturing that experience or the, you know, how it impacts

quality of care in a meaningful way.

This measure has also, just like the other ED measure, been around for some time. Endorsed for ten years.

In terms of the limited improvement that I mentioned earlier between 2014 and '16, the measure -- there was an improvement of just four minutes, which doesn't seem substantial.

Other points to make, I think the general consensus was that there could be a more high-value measure that could take the place of this measure.

Perhaps by, you know, taking this measure and segmenting it even further to different, sort of, points or milestones in the ED episode of care, I think, you know, from the hospital perspective, that could add to the burden of collecting the data to calculate that measure, but I can see how it might be a little bit more meaningful.

I'm not sure the benefit would outweigh that burden, however. So, that's really all I have and would recommend, obviously, to remove.

Member Ramsey: Hi. This is Phoebe from the Association of American Medical Colleges as the other lead discussant, and I think that covered a lot of what I wanted to cover.

I think the real question here is is this capturing actual differences in quality or simply immutable characteristics of hospital EDs?

And so, I do wonder if there's a better way at capturing this patient experience in a meaningful way that hospitals could actually use to improve upon.

I think that lack of improvement over ten years really suggests that this isn't the way to get at actual hospital improvement or target it for hospital improvement.

So, I, too, would probably recommend Support for Removal.

Member Shea: Yeah. And this is Suellen again.

I would recommend removal of this measure for the simple fact that it is a process measure. It is not an outcome measure.

Now, if you developed a measure and used this information in tandem with something else, potentially it could have merit.

That being said, as the lead discussed, differences in hospitals are huge because -- I worked in a private institution as well as a primary teaching institution at a Level 1 teaching hospital, and I can tell you that at that Level 1 teaching hospital I held onto patients a lot longer than I did the private.

And so, in looking at those differences in time, that would be huge. So, I don't think that it is a fair comparison in and of itself, I'll say.

Ms. Bader-Williams: Thank you all for the comments so far. I'm going to -- before we jump into the discussion, I was going to summarize the Health Equity and Rural Health Advisory Group feedback.

I'm just going to check one more time to see if we have Rebekah on the line and it looks like we don't. So, I'm going to go ahead and pull this measure up.

So, the Rural Health Advisory Group, 1 member supported retaining the measure in the program, 7 did not.

Again, I didn't have a lot of discussion and similar comments to the previous measure.

They see this as an internal QI metric. They don't see this as something that would be useful in the national context for public reporting programs or programs of quality.

Although, they did note again that low-value hospitals could potentially perform well on this measure.

The Health Equity Advisory Group said that this measure's results may be impacted by a number of factors; however, they thought it was important to retain if it helps hospitals better understand community need.

They thought a lot of social services issues could impact this measure and they did think there was an equity component to the measure.

So, Akin, I'll turn it over to you now for discussion.

Co-Chair Demehin: Alright. Thanks. Let's start with any clarifying questions for our colleagues from CMS.

(Pause.)

Co-Chair Demehin: Alright. Any hands raised? Alright. Not seeing any clarifying questions --

Ms. Bader-Williams: I'm sorry, I actually -- I do see Anita --

Co-Chair Demehin: Good.

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

Dr. Bhatia: Just to clarify, this was to provide clarifying comments or start --

Co-Chair Demehin: This is for clarifying questions from the Committee to CMS. But if you have other clarifications --

Dr. Bhatia: Oh.

Co-Chair Demehin: -- to offer here, please go ahead, Anita.

Dr. Bhatia: I just wanted to add that we did view it that we believe that the public, our consumers, find

this a useful measure to see how hospitals perform.

I know that there are some measured hospitals in this particular area that, you know, they tend to have these long wait times. And just because they don't change, you know, that, I think, is more of a problem than saying that the measure is not useful. So, I would add that.

And I would also add I think I heard that someone was suggesting that there be some stratification or adjustment for the Type A and Type B emergency departments; is that correct?

If so, we did discuss that once in rulemaking, but I cannot remember the full discussion at this time. So, we did look at that variable at one point.

Member Sumer: It was actually -- I -- my suggestion was to risk adjust for case complexity, case mix, that kind of thing.

Dr. Bhatia: Okay. Alright. I don't know if we looked at that. I thought it was the type. I may have missed the -- or I just confused that with the different types of EDs.

We did look at that factor and didn't find it to be a major factor. I do recall that. It was a while ago.

Member Shea: And were you able to look at the different facilities by, like, teaching institutions versus nonteaching institutions?

Dr. Bhatia: We have not, but we -- I believe that we would have the data to look at that. So, that might be something that we could examine.

Member Shea: Yeah, because I had worked at NDNQI and that is one of the things that we looked at was the difference between those primary teaching institutions versus secondary, versus non. You also have your trauma center designations.

So, if I am getting trauma, after trauma, after

trauma, then of course my length of time for other patients could be extended, you know, those types of things.

Dr. Bhatia: Okay. I think that would be interesting and we can look at that. This is a chart-abstracted measure.

Member Shea: Um-hm.

Dr. Bhatia: So, we have a great deal of information that we can look at.

Member Shea: And let me know if I can help.

Dr. Bhatia: Okay. I just think this just points out that, you know, ED measures in -- seem to be difficult.

Member Shea: Yes.

Dr. Bhatia: I think it's a complex area. These ED measures have a tendency to lose endorsement.

Member Shea: Um-hm.

Dr. Bhatia: But maybe looking at some of these finer granular factors would be useful.

Member Shea: Yes. Absolutely.

Co-Chair Demehin: Alright. Any other clarifying questions for CMS from the Committee?

Member Hatlie: Akin, this is Marty.

I'm not sure if this would be a question for CMS or NQF. But in the summary it says -- one of the surveyor respondents said the measure is hard to collect because of lack of definitions when the clock starts and ends.

If this is a chart-abstracted measure, why would this be hard to collect? It might be hard to be accurate, but is it hard to collect? Am I missing something?

Ms. Patel: Sorry, go ahead.

Co-Chair Demehin: Go ahead, Zeynep.

Member Sumer: No, no, it's okay. Go ahead, Shaili.

Ms. Patel: It is correct that it is chart-abstracted; however, the information for the numerator and denominator is what makes it not as burdensome, if you will.

Member Hatlie: Okay. Thank you.

Co-Chair Demehin: Alright.

Member Sumer: And I was going to add that I agree. I don't know that it's about it being burdensome, but more so that there could be inaccuracies in how it's collected.

Co-Chair Demehin: Alright. Why don't we have some additional conversation among the committee members about what status you would recommend for this measure.

It sounds like the lead discussants would recommend removal of this measure, but let's hear some additional perspectives on this.

(Pause.)

Co-Chair Demehin: Anyone? And if you're raising your hand, I may not see it. There seems to be a lag on my platform.

Member Shea: I wasn't a lead, but I did have input. And, again, if the measure could be developed in a way that had those stratifications based on, you know, trauma center designation or teaching institution, that sort of thing, and then the ambiguity of that ED arrival time, you know, would be more specific.

So, ED arrival time would be time that, you know, they walk through the door and the patient was

registered in the emergency room and that would take away that ambiguity.

Member Hatlie: Akin, this is Marty. I'll weigh in with a comment.

You know, CMS mentioned -- someone from CMS mentioned that consumers find it useful information.

And certainly in the context of COVID, I would consider how long I would have to be sitting in an ED as a relevant piece of information if I had to go to an ED at a time when I knew they were going to be busy and I knew I'd be exposed to something.

So, I can see it being relevant to what consumers might want to know as they're making some sort of a decision about where to go.

And if the burden is low in terms of collecting it, it might be worth keeping.

Co-Chair Demehin: Thanks, Marty.

Member Hatlie: Yeah, you're welcome. Thank you.

Member Shea: But also I think that, you know, for the reporting of the metric you're what -- I can't even remember the time lag that it is, but three to six months, something like that. So, I'm not sure that that gives you an accurate snapshot in time, you know.

If it was instantaneous, then it would help you make those decisions. But if you're talking about flu season and then you don't get the data until well after that, then it doesn't really -- it's not really very beneficial in that aspect.

Member Morse: Are there any stratifications on this for complexity of patient or the type of disease being seen or symptom being treated related to this? Because that could have a wide variation of times.

Co-Chair Demehin: So, there is a little bit.

Does one of our CMS colleagues want to answer that?

Ms. Patel: My apologies. Could you repeat that again for me, please.

Member Morse: Yeah. So, is there any risk adjustment or stratification based off of the conditions that are being seen in the different EDs?

Dr. Bhatia: There is for whether they're psychiatric patients -- psychiatric or mental health patients or transfers. Those are not included.

And it is also the median time that can -- to handle for outliers.

Ms. Patel: Correct. So, as -- this is Shaili again.

As I had mentioned earlier, it is stratified based on mental health patients and psychiatric patients and overall median time as well.

Co-Chair Demehin: Alright.

Member Lundblad: This is Jennifer and I know it's our job to look at each individual measure, but I also feel like stepping back and looking at the larger context is important as we consider each individual one.

And so, this may be a question for our CMS colleagues that I didn't have when you asked for those a few minutes ago.

If, in the end, this one and the prior one are removed, what remains of the set measures to assess quality in the emergency department in the outpatient set of measures?

Ms. Patel: Well, specifically for ED throughput, then, these are the two measures that we have, the one we are discussing now and the one -- the previous

one that we discussed.

Member Lundblad: Thank you.

Ms. Patel: In the entire outpatient quality reporting measure set, yeah.

Member Lundblad: Thanks.

Co-Chair Demehin: If I could follow up on Jennifer's question, which I think is a really good one, I would frame that question even more broadly than just ED throughput.

Are there any emergency department quality-related measures that would be remaining in the OQR should these measures be removed from the program?

Ms. Patel: Not that are up for discussion, but we do have ED arrival, ED-based measure in the program, which is head CT or MRI scan results for acute stroke or for patients who received head CT or MRI scan within 45 minutes of ED arrival.

So, that would be the only one left, but it is not included in the discussion for this cycle.

Co-Chair Demehin: Thanks. Very helpful.

Suellen?

Member Shea: Sorry. Also, you know, removing the measures also sends that message that we need to have better measures, more well-defined measures.

So, with the removal and making those recommendations of what we would see as beneficial moving forward, then those measures could potentially be developed. But maintaining the measure simply because there are no others, I'm not sure that that provides value either.

Co-Chair Demehin: Alright. Any other comments or discussion from the Committee?

Cristie, go right ahead.

Co-Chair Travis Upshaw: I'm taking off my co-chair hat especially since you're chairing this part of it.

You know, I'm struck by the most recent comments and, you know, just going back through what our decision categories are, you know, there is one that we might -- at least that I'm going to consider because I'm not running this part of it, but Conditional Support for Removal, which means that we're creating some type of measurement gap, you know, that we really don't think that this measure is that valuable.

But at the same time if we moved it out without commenting that there's a gap by moving it out, you know, that wouldn't be as helpful.

So, it is -- it's something that at least I'm going to be thinking about, you know, as we kind of come down to ultimately voting on this.

Member Shea: I agree, Cristie.

Co-Chair Demehin: Yeah. That's a great perspective.

Let me pause one more time to see if there are any other comments to offer here. Then maybe we can walk through the voting process. And I have a proposal for how we do that that I think may get at Cristie's suggestion.

So, any other last comments on this measure?

Ms. Bader-Williams: I just wanted to make sure that people saw Shaili's comment in the chat, which is that the measure is also used to calculate overall Hospital Star Ratings.

Co-Chair Demehin: Yes. Thanks, Jenna.

Alright. So, through this conversation I've heard a couple of potential categories that the group may be

sort of centering on in terms of recommendations. One is Support for Removal, and the other is Conditional Support for Removal.

So, let me ask my colleagues from NQF, No. 1, should we vote now given that the quorum is not entirely clear?

And, No. 2, if we do vote, should we start with the Support for Removal category first, see what it looks like, and then go to Conditional Support?

Ms. Bader-Williams: Yes. So, I do think we're still below quorum at this time. What would be helpful is to get the group to give us the best category to put forward in the survey that we'll be administering afterwards.

And if we don't get quorum on these categories, we will have to follow up, but, yeah, that's, I think, what would be most helpful as to figure out where we should start with the survey.

Co-Chair Demehin: Well, here's an idea, and you can push back on this if you want, but could we take a straw poll of the group of -- maybe on the -- it feels like we may be nudging a bit towards the Conditional Support for Removal category.

Is it worth taking a quick straw poll from the group to see whether that's the category we want to put forward for a vote?

How do folks feel about that? Okay.

Ms. Elliott: Akin, I saw some head nods and some chat. So, I think that appears to be the direction, Conditional Support.

Co-Chair Demehin: Alright. I think we may be in violent enough agreement to put that forward as the recommendation.

Alright. So, let me do a quick time check here. We're at about 230 Eastern Time. We still have

three more measures to get through and we do want to reserve time to talk about both measure gaps and some broader recommendations for the NQF team on process since this is the first time we've gone through this MSR review process.

What I would propose is since we are so crunched for time, I'm going to suggest we keep on trucking.

But obviously if you need to step away for a couple minutes for a bio break, for a food break, go ahead and do that and then we can keep the conversation on the measures going and hopefully get as far as we can.

Does that sound reasonable?

Alright. I'm seeing head nods and thumbs up. So, let's move on to the next measure, please.

00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain

Ms. Bader-Williams: Okay. The next measure then is 00140-C-HOQR: Magnetic Resonance Imaging Lumbar Spine For Low Back Pain.

This measure evaluates the percentage of magnetic resonance imaging, or MRI, of the lumbar spine studies for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI.

Antecedent conservative therapy may include claims for physical therapy in the 60 days preceding the lumbar spine MRI, claims for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI, and/or claims for evaluation and management at least 28 days, but no later than 60 days preceding the lumbar spine MRI.

The measure is calculated based on a one-year window of Medicare claims. The measure has been

publicly reported annually by the measure steward, the Centers for Medicare and Medicaid Services since 2009 as a component of its Hospital Outpatient Quality Reporting Program.

Seven survey respondents selected this measure for discussion and endorsement has been removed.

If we go to the next slide, please, and I will see if our CMS program leads would like to make any comments.

Ms. Patel: Hi. This is Shaili. If you like, I can provide some NQF history verbally or I can add it to the chat, whichever is useful.

Ms. Bader-Williams: You can go ahead and share verbally. Thanks, Shaili.

Ms. Patel: Sure. So, initially the endorsement for this measure was obtained back in 2008 by the Outpatient Imaging Efficiency Project.

But then we brought it back to the Musculoskeletal Project Standing Committee back in 2014 for maintenance -- endorsement maintenance and the Committee did not recommend the measure for continued endorsement based on, I believe, the results presented for acceptability. Mainly, the issue was the validity of the measure.

Within that same year, the Consensus Standards Advisory Committee overturned the Standing Committee's votes due to inconsistencies in the evaluation process related to the exclusions.

After that, I believe the off-cycle activities during that time we tried to submit the measure back into the endorsement process in 2016, I believe, but the voting again failed the measure on the scientific acceptability criteria.

After that, I believe the -- do not believe we pursued the endorsement in 2017, I believe, yeah, which was -- that's when the endorsement was

removed in July 2017 for this measure.

Ms. Bader-Williams: Thank you very much for those comments.

Let me now turn it over to the lead discussants, and I have the American Society of Health-System Pharmacists and Medtronic listed as lead discussants.

Do we have either on the phone right now?

Member Shehade: I'm here. This is Karen.

Ms. Bader-Williams: Okay. Would you like to go ahead and provide a summary here?

Member Shehade: Sure. Just some things that Anna and I had talked through about this measure.

The only thing to add in from what Shaili said was, I guess it was in 2018 with MAP, the recommendation was not to support for rulemaking.

And the rationale from the MAP recommendation was that they didn't support it for the Hospital Outpatient Quality Reporting Program because it was not recommended for that continued endorsement by the NQF Musculoskeletal Standing Committee back in 2017.

And Anna and I talked about some of the rationale for why we -- some of our rationale around this. So, Anna, I don't know if you want to take it away for the next part of this?

Member Legreid Dopp: Well, sure. I appreciate your comments, Karen, and then also to the CMS team for the background. I echo everything that was already shared.

This is an older measure. As we talked earlier thinking about all the changes since COVID, this measure doesn't incorporate things like telehealth or hasn't been maintained to incorporate changes in

access with some of the requirements that this measure might have might change it now looking at the post-COVID healthcare system. And so, in general, agreed with the feedback that it is a good potential for removal.

I had one question. In looking at the information on the measure summary sheets on page 18, you know, we talk about measures as being topped out and I'm curious, with a measure like this where the measure direction goal is to decrease and seeing that this measure has been pretty stable over the last number of years, but what do experts on the call consider topped out for a measure where we're looking for a lower number?

I'm used to seeing topped out measures where the goal is to be, you know, above 90 percent or something like that, but what is it if the goal is to be in a downward direction? Is there an acceptable one?

Is hovering between somewhere less than 50 percent, is that considered at-goal performance?

Dr. Schreiber: So, this is Michelle.

From a CMS point of view we have criteria for being topped out above 95 percent, but we don't have that on the reverse side.

Ms. McKiernan: Michelle, this is Colleen McKiernan from Lewin, so representing the developer.

Dr. Schreiber: Thanks.

Ms. McKiernan: Yes, of course.

We use the methodology that is described within both the IQR and the OQR rule to evaluate if the measures are topped out. We perform that for all of the OIE measures every year.

And even -- we adjust the methodology to account for a lower, better score and I can confirm that this

measure is not deemed topped out based on the two tests that appear in CMS' guidance.

Member Legreid Dopp: Okay. Thank you.

I was certain there was a process, I just -- OR I hadn't seen it for the opposite end of measure performance.

So, I appreciate that. Learning opportunity for me. That's all I have to add to this conversation.

Ms. Bader-Williams: Great. Thank you so much to our lead discussants.

I will -- before we turn to discussion, we'll do a summary of the advisory group feedback.

Let me see. Is there -- Is Melony on the phone?

Dr. Sorbero: Yes, I'm here.

Ms. Bader-Williams: Great. Hi, Melony.

Would you like to provide a summary of the Health Equity Advisory Group discussion?

Dr. Sorbero: Sure. So, mainly the discussion focused around that we thought there were likely differences by different groups of patients, but not in the direction that we normally see and are concerned about in terms of disparities because since groups that normally experience disparities are likely to be still getting lower amounts of the care being measured, they're actually going to be performing better on this measure.

So, there is a lot of discussion just about, well, do we still consider that an equity concern? Do we not consider it an equity concern?

So, overall I think the group was pretty ambivalent about this measure from an equity perspective.

Ms. Bader-Williams: Thank you very much, Melony. And then from the Rural Health perspective -- sorry,

switching to my notes here.

So, zero, and at zero percent of the Rural Health Advisory Group supported retaining the measure in the program. Seven, or 100 percent, did not.

They did not think that it would give a benefit in the rural setting as performance does not have a lot of variation and has not been seen as helpful. So, that was all of their comments.

Shaili has also posted something else in the Chat. I don't know if you wanted to speak to any of that, Shaili, before we turn over to discussion.

Ms. Patel: Yes. This is basically the consideration factors for removing, suspending or replacing measures in the Hospital OQR Program.

This is also available on -- it's codified language section, I believe, 45 419. Under that, you will find there are seven different factors that we use to either remove, suspend or replace a measure in the OQR Program including the -- sorry, I should say the topped out was considered topped out, which would be listed under Factor No. 1.

Ms. Bader-Williams: Thank you so much.

Akin, I'll turn it over to you for discussion and I do see one hand raised.

Suellen?

Co-Chair Demehin: Go for it, Suellen.

Member Shea: So, one of the other things that was brought up about this measure was in the feasibility section talking about data elements based on codes.

Of course I just lost my page, but that being said, the accuracy of your coders, you know, those things should be taken into account and it's not very easy when, you know, you use a third-party vendor, things like that.

And, mind you, I understand that's not -- the onus is not on us for that. I'm just saying that that's one of the things to consider when you're talking about whether to keep the measure or not.

Co-Chair Demehin: Alright. Other comments on this measure or questions for our colleagues from CMS?

(Pause.)

Co-Chair Demehin: So, I'm going to take my chair hat off for -- or co-chair hat off for a minute here and just reflect on this measure and the fact that it has been in the OQR program for as long as it has, and the fact that it has gone through a couple different rounds of NQF endorsement review and not been successful in those particular reviews.

I think we need to take a good hard look at whether retaining a measure that is not passing scientific acceptability criteria really belongs in the OQR Program.

To me, the argument around whether the measure is topped out or not almost doesn't matter if what we're measuring isn't really all that meaningful.

And I think that what Anna brought up in terms of how the field is changing and the more modern approaches to capturing information, to me, this feels like a measure that may have served its purpose and it may be time for it to be retired, but that is just my perspective with my co-chair hat off.

I will put it back on and see what other comments there are on this measure.

Member Shehade: Just one more comment.

Anna and I didn't want to give the impression that it did not serve its purpose in the time in which it came about, because the world was very different in 2007, you know, in the early 2000s and overuse was a huge issue at the time.

And so, commercial health plans took action with new models of benefit design, quality measures were implemented to help change clinical practice, but we've seen the world evolve.

And so, I think this is just a natural progression of this evolution as we've seen today, which is why we're here, but this is another example and, you know, we would say it's time to, you know, let this one go because it's not -- it's no longer required based in the times that we live in today.

Co-Chair Demehin: Other comments from the Committee or recommendations on what category to assign this to?

(Pause.)

Co-Chair Demehin: Okay. I'm not seeing any, but let me pause and just make sure because the hand-raising stuff is coming through very slowly for me.

Ms. Bader-Williams: I'm not seeing any hands raised at this time.

Co-Chair Demehin: Okay.

Ms. Bader-Williams: I'm not seeing anything in the chat.

Co-Chair Demehin: And what's our current quorum looking like? Are we at quorum or are we still below?

Ms. Bader-Williams: We still think we're below.

Co-Chair Demehin: Okay. So, I think our task, then -- oh, I'm sorry. Go ahead, Cristie. Looks like you're trying to jump in.

Co-Chair Travis Upshaw: I was and I apologize for being late again with a comment, but I was rereading some of the material.

You know, I don't know why this has never hit me

before and I apologize if this is not really something I should share at this point, but all the things that you should do before you have this MRI, I wonder if all of that is true, too.

Like, in other words, it seems like the patient experience of going through, you know, all the antecedent, if I'm understanding the measure right, you know, and if they don't work, then you finally go and get your MRI, just, for some reason, didn't hit me right today when I started looking at it. And that -- I wondered if that is also still true.

I mean, I don't -- I think we were trying overuse of MRIs, there's a lot of reasons why we don't want to do that, but that also seemed like a lot of stuff to ask patients to go through, quite honestly, before, perhaps, you get an MRI.

And I'm not really sure that's relevant to the discussion, but it really kind of rang to me when I started and wondered if they were still the right antecedent processes to go through before you would have an MRI.

Co-Chair Demehin: That's a really great comment, Cristie. Thanks so much for adding that.

Anything else? So, I think our task is to put forward a proposed category for voting offline after this particular meeting.

And hearing the conversation, it sounds like Support for Removal may be that category.

Let me just kind of do a rough straw poll. You can enter it in the chat. How do folks feel about that as a category to vote on?

(Pause.)

Co-Chair Demehin: Okay. Let me just make sure -- okay. Let's roll with that and if the vote comes back in an unanticipated way, we can cross that bridge when we get there. Alright. Shall we move on to the

next measure?

Ms. Bader-Williams: Yes. That sounds good.

Co-Chair Demehin: Alright.

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

Ms. Bader-Williams: Alright. The next measure is 02599-C-HOQR: Abdomen Computed Tomography (CT) - Use of Contrast Material.

This measure calculates the percentage of abdomen and abdominopelvic computed tomography (CT) studies that are performed, without and with contrast, out of all abdomen and abdominopelvic CT studies performed (those without contrast, those with contrast and those with both) at each facility.

The measure is calculated based on a one-year window of Medicare claims. The measure has been publicly reported annually by the measure steward, the Centers for Medicare and Medicaid Services, since 2009 as a component of its Hospital Outpatient Quality Reporting Program.

Six survey respondents selected this measure and the measure is not endorsed. We can go to the next slide, but I'll pause here to see if the CMS program lead would like to make any comments.

Ms. Patel: Hi. This is Shaili again.

Yeah, I do want to mention that, again, this is an efficiency measure and it's to promote high-quality efficient care, and is intended to reduce unnecessary exposure to contrast material and radiation, and ensure adhering to evidence-based medicine and practice guidelines, right?

And also provide data to consumer -- again, it's publicly reported -- and for our facilities to ensure that their imaging -- facility imaging use is appropriate.

Ms. Bader-Williams: Thank you very much for those comments.

I will now turn it over to the lead discussants. Although, I think -- is there anyone from the Service Employees International Union on the line?

Okay. In that case, I'll review this slide. So, the criteria used by survey respondents to -- when nominating the measure for discussion was that the measure does not contribute to the overall goals and objectives of the program, and the measure is not endorsed by a consensus-based entity or lost endorsement.

Additional survey feedback that we received was that this may be a standard of care or may be topped out. And they were interested in knowing if submitted for endorsement, but failed endorsement and why; or if not submitted for endorsement, why.

I'll also see -- Melony, do we still have you on the line?

Dr. Sorbero: Yes, I'm here.

Ms. Bader-Williams: Great. Would you like to summarize the Health Equity Advisory Group's feedback?

Dr. Sorbero: Sure. So, this is another measure where they -- where the group was unclear about the extent to which there would be equity concerns.

They did think that it was very possible that there would be differences in use of contrast material by different subgroups, but they weren't sure how that would play out in terms of what types of patients would be more or less likely to have contrast material used.

So, there really just wasn't consensus among the group of whether or not there were equity concerns on this one.

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

And then from the Rural Health Advisory Group, so aero supported retaining the measure in the program; seven did not support retaining the measure in the program, and that was 100 percent.

Their comments were that the use of contrast and noncontrast materials were meaningful when it's being stratified by reason for the CT order.

Overall the measure across all clinical scenarios doesn't provide a lot of information about clinical quality, in one member's opinion, and it doesn't provide -- the measure doesn't provide an actual response to identify poor or good quality in terms of diagnostic imaging.

So, I think I can turn it over to you, Akin, now for discussion.

Co-Chair Demehin: Thanks so much.

To start, any questions in terms of clarification for our colleagues from CMS?

(Pause.)

Co-Chair Demehin: Alright. Seeing none -- yeah, I don't see any here. Other reactions from the Committee to this measure and any recommendations you may have on a specific category?

(Pause.)

Co-Chair Demehin: So, seeing none, let me offer up an idea for the group to chew on and see how this reaction feels to folks.

To me, this is a little bit different than the other imaging measure that we just looked at in that it does more directly reflect something about quality and certainly inappropriate use of contrast material is a potential quality concern.

The fact that this measure doesn't have endorsement and has been in the program as long as it has, again, makes me very reticent to want to support its continued use.

I also suspect -- and the one thing that really stood out to me in reviewing the specs was the fact that the way in which it failed endorsement is really around specificity, which speaks to how potentially useful or not it may be to providers who are trying to improve.

This is one where I kind of struggle between categories of Support for Removal or potentially Conditional Support for Removal, in part, because I think the notion of focusing on use of CT material may have something to it.

I just don't have a lot of confidence that it's this measure that's going to get us there.

So, let me offer that to the Committee and see how that resonates with folks.

Ms. McKiernan: So, this is Colleen McKiernan from the Lewin Group.

While people are thinking if they have comments, would it be appropriate to respond to your NQF endorsement comment specifically? Because I think there's some context that could be helpful.

Co-Chair Demehin: Yes, you can respond to the NQF endorsement piece specifically, but I just want to say that this is really a section of the meeting that's about conversation between committee members.

Ms. McKiernan: Okay.

Co-Chair Demehin: So, unless it's to very specifically clarify a point --

Ms. McKiernan: It is.

Co-Chair Demehin: -- we really do want to focus on

hearing from the Committee here.

Ms. McKiernan: Of course.

Co-Chair Demehin: But go ahead.

Ms. McKiernan: Just to note, so the measure was brought forward to NQF in 2008 and it has changed rather substantially since then.

It was focused on a single diagnosis or a couple of diagnoses at the time. And so, now the measure just focuses much more broadly on abdomen CT imaging, removing diagnoses for which there are more appropriate uses of without and with contrast.

And so, the measure that was reviewed in 2008 is just like fundamentally different because of work with our expert panel and other inputs from the evidence base.

So, just to clarify that, 2008's review is different than where we are in 2022.

Co-Chair Demehin: That is very helpful to know. Thank you, Colleen.

Have there been any other attempts to submit this for NQF review since then?

Ms. McKiernan: No, but that was mostly out of constraint, like, resource constraints on our end and so less about the evidence base. So, we have not brought it back to NQF since the 2008 review.

Co-Chair Demehin: Okay. Thanks. Really appreciate that.

Any other comments from the Committee or ideas for what decision category to assign this?

Member Hatlie: Akin, this is Marty. This is not my area of any kind of expertise, but I do worry about removing a measure without kind of understanding what other measures are in the program that might

help us get at some of the same things.

So, again, just having that context of what else is in our constellation here and whether this would leave a gap, I think, is at least a factor I'd like to consider.

So, I guess that leads me to removal with conditions.

Co-Chair Demehin: Thanks, Marty. And that sounds pretty consistent with our decision criteria.

Let me see -- how do folks feel about offering that Conditional Support for Removal as a recommendation?

And as a followup question, what conditions would you attach?

(Pause.)

Co-Chair Demehin: You know, I'll suggest at least one. The first is I do think it would really be worth taking this current version of the measure through the NQF endorsement process and just to sort of tease out some of those underlying questions about the utility of the measure, how its scientific acceptability holds up, et cetera.

I do think to the -- I sort of get the -- a focus on the use of contrast material. I -- there is a part of me that wonders whether there needs to be a deeper examination of what other sort of imaging-related quality issues we want to try to tackle.

I'm not sure how to concisely say that, yeah, in a condition. So, other folks, please jump in.

Member Wisham: Akin, this is Lindsey. And, again, I'm looking at the notes for the slides from earlier in the meeting where we were talking about the differentiation in the decision categories; one being Conditional Support for Retaining, and the other being Conditional Support for Removal.

And at least my understanding was that for the removal is that that was more focused on if gaps should be filled first where Conditional Support for Retaining may be a better option if we're going to offer condition of NQF endorsement overview.

Co-Chair Demehin: Let's see. NQF staff, could you provide some perspective on that?

Ms. Bader-Williams: Yeah. I would agree with that.

I think again the condition, as it were for Conditional Support for Removal, would really be -- have a measure that fills this gap -- have a better measure that fills this gap.

And if there are thoughts around what the better measure could look like, I think we'd welcome those comments whereas, yeah, I would say that if you're supporting -- if you're recommending endorsement that does somewhat imply leaving the measure in the program and seeing what happens as a result of the endorsement process, in which case that would be Conditional Support for Retaining.

And also I see Michelle Schreiber has her hand raised.

Co-Chair Demehin: Go ahead, Michelle.

Dr. Schreiber: Oh, thanks.

I just wanted to make the point that this is not just about how much contrast somebody gets when they get a CT scan.

Part of this was also to prevent people from getting two CT scans because there was a practice where people would come in and get a CT, say, without contrast, and then they would come back and get a CT with contrast, a billing for both, which is when it became a CMS issue, but also that's extra radiation.

So, it's not just how much contrast did somebody get. It's the prevention of additional radiation from

the second study that could have been incorporated the first time around.

Co-Chair Demehin: Thanks. That context is very helpful.

Dr. Schreiber: And I'm sorry, Akin. Just one other thing that I would add is that obviously radiology studies are extremely common in hospital outpatient departments.

We don't really have very many good measures around radiology. We have some that we see that are coming through the pipeline, but there aren't that many traditionally. So, removing things like this does create a gap.

Co-Chair Demehin: Alright. So, does anybody feel differently about what potential category to recommend for voting here as a result of our conversation just now?

Member Wisham: Akin, this is Lindsey.

I would, I guess, recommend an initial starting place would be Conditional Support for Retaining with the condition of we're recommending that it be reviewed by NQF for, for endorsement review.

Co-Chair Demehin: Okay. How do folks feel about that? Looks like I see at least one, two, three agreements in there. Alright.

Member Hatlie: Akin, this Marty.

I think I'm still at Conditional Support for Removal if that is the category to choose that we wouldn't remove until there's a better measure, until there's a gap that's filled.

Co-Chair Demehin: You know, Marty, I'm kind of in the same boat where I'm struggling a little bit between whether it's Support for Removal or Conditional Support for Retaining.

Given that at least one of the conditions would involve NQF endorsement, it feels like the Conditional Support for Retaining may be at least a starting point for us and then we can see how folks vote.

How does that sit with you and others?

Member Hatlie: I guess I'm struck by the fact that it hasn't been reviewed since 2008 and the reason is resource constraints.

So, maybe that is a reasonable next step is to say, okay, let's have it go through the process and see if it can be improved or updated in some way.

Co-Chair Demehin: Yeah. Alright. So, sounds like we will go in with a recommendation, at least, the -- what we will offer up for voting to the Committee is Conditional Support for Retaining, condition being NQF endorsement.

This may be an area -- this, again, this isn't a condition, this is just a broader comment to CMS where it's good to hear that there are some other imaging measures that may be under development.

Given the amount of imaging that happens in the ambulatory setting, it certainly makes sense to have some measures that try to reflect the quality and the efficiency of those services.

So, looking forward to having a chance to look at those whenever they're ready to go through the MUC process.

Alright. Anything else on this measure before we move on to the next? I know I'm pushing us along a little bit here, but I want to make sure we get through as much of this as we can.

Alright. Let's move on to the next measure.

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

Ms. Bader-Williams: Okay. And I believe this is our last measure of the day. So, this is 02930-C-HOQR: Hospital Visits After Hospital Outpatient Surgery.

This measure assesses a facility-level, post-surgical risk-standardized hospital visit ratio of the predicted to expected number of all-cause, unplanned hospital visits within seven days of a same-day surgery at a hospital outpatient department among Medicare fee-for-service patients aged 65 years and older.

The measure is endorsed and five survey respondents selected this measure for discussion.

Let me see if the CMS program lead would like to say anything about this measure.

Ms. Patel: Hi. This is Shaili again. Yeah, sure.

Just want to point out, you know, we are all aware that a lot of, I believe more than 72 percent of, surgeries are now being performed in the outpatient settings, right?

And as the -- more procedures move from -- gradually, I should be cautious, gradually move from inpatient-only list, it is important that we retain -- I believe, you know, that we retain this measure.

While most outpatient surgeries are safe, they are well-described as potentially preventable adverse events, right, that occur after outpatient surgery, which can then result in unanticipated hospital visits.

Unanticipated hospital visits tat fall under same-day surgery, I believe, can reflect on quality of care, right?

And also, there are other issues that we are facing that are not directly linked to clinical aspects of

hospital visits. It's mainly the other nonclinical patient considerations such as transportation issues, right, to home once the patient is discharged, facilities -- there are logical issues or delayed start of surgery, so on and so forth, that can then result in an admission following the same-day surgery, which is also unanticipated yet preventable.

The quality of measure of hospital visits while on the outpatient same-day surgery, I believe, can improve, you know, transparency and inform patients and providers, again, because this measure is publicly reported.

Ms. Bader-Williams: Thank you.

Ms. Patel: And I believe you covered it is NQF endorsed, correct? I believe you covered that earlier.

Ms. Bader-Williams: Correct. Yes.

Ms. Patel: Okay.

Ms. Bader-Williams: Alright. Thank you so much for those comments.

Let me see. Do we have anyone on from Kidney Care Partners as our lead discussant?

(Pause.)

Ms. Bader-Williams: Okay. Well, I will go ahead and summarize then. The criteria used by survey respondents --

Member Bednarski: I'm sorry, I think I was on mute. This is Donna from KCP.

Ms. Bader-Williams: Oh, sorry, Donna. Go ahead.

Member Bednarski: I thought I hit the button, but it's kind of hiding underneath the toolbar.

When you look at the rationale -- it was Criterion 2 that measure is duplicate of other measures within

the same program -- there was only one measure that was listed in the document.

And although similar to the RSHVR, it was not really competing because it does not include colonoscopies; however, there are seven other measures that are listed in NQF documents that do overlap a bit.

So, it would seem that possibly a broader, more overarching measure addressing the various subcomponents and the numerous measures might be warranted to reduce the burden and confusion among end users.

Criteria 3 was also listed that it was not endorsed, but it is endorsed. So, I'm not quite sure where the confusion was there.

And then Criteria 7, where the measure performance does not substantially differentiate between high and low performers such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation.

Of note, this measure really highlights Kidney Care Partners' longstanding concern about the use of ratio measures and the preference for risk-adjusted rates or year-over-year normalized rates.

We have seen this with the use of CMS standardized ratio measures in the ESRD-related programs and, based on our experiences reviewing the ESR QIP measures, CMS standardized ratio measures have relatively wide competence intervals that can really lead to providers being misclassified and their actual performance being misrepresented.

So, there is some confusion with use of the ratio measures, which can really create an unnecessary burden with the providers and patients who are interested in really understanding actual performance if we're not giving them actual

numbers. So, that's what I had.

Ms. Bader-Williams: Thank you very much, Donna. Alright. So, let me summarize the advisory group feedback. For the Rural Health Advisory Group, 1 member, or 17 percent, supported retaining the measure in the program; 4, or 67 percent, did not; and 1, or 17 percent, was unsure.

The group did not have specific rural health concerns, but there was a concern that having this type of general measure, rather than measures of specific adverse events, could encourage patients to not come back to the hospital if they have a concern after surgery.

And then the Health Equity Advisory Group did not have many comments either, but did note that data from the CMS Impact Assessment, which is included in the measure summary sheet, indicates there are variations by age, income and dual eligibility and performance.

So, Akin, I will turn it over to you for discussion.

Co-Chair Demehin: Thanks. So, let's start with any clarifying questions for our colleagues from CMS.

(Pause.)

Co-Chair Demehin: So -- oh, go ahead, Cristie. I think you're on mute.

Co-Chair Travis Upshaw: Is there a similar measure in the ambulatory surgery center quality -- I don't think we -- well, I know we didn't do it today, so I'm --

Dr. Peter: Hi. This is CORE -- this is Doris Peter from CORE, the measure developer. Can I chime in? I can answer some of these questions.

Co-Chair Demehin: Go for it.

Dr. Peter: Okay. So, first, there are no other

overlapping measures for this setting. So, for surgery done in the outpatient setting -- (audio interference).

That wasn't my line. I'm not sure whose line that was.

Co-Chair Demehin: Go ahead.

Dr. Peter: Anyway, so there are no other measures in HOQR that address same-day surgery and adverse events from same-day surgery, which is what this captures.

So, I just want to make sure that's clear because everybody keeps talking about other measures. There aren't any other ones for this setting. So, it's the only one.

So, every year this captures about a million surgeries, same-day surgeries done on fee-for-service patients.

So, without this measure you'd be missing capturing these events from things like hernia repair, from hip and knee replacement surgery, from all these outpatient surgeries which CMS mentioned are, you know, sort of shifting towards the outpatient setting. So, it's really critical, I think, to keep this measure in there.

Regarding the -- so, we know it's a measure. It is endorsed. And then measure performance, I just wanted to point out that in terms of outliers the measure is actually -- so, it's reported as a ratio, as you mentioned.

And that's a technical issue because there are -- what we normally would do is multiply the ratio by a national rate, but there are many national rates because there are many different procedures.

So, it wouldn't really work because hospitals perform different mixes of these kinds of surgeries, so instead we report this ratio.

But then to aid in interpretation, the results are characterized as better than the national rate, or worse than the national rate, in 95 percent competence intervals, and that identifies about eight percent of facilities as outliers.

So, that's a pretty decent spread in terms of variation. So, I just wanted to point that out.

And then when you compare, like, the worst performer against the average performer, the worst performer is performing about 130 percent worse than the average performer, and the best performer is performing about 50 percent better than the average performer.

So, it's again a decent spread in terms of performance. So, thank you. That's all I wanted to say.

Co-Chair Travis Upshaw: That was very helpful. I was curious, though, if there is a measure like this in ambulatory surgery for the same reason that we talked about before about having information across different settings that could be used by consumers and also for quality improvement and I was curious if there was something like this in the Ambulatory Surgery Center Program.

Dr. Peter: Right. Sorry. I forgot to answer that question.

Co-Chair Travis Upshaw: That's okay.

Dr. Peter: So, there are other measures in the ASCQR Program, but there are more of them and they break it down into categories. So, this HOPD surgery measure captures a wide range of same-day surgeries.

In the ASCQR Program, in the ambulatory surgery center setting, we have separate measures. One for orthopedic procedures, one for urologic procedures, and then a final one which we call "ASC general

surgery" that captures everything else.

So, in that setting they were actually broken down into three and there was some talk among stakeholders for the last couple years about whether there's any interest in sort of doing the same thing.

So, it was aligned with -- in the HOPD setting. So, it's sort of a CMS decision about which way to go with that.

The ASC measures are more recently developed. So, that might be why you ended up with more granularity in the ASC setting.

There's also different mixes of procedures. So, it's unlikely to be completely comparable because of that.

Co-Chair Travis Upshaw: But it is measuring hospital visits after those -- in those categories?

Dr. Peter: Exactly.

Co-Chair Travis Upshaw: Okay.

Dr. Peter: So, it's the same approach.

Co-Chair Travis Upshaw: Thank you.

Co-Chair Demehin: Other clarifying questions for CMS?

(Pause.)

Co-Chair Demehin: So, I have one.

So, this measure I've always kind of understood as the outpatient analog to something like the hospital-wide readmissions measure which reflects performance across a variety of different conditions and for all causes.

When hospitals get reports on this, do they get reports that lay out by kind of clinical service what

their performance looks like?

The reason I ask that question is a rolled up rate is nice from a kind of simplicity of interpretation for patient's perspective. It may not be as helpful for pinpointing where there may be a gap in care.

So, could you talk through that a little bit? I just can't remember the level of detail that hospitals get on this.

Ms. Patel: Hi. This is --

Co-Chair Demehin: Oh, I heard someone try to jump in.

Ms. Patel: Sorry. This is Shaili again.

Co-Chair Demehin: Go for it.

Ms. Patel: Yeah, this is a facility-level report that they receive. So, it's not broken down into granular detail.

Dr. Schreiber: Akin, this is Michelle.

So, it always gets with the question of more measures versus fewer measures, you know. Like in readmissions, for example, there's a group that wants an all-cause readmission regardless, and then there's the group who still wants it broken down by, you know, the six diagnostic categories that we have.

In this particular case you are absolutely correct. This is a rolled up measure for lots of different procedures that may be done and we would expect, if the organization is an outlier, that they're looking at their own data to try and identify where they may be an outlier.

Co-Chair Demehin: Yeah. Thank you.

Dr. Schreiber: I mean, you're right. It raises the same question of if -- that has been discussed.

Do we parallel what's being done in the ASCs, which does have some granularity, but it gets to more measures then, too.

Co-Chair Demehin: Yeah.

Dr. Peter: Hi. This is Doris for the developer. I just wanted to chime in.

The facilities do get a claims detail report, actually, that shows them individual claims and which body system was there, you know, that claim fell into.

So, they do get some, you know, claim-specific information about their cases.

Co-Chair Demehin: That's what I suspected just because usually the preview reports for the readmission measures always come with a pretty decent amount of detail.

I just couldn't remember whether this one had service -- a thing that's called service line level reporting that they use in the readmissions measure.

Anyway, let me ask the Committee, are there any other clarifying questions you may have for CMS or for the measure developer?

(Pause.)

Co-Chair Demehin: Alright. Seeing none, what category would folks recommend for this particular measure?

Sounds like there were, among the reviewers, some concerns about these ratios and the developer talked through that approach, but other perspectives on this measure?

Member Wisham: Akin, this is Lindsey. I'll just -- my two cents is maybe this one starts off with retain -- or I should say the -- maybe I'm not naming the category right.

It would be Support for Retaining at least as a starting point given some of the explanation we heard, I believe, from the measure developer.

Co-Chair Demehin: Thanks, Lindsey. So, that's one for retain.

Any other perspectives on this?

Member Hatlie: I'd agree with that as well given the volume of data that's collected and the differentiation that we heard about from the measure developer. I think those are good arguments for retaining.

Co-Chair Demehin: Alright. Other thoughts?

(Pause.)

Co-Chair Demehin: I'll take my chair hat off for just a minute on this measure. I think I'm kind of somewhere between a retain and maybe a conditional.

I guess as I think about this measure, I think in terms of the topic that it covers and the breadth of procedures that it covers, it sort of feels like a good fit for a program like this.

I do think it is worth continuing to explore whether a reporting approach that looks at groupings of clinical services may make more sense.

And that the reason I say that is I do worry a little bit about the variation in services that are offered by hospital outpatient departments.

I don't have a great sense from these data whether there are any differences in performance that may be driven by those differences in service mix.

I know that this is a risk standardized measure. So, it may be that the risk adjustment model is enough to account for some of those differences, but, on the other hand, I do potentially worry about, as we

get into more and more of these procedures being offered in the ambulatory setting, are there some that are more complex that are -- that tend to concentrate at particular centers where the outcome comparability could become a little trickier.

I don't know that that's enough to sway to a Conditional Support for Retention, but it is a consideration that I would at least like to reflect back to CMS in looking at this measure.

So, I'll put my chair hat back on and see if there are any other proposals for categories here or any other perspectives that you think would be important for CMS to hear.

Go ahead, Cristie.

Co-Chair Travis Upshaw: Yeah. I would -- I appreciate your last comment, Akin, and I think that's where I was thinking about the Ambulatory Surgery Center Quality Reporting Program as well.

And I think of this more as a suggestion or a commentary than a condition, but I think the more that we can look at harmonizing the measures across ambulatory surgery center quality and hospital outpatient surgery quality the more meaningful that's going to be to both patients when they're making decisions, but also I would think to both the ambulatory surgery centers and the hospitals because it gives them a view into what's going on in the other setting and, you know, an understanding for how they compare and we know that that Hawthorne effect, you know, does actually have a significant impact.

So, you know, maybe this is kind of a more generalized statement, but I think -- I don't think I would want to make it a condition, but I do think that we need to have, you know, that as an intention ultimately of being sure, as Michelle put it earlier, thematically -- that we're looking at things thematically and then how do we implement them

across settings.

And, you know, I think the more that we can align hospital outpatient surgery with ambulatory surgery centers, I think that that helps achieve that.

Co-Chair Demehin: Really, really thoughtful comment, as always, Cristie. Thanks.

Alright. Any other recommendations for CMS? It sounds like the recommendation we'll offer up for voting is Support for Retention unless I hear otherwise from the group.

Alright. Let's start there and I think we have actually gotten through all of the measures that we were scheduled to review this afternoon.

Which even though it wasn't a huge number of measures, there was -- these were complex and nuance conversations and really so appreciate your thoughtful perspectives on all of these.

So, I think at this point I'm handing it back over to you, Jenna, right?

Ms. Bader-Williams: Yes, that's right. And thank you -- yes, thank you so much to the group. Definitely these are -- each measure needs such nuanced conversations. Appreciate all the feedback today.

Opportunity for Public Comment

We will be opening up now for the last opportunity for public comment and -- yeah, and I will turn it over to Cristie for this.

Co-Chair Travis Upshaw: Well, I'll be glad to open it up for public comment and, you know, this is your opportunity, having heard the deliberations and discussions today, to offer public comment on the measures that we have been discussing in the programs.

So, we'll start with those that are on the WebEx

platform. If you would raise your hand, please, to let us know that you would like to make a comment and please keep it to no more than two minutes.

(Pause.)

Co-Chair Travis Upshaw: I don't see any.

Do you, Jenna?

Ms. Bader-Williams: I do not.

Co-Chair Travis Upshaw: And we want to be sure we offer opportunities to those of you that may be on the phone.

So, if you're on the phone and would like to make a comment, please speak up.

(Pause.)

Co-Chair Travis Upshaw: Okay. Well, I don't think we have any, Jenna.

Ms. Bader-Williams: I am not seeing any as well. Just seeing if anything is coming in via the chat and I don't see anything there.

One last check of hands. I don't see any hands raised, so I agree. There are no comments.

Co-Chair Travis Upshaw: Thank you.

Ms. Bader-Williams: Thank you.

Okay. And so, we do have two more agenda items to get through. We would like to spend a little bit of time on each.

Discussion of Gaps in Hospital MSR Programs

So, first is a discussion of gaps in the hospital measure set review programs. So, the three programs that we reviewed today.

Akin, if this is okay with you, I'd like to suggest we

keep that to about ten minutes and then we leave the last 20 minutes to talk about -- to get feedback from the Hospital Workgroup and get their feedback on the process since this is new and we think that will be really valuable.

So, how does that sound?

Co-Chair Demehin: That sounds perfect.

Ms. Bader-Williams: Great. So, I will turn it over to you, Akin.

Co-Chair Demehin: Alright. So, in this part of the -- in this part of the discussion I think our goal here is to try to tease out -- now, Jenna, is this gaps in the process that we use or is this gaps in the measure programs themselves and suggestions for how to fill them?

Just can you remind us how to center this conversation?

Ms. Bader-Williams: Yeah. More so the latter. We wanted to -- because we were focused on very specific measures today, we just wanted to give the group a chance to take a step back and see if they had any broader comments about the measure sets that we've reviewed.

Co-Chair Demehin: Perfect.

Alright. So, any gap areas that are standing out to the group in OQR, ASCQR or the cancer -- the PPS-Exempt Cancer Hospital programs that you want to raise and make sure get addressed by CMS?

Go ahead, Cristie.

Co-Chair Travis Upshaw: Sorry about this, and of course I'm not wearing my co-chair hat at this point.

I just was struck by the conversation we had around imaging and emergency department. I, you know,

I'm sure that our comments will be sent along, but, you know, I think, in a way, what we were doing was identifying gaps because, in reality, the measures that we have are very limited in both of those categories.

And I would think that there could be even innovative approaches to thinking about, you know, both of those categories as to what matters, you know, what is a -- what is the most important thing to think about in emergency rooms, what is the most important thing to think about in imaging and, you know, to kind of step back and say, do we have those in these programs?

And I think, you know, we were all a little frustrated that we don't have very many measure in each one -- in either of those categories and they're critical in outpatient care.

So, I would at least suggest considering, you know, imaging in emergency department being considered gaps.

Co-Chair Demehin: Thanks, Cristie.

Any other ideas for gaps to try to fill in these programs?

(Pause.)

Co-Chair Demehin: While folks think about that, I'll take my co-chair hat off again and offer another sort of broader process thought here.

I have always thought that the Outpatient Quality Reporting Program was one of the most difficult programs to develop measures for just given how broad and how variable the set of services that hospitals may offer in the ambulatory setting can be, you know.

I certainly think that the measure that we just discussed around outpatient procedures was -- surgical procedures was an incredibly important

area to remain focused on, but I do think it's worth CMS continuing to evaluate sort of what sets of services are being offered in the ambulatory setting and trying to sort of back into potential gap areas using that sort of information about the volume of services.

It's going to be a bit of a shifting target, but I do think trying to make sure that we are doing the most good for the most patients who are served in that setting would do us well, you know, especially if there actually is a gap in those particular services.

I see Jennifer's hand is up as well. You're on mute, Jennifer.

Member Lundblad: Thank you.

The -- I have two comments that aren't maybe specific gaps, but would be worthy things for this hospital workgroup to undertake as we look ahead.

The first, is our understanding of patient safety has shifted as a result of the pandemic.

And while we have fairly robust inpatient safety measures, looking across the three programs that we discussed today, either the opportunity to flag measures that already exist that we might say contribute to assuring patient safety and then identifying if there are gaps in safety, would be, I think, really helpful.

And then the other thing that I'm struck by as I reflect on the whole set of measures we reviewed today, sometimes very appropriately we are diving down to a condition-specific, narrow view of something that occurs in one of these settings.

Other times, we're looking at more broad -- again, thinking about the emergency throughput measures -- broad, inclusive, not specific to conditions or patients.

I think making sure that we don't have gaps in the

balance between those is also really important.

Co-Chair Demehin: Perfect comment.

Other folks? I know we're drawing to the end of the meeting and folks are losing steam after a pretty draining set of conversations.

Let me offer up one more opportunity on gaps before we move on to a discussion of the process.

(Pause.)

Co-Chair Demehin: Alright. Seeing none, let me give the floor back to Jenna for a discussion of the process.

MAP Hospital Workgroup Feedback on MSR Process

Ms. Bader-Williams: Great. Thank you so much, Akin. And thank you to all of you who are sticking with us to the end.

I know it's a tiring day to discuss so many measures in depth, but if we could turn to a discussion about the process, we move forward one more slide.

So, we have some quick polling questions that we'll ask first just to get a sense for where the group is and then we can walk through the discussion questions.

So, if we could go ahead and pull up the poll -- alright. So the first question is about the survey and specifically that the measure set review survey to nominate measures for discussion worked well.

You can vote anywhere between 1, strongly disagree, and 5, strongly agree. We'll leave that open for a few seconds here.

(Voting.)

Ms. Bader-Williams: We might be at our max here. So, why don't we go ahead and close.

Right. So, looks like we have -- okay. Thank you, yeah. We've got 3 for disagree; 1 neutral; and 8 agree to strongly agree. So, thank you all for that.

Let's move on to the next one. I had what I needed to respond to the MSR survey. So, again, 1, strongly disagree, to 5, strongly agree.

(Voting.)

Ms. Bader-Williams: Alright. Why don't we go ahead and close.

So, here we see more disagree. So, 7 disagree; 3 neutral; and 2 agree. We'll circle back to this definitely in the discussion.

And lastly the -- oh, I'm sorry, that should say the workgroup review of the measures under review worked well.

So, specifically the discussion we had today. Again, 1, strongly disagree, to 5, strongly agree.

(Voting.)

Ms. Bader-Williams: We had 12 before. Just waiting to see if we get those last two.

Alright. There we go. We can go ahead and close.

Alright. And here we see more in the agree strongly agree. So, we've got 10 in that category. In those 2 categories; 1 neutral and 1 disagree.

Great. So, thank you all for responding to that poll. I think that gives us a good place to start.

So, we would like to talk about the survey. We know that was an important part of the process and we recognize that there was not a lot of detail provided about the measures when we sent out the survey.

So, what worked well during the survey and what do you wish had been different either about the survey or the supporting materials we provided?

Member Wisham: Jenna, it's Lindsey.

I will say that it's like I had some lightbulb moments today now looking backwards to the survey about, oh, this is how it's all coming together with the new process.

Like, what I saw in the measure summary sheets was extremely helpful and I recognize that is a lot of time and effort to create, but even a shortened version of those measure summary sheets would be really helpful when completing the survey.

I think it maybe would have answered even some of the questions that we saw pop up in the comments that the survey respondents provided.

So, just thinking ahead to next year. We may all be a little bit more intentional and specific about our answers if we have those summary sheets at hand.

Ms. Bader-Williams: Great. Thanks, Lindsey, for that.

And if I could ask a couple of followup questions, so are there particular sections of the measure summary sheets that you found useful or that you'd really want to see included at the time of completing the survey?

That's my first followup question.

Member Wisham: Like, I found myself -- when I was reviewing the measure summary sheets, like, I found myself actually, you know, there were some links embedded, I was going out and actually finding the measure specifications. So, it was almost like a pathway to find more information about the measure.

And then in addition, I mean, the information about the performance and reporting data I found particularly interesting and just the history of the endorsement status.

I would say those were kind of the key things that I would have found maybe extremely useful when initially completing the survey.

Again, I don't think -- I will say I also appreciated that the survey was simple, right?

It gave us the criterion and it had us, you know, which ones it met and which ones it didn't and then we were able to select from there.

So, I don't want to overcomplicate it. I just think that the measure survey -- I'm sorry, the measure summary sheets were helpful and maybe including some of that information up front when we complete the survey.

Ms. Bader-Williams: Okay. Thank you for that.

And one followup -- my second followup question then is, obviously there are a lot more measures included in the survey across the three setting-specific workgroups.

Member Wisham: Right.

Ms. Bader-Williams: I think there were somewhere between 200 to 250. So, for any given workgroup that might be somewhere between 70 to maybe 80 measures.

Member Wisham: Yeah.

Ms. Bader-Williams: We've heard this feedback before, but would --

Member Wisham: Yes.

Ms. Bader-Williams: -- you all actually want to review measure summary sheets for 70 to 80 measures?

And again, if not, what would be the pieces of information we could really pull out that would be critical to completing the survey?

Member Wisham: I mean, we welcome all the feedback. I mean, I know I would appreciate, you know, if we could find out, like, is the measure, you know, any -- again, recognize this is effort and time and energy spent by the NQF team to create these, any information on, you know, whether the measure is topped out.

Again, I found information about how long the measures have been in the program. Just trying to think of, like, quick hits that could be, you know, good barometers for us to assess the measure on, you know, when the endorsement potentially was removed.

Just trying to think of, you know, again if it could even, you know, so you don't have to create entire documents, but maybe just some quick data elements, per se, for each of those measures because I recognize that's a lot of measures to do that for, Jenna.

Ms. Bader-Williams: Thank you for that feedback, Lindsey. Really appreciate it.

I see some other hands raised. So, Anna, let me turn it to you and then I see Akin and Jennifer.

Member Legreid Dopp: Sure. I agree with Marty's comment earlier and then everything that Lindsey just said.

I do want to say thanks so much to the NQF team for outlining this very new process with the opportunity that we've been given from CMS.

So, recognizing, you know, as we started, there's a lot of grace with all of it as we learn together.

I was very appreciative of the earlier survey that went out. I did find that I had information I needed to complete it. I was able to save what I submitted so I could reflect back on it for our discussion today.

However, after today and, like, listening to the more

robust discussion, I do have a better idea of what I should have done to prepare.

And certainly don't want to create unnecessary work because we know NQF staff is already very busy with work, but I think just a little more context -- I think there's information that we can all pull from the QPS that could help give some insight into specifications and history, but more about how it's been in the field since then and then anything around, like, the crosscutting nature of those measures would have, I think, given me just a little bit more information to complete the survey.

But overall, honestly, the first time I think that it was really well done.

Member Ghinassi: Yeah, I agree. This is Frank. I want to echo that idea about how it's performed in the field. Has it produced change? Has it topped out? Those sorts of things.

And then just one request. I don't know how easy or hard this would be. If there were concerns raised about the construct validity or content validity or anything that made the scale, it may have passed, but it passed with concerns that were raised by certain people, very often I've noticed in the process when we do voting a measure may pass, but it doesn't always pass without concerns being raised by people who may not have either communicated those concerns strongly enough or maybe others didn't either understand or agree with them, but it would be important, I think, to at least hear them if they're known to you. That's all.

Ms. Bader-Williams: Thank you very much for that.

Okay, Akin, I'll go to you.

Co-Chair Demehin: Thanks. I would really echo the great recommendations that my colleagues have made here.

I especially found the performance information that was included in the information sheets to be useful.

So, if there is any way of providing that at the time that we fil out the surveys, I think that would be enormously helpful.

I would say the one frustration in filling out the survey I do think, quite frankly, was the time crunch and some of that was just brought on by the urgency of getting this process stood up and underway.

And now that we sort of have a process to start from and to iterate from, I suspect that will be a little bit less of a challenge, but I don't -- from my perspective, the survey arrived about the same time the inpatient perspective payment system rolled in, which was a lot.

So, now that we have a predictable cadence of this, I do think we can -- it, first of all, gives us the opportunity to plan better our own schedules to make sure we carve out the time we need to respond.

But overall, I mean, starting something this new is tough and I think that this was a very good first attempt that gives us a great starting point for iteration.

So, thank you for all the work and to the team for putting this all together.

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

Okay, Jennifer.

Member Lundblad: Great. Thanks. I, too, agree with the prior comments. They're really thoughtful and helpful, and I would also reiterate how well the process worked especially the first time through.

And I think the survey -- I maybe wasn't exactly sure at the time what the outcome would be, but it

met its purpose.

I think you were drawing on all of us to filter and screen to get to the measures that we want to focus on in this meeting and I think that works.

We all come with varying depths of knowledge depending on which measure set we're looking at.

And so, I think that resulted in the set of measures that we actually then focused our time and attention on today.

And what I would appreciate is, I think, what Marty put in the chat, having the broader context of the measures that we're actually focusing on that emerge from the survey is -- I mean, the comment earlier we're not just looking at the single measure, of course we need to do that, but how does that sit in the broader context of that program and that set of measures.

Ms. Bader-Williams: Thank you very much, Jennifer. Appreciate that.

Suellen?

Member Shea: Yes. And this is just maybe something helpful that you guys could do to save yourselves some time.

I notice that a lot of the information that was included in, you know, about the measure itself is information that we could glean from NQF's measure database.

And so, just putting the hyperlink to the measure, we could get a lot of that information without having to, you know, put it into this document.

And then adding those other pieces that everyone has spoken about would then make it very robust.

Ms. Bader-Williams: Yeah. So, to that point I appreciate the suggestion. One of the things we've

noticed, though, is that although there are measures that are in QPS as endorsed or used to be endorsed, that information does not actually always align to the measures in programs.

So, we had to work very closely with the CMS program leads to make sure that this version of the measure that's in this particular program is considered to be NQF endorsed.

And they aren't always and that might have even -- I think one of the measures was identified as not endorsed perhaps at the time of this survey, but in working with the CMS lead we determined it was endorsed. And I think we've had some -- it's happened vice-versa as well.

So, I think that would be the one caution and certainly that's one of the places where we've had the most back and forth with CMS.

Member Shea: Got it.

Ms. Bader-Williams: Well, thank you all so much for the feedback about what we could do to improve the information we provide at the time of the survey.

I know we're getting really close to the top of the hour here. So, just any feedback about the process today or in the week leading up to today with the measure summary sheets?

Anything else you'd like to suggest about the more immediate discussion and how we went through the review?

(Pause.)

Ms. Bader-Williams: Sounds like everyone has shared their thoughts. And again, we do -- to reiterate what others have already said, we do really appreciate your flexibility and grace as we've gone through this new process.

MUC has been around for quite a while at this point and so I imagine there might still be a kink or two there, but that's a well-established process and we really appreciate your feedback.

Actually, before we wrap up, any feedback on the actual criteria we used? There were 10 criteria. Some have mentioned that it's a lot of criteria.

Were there any in particular that really resonated with you or ones that didn't?

(Pause.)

Member Shea: I think I may be lacking in my understanding of the gap piece. I think what everybody is referring to when they say, is there going to be a gap, is there's not another measure to -- that would be similar that could fill it.

But the other part to that is is that if we continue to leave measures in because there is going to be a gap, well, then will people be compelled to develop more measures moving forward? You know what I'm saying?

Maybe I could be missing -- I could be all wet, but --

Co-Chair Demehin: Sorry, Suellen, that comment resonates very much with me, you know.

I think what we may have to challenge ourselves to do, as a group, is to be pretty specific about what we mean by "gap."

Is it the topic of the measure is exactly right, but there's something in how it's designed that's a little off, or is it, you know what, this topic is not the right one anymore and maybe it's time to move on.

As I've gone through multiple rounds of MAP conversations, I do think we sometimes struggle with making the differentiation between the conditional and the outright support.

And I think, in part, it's because we -- we're sensitive to the fact that these measures do get used by a variety of folks and they have a variety of perspectives.

On the other hand, I do think sometimes we have to be willing to say the time has come for us to move on to something different with these measures because otherwise I don't think it's sustainable to only add new measures to these programs.

I think we do have to be thoughtful about what we recommend for removal. So, that was such an important comment and I'm really glad you shared it.

Member Lundblad: Great. Thank you.

And I've seen that this has prompted a couple more hands. So, Frank, I'll go to you next.

Member Ghinassi: Thank you very much. Let me take that hand back down.

So, on the heels of that I just want to also make a suggestion that -- and I know this may be hard to do, but the organization that I'm here representing deals with the financial impact of accumulating measures.

And, you know, every one of these measures has a compelling human interest story and quality story, but the sentiment from some quarters is that we do a good job of adding and not as good a job at harmonizing or reducing.

And when you make the decisions in this room in this context, it's often hard to realize that a decision can cost tens of millions of dollars in work time and personnel across -- when you look at the country.

And I think the weight of that is sometimes hard to feel, but it's not far from true.

Sometimes it means adding an employee times

5,000 hospitals and, you know, we're all grappling with efficiency and effectiveness.

And so, I think if there was some way to give the groups that are doing the voting some sense of what this measure is going to cost in time or money, it's just a factor that we don't talk about.

And I think we talk about burden, but it's often restricted to that one measure as opposed to the suite of measures that are now -- and, you know, let's face it, many of these are, quite frankly, unfunded mandates and -- so, I just want to -- I want to just voice that. That's all.

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

I see Cristie's hand raised.

Co-Chair Travis Upshaw: Yeah. And I appreciated that last comment. So, I've got to remind myself what I was going to say.

I think that, in a way, we still silo what we're doing here. So, once a year we get together and hear the measures under consideration to add.

And then I don't know how often we're going to do the removal, but once again we're kind of siloing and we're voting in a context that's, in my mind, still not looking at the entire set at one time.

And I just would encourage us to think outside the box a little bit in terms of how to have those bridges in such a way that every time we're always thinking about the whole set, you know.

And if we're going to add one, you know, let's be sure that, you know, there may be one that can go away, but we're thinking about all of this at separate times.

It just seems like we're very process-oriented and not strategic in terms of thinking about these sets, and I would just suggest that maybe we think about

a way to structure it so that we're more holistic in our thinking.

And I think the sum of what Marty was trying to say, we need the context. And I think this was great today, but we were siloed on thinking about what to get rid of, but we needed to know what else was in the set before we got, you know, before we could get rid of it.

So -- and I personally think we are ready for what Frank was saying. I think that we do need to look at the cost.

And there may be some things that aren't, you know, that if we understood the cost, we may say, no, that's not as important as this other measure that we think, you know, really gets at what we need to be doing.

Ms. Bader-Williams: Great. Thank you so much, Cristie.

And then, Jennifer, I see your hand raised.

Member Lundblad: Yeah. As we approach the top of the hour, I'll try to be really brief.

I just -- as you're asking about criteria and I'm listening to my colleagues respond, I also -- I think the criteria are all important.

And then, in the end, I just ask myself every time we're doing this, is this measure making a difference? Is care better? Is health better? Is care more equitable?

And if there's any way we can crystalize all the criteria to get around that, we have to get where Frank was leading us.

We are probably better off with fewer, rather than more, measures if we can find measures that truly make a difference in care or health or equity.

Ms. Bader-Williams: Great. Thank you all so much. Such thoughtful feedback and again at the end of the day.

Really appreciate you sticking around to provide that. We'll definitely take all of this under consideration.

The intention is for this to be an annual process. So, we will be revisiting in the future and I think we can move on now to next steps.

And, Joelencia, I believe I'm turning it to you.

Ms. Leflore: Yes. Thanks, Jenna. I will now provide an overview of the upcoming activities and will be very quick.

Next Steps

So, next slide. We have now completed the first workgroup. The remaining workgroups will meet to discuss their respective measure sets.

The Clinician Workgroup will convene June 27th. the PAC/LTC Workgroup will convene June 30th. Additionally, the Coordinating Committee will convene in late August.

Once all the MSR meetings are completed, there will be a public comment on the final recommendations occurring July 22nd through August 5th. To conclude, the final recommendations report will be issued to CMS in September.

Alright. Next slide, please, and that was just an illustration of what was previously stated.

Next slide. And this slide has the MAP hospital content information and I'll turn it back to Jenna.

Ms. Bader-Williams: Thanks so much Joelencia.

And just to note, we will be sending out a followup survey, after today's meeting, for you all to vote

using the categories that we agreed to start with for those measures where we did not have quorum today.

And lastly, I'd like to turn it over to Akin and Cristie to see if they have any closing remarks they'd like to make.

Co-Chair Demehin: The only closing comment that I will make is, thank you, thank you, thank you, for engaging in this process in the way that you did and providing such good, constructive feedback on how to make the process better the next time we do it.

I always come away from these meetings learning something and being incredibly appreciative for all of your contributions. So, thanks again.

Co-Chair Travis Upshaw: And I'll just add thanks and thank you for your grace and patience as we did go through this process for the first time, but thank you all very much.

I always walk away with a great sense of really making a difference because of hearing what everybody contributes to this process. So, thank you very much.

Adjourn

Ms. Bader-Williams: Okay. I think we can go ahead and wrap up this Hospital Workgroup meeting. Thank you all so much. Have a great evening.

(Whereupon, at 4:01 p.m. the meeting was concluded.)