National Quality Forum
MAP Hospital Workgroup Virtual Review Meeting
Wednesday, December 15, 2021

The Workgroup met via Videoconference, at 10:00 a.m. EST, Akin Demehin and Sean Morrison, Co-Chairs, presiding.

Workgroup Members:

Akin Demehin, MPH, Co-Chair
R. Sean Morrison, MD, Co-Chair
Donna Bednarski, MSN, RN, ANP-BC, CNN, CNP, Kidney Care Partners
Tejal Gandhi, MD, MPH, CPPS, Press Ganey
Richard Gelb, MA, Individual Subject Matter Expert
Frank Ghinassi, PhD, ABPP, National Association for Behavioral Healthcare
Kelly Gibson, MD, Society for Maternal-Fetal Medicine
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
Aisha Pittman, MPH, Premier Healthcare Alliance
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 King, MS, Greater New York Hospital Association
Linda Van Allen, RN, BSN, PHN, CPUM, American Case Management Association
Jackson Williams, JD, MPA, Dialysis Patient Citizens
Lindsey Wisham, MBA, Individual Subject Matter Expert

Non-Voting Federal Liaisons:

Andrea Benin, MD, Centers for Disease Control and Prevention (CDC)
Raymund Dantes, MD, CDC
Michelle Schreiber, MD, Centers for Medicare and Medicaid Services (CMS)

NQF Staff:

Dana Gelb Safran, ScD, President and CEO
Tricia Elliot, MBA, CPHQ, FNAHQ, Senior Managing Director
Victoria Freire, MPH, CHES, Analyst
Ivory Harding, MS, Manager
Chelsea Lynch, Director
Becky Payne, MPH, Senior Analyst
Matthew Pickering, PharmD, Senior Director

Also Present:

Wilfred Agbenyikey, ScD, MPH, Yale University
Kathleen Balestracci, PhD, MSW, Yale CORE
Allison Bryant, MD, MPH, Massachusetts General Hospital
Kathleen Conroy, MD, MSc, Boston Children's Hospital
Caitlin Drumheller, American Society of Clinical Oncology
Jackie Grady, MS, Yale CORE
Veronica Gunn, MD, MPH, Genesis Health Consulting
Kendall Hall, MD, MS, IMPAQ International
Rachel Keever, MD, CPE, FACC, North Carolina Medical Society
William Lawrence, Jr., MD, FAAP, Carolina Complete Health
Lisa McGonigal, MD, MPH, Kidney Care Partners
Joe Messana, MD
Sri Nagavarapu, Acumen, LLC
Rebecca Onie, The Health Initiative
Rocci Perla, The Health Initiative
Gary Price, MD, FACS, The Physicians Foundation

David Ruiz, PhD, Cloud Harbor Economics LLC
Grace Snyder, JD, MPH, Quality Measurement and Value-Based Incentives Group, CMS
Richard Thomason, Blue Shield of California Foundation
Joseph Valenti, MD, The Physicians Foundation
Chana West, RN, MSN, IMPAQ International
Ronald Wyatt, MD, MHA, MCIC Vermont

Contents

Proceedings

(10:03 a.m.)

## Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives

Dr. Pickering: So good morning everyone who's on the line. My name is Matthew Pickering. I'm a senior director here at the National Quality Forum working on the MAP Hospital Workgroup.

So I know folks are being led into the meeting. So as you enter the meeting, you will see on your screen if you do have the web platform open, that we have just some housekeeping items before we get started today. So this is a Webex platform.

If you've used Webex before, you're familiar with some of the features. But if you've used other types of platforms, it's a very similar type of setup. So we do ask that you keep yourself on mute on your computer if you're using the web platform just to prevent any background noise.

We also encourage you to use the chat feature as well. For those Workgroup members that are trying to participate in the conversations, you can definitely take yourself off mute during that time to participate and ask questions and participate in discussions. Or you can use the chat feature.

There's a little chat icon at the bottom right of the web platform that you can use to open up that chat feature and participate through there. Secondly, we also encourage you to use the raise hand feature as well, especially if the dialogue gets pretty lively. We will recognize you through the raise hand feature.

And to use that, if you click on the participant list which is the little icon that's next to the chat icon on the web platform, your participant list will pop up. Your name should be the very first name at the top

of that list. If you hoover over your name, there's a little hand icon that's on there.

If you press that, that raises the hand and signals to us that you have your hand raised. And we will call on you in the order that we receive those raised hands, so just using those features within this chat feature. If you have any technical difficulties, please feel free to email the project box with is M-A-P, so MAPHospitalEqualityForum.org.

Again, if you're not speaking, please keep yourself on mute. For those Workgroup members and others during public comment, for example, if you are speaking, we encourage you to use the video feature as well as a way to be more engaged in our virtual environment. Please use the video feature so we can see who's talking, and we encourage you to use that also.

So go to the next slide, and again, I will say welcome to everyone who's joining the proceedings today. This is the Measure Applications Partnership Hospital Workgroup virtual review meeting. This is in support by our partners in this which is the Centers for Medicare and Medicaid Services. So we thank them very much for their support.

We also want to thank our co-chairs, Akin and Sean, who will be introducing themselves here in a bit for their time as well as all of the MAP Workgroup participants for your time in evaluating the measures that we have today. We also thank the developers as well and our CMS partners who are on the call to participate in the dialogue and answering any questions that come up from the Workgroup participants. We do have a full agenda today.

So we'll try to do our best to keep everyone on time. The meeting ends at 6:00 p.m. Eastern. We have a lot to go through, so we'll get started. So going to the next slide. Here's our agenda. So after we do welcome, introductions, and disclosures of interest, we'll then review the meeting objectives.

We also have Dr. Michelle Schreiber on the call today. She is going to provide some opening remarks from CMS. And that's prior to them going into the overview of the pre-rulemaking approach.

So in that section, NQF will present the pre-rulemaking approach, including our decision categories as well as our preliminary analysis algorithm. So we'll talk a little bit about that as well as the two Advisory Groups that have previously met to review these measures are Rural Health and Health Equity Advisory Groups which are providing additional inputs for the MAP Workgroup to consider for decision making.

We will then go into our first set of measures on the list today before breaking for lunch. We have a 30-minute lunch allocated for today's proceedings. And then after lunch, we will then go through the remaining set of measures and then also have an opportunity for the public to comment at the very end of the meeting in which we will then do a summary of the day and next steps.

Now the opportunity for public comment, that's not the only time at the end of the meeting. We also have an opportunity for the public to make comments related to the measures within the respective programs they've been submitted to prior to the Committee discussion or the Workgroup discussion. So we'll also have that built in. And again, there is also an opportunity at the very end of the meeting for any additional comments from the public. Next slide.

So again, I want to welcome everyone and your participation and your time today for this very important work that we do here, recommending these measures for inclusion in CMS federal programs. I also want to turn it over to our CEO Dana Safran who will also provide some welcoming remarks as well. So Dana, I'll turn it over to you.

Dr. Safran: Thank you very much, Matt. Good

morning, everyone. It's really my pleasure to welcome you today to MAP Hospital Workgroup Review Meeting for the 2021-2022 cycle.

NQF is honored to continue our participation and partnership with the Center for Medicare and Medicaid Services and the MAP Hospital Workgroup in its important work. All of you understand that this work really informs and advises CMS on performance measures that are being considered for use in public reporting and performance-based payment programs. And there, I would say, has never been a more important time for measurement in healthcare in our country.

And so we are proud and appreciative of this Committee's important work. MAP, of course, brings together a unique and multi-stakeholder group that represents quality measurement research and improvement, purchasers, providers, the public, and community health agencies, health professionals of plans, consumers, suppliers, and subject matter experts. And this diverse array of stakeholder voices ensures that we are able to provide the federal government with varied and thoughtful input as it considers measures for final rulemaking.

I would like to highlight as Matt did the work of our Rural Health and Health Equity Advisory Groups which met last week. The reviewed all the measures for all settings: clinician, hospital, and post-acute and long-term care. The Rural Health Advisory Group has been providing critical input on the potential impact of measures to rural facilities and clinicians for several years.

And new this year, we have the Health Equity Advisory Group that shared insights on each measure's ability to identify disparities and further promote equity. The meetings were full robust discussion and will be bringing forward today the feedback from those groups as you consider each measure. I'd like to add my thanks to those that Matt

expressed to you, the Workgroup, the federal liaison.

We know there's enormous time and effort that goes into this work. And we are very, very appreciative. I also want to give special thanks to our Workgroup co-chairs, Akin Demehin and Sean Morrison, for their leadership and for the time, effort, and leadership that they provide to make all of this work and be successful.

And finally, thank the members of the public who take time out of the schedules to provide input that is so necessary to this overall process. Thanks to all of you for the work you've done leading into today and for your time, attention, and participation today. We're looking forward to the discussion today, 13 measures under consideration for the Hospital Workgroup. And with that, let me hand it back to you, Matt.

Dr. Pickering: Thank you so much, Dana. And thank you for also recognizing our two co-chairs which I would like to provide an opportunity for them to give some welcoming remarks as well. So I'll start with Akin. Akin, would you like to go first and then we'll go to Sean.

Co-Chair Demehin: Thanks so much, Matt. And thank you, Dana, for those kind words at the beginning. Good morning, everyone. Welcome back for those of you who are participating again on the Hospital Workgroup and for those of you who are new, welcome. This is really an important opportunity to hear from CMS about what they're thinking in terms of the future of their programs and to hear from all of you about your perspectives on what should go into those programs.

We have an incredibly thought provoking list of measures to walk through today. And I really look forward to the conversation and learning from all of you. My thanks to the NQF staff in advance for all the hard work that you did to prepare for this, to CMS for preparing the MUC list for all of us to review and

engaging in the conversation with us, and to my co-chair Sean who is a wonderful partner in crime in facilitating this meeting. So let me take it over to Sean.

Co-Chair Morrison: Thanks, Akin, and right back at you. Welcome, everybody. It's really terrific to see everybody on Zoom. I wish we could be there in person and hopefully next year we can do that. I think the discussions are much more rewarding when we can be together.

As Akin said, we have a busy and very full agenda. He and I are going to work desperately to try and get us through so we finish on time and not late. Bear with us in that. One of the things we are going to try today is make sure the conversation stays very focused, the CMS hears as many perspectives as we can get to them and hopefully not be too repetitive so that they get the opportunity to hear everybody's voice.

And again, my thanks to Matt and his team who've just done a phenomenal job in preparing us for the meeting. And Dana, welcome to NQF. I know it's been four months, but it seems like yesterday. Welcome and thanks for everything you did to get this meeting started.

Dr. Pickering: Great, great. Thank you very much. So we'll now move to roll call and disclosures of interest. So just a reminder for folks on the phone, you've received a series of emails from the team asking for you to complete a disclosures of interest form to see if you have any conflicts with the measures under discussion today.

So in addition to doing some introductions here, we'll also be asking you for those disclosures. And if you have nothing to disclose, you can just state that. So bear with me ask I sort of go through this introductory script and then going through the disclosures of interest.

So as a reminder, NQF is a nonpartisan organization. Our of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendoes, 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've combine disclosures and introductions together. We divide the disclosures of interest into two parts just because there's two types of MAP members represented here: organizational members and subject matter experts -- so I'll start with the organizational members which you see listed on the slides here.

Organizational members represent the interest of a particular organization. We expect you to come to the table representing those interests. Because of your status as an organizational representative, we ask that you only -- only one question specific to you as an individual.

We ask you to disclose if you have any interest of 10,000 dollars or more in an entity that is related to the work of this Committee. So we'll go around the virtual table beginning with the organizational members only first. I'll call on anyone on the meeting who is not an organizational member. When I call your organization's name, please unmute your line, state your name, your role at your organization, and anything you wish to disclose. If you did not identify any conflicts of interest after stating your name and title, you may just add, I have nothing to disclose.

So we'll start in alphabetical order and going down the list. And again, I'll do the co-chairs after we go through the organizational members. So I'll start with America's Essential Hospitals.

Member Guinan: Hi, everyone. Maryellen Guinan with

America's Essential Hospitals. I'm a principal policy analyst, and I have nothing to disclose.

Dr. Pickering: Great. Thank you. American Case Management Association.

Member Van Allen: Good morning. My name is Linda Van Allen. I'm the Vice President of Case Management for Tenet Health. And for disclosure, I do receive stock from the for-profit company, Tenet Health, as part of my compensation.

Dr. Pickering: Great. Thank you so much. American Society of Anesthesiologists.

Member Joseph: Hi, I'm Vilma Joseph. I'm a professor of anesthesiology. My role at the ASA is that of Vice Chair of the Committee of Performance and Outcomes Measurement. And I have nothing to disclose.

Dr. Pickering: Thank you so much. American Society of Health-System Pharmacists.

Member Legreid Dopp: Good morning. My name is Anna Legreid Dopp, and I have nothing to disclose.

Dr. Pickering: Great. Thank you. Association of American Medical Colleges.

Member Ramsey: Hi, Phoebe Ramsey. I'm a manager of regulatory policy, and I have nothing to disclose.

Dr. Pickering: Thank you so much. City of Hope.

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

Dr. Pickering: Thank you. Dialysis Patient Citizens.

Dialysis Patient Citizens.

Okay. Circle back. Greater New York Hospital Association.

Member Sumer King: Good morning. My name is Zeynep Sumer King. I'm the senior vice president for regulatory and professional affairs at Greater New York Hospital Association. I have nothing to disclose.

Dr. Pickering: Great. Thank you. Henry Ford Health System.

Member Mudiraj: Hi, good morning. This is Santosh Mudiraj. I'm the quality manager for performance improvement analytics and I have nothing to disclose. Thank you.

Dr. Pickering: Thank you. Kidney Care Partners.

Member Bednarski: Good morning, everyone. I'm Donna Bednarski. I am a member of Kidney Care Partners representing the American Nephrology Nursing Association as a nurse practitioner. And I have nothing to disclose.

Dr. Pickering: Great. Thank you so much. Medtronic.

Member Shehade: Hi, I'm Karen Shehade from Medtronic. In terms of disclosures, I do receive company stock as part of compensation.

Dr. Pickering: Thank you. And Memphis Business Group on Health.

Member Travis: Hello. I'm Cristie Upshaw Travis, and I'm the CEO of Memphis Business Group on Health which works with purchasers in the Greater Memphis area. And I have nothing to disclose.

Dr. Pickering: Great. Thank you, Cristie. National Association for Behavioral Healthcare.

Member Ghinassi: Good morning. Frank Ghinassi, I'm president and CEO of Rutgers University Behavioral Health, and I have nothing disclose.

Dr. Pickering: Thank you so much. Premier Healthcare Alliance.

Member Pittman: Hi, good morning, everyone. I'm Aisha Pittman, Vice President of Policy with Premier. And I have no disclosures.

Dr. Pickering: Great. Thank you. And Press Ganey.

Member Gandhi: Hi, everyone. Tejal Gandhi here, Chief Safety and Transformation Officer at Press Ganey. And as part of compensation, I do receive equity in the company.

Dr. Pickering: Great. Thank you. Project Patient Care.

Member Hatlie: Good morning. I'm Marty Hatlie. I'm the president and CEO of Project Patient Care. We're a small nonprofit organization that works to bring the voice of the patient, family into improvement work. I'm a lawyer by profession. I have nothing to disclose.

Dr. Pickering: Great. Thank you so much. Service Employees International Union.

Member Nolan: Hi, I'm Sarah Nolan. I'm the Deputy Policy Director for Healthcare at SEIU, and I have nothing to disclose.

Dr. Pickering: Thank you so much. Society for Maternal-Fetal Medicine.

Member Gibson: Hi, this is Kelly Gibson, a member of the Patient Safety and Quality Committee for SMFM, and I have nothing to disclose.

Dr. Pickering: Great. Thank you. Stratis Health.

And Stratis Health.

Okay. UPMC Health Plan.

UPMC Health Plan.

Okay. I'll just circle back to one more time. Anyone from Dialysis Patient Citizens on the line? And another time for Stratis Health?

Member Lundblad: Can you hear me now?

Dr. Pickering: Yes, who is that? Sorry.

Member Lundblad: Hi, Jennifer Lundblad. Good morning. I'm president and CEO at Stratis Health, a nonprofit health improvement organization. And we have nothing to disclose.

Dr. Pickering: Great. Thank you. And then UPMC Health Plan?

Okay. These organizations may join a little bit later. So thank you. So thank you for those disclosures. Now we'll move to the next slide for the disclosures of our subject matter experts. And I'll also cover Akin and Sean at that point as well.

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

We are especially interested in your disclosure of grants, consulting, or speaking arrangements but only if you have relevant to the Workgroup's work. So just a few reminders, you sit on this group as an individual. You do not represent the interests of your employer or anyone who may have nominated you for this Committee.

I also want to mention that we are not only interested in your disclosures of activities where you are paid. You may participate as a volunteer on a committee where the work is relevant to the measures reviewed by MAP. We are looking for you to disclose those types of activities as well.

And finally, just because you disclose does not mean that you do not 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 disclosure. And I'll call your name that you can disclose. So let's begin with our co-chairs. Akin Demehin.

Co-Chair Demehin: Hi, Akin Demehin. My day job is policy director for the American Hospital Association. Nothing to disclose.

Dr. Pickering: Great. Thank you, Akin. And Sean Morrison.

Co-Chair Morrison: Hi, I'm Sean Morrison. My day job is Chair of geriatrics and palliative medicine for the Mount Sinai Health System in New York City. And I also sit as treasurer for the National Coalition of Hospice and Palliative Care. And I have nothing to disclose.

Dr. Pickering: Great. Thank you, Sean. I'll go down our subject matter expert list here. Lindsey Wisham.

Lindsey, are you on?

Richard Gelb.

Member Gelb: Retired behavioral health professional and cancer survivor advocate, involved at Yale Medical and National Coalition of Cancer Survivorship. Nothing to disclose.

Dr. Pickering: Thank you, Richard. And Suellen Shea.

Member Shea: Yes, Suellen Shea. I am a senior clinical consultant. And I have nothing to disclose.

Dr. Pickering: Thank you so much. And sorry, Suellen Shea. I recognized that after I said it.

Member Shea: Yes.

Dr. Pickering: I'll circle back to Lindsey.

Member Wisham: Akin, can you hear me.

Dr. Pickering: This is Matt. Is this Lindsey?

Member Wisham: Yes, this is Lindsey. Can you hear me?

Dr. Pickering: Yes, hi.

Member Wisham: Oh, good. Okay. Oh, sorry, Matt. I thought it was Akin. So apologies for that. I was double muted. I should've figured that out sooner.

I'm a senior director with Telligen. My only disclosure is I am a patient representative on the MACRA measure development plan and quality measure index technical expert panel.

Dr. Pickering: Great. Thank you so much, Lindsey. And at this time, I'd like to invite our federal government participants to introduce themselves. They are nonvoting liaisons of the Workgroup. So anyone from the Agency for Healthcare Research and Quality on the line that'd like to introduce themselves?

And our colleagues from the Centers for Disease Control and Prevention.

Dr. Benin: Hi, Matt. Can you hear me? It's Andrea.

Dr. Pickering: Yes.

Dr. Benin: Yep, it's Andrea Benin from the Division of Healthcare Quality Promotion and National Healthcare Safety Network. And just if I could briefly introduce Dr. Ray Dantes who will be filling in for me for several hours this afternoon when I have a conflict --

Dr. Pickering: Sure. Go ahead.

Dr. Benin: -- who's also on the phone. Thanks, yeah. I think Ray is here as well. Thank you.

Dr. Dantes: Yes, hello. Ray Dantes, Medical Advisor to CDC and Associate Professor of Medicine at Emory

University, no disclosures.

Dr. Pickering: Thank you. And then our colleagues from the Centers for Medicare and Medicaid Services.

Just circling back again to AHRQ. Anyone from AHRQ?

And I know that we have Dr. Schreiber on the line from CMS. But is there anyone else representing CMS today?

Dr. Schreiber: Matt, we have a number of people on the line from CMS. I don't know if you need them all to introduce themselves. The teams who support the hospital programs are all on the phone.

Dr. Pickering: Great. Thank you, Dr. Schreiber. No, no need for all of the introductions there. We do appreciate the time from our federal colleagues, our government liaisons. Thank you very much for your participation today as we go through the proceedings.

Well, thank you, everyone, for your disclosures. I'd like to remind you that if you believe that you have a potential conflict of interest at any time during the meeting, please do speak up. You may do so in real time at the meeting. You can message your co-chair or one of the co-chairs who will go to the NQF staff, or you can directly message the NQF staff themselves, myself in particular or other NQF staff on the line.

If you believe that a fellow Committee member may also have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting. Approach one of the co-chairs through a chat or directly message NQF as well. Does anyone have any questions or anything you'd like to discuss based on any of the disclosures mentioned today? And again, you can raise your hand or use the chat box.

Hearing none and seeing nothing in the chat, we'll

proceed to the next slide. So I just wanted to recognize the great work that this team has done in preparing the materials for today as well as these preliminary analysis and agendas, et cetera. So just going down the list, Ivory Harding who's our manager, Ashlan Ruth who's our project manager, Becky Payne, our senior analyst, Joelencia LeFlore, our coordinator, and then Taroon Amin who's our consultant.

So a big thank you to them for all of their work in preparing everything for today's proceedings. And going to the next slide, also thanking our CMS partners here, Kimberly Rawlings and Gequincia Polk, who's been very involved with working with us to get us ready for today's proceedings as well as the other MAP meetings that have gone on previously and still will happen going into the next year. So thank you to our CMS staff as well as Dr. Michelle Schreiber.

And going to our next slide, just talking about the objectives for today. So we will review and provide input on the measures under consideration for the MAP Hospital programs of which there are quite a few. So again, try to keep focus in moving forward through those proceedings.

And then we'll identify measure gaps for the MAP Hospital program. So we've worked in gap discussions with this Workgroup based on programs that have measures submitted to them. If we have time at the very end of the meeting today, we will do a gap discussion for the other programs that did not have measures submitted to them.

And so that's if we have time. We have a lot to go through. So we will make that call as we get closer to the afternoon, those slides for those discussions of measures that did not have -- programs that did not have measures submitted to the program.

They're at the very end of the slide deck. Again, we will use if we have time to go through those. Going to the next slide, any questions from the Workgroup

at this point in time?

Okay. Well, then I'd like to turn it over to Dr. Michelle Schreiber who's the Deputy Director for Quality and Value at CMS to provide some opening remarks and a brief presentation as well. So thank you very much, Dr. Schreiber. I'll turn it over to you.

Dr. Schreiber: Thanks Matt. It's a pleasure. First, can I do a sound check? You can hear me okay?

Dr. Pickering: Yes, we can.

CMS Opening Remarks

Dr. Schreiber: Okay, wonderful. Good morning, everybody. It's really a pleasure to be with you today. I know many of you. I've been at CMS now for three years and have worked with many of you in that capacity.

But for those of you whom I don't know, I'm also a primary care physician by background, have spent most of my career as a primary care doc in the city of Detroit. I have done extensive work with quality, including the Chief Quality Officer of Henry Ford Health System. So hello to my colleagues there as well as Detroit Medical Center. I've been a chief medical officer of large systems.

And so I bring really an extensive background of direct hands-on, both quality and practical experience in large healthcare systems to CMS. As Matt stated, I'm the Deputy Director of the Center for Clinical Standards and Quality. And I'm the Director of the QMVIG group. It's the Quality Measurement and Value-Based Incentives Group.

And it is truly our pleasure to be here today and to listen to your recommendations for measures to be included in the CMS programs. Matt, are you going to advance the slides? Is someone going to advance the slides?

Dr. Pickering: Yes, the team will advance the slides if

you just say next slide.

Dr. Schreiber: Okay. Well, if we can move to the next one, please. So as was already outlined but I'm sure you're aware, the purpose of the measure's application partnership is to have a convened group of experts. And this is really, as Dana pointed out, a multi-stakeholder perspective that we so appreciate to make recommendations to CMS about measures that we're considering putting in the value-based programs.

We really do appreciate all comments, in particular, multiple points of view because frankly these issues aren't always easy and there are usually multiple opinions on them. And we look forward to hearing as many comments as possible. As you all know, the MAP makes recommendations. But in the end, the final authority does rest with CMS.

But I will assure you and I know that we've gone through this on a few occasions, the MAP recommendations are really very meaningful to us at CMS. They do influence our decision making. They influence whether or not measures get put in or removed and then what time and how we may use them.

And so your opinions I will say have personally influenced decisions over the last few years that I've been there. This year, we've had the advantage of several other new committees from the Measures Application Partnership. One was the new Healthcare Equity Committee which was really a robust discussion about how measures may impact equity.

And the second this year was the Measure Set Review where the Coordinating Committee has an opportunity to comment on not just measures to be included in programs but measures to be removed from programs. So I think between adding measures, removing measures, this really helps shape what these programs look like. Next slide, please.

A hospital MAP, as you know, you're recommending measures that may potentially be included in our hospital value-based programs. And they include -- and there's a whole alphabet soup here, but I'm sure many of you are familiar with them -- the Inpatient Quality Reporting which is pay for reporting, Hospital Acquired Conditions which is really complications like the healthcare acquired infections, Hospital Readmission Reduction Program, the Hospital Value-Based Purchasing Program, a net neutral quality program, the Cancer Exempt Hospitals -- there are 11 exempt cancer hospitals in the country that have their quality program -- the dialysis programs which have their quality improvement program, Inpatient Psychiatry, the Hospital Outpatient programs, and the Ambulatory Surgery programs.

So there are a number of programs that are a part of the broader hospital program mix. There are a mix of paper reporting as well as pay for performance. And many of these metrics are also used in the calculation of the Hospital Stars program. And almost all of them are indeed publicly reported. So you just need to think about that as you're weighing in on your opinions about the measures. Next slide, please.

This year, the new administration has put forward the CMS Strategic Priorities that are actually nested within the HHS Strategic Priorities. And you can see that the vision for CMS is and has always been serving the public as a trusted partner and steward, dedicating to advancing health equity, expanding coverage, and improving health outcomes. You can see the pillars of CMS Strategic Priorities starting with as a very top priority advancing health equity by addressing underlying disparities.

And today you'll see several measures that are coming out around social determinants of health and around a structural attestation measure around disparities really as a signal of CMS' firm intent and belief in taking action to try and address health disparities. You can see the other pillars which

include expanding access to quality and affordable care, engaging stakeholders which we are doing today, driving innovation to tackle health system challenges, protecting the Medicare trust so that we're sustainable for future generations, and then within CMS, fostering an inclusive workplace. But I just wanted to make sure that everybody understood the strategic priorities of CMS.

And on the next slide, you can see that there are some key focus areas. First, of course, is COVID and the public health emergency. This continues obviously to be an important topic for all of us in the country. Equity as I spoke to already, equity around access, equity around quality and safety and outcomes, equity about patients getting appropriate referrals and their experiences of care.

So there's a great deal of focus on equity as well as maternal health and safety. Some of you, and I assume the maternal fetal medicine group, certainly watched the Vice President last week as she announced the national collaboratives that going on around maternal health safety. This is a very important topic at CMS.

Others include commitment to improving mental health, resiliency and emergency preparedness. We have all seen the challenges of COVID. And how do we ensure that moving forward we have systems that really are resilient and have a strong underlying capability for preparedness? When we speak of safety, it's not just patient safety but it's safety writ large, including workforce safety.

We have seen what has happened to the workforce, and I'm sure many of you can speak to this or know it personally. But safety is really a very important consideration at CMS. We've witnessed over the past several years during COVID a degradation of some of the safety metrics, such as healthcare acquired infections, the rise and falls in pressure ulcers, and realize that we really need to be recommitting to

patient safety and those metrics.

Digital transformation, many of you have heard me speak about CMS' goal of converting eventually to all digital measures. These can be electronic clinical quality measures or they can be other forms of digital measures such as downloadable devices or information coming from other sources like census information. But we believe that transforming to digital measures that have standard defined data elements that are digital, shareable, and interoperable is really key to driving our quality programs forward as well as healthcare.

This really is a use case scenario of digital data and how important that is to healthcare, and we certainly learned that in the COVID pandemic. Rising on the agenda for CMS are issues of climate change, and I would expect that you will be seeing addressing climate change in the future, and finally, as always, the drive to improve value. Next slide, please.

COVID has been obviously a tragedy for the country for the last several years. And with rising new variants, it looks like it's at least continuing for now. I know I am here in Michigan where we are one of the COVID hot spots right now. And I'm sorry to see that, and I'm sorry to see it continuing to rise across the country.

We've learned a lot of lessons, but we have much more work to go. I would like to just take a moment to pause and say thank you. Thank you to all of you who represent hospitals and providers and patients and other organizations for really the heroic work that has been done during the COVID pandemic. And on behalf of CMS, we'd like to thank each and every one of you.

The value-based programs, were as much as we could, adapted to ensuring that we did not penalize organizations -- hospitals in this case in particular, did not penalize financially the COVID response. And so where appropriate, you probably saw this past

year measure suppression, the recalculation of how we looked at measures in some of the programs actually that remain net neutral. As you can imagine going forward, we're still having conversations about what happened, that's 2020 data, what happens with 2021 data. And just so you know, those conversations are certainly fully underway.

Last year, we considered measures around COVID vaccination, and we had a healthy debate around those. You saw that those were introduced and finalized into rule writing for many of the programs, not just the hospital programs but also post-acute care. And I'm sure all of you know about the ongoing work and now pause for the national vaccine mandates. Next slide.

We've learned a lot of lessons actually about some of the key enablers and the challenges that helped organizations in implementing their response. And really the key enabler was leadership: leadership, culture, and governance, a deep commitment to infection control obviously and infection control expertise, but leadership also around local planning and more importantly coordinating planning within a region, within a state. These have all be absolute enablers for implementation and really better performance.

There are a number of challenges, though. And I think we're all aware of it, including what happened with vulnerable populations. And this is why the focus on equity is even more important after the lessons we've learned from COVID.

We've had challenges around data reporting and around the technical assistance that's provided as well as around the multiple different guidances that perhaps had been issued or adopted. And so there are certainly lessons still to be learned from COVID. But the most important one, I think, has to be protecting our vulnerable populations. Next slide.

So let me spent just a moment of what's new in the

inpatient rules that I'm sure you're aware of. These came out several months ago. As I said, measure suppression and payment impacts for the Hospital Value-Based Purchasing program. All hospitals were held neutral. There was measure suppression for HCAHPS, the Hospital Acquired Infections, Medicare Spending Per Beneficiary, and Pneumonia Mortality. So with suppression of all of those measures, the program was held at a net neutral.

The Hospital Acquired Condition program, this is two-year look back program. So in 2020, that would've been 2019 data and 2020 data. We did not use any 2020 data, but we did calculate the Hospital Acquired Condition program based solely on one year, 2019 data. Moving forward, there are conversations about where we will go with Hospital Acquired Conditions because in this next year, it would include 2020 and 2021 data.

The Hospital Readmission Reduction Program, we had a suppression of the pneumonia measures. And we removed COVID 19 from the denominator. We were still able to calculate the readmission reduction program but with certain exclusions.

Last year, as you recall, we also introduced and finalized into rule five new measures. And most of you may recall the conversations around these, the maternal morbidity structural measure that has hospitals attesting to participation in national quality collaborative that reduce maternal mortality as well as implementation of key actions to reduce morbidity and mortality as well. And you'll see another maternal measure on the docket for today.

We finalized the hospital hybrid wide mortality measure, the COVID-19 Health Care Personnel vaccination measures which we spoke of already as well as the electronic hyper and hypoglycemia measures which are really, again, our path towards electronic clinical quality measures, in this case, safety measures. And there are a number of these

that may be coming forward in the future. Next.

In the Hospital Promoting Interoperability, a few things of great importance including Public Health Reporting. So the support of the mandatory reporting of four of the public health electronic data: syndromic surveillance, immunization registry, electronic case reporting, and electronic lab results. We did this in collaboration with the CDC, and we really think that this will support public reporting and public health.

We also introduced the opportunity for organizations to use Bidirectional Health Information Exchanges as a way of attesting to sharing information. We expanded the number of reporters for electronic quality measures and also finalized the eCQMs will start being publicly reporting. And we included attestation to the safe use of electronic medical records with the review of the SAFER guidelines. Sorry about that. Somebody is at my door, but somebody else will get that. Next slide, please.

Some potential future directions just to keep in mind, again, I think you're going to hear more about maternal health and safety, safety as I spoke of before, including patient and workforce, mental health. And we'll have, obviously, a lot of conversations today about reducing disparities. This is as you saw at the top of the agenda for CMS and the Biden Administration and a lot of action towards moving to reducing those disparities. Next slide.

So again in summary, I thank those of you who others said before, to certainly you as Committee members and the time and the valuable insight that you provide, to our co-chairs, Akin and Sean, always a pleasure. And not that you guys are competitive. But I'm just saying the Physician Committee yesterday ended 11 minutes early. So just something to think about.

To all of you at NQF, certainly to those of you on the phone from CMS as well, there's a lot of behind the scenes work that gets put into these meetings. And

thank you for all of that as well as our measure developers. We're here to answer questions for you today.

So we deeply appreciate everybody's engagement in this, and as I already said, the work that all of you have contributed to and the heroic efforts for COVID. We very much look forward to your comments, your recommendations. I always enjoy these conversations and will really, I think, help shape better programs going forward. And if I don't get an opportunity to say it later, on behalf of CMS, let me wish you all happy holidays as well. Matt, thank you, and I turn it back to you.

Dr. Pickering: Thank you so much, Dr. Schreiber, for all of that. We do have a few minutes. So I don't know if there's any opportunity for questions at this point. We just have a few minutes.

If anybody does have any questions, you can use the raise hand or use the chat box at this point. Obviously, there'll be opportunity for Q&A as we proceed throughout the day on measures. But if there's any questions, you can use the raise hand feature or the chat box. If there's not, we'll just keep going.

Again, the raise hand feature, if you open up the participant list and hover over your name, you'll see the little raised hand.

Okay. Last call. I see Dr. Schreiber. You put a challenge out there for the group to try to finish up on time and they're going to try to keep to it. All right. It looks like Marty had, very nice to see climate change included as an emerging priority. So thank you, Marty. Just a comment there, very nice to see climate change included as an emerging priority for CMS. Thank you.

Okay. Seeing no others, I'm going to go ahead and continue us moving forward. Maybe we can get a little ahead of schedule. So thank you, Dr. Schreiber, for

those opening remarks and that presentation. Again, for the Workgroup, Dr. Schreiber will be around as well as other CMS colleagues and developers to answer other questions related to some of the measures that we'll be reviewing today.

I'm going to turn it over to my colleague, Ivory Harding, who is going to walk us through the overview of the pre-rulemaking approach. And we'll also do a voting test at the end of that. So before we proceed with the presentation, you did receive an email this morning with the voting link, sort of a voting poll survey link.

Please start pulling that up. That is what we will be using today to vote on the measures. So we'll be doing a voting test at the end of this presentation just to make sure everybody is up and running. So just letting you know to look for that email now and get that ready to go for our voting test. But Ivory, I'll turn it over to you and we can go through the overview of the pre-rulemaking approach.

Overview of Pre-Rulemaking Approach

Ms. Harding: Thanks, Matt. Next slide, please. So we will first begin with the preliminary analyses. Next slide. NQF conducted APA for each measure under consideration. The goal was to create a succinct profile of each measure to facilitate the Workgroup discussions and to be used as a starting point. NQF uses APA algorithm that will be discussed in the following slides. Next slide.

This algorithm is generated from the MAP selection criteria to evaluate each measure. This algorithm was approved by the MAP Coordinating Committee. So we will orient ourselves with the assessment. You see the definition of each assessment in the middle and then the outcome.

So the first assessment in the measures addresses a critical quality objective not adequately addressed by the measure in the program set. If the measure

meets its assessment, the review continues. If it does not, the measure will receive a Do Not Support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

For assessment number 2, the measure must be evidence-based and is either strongly linked to outcomes or an outcome measure. The definition is in the middle. If the measure meets its assessment, the review can continue. If it does not, the measure will receive a Do Not Support. And MAP will provide a rational for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

Assessment number 3, the measure must address a quality challenge. If the measure does, the review continues. If it does not, the measure will receive a Do Not Support. And MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization. Next slide, please.

For assessment number 4, the measure must contribute to efficient use of measurement resources and/or support alignment of measurement across programs. If yes, the review continues. If the measure does not meet this assessment, the highest rating can be do not support with potential for mitigation. And MAP will provide a rational for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

For assessment number 5, we look to see if the measure can feasibly be reported. If so, the measure review continues. If not, the highest rating it receives is do not support with potential for mitigation. And MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization. Next slid, please.

For assessment number 6, we look to see if the measure is applicable to and appropriately specified for the program's intended care settings, levels of analysis, and populations. If so, the measure can be supported or conditionally supported. If not, the highest rating can be conditional support. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

Assessment number 7 looks to see if the measure is in current use, no unreasonable implementation issues have been found that outweigh the benefits of the measure that have been identified. If no implementation issues have been identified, the measure can be supported or conditionally supported. If implementation issues are identified, the highest rating can be conditional support. MAP can also choose to not support the measure with or without the potential for mitigation. MAP will provided a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization. Next slide, please.

We will now cover MAP voting decision categories. Next slide, please. MAP Workgroups must reach a decision for each measure, and each decision category is as follows: support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, and do not support for rulemaking.

For support for rulemaking, MAP supports implementation with the measure as specified and has not identified any conditions that should be met prior to implementation. The measure is fully developed and tested in the setting where it will be applied and meets assessments 1 through 6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.

For conditional support for rulemaking, MAP supports implementation of the measure as specified but has

identified certain conditions or modifications that would ideally be addressed prior to implementation. The measure meets assessments 1 through 3, but may need modifications. A designation of this decision category assumes at least one assessment 4 through 7 is not met. MAP will provide a rational that outlines each suggested condition.

Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.

For do not support for rulemaking with potential for mitigation, MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such a modification would be considered to be a material change to the measure.

A material change is defined as any modification to the measure specifications that significantly affects the measure result. The measure meets assessments 1 through 3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4 through 7 is not met.

Lastly, do not support for rulemaking. MAP does not support the measure. The measure under consideration does not meet one or more of assessments 1 through 3. Next slide, please. We will now go over the MAP voting process. Next slide.

Quorum is defined as 66 percent of the voting members of the Committee present virtually for live voting to take place. Quorum must be established prior to voting. The process to establish quorum is constituted of, one, taking roll call, and two, determining if a quorum is present. At this time, only if a member of the Committee questions the presence

of a quorum is it necessary to reassess the presence of the quorum.

If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting. MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting positively and a minimum of 60 percent of the quorum figure voting positively. Abstentions do not county in the denominator. Every measure under consideration will receive a decision. Next slide.

We will now cover the voting procedures. For step 1, after a live in-meeting public commenting opportunity for all measures in the program, staff will review the preliminary analysis for each measure under consideration using the MAP selection criteria and programmatic objectives. At this time, staff will also review input received from the MAP Advisory Groups and from public comments submitted to NQF during last week's online public commenting period.

Step number 2, the co-chairs will ask for clarifying questions only from the Workgroup, including lead discussants who may have clarifying questions. Workgroup members and lead discussants should withhold other comments at this time. Questions will be answered one at a time. Measure developers will respond to the clarifying questions on the specifications of the measure. And NQF staff will respond to the clarifying questions on the preliminary analysis. Next slide.

Step number 3, voting on acceptance of the preliminary analysis decision. After clarifying questions have been resolved, the co-chairs will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a yes or no vote to accept the result.

If greater than or equal to 60 percent of the Workgroup members vote to accept the preliminary analysis assessment, the preliminary analysis assessment will become the Workgroup

recommendation. This will be the end of the discussion for that measure and the Workgroup will move on to the next measure. However, if less than 60 percent of the Workgroup votes to accept the preliminary analysis assessment, further discussion will open on the measure. Next slide, please.

Step 4, if the Workgroup did not vote to uphold the staff recommendation on the measure in Step 3, the co-chairs will open discussion in voting on the MUC. The co-chairs will first ask lead discussants to review and present their findings. The co-chairs will then open for discussion among the Workgroup.

Workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time. After the discussion, the co-chairs will open the MUC for a vote.

The co-chairs will summarize the major themes of the Workgroup's discussion, and the co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from discussions. If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not supp0ort with potential for mitigation, then do not support. Next slide, please.

And Step No. 5, tallying the votes. If a decision category put forward by the co-chairs received greater than or equal to 60 percent of the votes, the motion will pass and the measure will receive that decision. If no decision category achieves greater than 60 percent to overturn the preliminary analysis, the preliminary analysis decision will stand.

This will be marked by staff and noted for the Coordinating Committee's consideration. At this time, we would like everyone to participate on our test question with Poll Everywhere. So for our test

question, what region of the U.S. do you call home? Please select your answers from the choices below: the northeast, the Midwest, the south, the west, Hawaii, Alaska, or U.S. territories.

Dr. Pickering: And thanks, Ivory. So we're looking for 23 on the call. So we're looking for that number. Additionally, we request that you do not share this link through the chat, the Poll Everywhere link, or share it to anyone else via email.

If someone is having issues with their link, please speak up or message NQF directly. And we can provide that link to you. So please do not share that with anyone. This is a private link just for the Workgroup members or the voting members today.

If you are having any issues, please let us know. Looks like we have 22 in. We are sort of expecting 23 based on who's on the call. Is anyone having any issues with the voting link?

Ms. Harding: At this time, the poll is closed. And we will go over the responses for reach question when we have our voting periods. Thank you.

Dr. Pickering: All right. So maybe if we, before we proceed, just pause to see if anyone has any questions. Thank you very much for that vote. Looks like we have everybody up and running with the vote for today. Does anyone have any questions based on what Ivory has mentioned about the decision categories or the voting process? We recognize that was a lot.

And again, for those who have been through this process before and those joining new this year, it takes a little while to get through it. The first couple of measures, once we get into that cadence and comfortable with how this works, it should be flowing pretty well after the first few measures. But does anyone have any comments related to the process or decision categories as Ivory has presented them?

Seeing no hands raised, no questions in the chat, I think we can keep going. Thanks, Ivory. We'll hand it back to you.

Ivory, are you there?

Ms. Harding: Yes. So at this point, we will like to review measures under consideration by MAP Advisory Groups. Next slide, please. So the MAP Rural Health Advisory Group charge, to help address priority rural health issues, including the challenge of low case-volume. The MAP Rural Health Advisory Group would provide the timely input on measurement issues to other MAP Workgroups and committees, rural perspectives on the selection quality measures in MAP. Next slide, please, the Rural Health Advisory Group review of MUCs.

The Rural Health Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on relative priority/utility in terms of access, cost, or quality issues encountered by rural residents, data collection and/or reporting challenges for rural providers, methodological problems of calculating performance measures for small rural facilities, and potential unintended consequences related to rural health if the measure is included in specific program, gap areas and measurements relevant to rural residents and providers for specific programs. The Rural Health Advisory Group was polled on whether the measure is suitable for use with rural providers within the specific program of interest. Next slide.

The MAP Health Equity Advisory Group charge was to provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals. They also provided input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages. Next slide.

The Health Equity Advisory Group review of the

MUCs. The Health Equity Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on: relative priority in terms of advancing health equity for all, data collection and/or reporting challenges regarding health disparities, methodological problems of calculating performance measures adjusting for health disparities, potential unintended consequences related to health disparities if the measure is included in specific programs, gap areas in measurement relevant to health disparities and critical access hospitals for specific programs. The Health Equity Advisory Group was polled on the potential impact on health disparities if the measure is included within the specific program of interest. Next slide, please.

And then the feedback from the Advisory Groups' review of the MUCs. Feedback included the preliminary analyses a qualitative summary of the discussion of the MUCs, average polling results that quantify the Rural Health Advisory Group's perception of suitability from a rural perspective of including the measure within the program and the Health Equity Advisory Group's perception of the potential impact on health disparities if the measure is included within the program. A summary of each Advisory Group's discussion will be provided during right of the MUC during the setting-specific Workgroup pre-rulemaking meetings. Next slide. And now we will review programs and the MUCs. And I will turn it back over to Matt.

Dr. Pickering: Thank you so much, Ivory. So before we go into the first measure, I also just wanted to see if there's any questions one last time from the Workgroup related to what's been discussed up to this point.

Okay. So in advance of some of the discussions today, I also just wanted to tee up that you will notice that in the agenda you'll see cross-cutting measure. So the first measure, for example, is a cross-cutting measure. This means the measure has been

submitted to different programs. So same measure, just submitted to two or more programs. So that's the case for the first measure.

Now in the case for the preliminary analysis is the same, we would ask the Committee after the vote on the first program if they have any objection to carrying over the vote and the discussion points to the next program. So in the case of this first measure and the first two programs, if the Committee votes on the first program in a certain way, say the conditional support for rulemaking and lists out their conditions. If those discussions and conditions are the same and apply to the next program, if there's no objection, we will carry over the votes to that program.

Again, this is trying to make it a little bit more efficient and again trying to compete with the clinician group and try to end a little bit early today for hospital. But if there is an opposition, we will open up the discussion for that specific program. If a Workgroup member -- it just takes one Workgroup member to oppose that carryover.

You do not have voice that on the call if you're uncomfortable doing so. You can message myself directly just to say that you oppose the vote, oppose the carryover. And we will then just continue to proceed to talk about that measure for that program.

So again, after we go through the first program and vote, if there's no opposition to carrying over the vote, the next program because the measure is the same, just a different program, we will carry it over. If there is one opposition, and that's all it takes is just one, you can either voice it on the call or message myself directly. We will then open it up for that program and vote separately for that program.

Okay. So I don't see any other questions, nothing coming through the chat. Okay. So we'll go to the next slide. And then I will turn it over to Sean to start us out with our first measure and going through the

first couple programs. So Sean?

Co-Chair Morrison: Thanks, Matt, and again, welcome everybody. We're going to try and be as efficient as possible.

Matt and Dr. Schreiber noted the possibility of finishing early. Looking at this agenda, I'm worried about just finishing on time. So that is going to be our focus.

And I think as Matt said, we'll get into the flow of this pretty quickly after the first measure, and NQF staff are going to keep me on track, I hope.

We're going to begin with our first cross-cutting measure.

Cross-Cutting Measure: MUC2021-118 Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty

This is MUC2021-118 Hospital-level risk-standardized complication rates following elective primary total hip arthroplasty or a total knee arthroplasty.

We're going to begin with public comment, and I would just like to make a couple of remarks about public comment.

First of all, it should go without saying, but please limit comments to the measure under consideration, in which case this is 2021-118. Please keep your comments to two minutes or less.

If you agree with a comment that's already been stated, there's no reason to restate that.

CMS is really looking for the broadest array of comments and takes everyone very seriously and individually, and piling on five responses to the same thing is not going to change CMS in that way.

If you feel that you want to represent your organization's input on that, simply place agree in the chat, and we will record that.

And again, feel free to either put your comments in the chat if they're short and easy, raise your hand and we will make sure we call on everybody, to the extent that we can.

So with that, let me call for public comment.

Dr. Pickering: Thanks, Sean. And just for members of the public, as Sean has mentioned, you can use the chat feature, or you can use the raise hand feature, again through the participant list, and we will call on you accordingly.

So this is a public comment for MUC2021-118, and this is applying for the Hospital Inpatient Quality Reporting Program, or the IQR Program, or comments related to the inclusion of the Hospital Value-Based Purchasing Program, two programs that this measure's been submitted for.

So opening up the floor. Okay, I'm not seeing --

Co-Chair Morrison: I don't. Am I missing anybody? I don't see hands and I don't see chat.

Dr. Pickering: No, I don't, and thanks for the NQF team, and just a reminder about raising the hand.

So I don't see any hands raised on the participant list and nothing in the chat. I'd like to give it a few more seconds.

Again, just an opportunity for a public comment for this measure, 118 for the Hospital IQR and the Hospital VBP, the Value-Based Purchasing and Inpatient Quality Report.

Co-Chair Morrison: Okay. Matt, could we do the preliminary analysis then on the first measure we're going to be talking about?

Dr. Pickering: We certainly can. So thank you, Sean.

So the measure, as was on the previous slide, we're now going to evaluate for its use within the Hospital Inpatient Quality Reporting Program, or Hospital IQR Program, so just a reminder of that program, its incentive, structure, and goal, as you see listed here on the slide, it is a pay for reporting program and public reporting program.

The hospitals that do not participate, or participate but fail to meet the program requirements will receive a one fourth reduction of the applicable percentage increase in their annual payment update.

So the goal of this program is really to progress towards paying providers based on the quality rather than the quantity of care given to patients, and to provide consumers information about hospital quality so they may can form decisions about their care.

Next slide, please.

So again, this is 118 for the Hospital IQR Program. It's the hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty.

The description of the measure is on the slide there. It estimates a hospital-level risk-standardized complication rate associated with elective primary THA and/or TKA.

The outcome, which is the complication, is defined as any one of the specified complications occurring from the date of index admission to 90 days post date of the index admission.

This is a facility-level measure. The preliminary analysis of this measure was a conditional support for rulemaking.

This is a fully developed and specified measure which addresses a critical and preventable safety event in the hospital inpatient setting.

The measure is currently in use in the hospital VBP program, and was previously active in the hospital IQR program, and has been expanded to include 26 codes to mechanical complications definition.

The measure is otherwise identical to the previous version of this measure, thus the conditional support being pending NQF endorsement of those 26 codes that have been added to the mechanical complications definition.

And just to note, you may have seen in a preliminary analysis the removal of this measure from IQR because of the duplicative nature, but just to remind you, the workgroup participants also -- for those that may be unfamiliar with how the statute works with the IQR to VBP, is that the measure is coming back to the Hospital Value-Based Purchasing, but has to be updated.The measure is updated and put into the Hospital Value-Based Purchasing, but the measure has to go through IQR first and be reported through IQR prior to going into the Hospital Value-Based Purchasing Program.

So that's why it's being resubmitted to the IQR program, is because it has to be used within that program first before going to VBP.

But again, with this update of the measure being 26 codes, that gave it a conditional support from the preliminary analysis pending NQF endorsement.

Additionally, we also had rural health and health equity advisory groups weigh in on this.

There were no major concerns related to the rural health advisory group, and the average rating on a one to five scale -- five being the highest here -- five being the highest, meaning that it has a relative impact to rural health, has importance and priority for rural health -- one to five scale, five being the highest, it received a 4.1 on average from that advisory group.

For health equity, again it's a one to five scale. So this is -- five being that it has the ability to reduce disparities and promote health equity. The average for that advisory group was a 3.1.

As far as the public comments that have been received prior to our meeting today on this measure, they were all supportive, largely just requiring NQF endorsement.

Supportive of this measure, so there are three comments supporting this measure, but requiring NQF endorsement.

So with that, Sean, I'll turn it back to you for any clarifying questions.

Co-Chair Morrison: Thanks, Matt. So now this is to the workgroup.

This is the opportunity for clarifying questions around the measure itself to the developers.

Not discussion, but if you have clarifying questions, specifically from the measure that the developers can answer, now is the opportunity to ask them, and this year what we're going to do is we're going to take one question at a time rather than collating them all, and go one by one.

So let me turn it over to the workgroup, if people have a question.

Dr. Pickering: And you can use your raise hand again, or just put it in the chat, so if you have any clarifying questions for the developer or any clarifying questions on the preliminary analysis?

And it looks like a comment from Jennifer. Nothing to add or ask.

Support of NQF recommendation, validity and reliability and expert, and clinical input all support endorsement. Thank you, Jennifer.

Co-Chair Morrison: All right, Matt. That was 15 seconds, which is the average time a physician gives a patient to talk. It seems forever.

Why don't we move to voting on accepting the work of the preliminary analysis, I think is the next step, correct?

Dr. Pickering: It is. I just want to circle back. So there's a question from MaryEllen. She's --

(Simultaneous speaking.)

Member Guinan: Oh I'm sorry.

Dr. Pickering: Yes, it's in the chat. Sorry, Sean. It's in the chat here, so there was a question.

MaryEllen, can you please remind me the difference between wanting endorsement and the PA recommendation of the standing committee? Between wanting endorsement.

So the PA recommendation of the NQF standing committee. So maybe just to clarify --

Member Guinan: Yeah, sorry, Matt, I think it's been too long. It's been a full year, so I'm getting back into the mix.

The conditional support for rulemaking, and then pending NQF standing committee review, how is that different than if you're asking for NQF endorsement?

Dr. Pickering: So, right. So it's the same. So if you're requiring NQF endorsement, that's the condition under conditional support.

So that's why it's conditional support, and so supporting the measure pending NQF endorsement.

And so it'd be the same thing. It'd be conditional support requiring NQF endorsement. Does that answer your question, MaryEllen?

Member Guinan: So would that be in agreement with

the preliminary analysis, or would that be different in some way? Just the wording.

Dr. Pickering: It would be in agreement with the preliminary analysis.

Member Guinan: Okay.

Dr. Pickering: Conditional support requiring NQF endorsement, or conditional support pending NQF endorsement.

Member Guinan: Okay, thanks.

Dr. Pickering: Yep, thank you.

Co-Chair Morrison: And then just to respond to Linda, you also should have received a copy in the pre-meeting work of the committee's analysis and the measures and the MUCs, and so those codes should be in there, if you'd like to look at the additional -- or not CPT codes, the additional codes, but I'm having a senior moment.

Member Van Allen: Good morning, thank you, it's Linda.

I actually did review the document and I just didn't see it because as I understand, this is expanding those codes.

So I can take it offline. Maybe I'm just missing it in the document.

Co-Chair Morrison: Okay.

Member Van Allen: I'm trying to understand what's changing.

Co-Chair Morrison: And --

Member Van Allen: And is there a substantive change?

Dr. Pickering: Yeah. Great question, Linda. So this is Matt. Is the developer on the line for this measure?

Just because if you wanted to speak to maybe generally what the 26 codes have been updated for the measure to support maybe the committee's discussion?

Is the developer on the call?

Ms. Grady: Yes, this is Jackie Grady. I am the director of the work for measure reevaluation at Yale CORE for this measure and others, as well.

So as a result of our annual process of measure maintenance, you know, we look at new codes and existing codes under surveillance, and our clinical experts agree that this set of codes should have been included with the mechanical complications.

And just to give you a flavor for what those codes are, there's a number of fracture codes that follow the insertion of orthopedic implants, so those seem to be, you know, something that would obviously be includes as a mechanical complication.

And then there's a number of periprosthetic fracture codes that we would like to add as a result of, as I said, our measure surveillance. So hopefully that helps.

Co-Chair Morrison: Terrific.

Member Van Allen: Yes, thank you.

Co-Chair Morrison: Does that help, Linda?

Member Van Allen: Yes, thank you.

Co-Chair Morrison: Great. All right. All right, Matt, I think we can move to a vote on the recommendation of NQF staff.

Dr. Pickering: Yeah. Actually, Sean, I did see a hand just come up from Marty.

Co-Chair Morrison: Oh, okay.

Member Hatlie: Thanks, Matt. Thanks, Sean. I feel

like I should know this but I might need a refresher, too.

When we vote for conditional support for rulemaking and the condition is endorsement, how long a process is that?

Is that a month, is that six months, is it a year? What's the time frame for the endorsement process?

Dr. Pickering: Yeah, and Sean, I can take that.

Co-Chair Morrison: Yeah, it just came up.

Dr. Pickering: Thanks for the question, Marty.

So it's about nine months to go through the full endorsement process, so that's submitting the measure, and then it gets evaluated by our standing committees, and then goes through a series of other evaluations, including a final recommendation for endorsement.

It takes about nine months to go through the endorsement process.

Member Hatlie: And then Matt, once it goes through that process, then it goes to CMS, can you give me an estimate of like the typical time from endorsement to implementation? Is that usually within a year?

Dr. Pickering: So I would maybe see if Dr. Schreiber would want to pick that one up for the implementation aspect of endorsed measures. Yep.

Dr. Schreiber: So thank you for that, Matt. Marty, we don't necessarily have to wait for endorsement in order to implement the measure.

So for example, if the committee supported the recommendation of conditional support, we would feel comfortable proposing it in rule writing -- in the next rule writing cycle, which frankly starts in a few months.

Member Hatlie: Terrific. Perfect, thanks, Michelle.

Co-Chair Morrison: Okay, Matt, I'm trying again.

Dr. Pickering: Okay. Just taking another through the chat here.

There was a question from Cristie Travis about what year is the measure being considered for inclusion by CMS?

Dr. Schreiber: Oh, if this were to go into rule writing, we would first propose it in the IQR program because by statute, new measures have to go into the IQR program before they can go in the VBP program.

So we probably have a period of time of a little overlap.

It would go first then into the IQR program for at least one year, and then be proposed into the VBP program.

Member Travis: If I can just ask a clarifying question, Michelle? What do you think the first year -- if it were to go into rulemaking, what would be the first year you would have it in an IQR?

Dr. Schreiber: So if it got proposed, Cristie, in 2022, it would be implemented and publicly available for reporting in 2023, and in 2023, we would propose it in VBP for inclusion in 2024.

Does that make sense?

Member Travis: Yes, it does, thank you.

I was trying to put that together with the length of time to takes to get something endorsed. So trying to see those parallel lines. Thank you.

Co-Chair Demehin: Hey, Sean, do you mind if I take my chair hat off for just a minute and --

(Simultaneous speaking.)

Co-Chair Morrison: Absolutely not, go ahead.

Co-Chair Demehin: Thanks. So, you know, in terms of the preliminary recommendation, it seems to me just reviewing the details behind the measure and the algorithm that we have established, it seems like the right one.

I guess my comment would be just a bit more general for CMS, and that is because this measure already exists, and is already publicly reported, I would just urge you to be cognizant of the need potentially to do some messaging around why measure performance might change.

It looks the overall change is pretty small here.

But that being said, you know, a change across the average of all hospitals, that may not necessarily be the case for all hospitals.

Some hospitals are going to see a much bigger change. So whenever it comes time to publicly report the data, I would just be cognizant of that.

Just be prepared to help folks understand why that might be the case.

Dr. Schreiber: Thanks, Akin. That's actually a very, very good comment. Just to remind the group why we sort of do it this way.

When measures have a substantive change to them -- so in this case, there's 26 new codes that are added -- this is considered a substantive change.

That revised measure comes back through the MUC process and the MAP process and goes back in rule writing to be introduced into these programs.

So that's why, you know, you're saying we have a measure. It's in the VBP program. Why is it back and we're going through this?

It's because the measure is being substantively

changed, so we kind of restart the clock, restart putting it back in IQR, we're closing it for VBP, but that's why, because it's a substantive change.

For minor changes, we can do that without rule writing and without restarting this clock.

But your comment about that you might see different performance levels, Akin, is important.

Co-Chair Morrison: Thanks, Akin. Thanks, Michelle. And I gather Phoebe from double A MC, hand raised?

Member Ramsey: Yes, and I think a question that kind of follows off of Michelle's response, and that is, with the changes in shifting care, especially for these procedures in terms of opening up into the outpatient setting, would any changes to the measure regarding risk adjustment, if needed, if we see a different population that is inpatient for these procedures, would that be a similar change that would then go through this sort of review and go through the IQR first, before the VBP?

Dr. Schreiber: So let's just say, Phoebe, that you wanted to use this in an ambulatory surgery program, for example, where, you know, procedures are moving towards the ASC, that would probably come back as a separate measure because it has to be specified for an ambulatory surgery cohort.

Member Ramsey: Perfect. Thank you.

Dr. Schreiber: I think that's what you were driving at, if I'm not mistaken.

Member Ramsey: Yeah. Just kind of where we're -- we don't really know what's ahead in terms of which patients are going to go to which setting, and how these measures might need to be modified.

Dr. Schreiber: Absolutely.

And it's really an important question especially as the inpatient only list sort of gets modified, that more and

more of these procedures may in fact be done outpatient, so it's an important topic.

Finally, I want to note that the Yale CORE group by the way is looking at, and is going to try and post -- I think they may have just posted it -- a list of all the codes in the chat.

Co-Chair Morrison: In fact, they did. Thank you, Yale group. Matt, are there any other hands that I can't see?

Dr. Pickering: No, Sean, no other hands, and I also don't see any other questions that have come through in the chat.

Co-Chair Morrison: All right, so we're going to do our first vote, which is to vote on whether we accept the preliminary analysis?

So we go to the poll everywhere screen.

Dr. Pickering: Correct. And just a reminder that the condition here that you're voting on -- so it's conditional support for rulemaking -- is the decision category, and the condition is NQF endorsement. So pending NQF endorsement.

Go ahead, Ivory.

Co-Chair Morrison: And to be crystal clear, if you support the preliminary analysis, you vote yes, if you do not support it, you vote no.

And just vote once, please.

Ms. Harding: Voting is now open for MUC2021-118, hospital-level risk-standardized complication rate following elective primary total THA and/or TKA for the Hospital IQR Program.

Do you vote to support the staff recommendation as the workgroup recommendation? And it looks like everyone has voted.

Dr. Pickering: So if we could just pause real quick, Ivory?

I see we have 24 votes, where originally we had 23 on the call. Has anyone joined the workgroup that we didn't recognize during roll call?

I know we had Dialysis Patient Citizen and UPMC that weren't originally on the attendance. Has anybody joined?

Co-Chair Morrison: Somebody must be from Chicago, then.

Member Hatlie: This is Marty. I am from Chicago, and I might have voted twice because I clicked yes twice.

Member Ramsey: This is Phoebe. I didn't have a link for the test pool, so I didn't partake in the first one.

Dr. Pickering: Okay, so maybe that was probably it. And sorry --

(Simultaneous speaking.)

Member Nolan: And I'm from Chicago, but I didn't vote twice.

Dr. Pickering: Okay. All right, so I thank you, Phoebe, for that. All right, just to confirm, anyone else?

Okay. So we'll close the vote. Go ahead, Ivory. Sorry.

Ms. Harding: Okay. The vote is now closed for MUC2021-118, and the responses are as follows.

Twenty four members voted yes to support the staff recommendation as the workgroup recommendation.

Dr. Pickering: Okay.

Co-Chair Morrison: Wow. Well done, everybody.

So Matt, now we vote whether we move this forward to the next program. Is that correct?

Dr. Pickering: So, right. So what I'll do is I'll summarize the next program, and I'll summarize the PA for that.

If there's no opposition to carrying over the votes, we'll carry over the vote and we don't have to vote on that.

One member of the workgroup, if they do not wish to carry over the votes, you can either voice up, say it in the chat, or directly chat myself that you oppose carrying over the vote.

So we can go into the next program, so again it's the same measure submitted to the Hospital Value-Based Purchasing Program.

So this is a pay for performance program.

The amount equal to two percent of base operating diagnosis related group or DRG, is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments.

So the goal of this program is to improve healthcare quality by realigning hospitals' financial incentives and provide incentive payments to hospitals that meet or exceed performance standards.

So going to the next slide, same information that's on the next slide about the measure, it's the description of the measure. And you can see that there's still conditional support for rulemaking.

So the condition here is due to that this is a fully developed and specified measure, which addresses a critical and preventable safety event in the Hospital Value-Based Purchasing Program.

The measure is currently in use and has an expanded set of 26 codes to the mechanical complications definition.

Those codes were added into the chat by Yale, so thank you Yale. And the measures are otherwise

identical to the measure that's currently in the HVB -- VBP programs.

So the condition here is again, pending NQF endorsement, so the conditional support is pending NQF endorsement, and we've heard from CMS Dr. Michelle Schreiber about the trajectory or timeline for this, going into this program, and why it's going into the IQR program, and then going to a VBP.

So there was also rural health, evaluating this, and as well as the health equity group.

No major concerns for rural health. It was an average of 4.1 on that one to five scale, and an average for the health equity group being a 2.9 on the one to five scale.

So again, the higher the better, being more aligned with rural health, or more aligned with promoting health equity.

As far as the public comments, the same thing. Support of comments pending NQF endorsement. So three comments submitted pending NQF endorsement, in support of the measure.

So at this time, as Sean has mentioned, if you are opposed to carrying over the votes -- so that would be, you know, 100 percent of those votes being approving or agreeing to uphold the preliminary analysis category.

If you oppose carrying those over to this program, speak up now, or directly chat myself or send it through the chat, and if there's no opposition, we'll carry over those votes, and that will end any discussion on this measure for this program.

So please go ahead and speak up, or directly chat. I'll give it a few seconds. Again, if you are opposed to carrying over the vote, you can just say yes, opposed, and we won't do that. One last call. So I got a -- it's a message from Jan saying yes in the chat.

I'm sorry, Jan, was that in regard to in opposition or in favor of carrying over? I'm not sure. Oh, responding.

Co-Chair Morrison: Jan, can you --

Dr. Pickering: Oh, it looks like Jan's responding to a private chat from us. Okay.

Co-Chair Morrison: Okay.

Dr. Pickering: Never mind.

Co-Chair Morrison: Okay. So I don't hear any objections then, so I think we can move to carry the measure over.

My job now is to call for lunch, but since Dr. Schreiber has gotten us ahead of schedule, I don't know, Matt and Akin and team, whether you want to push through to do one more measure lunch, and have lunch around 1:07 -- or 12:07?

Dr. Pickering: So let me just confirm with the team. Just make sure -- the reason why is we do have a lot of individuals from the public --

Co-Chair Morrison: Right, can --

(Simultaneous speaking.)

Dr. Pickering: Keeping an eye on her agenda.

So I'll confirm with the team, but I'll just before we make that confirmation, so I will just confirm that the votes from 118 from the Hospital IQR Program, which we're 100 percent yes to uphold the conditional support for rulemaking pending NQF endorsement, have been carried over to this measure, the same measure, 118, Hospital-level risk-standardized complication rate following elective primary total hip and/or total knee arthroplasty, to the VBP program, so those votes will be carried over.

Thank you very much to the workgroup. So let's see.

## Cross-Cutting Measure: MUC2021-131 Medicare Spending Per Beneficiary Hospital

So the next measure we have is the MSPB measure, so that is MUC-131. I'm just confirming one last time here.

Are the teams chatting? Just making sure that we are -- we're really ahead of schedule, which is great.

Co-Chair Morrison: Don't jinx us.

Dr. Pickering: Yeah. Okay, so I think --

Dr. Schreiber: I'll caution you, Matt, that the Clinician Committee was ahead by an hour yesterday, and that it didn't matter. They used the time.

Dr. Pickering: Okay. So I think we are okay to do the MSPB measure. I want to be sensitive to the next set of measures for the IQR program.

Those have a lot of the health equity measures, which we anticipate having a lot of discussion around. So let's proceed with the MSPB measure.

I just want to check in. Is the developer for this measure on the line for the Medicare Spending Per Beneficiary measure?

Dr. Ruiz: Hello Matt, we are.

Dr. Pickering: Fantastic, thank you. Okay so we'll go ahead and proceed with the MSPB measure, so thank you all for being ahead of schedule, and I just want to thank you, Sean, for kicking us off.

Now it's going to be Akin, so again, this is a cross-cutting measure. It has been submitted to the IQR program and also to the VBP program.

Very similar, as we've heard before, this measure had been removed from the IQR program due to the duplicative nature of its existence in that program, but updates to this measure require that it be

submitted to the IQR program prior to going to VBP.

We heard those timelines that Dr. Schreiber had laid out for the previous measure, which would also apply to this measure, as well.

So Akin, I'll turn it to you to kick us off, and see if we have any comments from the public.

Co-Chair Demehin: Sounds good. Thanks, Matt. So Sean covered the ground rules for public comment previously, but let me just briefly reiterate that if you do want to make public comment, please limit it to the measure under consideration right now, Medicare Spending Per Beneficiary.

Please do limit your comments to two minutes, and you're welcome to either enter comments into the chat, or if you're on the phone, you're welcome to make them live, as well.

So let me pause here and see if there are any public comments on Medicare Spending Per Beneficiary.

Going once. Okay. Matt, let me kick it back to you to talk through the preliminary analysis.

Dr. Pickering: Sure. I will do that. Before I do, MaryEllen, did you have a process question? You had your hand raised just briefly, and then you sort of messaged me.

Member Guinan: Yeah, thanks, Matt, and I love the efficiency so I don't want to take up time, but setting up for the rest of the day, I just want to have an understanding in terms of what's being documented, the discussion before we have the vote on the preliminary analysis because it sounds like we're having discussion before that vote.

That's all included, correct, or is it, or if we want to have discussion on the measure, do we have to vote no to the NQF preliminary analysis?

Dr. Pickering: So it's a great question.

So the discussion that happens before the vote is clarifying question, so if you have any questions that weren't very clear to you as you were reading the specifications of the measure, or what's been provided around the measure, in the measure submission information that's within the preliminary analysis.

Or, if you have clarifying questions related to, well, why did the preliminary analysis NQF voted as conditional support for rulemaking? What was the condition or how did you interpret it this way?

So anything around interpretation of the preliminary analysis and the decision category that's been presented, those are clarifying questions that also can be asked during that time.

So questions related to, you know, the specifications of the measure, maybe some better understanding of why the measure is listed the way it is, for example.

Some of the other questions around how this could apply to the program, just clarifying questions in that way, as well as preliminary analysis and decision categories.

If you disagree with the decision category, please vote no. If you vote no, and less than 60 percent are in favor of keeping the conditional or the decision category, it opens up the measure for a different decision category vote.

So that's where lead discussants will come in and discuss the matter, any concerns that they have, any questions that they have, if they do have any, and the rest of the committee members can also then discuss the measure in more depth.

So the clarifying questions is just to clarify any questions that you have related to understanding the measure a little bit better, but if you disagree with the decision categories in the preliminary analysis, then please vote no, and if, you know, a larger

number of folks vote no, then we would open up the measure for further discussions with the lead discussants and the rest of the workgroup, and then assigning a different decision category and voting on that accordingly.

So that's --

(Simultaneous speaking.)

Co-Chair Morrison: And that was my fault, MaryEllen.

We strayed slightly over into discussion rather than clarifying questions, but not enough that I thought it was going to be at the time, a big issue, but I hear what you're saying.

Member Guinan: Yeah, I think that, because I think there were good points Akin, Phoebe, in terms of kind of, yeah, larger context that I don't know if I put them into the clarifying category of the measure.

So I just want to make sure I'm voting correctly in terms of getting a full discussion. So thanks.

Co-Chair Morrison: Yeah, and MaryEllen, that's what the chat function is for also, that if there is something like that that you feel is not clarifying but you want to make recorded, drop in the chat and one of us will read it so we make sure it goes into the record.

Member Guinan: Will do, thanks.

Co-Chair Demehin: Yeah, so in other words, Matt, you know, if folks have comments they want to offer that don't necessarily change the recommendation that they want to support, they can make them in the chat function, they can make it during the clarifying question section, and the staff are going to capture that in some fashion, right?

Dr. Pickering: Correct. That's correct.

Co-Chair Demehin: Okay. And Cristie, I believe that answers your question, what if you agree with the PA

but still want to share comments with CMS and the committee? That would be the same approach.

Member Travis: Yes. Thank you.

Dr. Pickering: Thank you.

Co-Chair Demehin: Perfect.

Dr. Pickering: All right. So thanks for that. Just want to make sure we're good. So I will then talk about this measure for this program.

Again, this is the IQR program, paper reporting, public reporting.

So hospitals that do not participate or fail to meet the program requirements received a one fourth reduction in the applicable percentage, increase in their payment update.

So you can see the goal of that program listed there, which we stated previously. So we will go to the next slide, which is the description of the measure, as well.

So this is the Medicare Spending Per Beneficiary, or MSPB Hospital, so it's for the Hospital IQR Program. It's MUC2021-131.

The description is the measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital, and assesses that the cost of the -- to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during the MSPB episode, which is comprised of the periods three days prior to, during, and 30 days following a patient's hospital stay.

The measure is not condition specific and uses standardized prices when measuring cost. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B, and who are discharged between January 1 and December in the calendar year.

In the short-term, acute hospitals paid under the Inpatient Prospective Payment System, so this is a facility level measure. This did receive conditional support for rulemaking.

I'll also just add, this is an updated version of the risk adjustment and payment standardized MSBP hospital measure that has been in the Hospital Value-Based Purchasing Program since 2012.

The measure was reevaluated last year with two refinements that were informed by a technical expert panel and previous stakeholder comments to include episodes that are re-admissions, and to adjust the measure calculation.

The developer notes that costs are only ever included once per episode, so there is no double counting of costs with this refinement.

This updated version of the measure was reviewed by NQF and received endorsement a few months ago.

The measures before the measure application partnership for both the IQR and Hospital Value-Based Purchasing Programs, as there are statutory requirements as we stated previously around both programs prior to inclusion in the HP -- VBP.

The updated measure must go to the IQR for public reporting for one year. It would then be able to be replaced, the version that's currently within the VBP program with the updated measure.

So by statute, there must always be a cost measure in the VBP program, so the process of going from IQR first is the only way for the updated measure to be used incorporated into the VBP program, as we've stated previously.

With this conditional support, so this MSPB measure was removed from IQR beginning in 2020.

In order to reduce that duplication with the measures in the VBP program, but as we stated, due to the

statute, this is the process that the measure needs to follow to be added to the VBP program as an updated measure.

So this was endorsed by NQF in June of 2021, and this did receive conditional support for rulemaking, and the conditions here -- it's during the time of the preliminary analysis, was pending the resolution by CNS of any particular duplication concerns that result in reintroducing the measure.

So that was a conditional --condition for the measures, pending that resolution of that duplication, which we have thus discussed and presented accordingly to you.

So you could still have that condition if you'd like, but that duplication issue has been resolved through that information about the statute.

So if there's other conditions that the standing committee would like to propose, they can do so, or change the decision category.

For the Rural Health and Health Equity Advisory Groups, rural health, that one to five scale, the average was 3.7

There was discussion that this measure is not addressing the needs of a number of rural hospitals, however, the developer during that meeting did clarify that there are some critical access hospitals that are included within the measure.

The measure was also removed from IQR to make room for the updated versions, and this updated version, the measure would go first into IQR, and then into VBP, so that was what was discussed during the Rural Health Advisory Group.

And then health equity, on a one to five scale, it was a 2.9 for health equity. And then for the public comments that have been received prior to our proceedings today, one supportive.

It was a conditional support pending NQF endorsement, but again this measure did come through NQF endorsement just recently this year, and wasn't endorsed in June 2021.

There are also two non-supportive comments or commenters. There's concerns that there isn't adequate justification of why the waiting of the risk adjustment for hospital episodes was changed.

There was concerns about the scientific acceptability of the measure based on the risk models fit, and the unadjusted and adjusted r squared values, ranging from .11 to .67.

And there were some recommendations through those non-supportive comments of moving to a do not support with the potential for mitigation.

And then lastly, just concerns with the risk adjustment approach to determine whether there was inclusion of social risk factors.

So I will stop there to see, and turn it back to Akin for further discussion from the workgroup on clarifying questions.

Co-Chair Demehin: Thanks, Matt. It looks like we have Cristie with a hand up. Go ahead, Cristie.

Member Travis: So I just want to ask the clarifying question to kind of clarify the status.

The preliminary analysis recommendation still stands at conditional support for rulemaking with a condition around the resolution of how it would move into the programs, if I remember correctly.

And I apologize. I don't have it in front of me. But we've had that resolved, so the only way for us to -- if that was our only concern as a committee member, it would be to vote no?

I'm trying to figure out, you know, what would I vote for if I consider this a resolved issue. So just helping

me understand that would be good, Matt.

Dr. Pickering: Yeah. Akin, if you want, I can take that, the process question.

Co-Chair Demehin: Go for it.

Dr. Pickering: Yeah. Thanks, Cristie. So, correct.

Since the condition here in the preliminary analysis was the resolution of that added measure back after it being removed due to duplication issues, since that has been resolved through the discussions that we've had today, and the committee agrees with that, the workgroup would agree with that, it would not uphold the preliminary route and analysis recommendation.

So you would vote no for that, and then if you decide to change it in any way, if you want to support the rulemaking or something else, then we would open up the vote for supporting for rulemaking or whatever decision category the committee would like to select outside of conditional support.

However, if there are other conditions that have not been recognized through this preliminary analysis that the committee would like to see with this measure, we can keep the conditional category decision, and then just add on the additional conditions that the committee feels would be needed for the measure.

So if there's no other conditions, the committee would vote no and then change the decision category accordingly to how the committee would like to proceed.

Member Travis: Thank you.

Co-Chair Demehin: Okay, it looks like we have a couple other hands up. Phoebe, why don't you go?

Member Ramsey: Sure.

So I actually have a duplication concern that's

outstanding that I wonder if CMS could speak to it, and that is, so we currently have a version that's publicly reported on Care Compare from the VBP.

If there's a period in time when there are two versions of this measure, one in the IQR and one in the VBP, which would be publicly reported, and/or would they both be publicly reported?

I guess just trying to understand how that would work if there are two in play at the same time in different programs.

Dr. Schreiber: Grace, I know you're on the line, I'm going to ask you to answer that, if you could.

Ms. Snyder: Sure, I'm happy to address that question.

So in practice -- and we have had to do this with other measures previously, that we've had to make significant updates to -- so I think some of it is also -- it's really related to the statutory requirement for the hospital VBP program, that any measures used for hospital VBP are first publicly -- are specified under the Inpatient Quality Reporting Program and publicly reported for a year.

And so it does sort of -- for practical purposes, it does create a short period of time where we are using two versions of the measure.

You know, we would do a lot of outreach and education to make sure stakeholders understand what the differences are, and then moving forward, we would use the updated version of the measure.

But at the same time, we prefer not to have a gap, not using either measure.

So I think we would for public reporting -- for the, like, our Care Compare website purposes, we would use the updated version of the measure, and that would allow us to also meet the statutory requirement of at least a year of public reporting so

we can then use that updated version for the hospital VBP program.

Hopefully that made sense.

Member Ramsey: That definitely makes sense, and I think that I was more concerned that patients were going to see two different values and try to reconcile that, and that could be really confusing.

Ms. Snyder: Yep, that's definitely a concern, and so our plan is to do a lot of outreach and education to try to minimize that risk.

Co-Chair Demehin: Thanks, Grace. I have a couple more hands up. Jackson and then Sarah?

Dr. Pickering: This is Matt. There's a J. Williams. Is that Jackson Williams with their hand raised?

Co-Chair Demehin: And if you're speaking, you're muted.

Dr. Pickering: So we'll message -- hello, are you there?

J. Williams?

Co-Chair Demehin: Why don't we come back? Oh.

Dr. Pickering: Yeah, we'll come back, Akin. We'll message J. Williams directly.

Co-Chair Demehin: Okay. Sarah?

Member Nolan: Yeah, just a very technical process question about the voting. Not to beat a dead horse, but if the proposal is conditioned on one condition, and that condition has been met, can we vote for the proposal knowing that the condition has been met and it will move ahead, or do we have to vote no and change the proposal to straight up endorsement?

In other words, isn't it kind of six of one half, dozen of the other, as long as that's the only condition?

Dr. Pickering: Yeah. So --

Member Nolan: I'm from Chicago, so I just wanted to be told how to vote.

Dr. Pickering: Thanks, Sarah.

So just following our process, if there's no condition or the condition has been resolved from the workgroup's standpoint, then we would need to vote no for the PA condition, and then change it to a different condition of categories, a different decision category.

So if that would be support or something else, we would need to vote no on the conditional support as it is now, and then open it back up for another vote on a different decision category.

Now to state that, the conditional support category doesn't have to just be the condition that's in the PA.

If there are other conditions the workgroup would like to see, we can add those on, and then continue to vote to uphold the current decision category that's in the PA.

Member Nolan: Thanks.

Dr. Pickering: Loving the Chicago jokes today. That's great.

Co-Chair Demehin: There are a couple of comments and questions in the chat function that I do think are worth us talking through live. First, this from Christie indicating that the preliminary analysis supports the use of MSPB for VBP but conditional support for the IQR.

Matt, I don't think that Christie is misreading that. I believe that is correct and I believe it's for some of the reasons we've been talking about in terms of the duplication of reporting between IQR, VBP, and the fact that this measure was removed from the VBP program. Or, at least, the prior version of this

measure was removed from the IQR program. Correct?

Dr. Pickering: You are correct. You are correct. The reason was because of the removal of the IQR and that's why it's receiving conditional pending that resolution. However, for VBP there was an update to this so it was support for rulemaking. Because of that update, it has since been endorsed. That's correct.

Co-Chair Demehin: Thank you. Then there's a comment here from Denise around whether the focus on addressing social determinants have helped make a fact measure performance here, which I think is a good and valid point. I'm also seeing a couple of hands up here. Let's take Linda and then -- were we ever able to get Jackson's audio working?

Member Williams: This is Jackson again. Am I coming through now?

Co-Chair Demehin: Now you are, yes. Please go ahead.

Dr. Pickering: Jackson -- sorry, Jackson. Didn't mean to interrupt. You are Dialysis Patient Citizens. Is that correct?

Member Williams: Yes, I came on a little late. I'm attending a conference in San Diego. You can see I'm sitting in a hotel room. I apologize for that background.

Dr. Pickering: It's okay, Jackson. Thank you so much for taking the time to be on the call today. Since we missed you on the disclosures of interest, could you just state your name, your role within the organization, and if you have anything you would like to disclose that could be a potential conflict of interest for the measures under discussion today.

Member Williams: Sure. I'm Jackson Williams. I'm the Vice President for Public Policy at Dialysis Patent Citizens so I'm the staff. I am not a patient myself.

No, I have nothing to disclose.

Dr. Pickering: Great. Thanks, Jackson.

Go ahead.

Member Williams: So my question was one of the commenters had raised concern about the social needs so I was curious whether there is any correlation that's been shown between performance analyst measure and the deprivation in the area where the hospital is located.

Co-Chair Demehin: I think that's a question more for CMS or possibly for the measure developer.

Dr. Schreiber: I think, to my knowledge, no, but let me ask Acumen if they have done that.

Dr. Ruiz: Hi, this is David. Yes, as part of the social risk factor testing in the very recent NQF reendorsement process we did actually include the ADI index within our models to determine the overall impact and whether we could actually disentangle that between any potential provider and patient-level effects.

The testing that we went through with NQF recently was the prior year's data and we actually updated it for this map as well and found similar results which was that the impact was extremely minimal with and without that index in there and high correlations basically between the original measure and the measure with the ADI control. So, yeah, we did look at those kind of correlations. Not correlation with the index itself and the measure but trying to introduce it to see the impact it would have on capturing costs.

Member Williams: Thank you.

Dr. Pickering: Thanks.

Linda.

Member Van Allen: Thank you. Representing the

American Case Management Association, the question or concern -- I guess it's more a concern I want to express -- as I understand this measure, the episodes were expanded to include all-cause 30 day readmissions.

The concern is the overlap, or potential for double counting, if you will, the other rehospitalization and excess-day measures.

If there is any way you can speak to that concern, I will take that back to the ACMA. Thank you.

Dr. Ruiz: Thank you for that question. To clarify, the rehospitalizations were already counted within the measure within the 30-day post discharge period and the modification for the measure was to allow that rehospitalization to trigger a new separate episode.

So allowing for this new triggering of episodes isn't double counting because the hospitalizations only counted once per episode and these episodes are not like summed up, stacked up in that sense, but contained within the episode itself so it's an averaging and allows us to also follow the care continuum further.

In addition, I would note as part of that modification in that newly-triggered episode from the rehospitalization, we do include a control to indicate that this was a rehospitalization so as not to negatively penalize that particular hospital. So if the patient went from hospital 8B for whatever reason, during that readmission B wouldn't be necessarily negatively penalized for any kind of potential missteps in hospital A.

We also during the endorsement process recently, we did provide a lot of different statistics looking across different risk deciles of patients and saw that with this modification while we did expand the measure surveillance by, I want to say 15 percent, but it might be 15 to 17, I would say, in terms of the number of episodes that were included.

We also saw that those discrimination statistics show that we weren't over or under estimating any of these risk deciles even for the most riskiest of patients or the least riskiest of patients. Hope that answers the question.

Member Van Allen: That's all. Thank you.

Co-Chair Demehin: All right. Any additional clarifying questions on this measure? Then I want to turn to sort of the process of voting on the recommendation.

Before we move there, I want to follow up on one thing that you said, David, around the double counting, I guess I'm a little confused about whether a new episode is triggered by readmission to the same hospital or to a different hospital, or could they be triggered by either one of those things?

The reason I ask that is if you have an index episode attributed to hospital A and you kick off an additional episode at hospital A that's a brand new episode, I'm finding it a little hard to track that it's not double counting. Can you clarify, please?

Mr. Nagavarapu: David, this is Sri from Acumen. I want to jump in real quick and, David, feel free to follow up.

Essentially, as David noted, each episode's observed costs are compared to the risk adjusted expected cost of that episode. The actual measure score is a ratio observed to expected cost, rather than just an adding up of cost.

For your specific question, a readmission that occurs at the same hospital, let's say 20 days after the initial discharge, would still trigger its own episode. But the sense in which there is no double counting is that the observed costs for that episode are first compared to the expected cost of an episode that's a readmission.

That ratio is constructed and then the measure is based on the average of those ratios. There's no

double counting in the sense that costs are not being added up and counted twice. Instead, costs are always compared to expected cost of an episode.

As David mentioned, we had a chance to discuss this question pretty extensively during the AQF endorsement process and look for any sort of discrimination statistics that David mentioned to show that the risk adjustment approach accounting for prior admissions to indicate that an episode as a readmission does neutralize the sorts of concerns that people initially had before that discussion.

David, was there anything that you wanted to add to that?

Dr. Ruiz: Yes, thank you. I seem to have a stuck mute button here. One thing that I would add to Sri's note here is that this kind of change also goes hand in hand with the measure calculation change that Matt had noted. Indeed, that's where we went through and ensured that episodes were first compared -- their observed cost was first compared to the expected cost. Previously, in the previous measure, these were summed up initially and so if we had made the readmission change without making the measure calculation change as well, then there might -- that might have led to that double counting, the stacking or summing up of these kind of costs.

However, with the change in hand, it doesn't because we are comparing it with the risk adjustment model that has shown great discrimination statics first and then taking some of those ratios to calculate the measures for.

Co-Chair Demehin: All right. Linda, I see your hand is up. Let's see if we can make this the last sort of clarifying question before we move to voting.

Go ahead, Linda.

Member Van Allen: Thank you. I appreciate the opportunity to ask one more question to clarify as I'm

processing this. My understanding is with this measure, it's measuring cost so observed versus expected cost versus other rehospitalization or readmission measures are more focused on utilization versus cost. Am I understanding that correct?

Mr. Nagavarapu: This is Sri from Acumen. That's correct. These measures capture distinct ideas for exactly the reason that you have in mind. I think the readmission measures are really focused on a specific type of utilization. The MSPB measures are focused on the overall cost of Medicare of the resources expended.

That could include readmissions for sure, but it also captures sort of the intensity of services so the number of readmissions, the number of ER visits, things like that. But I think the distinction you have in mind there between the two types of measures and how they work together is exactly right.

Member Van Allen: Thank you.

Co-Chair Demehin: All right. I'm not see any other hands raised or any other sort of clarifying comments or questions in the chat so let's shift gears and talk through the voting process.

Matt, I'm going to have you help me out with this.

First we have to vote on the measure recommendation for the IQR program. The first question --

Dr. Ruiz: Sorry. I'm so sorry but I noticed there was a question in the chat about stratification of results, Vilma Joseph. This is from the health equity workgroup so if I might interject very quickly.

Co-Chair Demehin: Very quickly, please.

Dr. Ruiz: Sorry. So as part of the NAF testing, we did provide several different types of stratifications across the measured scores looking at different

deciles, percentiles, etc., as well as average measure scores. This was by safety net status, DIS percentage, teaching hospitals, Medicare percentage in the hospitals to further demonstrate the stability of the measure which was demonstrated by the data. I just wanted to put that out there. Thank you.

Co-Chair Demehin: Thank you.

All right. So the first question in front of us is whether to accept the preliminary analysis recommendation from the NQF staff on this measure or the IQR program.

So, Matt, do you want to walk us through that process?

Dr. Pickering: Sure. So, again, this is a vote whether or not the workgroup wants to uphold that decision category and that condition. The condition here was the duplicative -- having seen this resolve, that duplicative concern which based on some of those discussions in what has been presented today, the reason why submitted IQR is to subsequently be submitted again in VBP as an updated measure.

If the Committee does not have any other conditions, then you can disagree with what's listed within the PA, and then we'll go into further discussion of the measure with the lead discussants and then revote on a different decision category. If the Committee would like to see other conditions with this measure, those could be added on, and then also upholding the conditional support for rulemaking.

Any questions from the workgroup? Okay. So, Akin, if you're good, we can move to vote.

Co-Chair Demehin: Let's do it.

Dr. Pickering: Okay. I'll turn it to Ivory.

Ms. Harding: Voting is now open for MUC2021-131 Medicare Spending Per Beneficiary Hospital for the Hospital IQR Program. Do you vote to support the

staff recommendation as the workgroup recommendation? A few more seconds.

Dr. Pickering: I know that one of our participants had to step away for a few minutes so we are down to 23 so I think we can close the vote.

Ms. Harding: Okay. Voting is now closed for MUC2021-131. The responses are as follows: 11 members voted yes and 12 members voted no.

Dr. Pickering: Okay. So we did not

-- it's less than 60 so, again, you have to have 60 or more to agree to uphold the vote. It's less than that so we will go to the next step in the process which is open for any further discussion starting with the lead discussants.

Akin, I'll turn it back to you.

Co-Chair Demehin: Okay. So for lead discussants on this measure, we have, first up, Aisha Pittman followed by Cristie and then Jackson.

Member Pittman: All right. I'll kick it off. I think -- I mean, from our perspective we are okay with this measure as long as it's endorsed. I do think in the Committee discussion there was a comment in the chat thinking about it in terms of social risk. I think I would want to see us directing CMS to maybe study that.

I don't think they are in any way ready for incorporation into the measure but I think something that would be useful for this measure to think about stratification on social risk and of CMS could look into that. Overall, I was supportive of the staff recommendation, I think. Maybe it's a little bit of since it is endorsed, I don't know if folks are actually leaning to more support.

Co-Chair Demehin: Thanks.

Christie.

Member Travis: Yes. I am leaning towards support for rulemaking since the condition that was in the preliminary analysis seems to have been resolved regarding the duplication. I felt the rest of the preliminary analysis was really strongly supportive of the measure itself other than this major concern so I'll be moving toward support for rulemaking.

Co-Chair Demehin: All right. Thanks so much.

Then let's hear from Jackson.

Member Williams: Yes. I did not vote no either so I will defer to whoever wants to address that.

Co-Chair Demehin: All right. Let me open it up for folks, especially anyone voted no in terms of supporting the staff group recommendation. Could you tell us a little bit more about why? You can use the raise-hand function if you would like.

All right. I have Maryellen followed by Anna.

Member Guinan: Thanks, Akin.

So I guess following up with Aisha's point but maybe a little bit stronger. If we feel that the social risk aspect should be a condition in terms of the conditional support, apologies that that was the prior vote.

I'm a little confused on that but I think we would want to see that as part of this measure. If that requires retesting or is more of a substantial change, I don't know if that changes what the NQF recommendation would be if it's now outside of conditional support. I just wanted to be a little stronger on the inclusion of social risk.

Co-Chair Demehin: Okay. So it sounds like your proposal would be to add a condition. Not necessarily to change the decision category but to add a condition to the conditional support?

Member Guinan: Yeah, if that's the way to get in

social risk then, yeah.

Co-Chair Demehin: Okay.

Dr. Schreiber: Akin, may I for a moment?

Maryellen, to introduce social risk stratification into this measure frankly would be a new measure and I don't know that's a condition on this measure. Essentially what you're asking CMS to do, quite honestly, is to develop a very

-- I think very different measure.

The other consideration when we talk about stratification that I wanted to bring up is that CMS is looking at strategies of providing stratification of the performance back to hospitals so I think we spoke of this last year and we had it in the RFI about starting with some of the metrics and providing confidential feedback reports to hospitals based on stratification. I think that is another way to do this but to include this in the specifications for the measure I actually think is another measure.

Member Guinan: Thanks, Michelle. I think that was my concern and kind of why I voted no thinking it might have to be a different recommendation if wanting to have that included if it changes the measure, if we're adjusting at the measure level rather than a reporting out of performance stratified, which I understand the two different ways of going at this.

Co-Chair Demehin: So, in other words, it sounds like, Maryellen, what you're advocating for is an adjustment to the measure specifically around social risk which is different from the stratification approach that Michelle is talking about which could be done on the same measure. It does sound like adding a condition is probably not the right -- would not be the right approach. It would probably be something more like do not support with potential for mitigation or do not support. Okay.

Member Guinan: Which is hard because it's already endorsed and in the program to an extent.

Mr. Nagavarapu: If it's helpful -- this is Sri Nagavarapu from Acumen. When this discussion about the potential risk adjusting for social risk factors came up with the NQF endorsement the standing committee and the Scientific Methods Panel, we conducted -- we presented testing results that showed the minimal changes that David noted.

Then we also added a method that the Scientific Methods Panel specifically requested in testing to ensure that the measure is not affected by the inclusion of social risk factors like dual status and SES index and so on. If you look at that recommended method from the Scientific Methods Panel, 99 percent of facilities do not change their measures score by more than 1 percent.

The remainder basically less than 3 percent and the correlation of that measure score risk adjusting for social risk factors is on the order of .98, .99. Their recommended method is more like .99. In case it's useful, that's a discussion that we had extensively with the standing committee during the endorsement process.

Member Guinan: Thanks. And I think that goes to the point of kind of the data that we don't have on social risk understanding that you did the analysis on dual and SES. It more goes to maybe a comment to CMS and I know they are thinking of future measures and incorporation at the measure level with the data when available. Thank you.

Co-Chair Demehin: All right. Let me open it up to the Committee for any additional comments or proposals or what to vote on. Okay. So what we typically do in this process --

I'll describe it and, Matt, I'm going to lean on you to correct anything that I --

Dr. Pickering: Sorry, Akin. I don't mean to interrupt.

Linda, I saw your hand go up and then go down. Did you have a question?

Member Van Allen: I didn't know if we were moving on. It's a comment. So relative to the 30-day rehospitalization triggering a new episode, the concern is that ACMA would like a further look and work to ensure that hospitals aren't being double penalized but also further readmissions, if you will.

On performance we agree it's an important element related to the cost of care. We are fully supportive of that. The concern is the multiple metrics and impact to hospitals.

The other concern that I haven't brought up yet is just with these measures there is a community provider element that's related to rehospitalizations and that's really difficult to take into consideration with some of these measures. That's the concern from a case management perspective.

Mr. Nagavarapu: Great comments. Thank you. In case it's helpful --

Co-Chair Demehin: Sri, I'm sorry. We're in the middle of Committee deliberation. I think we're going to move to the voting process now. Sorry.

All right. So we now have to step through the process for what we do when we don't support the initial preliminary analysis recommendation. I think, and I'm going to lean on Matt to help walk us through this here, it sounds like we have a couple of different categories that are on the table for folks to vote on.

The first is to vote on a recommendation of support for rulemaking. The second would be maybe do not support or with potential for mitigation. I think what I'll do and, Matt, again, feel free to correct me if I'm goofing this, is to ask for a motion to vote on support for rulemaking.

Dr. Safran: I'll give you a motion, Akin.

Co-Chair Demehin: All right. Do I hear a second?

Member Travis: Second.

Co-Chair Demehin: All right. So I guess I'll turn it over to Matt and Ivory to open it up for a vote. Correct?

Dr. Pickering: That's correct. So we are now going to vote on measure 131 Medicare Spending for Beneficiary (MSPB) Hospital, Hospital IQR Program. The decision here is support for rulemaking so you are voting yes to uphold that decision category of support for rulemaking or no.

I'll turn it to Ivory.

Ms. Harding: Voting is now open for MUC2021-131, Medicare Spending Per Beneficiary Hospital for the Hospital IQR Program. Do you vote support for rulemaking? Okay. The poll is now closed for MUC2021-131 and the responses are 15 members voted yes and five members voted no. That gives us a percentage of 76 percent.

Dr. Pickering: Okay. So the decision category of support for rulemaking holds.

I'll turn it back to you, Akin.

Co-Chair Demehin: All right. So we've voted on this measure for the IQR program. For now turning to its application and the value-based purchasing program.

Matt, is there anything else you want to add here?

Dr. Pickering: So I will -- there is nothing else as far as the description of the measure. As you can see, the program we're talking about here we've disclosed in the previous measure, which is the Hospital Value-Based Purchasing Program.

If you go to the next slide, you'll see that this -- the

decision category in the preliminary analysis is support for rulemaking here. This measure under consideration is refinement to the MSPB measure currently in the program and the updated measure now equal weights all risk adjusted hospital episodes, expands the coverage of included episodes and updates the risk adjusted model to account for these expanded episodes.

Again, this measure was endorsed June 2021 in support for rulemaking due to its endorsement of these updates. I will just touch on rural health. It was an average of 3.7 so 1 to 5 scale, higher being better aligned with rural health, rural providers. It was 3.7 on average.

In similar discussions that they had previously around this measure, it's not really addressing the needs of a number of rural health hospitals. However, during that meeting the developer clarified that critical access hospitals, or some of those critical access hospitals, are included in the measure.

For health equity that's a scale of 1 to 5. They rated it a 3.1, again the higher the better in a measure that can promote health equity and reduce disparities.

As far as the other comments received, very similar to the previous measures. There was one supportive pending NQF endorsement which we stated was endorsed in June of this past year.

Then two non-supportive due to similar concerns we heard from the last program so just the justification of the waiting for the risk adjusted hospital episodes, concerns of scientific acceptability related to the r squared values for the unadjusted risk-adjustment model and adjusted risk-adjustment model.

Then they had concerns with the risk-adjustment approach for social risk factors. Then there was just this recommendation do not support for potential mitigation as opposed to where we are currently with the measure. So those are the comments, very

similar to what it was for the IQR.

Since the vote did change to support for rulemaking on the IQR program, this is a measure again submitted to this program. We will now see if there is any opposition to carry over the votes from the IQR program to the value-based purchasing program since the decision categories are the same.

Again, if you oppose carrying over those votes, you can speak up now, you can message in the chat, or you can directly message myself if you oppose the carryover and then we will open the measure up for discussion and voting separately. If you have any opposition of carrying over those votes, please do so at this point.

Co-Chair Demehin: I am not seeing any at the moment, Matt.

Dr. Pickering: And I don't see any direct chats at the moment. Again, last call. Okay. All right. I don't see any so we will carryover the votes to support for rulemaking from the IQR program for MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital Measure to the VBP Program. So support for rulemaking will stand.

Okay. All right. So that brings us to the end of our morning. We are five minutes over -- six minutes over as I keep rambling on. We will break for lunch so we will come back at 1:00. We'll try to keep to our agenda since the rest of the afternoon is tightly packed.

I want to thank Akin and Sean thus far and, and CMS colleagues thus far this morning, as well as the workgroup participants. We'll break until we come back at 1:00. So 1:00 sharp on the Eastern side and we'll pick up with the other IQR measures in the program.

Just to note, we'll be started out in a different order that's listed on the agenda. We'll start out with

measure 136, which is the Screening for Social Drivers of Health, followed by 134, then 106, then 122, then 121. We'll start in that order as opposed to what's listed on the agenda. We are just sort of reversing everything. We'll reconvene at 1:00 and thank you all very much. We'll see you in a little bit.

(Whereupon, the above-entitled matter went off the record at 12:36 p.m. and resumed at 1:00 p.m.)

Hospital IQR Program Measures

Dr. Pickering: I know folks are sort of getting back to the table, our virtual table here. I do have 1 p.m. Eastern which we are going to reconvene here and pick up where we left off. So as a reminder, we're now going to be starting with the other measures in the Hospital IQR Program, so for this portion of the meeting we have a lot of time allotted for this portion. There are five measures that will be evaluated.

As you saw in the Webex chat, there's a new order that we're going to be having that's just a reorder of those measures that are currently listed in the agenda. So the new order is -- after we go through public comment, the first measure up will be 136. Following that will be 134, then 106, and then 122, and 121. So just a different order that's listed in the agenda, but still the same of measures and we will kick it off with hospital IQR and turn it over to you, Sean, to start us out.

Co-Chair Morrison: Terrific. Thanks, Matt. So we are back at 1 o'clock. We are back on schedule and we are going to start with the one, two, three, four, five measures in the order of 21-136, 134, 106, 122, and 121.

And let me begin by opening for public comment. And just as a reminder, please keep your remarks to two minutes or less. Please do not repeat if somebody has already made a comment. Please do not repeat it. If you'd like to express support for it, just drop it in the chat.

And I think, Matt, we have a couple of comments to start from developers. Is that correct?

Dr. Pickering: I believe that's correct. I think see Allison Bryant has the first hand up and I just remind everyone who's on the call today as members from the public, this is for the Hospital IQR Program. That's a pay for reporting and public reporting program. You can see the description listed here, the intent of structure is that hospitals that do not participate or fail to meet the program requirements receive one fourth reduction in applicable percentage increase in their annual payment update. And the goal of this program is really to pay providers on quality rather than quantity to better inform consumers about the care they're receiving.

So we'll go to that public comment --

Member Nolan: I'm sorry to break in, but could I just ask a sort of process question. So comment is open for all resistant measures and we're doing them in whatever order they -- we're not doing them sort of seriatim, one by one, right?

Dr. Pickering: Go ahead, Sean.

Co-Chair Morrison: Yes, so that is true for public comment. It's not going to be true for the discussion of the committee.

Member Nolan: Oh, okay. Thanks.

Co-Chair Morrison: We're going to be doing them one by one. This is just for the public.

Dr. Pickering: Thanks for the question, Sarah.

Thanks, Sean. I'll turn it back to you, Sean, for public comment.

Allison was a first.

Co-Chair Morrison: Allison, go ahead.

Dr. Bryant: Hi. Thank you so much. My name is Allison Bryant and I am a maternal fetal medicine doc at Mass General Hospital and the Senior Medical Director for Health Equity at the Mass General Brigham Health System which is an enterprise of about 14 hospitals that include AMCs, community hospitals, and specialty care facilities. And so I'm speaking in support of measures 134 and 136.

So I want to say just those of us who have the privilege of delivering healthcare know that the things that we say that we want to do like building relationships with our patients, achieving equity, reducing costs, really depend on our recognizing the realities of the lives of our patients that they live outside of the proverbial four walls of our institutions. And we have certainly seen how critically important unmet social needs such as food insecurity and housing instability have escalated under the dynamics through construct of COVID.

But unfortunately, in the current environment, our health system's code and the screen and the measure and risk adjust for conditions like diabetes, but irregardless or irrespective of things like food insecurity, even though we know that our diabetics, who are food insecure, have worse health outcomes than those who have access to healthy foods.

So at Mass General Brigham, alongside other health delivery systems across the country, we have committed to screen for and address health related social needs. As committed as we are to this work, we're doing so without the benefit of any social determinants of health measures and any federal payment model.

So in our current system, we are committed to screening for social determinants of health in our Medicaid ACO in the context of primary care under our United Against Racism campaign. We scaled up these efforts payer blind to 23 communities that have the highest level of need. And we're currently

expanding this work to engage our specialty care providers so in maternity care and NICU care, really recognizing the absolute importance of this to meeting social needs at critical times in our patients' lives.

We're building a program with nutritional equity to ensure access to healthy foods and medically-tailored meals for patients who have need. And within our network, we've also begun trials of social determinants of health screening in our inpatient bases learning that it's not only feasible, but it's incredibly meaningful to a population enriched for medical and social complexity.

So it's just important to note that both of the social determinants of health measures that are under review today are critical to make visible the impact of these issues in the lives of our patients. Given the disproportionate impact of social determinants of health on people from historically marginalized communities, the equity agenda for us is very clear. We really must recognize providers and institutions for screening their patients and reporting the screen positive rate to really get underneath the sort of racial and ethnic disparities and determinants of health that, in turn, fuel health inequities.

And so finally, we're totally aware that only three of the measures that are tagged to the domain of equity are in the current slate and that those being reviewed today are the only patient level SDOH or equity measures under review, so we really hope to push these forward under the guise of really improving equity for all of our patients. And I appreciate the time to share.

Co-Chair Morrison: Thanks, Dr. Bryant.

We have Gary Price. Did you want to make a public comment?

Dr. Price: I would. Thank you. I am Dr. Gary Price, an attending surgeon at Yale New Haven Hospital and

I am Assistant Clinical Professor of Surgery there. I'm also a past president of the Connecticut State Medical Society. In addition to that, I'm a board member and the current President of the Physicians Foundation which is directed by physicians from 21 state and county medical societies across the country from Honolulu to Hanover and Fairbanks to Florida and all regions in between.

We are the major developer for MUC2021-136, social driver of health screening rate; and MUC2021-134, social drivers of health screen positive rate.

Despite the well-documented impact of SDOH on health outcomes and cost and their disproportionate impact on communities of color, there are still no drivers of health measures in any federal healthcare payment or quality program.

On behalf of physicians across the country, we believe this is untenable. We submitted these first ever SDOH measures to address CMS's commitment to address the stated measurement gap for social and economic determinants, and the MIPS program's commitment to advance health equity.

Ahead of today's discussion, I wanted to speak to two key issues. First, these two SDOH measures are interrelated. Each of these measures was extensively tested via the CMMI, Accountable Health Communities Model, with over a million patients in 600 plus clinical sites with 40 percent of the DOH screenings performed in hospital inpatient or ED settings.

This testing relied on both screening beneficiaries and the results of the screening, the two measures under discussion today. Of course, it is not possible to validate any type of screening tool without knowing the results of the screen.

The second issue is that these foundational SDOH measures do not at this point require that health systems act on the findings from the screen. The

concern is the screening without acting on the results could frustrate patients and providers. We agree. But empirical evidence from the extensive testing of social needs screening completed to date indicates that providers will, in fact, act on the screening results even if not required to do so. For example, in one CMS Innovation Center model, 1200 of the practices were not required to screen for social needs, but the vast majority did so anyway.

Most importantly, 93 percent of the physicians in these practices reported taking action on those SDOH screening results including linking patients to community resources without any requirement that they do so.

Ultimately, today's review of these two measures comes down to leadership. These two social driver of health measures have now been tested for five years in an existing CMMI model across hundreds of clinical sites. They've undergone independent review to assess their psychometric properties, and have driven significant, pragmatic learning about how to collect and use SDOH screening data, including in inpatient settings.

We anticipate that the measure should and will be improved over time. But we also recognize that as with all measures in the federal payment and quality frameworks, we must begin using, learning, and improving them.

We appreciate the MAP's consideration of these measures, the only patient level equity measures under review this cycle, and urge it to support both of them for rulemaking.

Thank you very much for the opportunity to make these comments.

Co-Chair Morrison: Thank you, Dr. Price, very much. Appreciate it.

Open for other public comment.

Dr. Gunn: Good afternoon. My name is Veronica Gunn. I am a pediatrician and a public health professional with more than 20 years of experience in clinical care, healthcare administration, and public health leadership, having previously served as a state health officer.

Currently, I am CEO of Genesis Health Consulting which is a national firm that works with hospitals, health systems, and networks to advance the health and well-being of children and families through an equity lens.

I greatly appreciate the inclusion of patient level measures of social drivers of health for the very first time. Although equitability has been a domain of quality, this is the first time that I'm aware that equity is being recognized in this CMS measure cycle. Providers in all settings are exhausted with seeing these issues arise with their patients, especially given COVID's devastating impact. Food insecurity, housing instability, utility needs, et cetera, all make it extremely difficult for our patients to achieve optimal health. And we know that populations of color disproportionately experience these social and structural drivers of health. And, as in my work, when that patient is a child, the burden is experienced by both the patient and the care giver.

How do these measures validate the importance of screening for these needs and allow providers' recognition for reporting the results of this screening? As a physician, I would not adopt the screening process without seeking the results of the screen. In the same manner it is important that this group acknowledge the importance of including both measure 136 and measure 134 in the measure set.

According to a recent study in JAMA, this is not a new practice for hospitals. Twenty-four percent of hospitals are already screening for all five SDOH domains, food, housing, transportation, utilities, and intimate partner violence. And 92 percent of hospitals

are screening for one or more of the five domains specified in these measures.

These measures would be a powerful and timely way to bring the latter institutions along towards a more complete approach to addressing their patients' social drivers of health needs.

And finally, from a practice standpoint, I would want to be able to establish a baseline prevalence of positive screens from my patient population before being required to report on those referred to navigations. Again, similar to my practice comments about the importance of having staged approach to measure development this allows for adequate data collection to inform subsequent measures and also enables clinicians and hospitals and networks time for planning. For example, will they need to bring on or train additional staff to ensure adequate navigation support?

Thank you again for inviting public comment on these two important measures.

Co-Chair Morrison: Thank you. I have Rachel Keever next. And again, if people could keep their comments to two minutes, it would be appreciated. And again, please don't repeat what's been previously said.

Dr. Keever: Thank you. I'm Rachel Keever representing the North Carolina Medical Society Board. I'm a clinical cardiologist that practices at Mission Health in Asheville, North Carolina through the ridge of the Appalachian Mountains. I'm also CEO of Carolina Complete Health Network, a first in kind partnership between insurance and physicians trying to drive better health, lower cost, and increase health equity in communities.

I'd like to speak in favor of measures 134 and 136, in particular, to challenge us to screen MAP and work to realize health equity. Since it's after lunch, I'd like to tell a story. We're all sitting around an old fashioned conference room. You have a little chest

pain and you don't feel well. The person besides you happens to be a doctor and they activate 911 and you come to our luxurious hospital systems quickly by design system to a cath lab. We realize that you have artery blockages and your heart is failing. But somehow in this weird transport, you also end up in a cath lab 30 years ago. We realize that the only option for therapeutics is heart transplant. Even 30 years ago, the next measure would be to stop and ask does the patient have the social support network to drive a good outcome?

Knowing about the social drivers of health is not new. We've known about this for decades. In support of what's been discussed already, what we need to do is map and understand where we need to invest dollars to get better health. That is the important work of 136. I think it's important for us to understand where we might need to change our healthcare system.

Screening for social determinants or social drivers of health at the point of emergency does not help the patient. We need to do it ahead of time and we need to create those investment maps that we follow to invest in our communities to truly realize health equity.

Thank you for allowing public comment on these important measures and I would like to make sure that we understand that just screening is not enough. We need to be able to help the next patient who comes to our hospital in acute emergency have the social supports in place to be a candidate for those emergency procedures.

Co-Chair Morrison: Thank you. I have D-D-R-O-N as the next.

Dr. Wyatt: That's Ron Wyatt. Is that me?

Co-Chair Morrison: Okay, Ron.

Dr. Wyatt: Yes, so thank you, and I'm not going to

repeat anything that's already been said because I'm going to talk to you from my heart and that's different.

So I'm an African American male, internist in practice for 25 years mostly in St. Louis and in north Alabama. I grew up in the Black Belt in rank poverty in Alabama where I was motivated to go to medical school when I was 14 by a young Black kid whose sutures were removed by a general practitioner only to be replaced by a veterinarian after his mom couldn't pay. That was my driver.

Currently, I was the first co-chair of the Equity Advisory Group at IHI. I worked on five equity collaboratives from Boston to Chicago to Kansas City to Portland and leading those equity initiatives.

I practiced in Alabama as I said, but beyond that who I'm here to represent in these measures is who as we talk about the how which is psychometrics and harmonization and waiting and kappa statistics, I want to talk to you about who and the who is the people, it's the young mother in Chicago who lives under a coal-dust cloud --

Dr. Pickering: I think we lost Ron. We lost your audio. Ron, are you there?

Sean, maybe we can go on to the next and maybe circle back.

Co-Chair Morrison: Who do we have next?

Dr. Pickering: I have William Lawrence, Jr.

Dr. Lawrence: Good afternoon. William Lawrence. I'm a general pediatrician in North Carolina and Chief Medical Officer of Carolina Complete Health, a Medicaid managed care plan in North Carolina. And having had a history working with the Medicaid administration in North Carolina, having worked in several underserved settings as a primary care physician, I'm also not going to repeat what's been

said because I think all of my colleagues who have spoken before have laid out the case there and particularly Dr. Price's very clear comments regarding the specifics and the outcomes of testing on these measures so far. But I do want to actually share our support for that, both from the standpoint of a primary care pediatrician, as well as from the standpoint of a health plan director.

I think the one thing we know is that despite the recent events, COVID and other things that have exposed much of the long-standing ratio of economic injustices embedded in many of our systems including our healthcare system, it is very clear that that attention now is either generated in some or renewed in others a real commitment to improving health equity and addressing the social determinants of health.

With that in mind, recognizing that physicians and other healthcare providers have been impacted by the lack of visibility into those measures and the fact that for some these are the factors that impact drive physicians' burnout and you know, in some cases even increase financial risk through lower MIPS scores and similar measures.

Having the ability to shine light on that and improve our ability to really draw down on what those folks are doing is a great opportunity and thus brings about our support for these measures.

I think promise has been shown by many of the innovative efforts evaluating them and it really should be encouraging to see, as Dr. Price said, that all of these proposed measures have been implemented for a fair amount of time with good results. And it's also pretty reassuring that the AHC screening tool has had objectives that to show that it's reliable and provides concurrent and predictive validity.

So I just want to add our support in that regard. Thank you for the opportunity to speak.

Co-Chair Morrison: Thank you. Thank you very much.

Do we have further public comment now?

Dr. Pickering: Yes, there's two more hands that are raised. Nothing else in the chat thus far, so the first is Kathleen Conroy and the last hand raised is Richard Thomason. So may we start with Kathleen.

Co-Chair Morrison: And again, this committee's work is to address the measures on the table and I think not to weigh in on the importance of social determinants of health which I think we all recognize are critically important. So if I could ask people to keep their comments specifically around the measures which is the focus of this committee and again, if it is simply to support the measures, please put that in the chat.

So Kathleen Conroy, you're up next.

Dr. Conroy: Hi. My name is Kathleen Conroy. I'm another pediatrician presenting today. I'm at Boston Children's Hospital and I'm the Clinical Chief of Primary Care.

I wanted to speak just because I want to talk about the importance of integrating 136 and 134 together and talk a little bit about our experience in Massachusetts which led me to believe that that's really important.

So my own practice, we've been screening for over a decade for social determinants of health and we're very dedicated to that practice. But then in 2018, as part of its current 1115 waiver, in the Massachusetts Medicaid program, it introduced two quality measures that are nearly identical to 134 and 136 that we're talking about today.

And so though we were already screening, the need to report out on the percent of our patients screening positive for various needs, both across our clinic and then across our entire ACO, really changed things for

us. It allowed us to understand who in our population was most likely to have needs and how these needs were changing over time. And then interestingly, whether our systems of screening and response were unintentionally inequitable.

And so this knowledge that would come about from the implementation of these measures before us became the foundation for both disparities focused quality improvement programs and also the impetus for the creation of new community partnerships to better address the needs of certain population. And so for this reason, I think these two measures really need to be implemented together.

I also want to say that Massachusetts also did not require navigation to resources as a part of a lot of these measures. And it had the effect of allowing healthcare organizations the opportunity to build their response systems after initially understanding families' needs and the time to build the data systems necessary to record the interventions on those social needs of families that will ultimately be needed to reflect out system response.

And so we, for example, although we had been screening for over a decade, recognize that we were under documenting our work of response and so we worked really hard to improve this in anticipation of meeting ultimately to say this is what we did when folks screened positive.

And so as a pediatrician who works in a system that's using these measures and screening thousands of adult caregivers every year for social needs, I strongly endorse the creation of the federal social needs screening measures. Thank you.

Dr. Pickering: Thank you. Richard, go ahead.

Dr. Thomason: Thanks, everyone. I'm Richard Thomason, Policy Director for Blue Shield of California Foundation. We support lasting and equitable solutions to make California the healthiest

state and end domestic violence. We strongly support both measure 136 and measure 134.

As you've heard, nearly ninety percent of hospitals and health systems across the country are already conducting SDOH screening to identify patients' unmet social needs including a number of CMMI models, but without the benefit of any formal quality measures, guidance, or tools from CMS.

I can tell you from our experience, hospitals and clinicians are really groping and needing that kind of direction from the Federal Government. As evidenced by the momentum for these measures across the health sector, it is imperative that we begin to implement social drivers, health measures in the federal payment programs --

Co-Chair Morrison: Mr. Thomason, I don't mean to interrupt, but we've heard the importance of this and that there are no measures. Are there additional comments you'd like to make?

Dr. Thomason: I'd like to say this is a very pragmatic way of getting started in collecting SDOH measures. It's really important to collect those screening and the screen positive rate because if you don't, you would really run the risk of masking disparities and exacerbating inequities. So you have a real historic opportunity today to move forward these SDOH measures. I urge you to take it up and approve both of them. Thank you.

Co-Chair Morrison: Thank you. And Joseph Valenti.

Dr. Valenti: Yes, thank you. Good afternoon. I appreciate you allowing me to be on the call. My name is Dr. Joseph Valenti. I'm a practicing gynecologist in north Texas. I'm a member of the Board of Directors of The Physicians Foundation and a member of the Board of Trustees of Texas Medical Association.

Over ten years ago, our Foundation took up this

cause with Dr. Buzz Cooper who wrote the book, Poverty and the Myths of Health Care Reform, in response to the Dartmouth study, alleging that social drivers were not the real issue. And when we looked at the subway system in New York and looked at the cost of people living in the Harlem area and the cost of people for healthcare living in the Upper East Side area, the disparity was enormous and so we've been working with this cause for quite some time. In my own practice, we see patients who simply cannot afford their medications and that is what's driving the costs up. And so we have patients whose children have diabetes, cannot afford to have a refrigerator in the house. Their insulin becomes denatured. So for a $200 refrigerator, then end up with a $20,000 ICU admission which is just a terrible disparity in healthcare costs and a really bad outcome for something that could have been prevented.

So both The Physicians Foundation on which I sit and the Texas Medical Association on which I sit really support these two measures and we have multiple anecdotes of patients like this and I think all the practicing doctors here do. And it's really important for us to screen and identify these patients so something can be done about this.

So thank you very much for your time and I appreciate being able to testify here today.

Co-Chair Morrison: Thank you very much. Do we have anybody else?

Dr. Pickering: Sean, I don't see any other hands raised and nothing else coming through the chat.

Co-Chair Morrison: And I would just say is there anybody in the public comment who has a comment that is not in support of these measures given everything we've heard? I want to make sure that people have that opportunity as well or at least CMS has that opportunity to hear.

Okay, we will move forward then. Matt, I think you

need introduce the program, yes?

## MUC2021-136: Screening for Social Drivers of Health

Dr. Pickering: Yes, so the first measure up for the IQR Program, so that's measure 136, Screening for Social Drivers of Health. You can see the description listed there. The percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. The level of analysis of this measure is clinician and clinician group, as well as facility, as well as the population level.

So this measure did go through the Clinician Workgroup yesterday, as well as 134, so that's why they're listed as clinician and clinician group level.

This workgroup is charged with evaluating at the facility level for the program of IQR, so you can see that's why it's listed as clinician and clinician group because it's also submitted for the MIPS Program.

So for the preliminary analysis of degradation was conditional support for rulemaking. This measure assesses the rate at which providers screen when there are adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. As the first screening measure addresses social determinants of health and healthcare equity, this measure is consistent with CMS' need for measure 2.0.

This measure is not NQF endorsed and the conditional support for rulemaking is recommended pending testing of the measure's reliability and validity and NQF endorsement.

So the Rural Health and Health Equity Advisory Groups also evaluated this measure. For Rural Health, the average of a 1 to 5 scale is 3.5, again, the higher, more relevant for rural healthcare and rural healthcare providers.

Rural Health also mentioned that it's great to know this information, but if its only intention to issues the Commission cannot support or to which they can intervene, this is a concern. Hospitals are more equipped to steering patients to community resources and having social community workers on site to facilitate discharge to communities rather than clinicians.

With health equity, on a 1 to 5 scale it was 4.1, meaning that 5 is the highest, a measure that can promote health equity and reduce disparity. The comments shared from Health Equity Advisory Group mentioned that it was aligned with the vision of CMS to improve health equity. There is concern regarding the standardization to be put in place that says screening in uniform across the country, the developer did clarify on the call that the measure is standardized and the intervention towards use would be standard and that's tying to the measure. The data collected would also then be standardized, but the process for collection would be left up to the provider. Some of the public comments we've heard mention -- speak to that as well.

There may be some issues with people being labeled for having some of these social needs and not answering the questions truthfully, so this is some response bias. And there is some concern regarding intensity of resources that are required to do the screening. Some implementing the measure of cost of various IT systems can be challenging for some providers including critical access facilities. And many facilities also have a lack of community resources and links to those may also be nonexistent. So again, these are inputs from the Health Equity Advisory Group.

Lastly, I'll mention that there was some concern about providers should deal with patients -- what they should do with patients is screen positive, excuse me. There was discussion that you may need to collect the data in order to implement the change

and some advisory group members agreed that the consequences of not asking are greater than asking.

Regarding the public comments that have been received prior to this meeting today, there were 33 comments related to this measure for this program. Twenty-two of those were in support of the measure, so recognizing the importance of this measure and aligning with CMS priorities, mentioning the measure is really important to move forward with screening and assisting those patients further who screen positive recommending that additional measures should be considered that evaluated beneficiaries who are screened positive received services to address their social drivers of health in a timely manner. Also support comments mentioned the benefits of the measure, the measure of social risk far outweigh the burden of data collection reporting, noting numerous studies within these comments that have shown relatively high acceptability of social needs screening and referral among both patients and providers.

It is an important first step in making quality measures in use truly patient centered by incorporating patient's social needs, as well as their clinical needs into care provided.

In addition, some of these supported comments encouraging the use of these measures, measures can be used to improve over -- or they can be improved over time through CMS' annual review process and can provide groundwork and comparable measures from the Medicaid core set and guidance to states in their efforts to standards SODH. Further, these measures could lay the foundation for subsequent measure focused on ensuring patients secure resources, a need to be healthy, to accelerate in enabling investors in community capacity.

Lastly, for support of commenters talks about how this could facilitate standardization. So the integration of the proposed measures facilitates the

consistent screening of patient's social needs and incentivizes providers in healthcare delivery systems to navigate patients to address those social needs and evaluate the impact of those efforts on patient health outcomes and that these measures are needed for quality improvement activities, payment, research, and public health activities as well, including disease surveillance and mitigation measures in order to address health equity for healthcare inequities. Those are some of the supportive comments.

For the non-supportive, there are about 11 non-supportive comments out of that 33, focused on the implementation challenges and the need for appropriate resources. Several commenters noted implementation challenges such as the need for the mechanism of the administration of the screening must be developed and with appropriate privacy protections. The availability of multiple languages and the sensitivity to the concerns of those without documentation.

Although there's abundant evidence that social factors strongly shape the health and healthcare outcomes and inequity, it is not yet clear whether social screening, that's assessing the social needs, without subsequent intervention, thus addressing the social needs, can actually improve outcomes.

While the benefits outweigh the burden of data collection, hospitals will need to have the appropriate staff for assessing and addressing SDOH such as social workers and community healthcare workers and there needs to be more guidance about how to conduct the screening in a way that is patient centered, maximizes confidentiality, and minimizes risk for stigma and discrimination.

There's also concern with the link to improve health outcomes as we've stated previously. The developer did provide -- there was a comment saying the developer did not provide any evidence

demonstrating that the process is linked to include improved patient outcomes or health outcomes who are testing for the measure has been completed.

The last two comments, generally, were about the need for NQF endorsement, so greater clarity is needed how CMS is defining the screenings since there's no standardized tool. And CMS should not move forward with this measure until it has received NQF endorsement.

And then lastly, having the right social domains. So there was some commenters expressing concern about the social domains included in the measure, citing that the National Academies of Medicine recommended routinely incorporating information about financial strain and insecurity into electronic health records with a follow up successfully conducted only if needed around basic material needs such as transportation, utilities, food, and housing. This recommendation, that recommendation from the National Academies of Medicine, is not reflected in the proposed measures and so that was another concern. So that really summarizes the 33 comments we received from the public, some of which we've heard coming through in the public comments we've just had.

With that, and that summary of the measure, I'll turn it back to you, Sean, for any clarifying questions from the workgroup.

Co-Chair Morrison: Thanks, Matt, and thank you all for throwing these in the chat. That's really helpful, will make us move a little faster.

Let me just start going through them and asking the measure developers to answer them one by one.

Starting with is there a specific tool that needs to be used to screen?

Ms. Onie: Rocco, you're muted.

Co-Chair Morrison: Do I have one of the measure developers who can answer that?

Ms. Onie: Rocco, we cannot hear you.

Dr. Pickering: So is there anyone else from the developer side that may be able to address the question?

Ms. Onie: Yes, this is Rebecca Onie. Rocco may be having some audio issues.

This is with respect to the standard screening question?

Co-Chair Morrison: Yes.

Ms. Onie: Yes, so there is not a requirement -- the measure is the standard. There is not a requirement that there be a standard screening tool that is used. We would anticipate that potentially over time, CMS may ultimately make a recommendation on this regard, but as was evidenced in the public comments, there was a preference to a large degree on the part of providers at this point to be able to use, have flexibility with respect to the screening tool that is used. And so at this point that is not a pre-determined tool.

The fields are crucial. The five domains are crucial. The tool needs to match those five domains, but the tool itself is not predetermined.

Co-Chair Morrison: Thanks. There's a follow up then which is are all five domains required to be screened? Is it an all or none? Or if you screen three out of five, does that get you a pass?

Ms. Onie: Yes, so the requirement is that yes, all five domains must be screened in order to satisfy the requirements for the measure.

Co-Chair Morrison: And then following up on that, is there a time interval? Is it annual? Is it every interaction? What counts? What doesn't?

Ms. Onie: Yes, the measure would be reported quarterly.

Co-Chair Morrison: Quarterly. And the reporting mechanism is, how is it reported?

Ms. Onie: Yes, Rocco, is your audio working at this point? If you can give us one second, we will get the audio up.

Co-Chair Morrison: Okay. I will go on then and see if -- and then the last one I have is what demographics will be captured to allow for segmentation?

Dr. Pickering: So Sean, maybe while we're waiting for the developer to get back on, were there any questions related to the preliminary analysis? Any clarifying questions from the workgroup?

Mr. Perla: It's Rocco.

Dr. Pickering: It's Rocco. We can hear you.

Mr. Perla: I'm real sorry about that. I don't know what's going on.

So the question was around -- Sean, could you reframe the last question?

Co-Chair Morrison: Yes. Quickly, what is the reporting mechanism? We've heard that the frequency of reporting is quarterly, so let me just start with how are the data reported?

Mr. Perla: Great question. So the two possible options are through chart abstraction or through EHR. Many hospitals and health systems have access to these current domains in their EHRs or chart abstraction.

I will say through the Accountable Health Communities Model, which you heard referenced quite extensively today, CMS did establish a platform that can actually link the screening data plot files of the Medicare claims have more data in the chronic condition warehouse. So there's a possibility that that

data could possibly be put into a --

(Audio interference.)

Co-Chair Morrison: And then a follow up which I didn't realize, but I will clarify my question, is the patient screened quarterly or do the hospitals report their screening rate quarterly? I'm sorry, I think it was the latter.

Mr. Perla: Correct. That's right.

Co-Chair Morrison: So hospitals report the screening rates quarterly.

Mr. Perla: Correct.

Co-Chair Morrison: Got it. Got it. I think -- oh, and Jan asked two other questions. Is an overall score generated? And then how often then are patients asked? I guess the question is are patients asked on every encounter?

Mr. Perla: The standard would be quarterly so you can actually -- there's going to be a significant degree of patient turnover, so it's not the patient that's going to be asked every visit. It would be a quarterly statistic that would be provided and there is no real performance standard. The actual standard is reporting, so it will be every quarter the hospital would present the percentage of beneficiaries that screened -- that were screened.

Co-Chair Morrison: Okay. Wendy wanted to know whether -- in the measure 1386 analysis states there's no ECQM, but later in the form it states data collection is through ECQM claims. Can you guys clarify?

Mr. Perla: Yes. This is not an electronic measure. We believe there's potential to develop that based on a lot of the standards that are being developed through ONC and others and with developments through EHR, but right now the primary mechanism of collection would be through primary screening of patients,

chart abstraction through EHR.

Co-Chair Morrison: Terrific. Sarah, I know I've got you, but I've got one more that I'm just going to follow up because it's showing up again which is, let me just try and clarify. Hospital report quarterly. What is the expectation in terms of patient encounters and just how frequently are individual patients screened? Is it once per encounter, or once per visit? Once over the course of a quarter? How's the numerator?

Mr. Perla: So the position of the measure developers that this should actually be a census. It should be also screening on admission. How that gets reported quarterly would need to be factored in in terms of developing the standard for IQR, but the expectation is that every patient eligible beneficiary is screened on admission.

Co-Chair Morrison: And this is for inpatients only then?

Mr. Perla: Correct.

Co-Chair Morrison: Sarah, you've been very patient.

Member Nolan: That's fine. So my question is actually specifically about the recommendations from the preliminary analysis -- it's a technical question.

Co-Chair Morrison: Can I put you on hold then while I get through the measure developer?

Member Nolan: Yes, absolutely.

Co-Chair Morrison: I'll come right back to you first and I'm writing it down.

Member Nolan: You can come back to me whenever.

Co-Chair Morrison: Okay. So oh, my goodness. Here we go. Okay. Let me start with Christie, what level of reliability and validity testing has been performed for the measure?

Member Travis: That was my question.

Co-Chair Morrison: That was your question. Okay. So let me hold that up -- no, I'll ask it because that goes to the measures.

Mr. Perla: Yes, great question again. So the AHC screening tool that was used to generate the measure has been psychometrically tested. Interestingly, both at the item level, so food, housing, transportation, and at the overall tool level demonstrating evidence of reliability and validity, both concurrent and predictability. That includes comparisons with other tools following psychometric standards which is gold standard of multi-method, multi-matrix approaches.

The reliability statistics have been quite good. High kappa stats, generally greater than .6 and as well as fairly excellent sensitivity and specificity. In some of the cases, the sensitivity resulted in greater than 95 percent.

More work can always be done though. I will say with psychometrics it's never something that's completely validated but it has been tested pretty extensively.

Member Travis: Can I just ask a follow up question to that, Sean? This is Christie.

Co-Chair Morrison: You can ask whatever you would like.

Member Travis: I appreciate the testing of the tool itself, but I was really wanting to get some information about the measure results and how they have been tested for reliability and validity, not so much just the tool and given that there is no standardized tool that would be required, how do you think that should be factored in?

Mr. Perla: That's a great question. I think modeling is a concept of validity, so how well does this tool actually capture someone who in reality is housing instable? Actually, that level of testing has been

done.

I think the position of the measure developers that there are a number of different tools that have been used. Many of them are currently under active testing now, and the intent was not to impose any rules or a tool at this moment, given that health systems are using a number of different tools. The primary focus is really on collecting data. So I'm not sure if that answers your question, but there is some fairly extensive psychometrics on the measure we could share as well. That was part of the MUC submission.

Member Nolan: Could I also ask a follow-up question?

Co-Chair Morrison: Sure, go ahead Sarah.

Member Nolan: And I guess my question is not just that testing has been done because I think some of that was in the preliminary analysis and the public comment, but if the proposal is conditioned on or is pending further testing for validity and reliability, I guess my question is what more needs to be done that hasn't been done from the point of view of the staff who formulated the recommendation? And part of the reason I'm asking is when I -- I think the overarching question here is how perfect does it have to be before we move ahead with what I think is sort of a moral imperative, and something we've been talking for ages and ages. You know, yet this is the first time an actual measure is being proposed.

So I am not trying to be contentious here. If there are valid concerns about the measure that, for instance, has been used in the CMMI model, that would be interesting to know, but the fundamental question is what more testing needs -- what more testing needs to be done before we move ahead?

And I am open to conditional approval. I would just like to know conditioned on exactly what.

Co-Chair Morrison: Sarah, I think the condition was on NQF endorsement which would be addressing all

of the questions that you --

Member Travis: Okay. As part of the process of NQF? Okay.

(Simultaneous speaking.)

Co-Chair Morrison: -- the process, that they will be answering all of the questions that you just asked.

Member Travis: Okay.

Co-Chair Morrison: That's the rule of those committees.

Member Travis: So, but I think my question still remains so what more testing needs to be done?

Co-Chair Morrison: And just to come back again, I think that's the purview of that committee to answer, not ours.

Dr. Pickering: I'll try a little bit. Sean and Sarah, great question. There's the tool itself, is sort of the instrument that has to -- is for psychometrics which definitely has been done is what Rocco and the developer have provided and stated that there are psychometric testing of the tool when it's put into an actual performance measure with a calendar year or a different performance year with a denominator and a numerator for inclusion of patients who are eligible, any exclusions of those. The testing that the NQF Standing Committees, which is not this group, but the endorsement committees will be looking at is how that survey instrument is tested within the performance measure framework. So numerator, denominator exclusions for validity and reliability.

In addition to that, are any threats to validity. That could be through excluding the analysis, through any type of potential risk adjustment if risk adjustment is needed. So any of those assessments, those standing committees will be evaluating as the testing components for the measure in which this survey instrument is used within. And so they would be

evaluating that within the performance measure framework for endorsement. That's the type of testing evaluation that would be needed on the NQF Standing Committee side for NQF endorsement.

Member Nolan: That is super helpful, and I would just note as somebody who comes from literature and it's not quantitative analysis that rephrasing and losing that comment and comma would have helped me understand that one was part of the other.

Co-Chair Morrison: Sorry, Sarah, my fault. And just to say an unequivocal plug for the NQF work on these measures because that is key and that is really important for those evaluations.

Akin, I've got you. I'm going to tackle just a couple of short, quick ones first, stuff that I missed. Demographics that are going to be collected to allow for segmentation that comes through a couple of times and I missed that.

Mr. Perla: Yes, great question. So on that, the measure developer has strongly recommended that these measures be stratified by race and ethnicity. In fact, the Accountable Health Communities model also collected data on race and ethnicity and was able to determine that racial and ethnic minorities are over represented in the screen positive rate. So from a health equity perspective, this is absolutely essentially.

However, as Michelle and others from CMS have said, the ability to stratify is a global issue and one that CMS will need to tackle more generally because we believe that measure should be stratified, or I would say the majority of them by race and ethnicity, so we understand disparity. So that is the position of the measure developer and we know that CMS knows we're making progress on making sure we collect highly reliable race and ethnicity data moving forward.

Co-Chair Morrison: Thanks and then a couple of

questions which I'm hopeful that maybe you can refer to, there's some questions around the denominator question such as incapacitated trauma patients, do they come into the denominator?

And are individual patients admitted more than once, are they counted as one individual or are they counted as two admissions?

Mr. Perla: In terms of the incapacitated trauma admissions, anyone admitted in terms of the census approach versus the sampling approach would be asked that question. It could be asked to a family member or the person who's responsible for the patient.

Relative to patients counting once or twice, I think given that we are encouraging universal screening, it would depend on the window of reporting and what would actually be captured during that time, so because food insecurity and other conditions can actually change, we would be encouraged to basically capture all patients with no reporting window and report that during the respective period.

Co-Chair Morrison: Thanks. Akin, you have been waiting incredibly patiently. I appreciate it, but if I didn't tackle the comments, I was going to lose them as I keep scrolling up. So the floor is yours.

Co-Chair Demehin: No, I'm glad you walked through those questions because many of them were the same ones that I had. But I do want to circle back to just a couple of clarifications here. And the first is around the instrument.

So I know that you're saying that you don't have to use the Accountable Health Communities' instruments specifically, but if I'm hearing you correctly, you do have to use the questions including the exact wording of the questions no matter what mechanism you use to collect the data, right?

Mr. Perla: That's correct. You would need -- in order

to report for it to be a valid report, it would have to actually -- the tool would have to mirror the question. And our experience in the review of the multiple tools that are available, they are very close in terms of capturing the actual definition of the measure, so we believe that the flexibility of allowing multiple entrance views at this point doesn't actually create a significant negative impact relative to the minor variability that might be available to the wording.

In the future, CMS could decide, for example, to require a small set of tools. We just don't believe we're there yet since the priority needs to be collecting the data. It builds the momentum to have that conversation around highly reliable standard tools that could be used in the program.

Co-Chair Demehin: Okay, so in this case, it really is those questions that we're asking. So I think some of the testing results that we see do have to be understood in the context of the fact that they were part of a tool and that that tool was tested as a whole, right?

Mr. Perla: Exactly.

Co-Chair Demehin: Okay. The other follow-on question that I had really is around the issue that I think many of us struggling with and it sounds like this is one that you would anticipate hospitals collecting on each and every inpatient admission.

Are you thinking about whether the denominator needs to be broader than that? The reason I say that is the wording of the measure right now says beneficiary.

I would argue to you that it would look a little strange to ask the question of just Medicare beneficiaries and not everybody else. And I think when hospitals think of beneficiaries and they think of who their patients are, yes, inpatients would be their patients, but sometimes that relationship is more longitudinal and I think that's where it starts to become very, very

challenging to identify an appropriate denominator for this measure. So can you talk a little bit about how you're thinking about that?

Mr. Perla: That's a great question. Obviously, this is a Medicare program and so the focus is on Medicare beneficiaries. In fact, we know that a lot of health systems and hospitals and many of the folks that we've heard during the open comment period are screening not just Medicare beneficiaries, but all patients. And so we believe that that would be the best approach to take.

However, in this program because we are talking about a Medicare program, it is being framed and couched in the language of beneficiary, but we would fully expect and hope that any system that's doing this isn't just actually carving off the Medicare beneficiaries, but the measure does need to be linked to CMS and Medicare.

Co-Chair Demehin: Okay, one final question and then I'll let the rest of the group turn back.

In terms of patients who are unable to complete the assessment for the reasons that Phoebe was alluding to in her comment, or those who just refuse to answer, do you have a process for handling that?

Mr. Perla: Yes, that would be a category as well in the reporting. So that would be under exclusion category and so there are non-responses and there are folks who will not respond. And that needs to be factored into the response format and measured and captured as well. It's also very good learning from the institutions.

Co-Chair Morrison: Thanks, Akin. I am taking a quick look through the workgroup. I do not see any further raised hands. I think we've gotten everything in the chat which means we've clarified the question and now, Matt, unless I mistakenly go to whether we vote on whether we accept the recommendation of the NQF staff, is that correct? Yes, hopefully?

Dr. Pickering: That is correct. It looks like Aisha just raised her hand though.

Member Pittman: I just had a quick question about conditions and when we raise those conditions. Is it now? Is it after the vote?

Co-Chair Morrison: So -- well, Matt, I'm going to let you follow this. Well, let me say, when we tried this and I just want to get right. What we are voting on now is the committee's recommendation. The committee recommended -- the committee's condition with NQF endorsement. If you have other recommendations, you vote no because you want to add them to what the committee said. What we're voting right now is do we accept the committee's recommendation and their condition as written. Period.

Is that right, Matt? Did I get it -- please, tell me yes.

Dr. Pickering: So right, the condition here that's NQF endorsement so now you're voting to accept that condition with NQF endorsement.

If you would like to add on additional conditions, we'll have to reopen the vote for those additional conditions in a different decision category, if you choose to have a different decision category.

Co-Chair Morrison: The only thing I would add and I say this every year is we should try not to duplicate the work of the standing committees and recognize their charge is to look at a lot of the issues that came forward as part of the endorsement process.

Dr. Pickering: And I would just add that anything related to testing for the measure, so reliability and validity, as well as evidence to support the measure, so evidence from the primary literature to support the need for the measure. In addition, performance gap, so is there really variation in care that's being seen related to the measure, so screening rates are very -- there's a huge gap in screening rates that are

happening across providers.

Those types of assessments in addition to feasibility of actually reporting the measure, feasibility component, and the usability of the measure, all of those aspects get evaluated in the NQF endorsement by the standing committees. So if your conditions are trying to think about evidence or conditions are trying to think about testing or your feasibility reporting, those get evaluated by the standing committees. So the condition, if that is something that you think you would like to see as a condition it's underneath the NQF endorsement evaluation.

Co-Chair Morrison: Okay. Thank you, Matt. Should we move to -- let's move to a vote whether we accept the committee's -- the staff's recommendation which was conditional support for rulemaking. The condition was NQF endorsement.

We'll turn it to Ivory.

Ms. Harding: Voting is now open for MUC2021-136, screening for social drivers of health for the hospital IQR program.

Do you vote to support the staff's recommendation as the workgroup recommendation?

Okay, voting is now closed for MUC2021-136. And the responses are 23 members voted yes and 2 members voted no. And that gives us a percentage of 92 percent with the workgroup support to uphold the staff recommendation.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

Co-Chair Morrison: Thank you, guys, very much. And thank you for really focusing the discussion where it needed to be.

So we're going to move to 21-134. Mr. Pickering, I think it's yours.

Dr. Pickering: Oh, thank you. I see that we have 25, so just confirming. We did -- you know, that dial for patient services is on -- is UPMC on the call? Just wanted to confirm that.

Jan, is that you, UPMC? Thanks, Jan. I'll circle back and message you directly.

Okay. So I apologize about that. We seem to have some audio issues. Oh yes, mike's not working. Okay.

Thanks, Jan. We'll message you directly just to make sure we get your audio working.

I'll proceed with the next measure, which is the 134. So this is the Screen Positive Rate for Social Drivers of Health.

So as the committee has heard through the public comments that this was a recommendation through the public comments to have these measures paired. This was also a decision from the MAP Clinician Workgroup, as again both these measures were submitted to the MIP program.

So we're looking at these measures together. So the previous Measure 136 was screening, so just the rates of screening, are providers actually screening for these social needs, the social demands?

This measure is the report out of that screening. So as you can see, the do not support for rulemaking was based on that, that understanding initially that these measures would be reported separately. And that's why they do not support for rulemaking was due to some uncertainty in the evidence to support the just having the positive rate screening. So the evidence to support that solely.

And, also, just what that scorer would actually mean in a performance type of program. However, this is just a reporting of the output. So with that understanding in mind, just take that into

consideration that this is paired with the other measure, and with that it would be sort of the report out of what that screening rate is.

So the description of this measure is percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility health needs, and interpersonal safety. Again, the level of analysis is at the clinician or furnishing group, as well as facility and the population level.

The NQF recommendation was do not support for rulemaking, as this measure assesses the percentage of patients who screen positive for their social health needs, it would be the first in-hospital IQR program to specifically address screening for social determinants of health, which is consistent with the Medicare -- or meaningful measures 2.0 priorities.

However, the same concept would be better addressed by alternative approaches that do not present on its own consequences, and shows stronger correlation to outcomes.

Again, this was when originally putting these PAs together, these preliminary analyses together, that correlation outcomes was taking the measure solely alone as it is. But in discussions yesterday, during the commission call which we made here today, this is intended to be paired together so that there is a screening rate measure and then, of course, the report out of that screening rate measure.

So specifically there is this relationship that was not clear if this measure was to be taken solely alone in the program. It is not NQF endorsed, and that's why we assessed it as a do not support for rulemaking.

For the rural health and health equity, the rural health on a 1 to 5 scale the average was 3.5. There was some discussion on what the role the relevance of this measure is if there is no link to payments, as the screening rate measure would accomplish the

data collection issue.

The develop -- Excuse me. There was some concern on whether the positive rate is standardized. So the developer responded that since the screening is standardized, then the positive indicator would also then be standardized. The developer clarified that on the rural health call.

For health equity, the average score on a 1 to 5 scale was 3.7 for this measure. So this measure is supplemental to the screening measure, which is 1 through 6. And it will report the populations that have been screened.

There was some discussion that it was a good performance -- what good performance would be for this measure. The developer stated that this should be included in the pay for reporting measure and that there is no, there are no thresholds of what it looks like.

So thinking, again, this is just for reporting as opposed to the pay for performance.

The variability of the measures makes this challenging and will make it difficult to compare costs at practice sites. Again, inputs from the Health Equity Advisory Group.

It is not fully baked for its intent. And the intent is still unclear. And there are similar concerns for 1 through 6 in setting an expectation that you screen for these needs, but then what you do with the patients after you screen for those needs.

Moving to the public comments submit, there were 32 for this measure. The last measure it was 33. There were 21 in support of the measure.

Very similar comments to the previous measure around the importance of this measure and aligning the CMS priorities. At facilities this measure will facilitate standardization once implemented.

For the non-supportive comments there were 11, and also very similar themes for the last measure. So thinking about implementation challenges and the need for appropriate resources once screened.

Linking the improvement on this measure's health outcomes was also a concern in a non-supportive comment.

And then the need for NQF endorsement was having the right social needs.

So those are a summary of those comments as well.

And I'll turn it back over to you, Sean, for any clarifying questions.

Co-Chair Morrison: Thank you, Matt.

So we are going to -- right now these are clarifying questions for the measure developers and around the staff's preliminary recommendation on do not support. So let me open it up to clarifying questions.

I see questions for Phoebe and Abbie. But I think Guy's are more in the discussion. I will ask, in the materials of committee it says measure performance score interpretation, lower score is better. Does this invite unintended consequences?

And, Phoebe, I'd ask you if you could just elaborate on what you actually mean by that?

Member Ramsey: Sure. I think if you're reporting a rate of positivity, that seems to suggest if the interpretation is to be lower is better are we saying that the hospitals will be judged based off the social risk factors of the populations they serve, and thus be incentivized to treat wealthier patients to keep their score low?

Co-Chair Morrison: Got it. I'm not sure that's a question the developers are going to be able to answer.

Mr. Perla: I can take a shot at that, Sean, if that's helpful.

Co-Chair Morrison: Please.

Mr. Perla: I appreciate the question.

It's interesting. So when you saw the MUCs addition, the question is around, you know, performance. And, ideally, we would hope and expect that a lower rate, a food string is a big thing in a population, you know, we would want that.

This is a pay for reporting measure, so the only thing that gets reporting is the actual rate, not necessarily a judgment as to whether or not it meets a particular threshold, whether or not it's good or bad, it just was the rate actually reported.

Member Ramsey: Right. But how could that be, I was just worried about how that could be interpreted by the public and bringing on the unintended consequences of hospitals seeking to try and ensure that they're not looking bad in how it's interpreted.

Mr. Perla: Yeah. And I think that's a separate question in terms of the actual reporting category. But I understand and appreciate that question.

I will say the way that statistic gets perceived or interpreted by the public is something I think that is important. One way to do that is that higher screened positive rates or lower screened positive rates basically help understand the community in which care is being delivered and the investments that may need to be made.

So it's a broader question around perception than I think that the measure on its face speaks to.

Co-Chair Morrison: Yeah. I'm going to jump to Cristie. Cristie always asks the -- goes right to the heart of the matter.

And this is very specific. This is the IQR program.

How do the developers think patients, individual patients could use this information? Because it is IQR.

Mr. Perla: I can take a crack at that, Sean.

So the intent of the measure developer is that that information is used to drive a conversation with the care team and, ideally, more broadly the community. I mean, I think we've heard overwhelmingly from folks that called in around the role that the practices in communities play relative to the realities of patients' lives.

So to the measure developer this is no different than having a conversation about any clinical condition, given that it is also viewed as, in many cases, a clinical comorbidity.

Co-Chair Morrison: Okay. Jennifer would like to know a little bit more about how you envision pairing this with 136.

Mr. Perla: A great question.

Co-Chair Morrison: Measure 134 does not address action and the fact of unintended consequences. Reporting a percent positive screening rate does not present a reasonable basis for reporting payment. Percent positive screening rates will naturally be different based on the population of communities served by any given hospital.

So just putting that out there.

Mr. Perla: All right. Just in response, Sean, I think Matt did a nice job of framing up how these, these measures were developed and introduced.

So the two driver health measures were actually tested together in the accountable health communities pilot. So the field testing really relied on both screening beneficiaries as well as knowing the results and using that to drive implementation of the program.

And so we believe, based on the conversation yesterday, that a lot just of clarification, that they could be implemented as a set, similar to how other measures are developed and introduced -- for example, the access to inpatient, there are three different ways to look at that. You can look at through AMI. You can run heart failure, pneumonia. So these are really viewed as a, as a set. And that's how they would be tested initially in the agency.

Co-Chair Morrison: Got it. Thank you.

Let's see. I think we got most of the questions in the chat.

Do I have hands or did I miss any of them scrolling through?

Dr. Pickering: Sean, so Maryellen just raised her hand.

Member Guinan: Yeah. Just for clarifying, again, between the two measures. Am I correct the screening measure required you screen for all five domains, but this reporting out is only if you reported one of the five potentially?

Mr. Perla: Great question, Maryellen.

Member Guinan: Yeah.

Mr. Perla: So the screening question is an and. So the requirement is that you screen for all five for drivers of health. Again, that's how it was tested and implemented over the last five years in the accountable health needs pilot.

The reporting out is an or. So the main statistic that's been reported through AHC has been what percentage of patients screen positive for one or more health-related social need?

So that's the approach that the measure developer took to create consistency with the measure that was actually in development and testing.

Member Guinan: Thanks. I think that should be maybe made a little more clear between the two, the two measures, and particularly the public reporting of a percentage rate.

Co-Chair Morrison: Do I have anybody else who has clarifying questions or follow-up?

If the answer is no, which is appears to be, I'll turn things back to Matt for a vote on whether we accept the committees -- or the working group's recommendation.

Dr. Pickering: Yeah. Thanks, Sean.

And before we go there, I just want to check with Jan from UPMC. Do we hear you now? Are you there?

Still don't think we have Jan.

Okay. So I'm still trying to follow-up with Jan. Seems she's having some audio issues.

And before the vote, I think, you know, just as we were doing this through the Clinician Workgroup, it was the same preliminary analysis ratings for both 136 and 134. The MAP clinician after discussion, recognizing that these would be paired, decided to not uphold the 134 recommendation of do not support, and then moved to a conditional support for rulemaking pending NQF endorsement, similar to the 136, recognizing that these are, these are to be paired.

So wanted to mention that as we also had stopped generating these preliminary analyses, took the measures as separately in sort of a silo in our assessment, which is why we had the do not support here, and why we had do not support for MAP clinician.

The clinician moved to not accept the do not support, recognizing that these measures should be paired, and putting conditional, pending NQF endorsement.

So wanted to, just in case some questions came through around how the MAP Clinician Workgroup landed on these measures, that's how they landed as well.

Okay. So I think we can -- Oh, is there another question from Jennifer?

Co-Chair Morrison: Yeah. So, Matt, this is -- I was going to ask, I was going to ask you specifically because this is an area I'm confused about, too.

So that the initial committee's recommendation was to send this back, or conditional approval based upon NQF endorsement. If these are to be paired the way the Clinician Workgroup did, that would need to be a second condition; right? Because right now they're coming in as standalone measures.

Is that correct?

Dr. Pickering: Correct.

Co-Chair Morrison: So that if the committee wanted to see these paired they would have to vote down the staff's recommendation, we'd come back at another condition that is this needs to be paired with 134, and then move forward with a vote.

If we believe it's a standalone measure and we accept the committee's recommendation, need to get the NQF endorsement, it goes through as an independent measure.

Is that correct?

Dr. Pickering: Yes.

Co-Chair Morrison: Okay.

Dr. Pickering: Correct.

Co-Chair Morrison: So are people clear on that or clear as mud?

Cristie, I see your hand up. Clear as mud, I'm sure.

Member Travis: Well, it also begs the question of what does it mean for something to be paired? And so, for example, are they reported together?

What, what does it mean other than philosophically we think about them as paired?

From a practical standpoint, how does it look on IQR if these measures are paired?

Mr. Perla: I can answer that, Sean and Matt.

Co-Chair Morrison: Sure.

Mr. Perla: Great question, Cristie.

So I think just to be clear, these are two individual measures. The pairing just means they would both be included in IQR, just like we have three different measures for excess inpatient hospital days. We've got a separate measure for pneumonia, a separate measure for heart failure, and AMI. We could have more than three, we could have less than three, but the decision was three.

And so, basically, pairing I think is basically just saying that both of them would be included together.

And our strong recommendation, speaking on behalf of the measure developer, is that they are both included because a lot of the psychometrics that have been done on these have been done on the assumption that the screening was done and the result is known.

To separate these out calls the question in terms of the validity. And it also calls for serious questions around health equity. What does it mean that the hospital group would accept a measure where we agree we'll screen, but we aren't going to make visible the report or the results.

So I think those are the, those are the questions that we had. That's our thinking as we were developing the measure. But, again, these are two individual

measures. The pairing just means they would both be included in the IQR domain, the domain that we had formed as the clinical process of care measure. And that's where we put it. So you see those two measures in that domain and report on them.

Co-Chair Morrison: Thank you, thank you.

Okay. If there are no other -- thanks, Cristie, again, for that. So if there are no further, if there's nobody else, could we, can we move to vote on whether to accept the staff initial recommendation?

Matt, I think it's up to you guys.

Dr. Pickering: Yeah. Just looking through.

Okay. I think we can move to a vote on this Measure 134.

Ms. Harding: Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the Hospital IQR Program.

Do you vote to support the staff recommendation as the workgroup recommendation?

Okay. Voting is now closed for MUC2021-134.

And the responses are 13 members responded yes; and 11 members responded no. And that gives us a percentage of 54 percent.

Co-Chair Morrison: So that is below the filibuster line. So now we move to a discussion. Correct, Matt?

Dr. Pickering: That's correct. We need to start with open the measure to our lead discussants who are listed on this slide.

Co-Chair Morrison: So, Jennifer, why don't we start with you.

Do I have you, Jennifer?

Member Lundblad: Yes.

Sorry, are you able to hear me?

Co-Chair Morrison: Now we are.

Member Lundblad: Great. Thanks.

So as we put in the chart, we're really supportive and excited to see this set of measures appearing before this group and being able to move forward. And I think that it's an important signal that hospitals should be looking beyond the walls of their hospitals to care for patients in the community. And so the screening, the 136 measure, makes enormous sense to us.

But we, we remain concerned about reporting what is essentially a demographic measure of what the social needs are in a community. Those are really important things to do. And every hospital should be doing that.

But just for purposes of comparison for benchmarking for these payments and reporting programs, it does not feel like this is a quality measure. It's absolutely essential work so that care plans can be appropriately developed. And all of the public comments were really eloquent in describing that.

But I think that the signal to send is reporting the screening, that screening is occurring, and that the actual percent positive on those five areas does not constitute a performance measure for reporting and payments in person and benchmarking from our comparison.

So I, I voted in support of what the staff recommendation was, that's essentially unpairing these two measures.

Co-Chair Morrison: Maryellen.

Member Guinan: Very well said, Jennifer. I concur.

I think to take the words of a panelist from a recent

CNF Innovation Center webinar, you measure what you treasure, which is I think a good variation of the sayings around measurement. And so that's why I think we fully support the screening measure and think that will drive us forward in this conversation around health equity.

I think the point that's been made earlier in terms of there being this kind of full circle or feedback loop that we're creating between first, started a screening; next step being that, you know, what is the impact to your patient population in terms of the screening. But then there is that important third final step of the navigation and referral.

And we don't yet have that part of it. And so I think throwing this measure in the mix right now sort of convolutes it and confuses patients and consumers, especially if it's reported publicly.

And not to mention just other stakeholders that are looking at this information and seeing a rate, and tying that to a hospital without real context about the patient population, as well as, you know, what then happens after that positive rate in terms of the connection to the navigation and those resources.

So we support NQF's recommendation to not support for rulemaking.

Co-Chair Morrison: Got it.

So, Jennifer, and I just want to -- don't want to put you on the spot, but I just want to be clear because there was some confusion of mine. When you say you support the committee, the support is for do not support. Is that correct?

Member Lundblad: Correct.

Co-Chair Morrison: Okay. I just wanted to be clear.

Member Lundblad: No, it's a double negative; right?

Co-Chair Morrison: Yeah. I get it. I get it.

Sarah, you're our third discussant.

Member Nolan: So you won't get a double negative from me.

So I voted no because I think that this should be paired with 136. You know, I can't -- well, I would start by saying, you know, I represent an organization that is made up of mostly low income people of color who are impacted by socialism and health every day. And who work in health care facilities they are mostly treating and caring for people were impacted and have health-related needs.

And they work for an organization that has an official position committed to dismounting structural racism and does not believe that you can address health inequities or economic inequities without addressing racial inequities.

That's where I start from.

I would say that having done my homework to an unusual degree for this meeting, I just remain baffled by why would you do screening and not report the results? It kind of reminds me of conversations I had when I was a teenager with my parents where they wanted to kind of ask a question but didn't really want to hear the answer.

And I think it is, I think, it's crucial to have this data. I totally, I appreciate some of the concerns that have been raised. And I appreciate the fact that the IQR is focused on providing information to consumers. But I would say it is also focused on sort of broad system change. And it is not clear to me how we ever achieve that system change if we're not actually, if we're not always asking the questions about the reporting.

The answer, and what was really interesting to me about the public comment is Dr. Conroy's discussion of some of the work that BMC is doing. I actually 15 years ago wrote a large part of Massachusetts' health

care reform, but weeded out the first pay for reporting measures. And I had no idea that 15 years later it would lead to where I was glad.

And so I think it seems to me a lot of the objections that were reflected in the preliminary analysis to actually reporting the positive screen are related to inability to act on it in any meaningful way today.

But I don't, from an old time user perspective, I'm not sure how you ever act on something and how you ever address an inequity if you don't have clear data about it, and if you don't sort of put out the information and create the demand for change.

Co-Chair Morrison: Thank you, Sarah.

Let me open it up to the rest of the workgroup. And if you're putting your hand up, just jump in, because it's hard for me. I still haven't figured it out.

Member Joseph: Hi. This is Vilma Joseph.

I think Sarah said it so eloquently. Really, it's just the fact that we need to have data. And I think once you get the data then we'll find that resources will be utilized to make some innovative changes. I think that if we just have screening by itself, you're going to find a little bit of apathy. Say, okay, I've completed the task and I don't have to put any more resources into improving the conditions.

So, you know, I'm thinking in terms of anesthesiology. This is a great idea. And we have preoperative anesthesia clinics. And you can imagine that if they added that to their screening tools it would be great. And, therefore, you can see what people are doing to find resources to improve the social terms of health in the community.

So, again, I'm in favor of having the information available. Again, it could be something where you report back to the hospital. You know, because, you know, the social risks, you know, they're just going

right back to the hospital. It's not up to public reporting yet.

So I think the hospitals need to know. And I think it's time for this kind of innovation.

Co-Chair Morrison: I've got Suellen and Marty. And just, just so everybody knows, the chat is recorded, so the comments in the chat will be taken down. I really appreciate you guys typing them in.

Member Shea: Sure. This is Suellen.

I worked at a facility where the social determinants of health is an enormous issue. And we didn't have the resources in which to do anything about it.

And so in order to drive improvement, we need to then attach to it some sort of outcomes, so where do I need to focus my efforts. If I find that my patient population needs transportation, then what can I, as a health care institution, do about that? What are my resources, that sort of thing. Because without tracking that data specifically, I'm not sure how we could then drive the effort.

Co-Chair Morrison: Thanks, Suellen.

Marty.

Member Hatlie: My comments are very similar. I think that social determinants issues cannot be solved by hospitals or health care alone. It takes the attention of political leaders.

And the data that would be generated from public reporting would help hospitals, like, to get the attention of political leaders that need to weigh it and ensure that they have the resources to meet the needs of their communities.

So I think it's a very important reason for advocacy as well to report that.

Co-Chair Morrison: Anybody else?

Dr. Pickering: Aisha has her hand raised.

Member Pittman: Yeah, it is.

I think what we're all struggling here -- with here is the public reporting nature of it and how patients are going to use this information. I wonder if, and sort of resonating with Vilma's comments of the hospitals need that information but maybe it shouldn't be publicly reported, maybe there is direction that we could give from the measure developers with the first measure that the information is collected in a way that CMS can give confidential reports back to hospitals about their rate, and how other hospitals in their regions or areas are scoring on that rate, rather than having it publicly reported. Just throwing it out there.

Because I'm in the do not support camp for a lot of the reasons stated, and how do you use this information for public reporting. And maybe there's some in-between of how we can direct CMS to structure the other measure so that it can give some confidential reports back to the hospitals.

Co-Chair Morrison: So let me --

Dr. Schreiber: Can I clarify what Aisha just said?

Co-Chair Morrison: Please, go ahead, Michelle. I was going to ask you to.

Dr. Schreiber: Because I know we would certainly listen to those kind of recommendations. And so if you put support with, you know, conditions, or do not support with mitigation, we would take that under advisement. But I do want the committee to recognize that, in general, once we collect data we have to make it publicly available.

And so I think that our ability to suppress it or to use it for confidential feedback would be something that we don't normally do. And I'm not -- I can't, I can't guarantee that we could do that.

Co-Chair Morrison: Got it. Thanks, Michelle.

Any last thoughts? I'm going to try and summarize the discussion and see if we can move us forward.

Dr. Pickering: I don't see any hands raised.

Mr. Perla: Can you guys hear me?

Co-Chair Morrison: Is this, is this clarifying?

Mr. Perla: Yes.

Co-Chair Morrison: Okay.

Mr. Perla: And this is speaking to the conversation that folks just had around public visibility, this is something the measure developer thought pretty intensely about.

Just wanted to put on the record that we were in the same spot around never events for surgery, and wrong site surgery, and other things that folks definitely didn't want to be public because of a misperception. The questions are on the degree of visibility we decide to bring to these things.

So just wanted to get that on the record.

Co-Chair Morrison: So what I'm hearing is a lot of support for the concept of measurement. The concerns that I'm hearing relate to a lack of NQF endorsement, the question of carrying this measure.

And I think the other big concern that I've been hearing is whether this measure is the right fit for the IQR program. Because of what I think I saw in the chat, what I definitely saw in the chat was the question of is this usable or can patients use this information to make appropriate choices in the IQR program?

So the next step is for us to try and, try and come down where we might -- whether there's consensus around, consensus around category. And I'm not sure

that I'm seeing that. Because what I'm hearing is that there's both a strong group for the group that has thought around approved with conditions. And then there is another group around do not support. And it doesn't seem like we've got consensus on either.

Matt, can I get some guidance?

Dr. Pickering: Sure, Sean. And I do see that Sarah has her hand raised. And then we'll circle back to you, Sarah.

So in a case where there is not really clear consensus from the conversation, we start from the top. And we can start with support for rulemaking. But it sounds like from the committee it sounds like that wasn't a discussion point. But that's our policy is, or process, we start from the top.

If there's no decision that could come through the discussion, we'll start at the top from support, support for rulemaking, and then go down. And we'll go to conditional, and then support with mitigation, and then do not support.

I will just emphasize as well that if we go to conditional, the conditions need to be clearly articulated what the conditions are in order to support for rulemaking. The same thing with do not support with a potential for mitigation.

So just wanted to clear that up.

Sarah, did you have another clarification item before we go to vote?

Member Nolan: Yeah. It was actually kind of directly related to the topic, which is as I said, my instinct is for conditional support. But it seems to me it would, it could also be useful to consider what -- what it might look like to adopt the next level down, so support the opportunity for mitigation.

And I guess until we do that, when we get to that vote, and I'm simply raising that because it seems

incredibly harsh to completely dismiss, to vote this down when I think a lot of people recognize the value of the measure. Again, recognizing all the concerns people have raised.

So it's really a pop-up question: is it worth having that discussion; at what point do we have it?

Co-Chair Morrison: Okay. Got it, Sarah.

So I'm going to take Chair's prerogative and say we're going to start with approve with conditions, and see if I can get a motion from somebody for that with the conditions they want put on it. The two that I've heard is NQF endorsement, and pairing with Measure 136.

Does anybody want to put one forward? If not, we will move down.

Dr. Pickering: Sarah, I see your hand raised again.

Member Nolan: Probably because I didn't take it down. I thought I did.

Dr. Pickering: Oh, sorry.

Co-Chair Morrison: Matt, should I just go down one? Or do we do a vote? Because I don't have a, I don't have a motion.

Dr. Pickering: Well, so if there's no motion for conditional, we'll start with support.

Co-Chair Morrison: Okay.

Dr. Pickering: If there's no motion for any decision category, then we'll start with support for rulemaking and we'll go down the list.

Co-Chair Morrison: Okay. So we're going to start. Click, vote on do you support this for rulemaking.

Dr. Pickering: Okay. So we'll go to the vote.

And I will just read off, since Jan from UPMC, she is

on the line. Her name is Jan Donis. She's having some audio issues. So I am just going to read off that she is senior director of value-based care at UPMC. And she also has no disclosures. There's nothing to disclose.

So thank you, Jan, for participating. Sorry that we were having some audio issues. Hopefully, we can get that resolved. But thank you for providing your disclosures.

All right, Ivory, I'll turn it to you.

Ms. Harding: Thank you.

Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health to be used in the Hospital IQR Program.

Do you vote support for rulemaking?

Okay. Voting is now closed.

The responses are 3 members voted yes; and 20 members voted no.

Dr. Pickering: Okay. So now we move to conditional, or to approval with conditions. The current conditions from staff are NQF endorsement.

Do I have any other conditions?

All right. So I think we go to a vote to endorse screen positive rate for social drivers of health under the condition that it is NQF endorsed.

Member Travis: I have a question, Sean. I'm sorry. I didn't come off mute.

Co-Chair Morrison: Yes.

Member Travis: If we were to vote for conditional support with the condition being NQF endorsement, in my opinion that does not take into account the IQR program specifically or where this measure is being proposed or considered. And if we were to vote for

condition with NQF endorsement, and then NQF endorsed it and it doesn't look at how it's going to be used, I assume then NQF, we are saying you can put it in the IQR program -- or we recommend you put it in the IQR. They could put it in there one way or the other.

But do you see?

Co-Chair Morrison: Yes. A the former co-chair, Cristie, you have got it spot on.

It is not, it is not the standing committee's role to decide on the program it's used in. That's our role.

So, yes, so if it is NQF endorsed, CMS can decide to put it in the IQR program. As you said, they can put it in at any time, anyway.

Member Travis: So we would be saying it's fine with us for them to put it in there.

Co-Chair Morrison: We would be saying it was fine with us. Yes, that is correct. That is correct.

Member Travis: Thank you.

Co-Chair Morrison: Thank you.

So I am still hearing conditional support; condition being NQF endorsement. I think we should go to a vote then.

Dr. Pickering: Okay. Then we'll move to a vote.

I read for conditional support for rulemaking, and the condition being NQF endorsement.

So, Ivory.

Ms. Harding: Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the Hospital IQR Program. Do you vote conditional support for rulemaking?

One more second. Okay. Voting is now closed for

MUC2021-134.

And the responses are 9 members voted yes and 14 members voted no. That gives us 39 percent.

Co-Chair Morrison: Okay. Matt, since we have not discussed mitigation yet on the committee, can you just remind us what we're voting on?

Dr. Pickering: Right. So going to do not support with the potential for mitigation means there are some material changes to the measure that the committee -- or the workgroup, excuse me, would like to see with this measure prior to rulemaking.

So material changes are things like large changes to the measure specifications requiring any sort of re-testing, any other changes to the measure that really just changes it substantially they would want to see prior to actually it being implemented in the program.

So that's the do not support with potential for mitigation.

So, yeah, these are material changes, any modification to measure specifications that significantly affect the measure result is the recommendations you would put forth for the do not support with a potential for mitigation.

Co-Chair Morrison: Thanks, Matt.

So can we go to that vote?

Dr. Pickering: So if we did, we would need to hear what those potential changes would be, if the committee had any.

Co-Chair Morrison: Right. Well, I'm not -- I guess the question, Matt, I'm not sure that I heard any.

Member Gandhi: Oh, I have a comment. This is Tejal.

So I'm wondering about, because we're talking potential substantial change here, if we have a

change in here that really talked about actions based on screening positive or that the panel suggests screening positive, is that a totally new measure or could that be something that we could put into this is how you would mitigate this particular measure?

Dr. Pickering: So the question -- Yeah, go ahead, Sean.

Co-Chair Morrison: No, go ahead, Matt. I was --

Dr. Pickering: Requesting to clarify that again, it's requesting to see actions reported with the measure?

Member Gandhi: Yeah. I mean, understanding, you know, the concern raised that that screen positive actually then were referred for some other service or, you know, you could figure out what the definition of action is.

And it seems like in the chat as well that really what we're trying to get at is you screen positive and then you actually do something about it as opposed to just screening positive.

So my question is, is that just an entirely new measure versus could that be a recommendation to sort of modify this measure?

Dr. Pickering: It could be, it could be a recommendation. Sorry, Sean. It could be a recommendation for mitigation.

Co-Chair Morrison: Yeah. I was going to say it probably could be a recommendation for mitigation. It's sort of on the fence. As a measure person, it's kind of on the fence.

But, would you like to propose that, Tejal?

Member Gandhi: Yes, I would.

Co-Chair Morrison: Do I have somebody who would second that?

Member Shea: I second it.

Co-Chair Morrison: I have a second. Thank you, Suellen.

So the vote is do not --

Member Wisham: Sean, this is Lindsey.

Co-Chair Morrison: Yes.

Member Wisham: Can I actually introduce a second condition?

Co-Chair Morrison: Sure.

Member Wisham: I think that if we're going to be reporting and using basically the input from the standardized tool, or the tools that aren't therefore standard, I think you really need to look at to make sure that the answer values are in alignment with how they're reported then.

So how does one of the -- how does instability or food insecurity actually get measured and codified? I think that's an important part of this. If we're going to be taking the percentage and then, obviously, identifying, as Tejal said, the action off of that.

So I think there's an element of standardization of how do we define the data elements of each of these questions?

Co-Chair Morrison: Okay.

Member Nolan: Sorry. Could I just ask a question about that?

So if you've got more initiatives that do what they do for the measure?

Member Wisham: And what we learned in 136 is that the measure is considered separate from the actual tool. The measure should stand as it is outside of the tool, even though the testing was dependent on it.

So that's kind of where my comment was coming from is I could accept that as far as 136. But when we get into 134 and actually reporting that there was a recognition that one of these questions was scored positively, then I think we get into making sure that they're in alignment, so that these elements have to be more specifically defined.

Co-Chair Morrison: Okay. So I'm hearing in terms of mitigation pieces NQF endorsement linked to actionable -- I was going to say actionable actions, but that doesn't really come.

Dr. Pickering: Maybe interventions.

Co-Chair Morrison: Thank you. Actionable interventions. And what I'm really hearing is data -- measure reliability and validity which would, hopefully, fall under NQF endorsement per se.

Is that right?

Member Wisham: Yeah. Data, data element more than measure. But, yes, Sean.

Co-Chair Morrison: Okay, data element.

Okay. So let me see. Sarah, were you the one who initially proposed the measure? Who initially proposed?

Member Travis: Tejal.

Co-Chair Morrison: Tejal. Tejal, are you okay with those friendly amendments?

Member Gandhi: Yes, absolutely.

Co-Chair Morrison: Terrific.

And then, Denise, are you okay secondary, as a secondary to those friendly amendments? She is.

Okay. We will go to a vote on that.

Member Travis: Excuse me. I don't know if

mitigation, if NQF endorsement is a mitigating factor, but I would certainly want this measure to be NQF endorsed.

Co-Chair Morrison: I think it's a mitigating factor. Yep.

And we add a third friendly amendment.

Member Lundblad: Clarifying question as well?

Co-Chair Morrison: Yes.

Member Lundblad: If we approve with mitigation, is there a role for this workgroup again? Would the measure come back here with those mitigating factors, or we would just trust the process that you voted?

Co-Chair Morrison: We are not approving that. No, no, no. This is disapproval with mitigation.

Member Lundblad: Okay.

Co-Chair Morrison: We've gone, we've already decided we're not approving.

Member Lundblad: Yes, okay. Just checking on the process.

Co-Chair Morrison: Yeah. So, Jennifer, you'll see it again.

Member Lundblad: Yep.

Co-Chair Morrison: Depending on what CMS decides to do.

All right, let's go to a vote.

Dr. Pickering: All right. So just to confirm, the mitigation here was that do not support with potential for mitigation with the change to the measure that you want to see action -- actionable interventions, as well as testing of the data elements to ensure standardization, which would be captured under the

NQF endorsement process.

So those would be the mitigation points.

Okay. Go ahead, Ivory.

Ms. Harding: Voting is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health for the Hospital IQR Program.

Do you vote do not support with potential for mitigation?

One more second. Okay. Voting is now closed for MUC2021-134.

And the response are 18 members voted yes and 6 members voted no. And that gives us a response of 75 percent.

Dr. Pickering: Okay. So, Sean, we're now at 2:55. I was thinking of maybe doing a little break if that's okay for folks. We've been at this for a little bit. And maybe give them about 10 minutes, so coming back at 3:05. Would that be okay, Sean?

Co-Chair Morrison: That works for me as I have successfully got us way behind already. But we will catch up because a team will be taking over soon.

Dr. Pickering: All right. Well, thanks, everyone.

So we'll take a 10-minute break, reconvene at 3:05 Eastern, 3:05 p.m. Eastern. And we'll pick up with the Hospital Commitment to Health Equity.

(Whereupon, the above-entitled matter went off the record at 2:55 p.m. and resumed at 3:05 p.m.)

Dr. Pickering: So I have 3:05 p.m., I'm just going to see who is all back, and also, Ivory, I see you. Can you hear me, Ivory? You can just do a thumbs-up if you can hear me okay.

Hi, Sean.

Co-Chair Morrison: Sorry about that. I didn't realize I was both on mute and off video.

MUC2021-106: Hospital Commitment to Health Equity

Dr. Pickering: No worries. I think we're going to bring this back up. We're going to start MUC 2021-106: Hospital Commitment to Health Equity. So, Sean, I can take it from here.

Co-Chair Morrison: If you could?

Dr. Pickering: All right, so as you can see on this slide, we're now talking about the hospital commitment to health equity. This is still for the IQR program so it's still for hospital IQR.

The description of the measure you see listed, it's among the Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disability often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics.

Strong and consistent hospital leadership can be instrumental in setting specific measure-attainable goals to advance equity priorities and improve care for all beneficiaries.

This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.

So although performing well on this measure does not guarantee the provision of equitable healthcare or a reduction in health disparities, the measure was constructed to represent some fundamental activities that are likely necessary for a hospital to address healthcare disparities.

For some of the domains, there's a direct evidence in

the literature of hospitals and health systems implementing similar activities as a pre-cursor to successful reduction in healthcare disparities, such as standardized data collection and use of stratified measures.

Many important organizations, such as the Institutes of Healthcare Improvement Joint Commission and the Office of Minority Health, are promoting the importance of strategic planning around reducing disparities in healthcare.

Finally, evidence from other critical quality improvement initiatives have demonstrated the benefit of leadership engagement and quality improvement collaboratives focused on reducing disparities to produce meaningful improvements.

The level of analysis is the facility level. For this, NQF recommendation is do not support for rulemaking.

The preliminary analysis mentions that this measure assesses whether the hospital has developed a plan to address health equity issues, has collected and analyzed the data needed to act on the plan, and has evaluated their progress towards obtaining their objectives.

So if approved for rulemaking, this measure would be both the only structured measure and the only measure addressing health equity in the IQR measure set.

And thus, it would present an important first step to addressing meaningful measure area. However, reducing healthcare disparities would represent a substantial benefit to overall quality of care.

The literature currently does not closely link this measure to clinical outcomes. Likewise, a performance gap at the individual hospital level and specific structural elements has not been well established in the literature.

So finally requirements for the IQR include that the proposed measure must be fully developed, tested and validated. Field testing and face validity evaluations have not been conducted.

Thus, why there is a do not support rulemaking. For the advisory group input, rural health, one to five scale, five being the best and in alignment with rural health.

There's a 3.9. The comments there was that elements of the measure seem appropriate for rural settings but not seeing any evidence in the literature for the elements of this measure to clinical outcomes.

There was also some question on whether patients are engaged in their primary language and the developer provided a response that hospitals can leverage internal resources to engage their patient populations with differing languages.

Overall, the advisory group did agree the measure has importance for health equity. One to five scale, the average was 3.7 with 5 being the highest. There are certain things that are not present in this measure.

This is input from the health equity advisory group, such as community engagement and transparency. They didn't see that reflected in the measure.

Again, they rated it a 3.7. As far as the public comments received for this measure, there were five supportive comments supporting the direction of this measure.

The next iteration of structural measures we'll need to consider strategies to develop solutions to the problem. They're supportive, noting that this is a crucial step to achieving health equity and they support the concept.

But if CMS pursues a structural measure, it should be specific to advancing specific efforts, so a structural

measure on collection of social determinants of health will better support CMS efforts to understand how to incorporate social determinants of health information.

For non-supportive comments, there were two.

They encourage CMS to shift the focus from developing this type of measure and target those measures, initiatives, and activities that prioritize the collection and reporting of additional relevant disparity data that promote interventions that address them.

And it encourages CMS to explore other measures that are more directly linked to quality improvement and accountability, while also minimizing reporting burden for hospitals.

Therefore, the request for MAP from this commented was to assign the highest recommendation of a do not support. So with that summary, I'll turn it back to you, Sean, for any clarifying questions.

Co-Chair Morrison: Thanks, Matt. Clarifying questions from the Workgroup? We're clear, I guess. Okay, we are very clear, Matt.

Dr. Pickering: I don't see any hands raised and nothing in the chat from the Workgroup so we could go to a vote for upholding the Staff's preliminary analysis.

Co-Chair Morrison: Everybody go to your vote screen and this is to uphold the Staff analysis of do not support. Correct, Matt?

Dr. Pickering: That's correct.

Ms. Harding: Voting is now open for MUC 2021-106: Hospital Commitment to Health Equity for the hospital IQR program. Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed for MUC 2021-106: Hospital Commitment to Health Equity. The responses are 19 Members voted yes and 4 Members voted no.

That gives us 82 percent.

Co-Chair Morrison: Thank you, Ivory, and thank you Committee. Matt, could you introduce the next MUC?

MUC2021-122: Excess days in acute care after hospitalization for acute myocardial infarction

Dr. Pickering: So the next measure under consideration is MUC2021-122. This is excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI).

The description for this measure is that it estimates days spent in acute care within 30 days of discharge from the inpatient hospitalization for AMI.

This measure is intended to capture the quality of care transitions provided to discharge patients hospitalized with AMI by collectively measuring a set of adverse acute care outcomes that occur post-discharge.

So either in the emergency department visits, observation stays, and unplanned readmissions at the time during the 30 days post discharge.

Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. Days spent in each care setting are aggregated for 30 days post-discharge with a minimum of half-day increments as a facility level measure.

That NQF recommendation is suppression for rulemaking and the measure under consideration totals ED visits and observation stays and readmissions for patients 30 days after discharge following an acute myocardial infarction.

The measure is currently included in the IQR program, the measure under consideration updates the minimum admission threshold, the measure distinguishes itself both for its condition specificity and the inclusion of other healthcare visits beyond hospital admissions.

The measure is currently NQF endorsed and thus, having the support for rulemaking. For rural health and health equity inputs, rural health on a 1 to 5 scale is 3.7 overall.

And some raised concern in the Rural Health Advisory Group that this measure is not relevant to rural areas as most patients are transferred to other facilities for treatments, or are treated in the outpatient setting.

For health equity, on a 1 to 5 scale, it was a 3.3 There was some concern with misaligned incentives with this measure but overall, there was a 3.3 evaluation or polling for health equity.

As far as the public comments, there were three non-supportive and zero supportive. So for the three non-supportive, it was mentioning that even with an increase of cases to a minimum of 50 commenters, I do not believe the measure meets what is considered to be a reliability threshold of 0.6.

Because the minimum number of cases that would be required to achieve this threshold is 300 commenters and anticipate that it will significantly reduce the number of hospitals to which the measure would apply.

As a result, the commenters did not believe the measure is appropriate for the program or recommends the highest level for the NQF recommendation of do not support.

Sean, I'll turn it back to you for any clarifying questions.

Co-Chair Morrison: Thank you, Matt. Clarifying

questions from the Workgroup for the developers or for CMS?

I am not seeing any and if I don't see any, that means we will go to a vote on the Staff's preliminary recommendation. I think, Ivory, that is you again.

Ms. Harding: Thank you. Voting is now open for MUC2021-122: Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI) for the hospital IQR program.

Do you vote to support the Staff recommendation as the Workgroup recommendation? A few more seconds. Okay, voting is now closed for MUC2021-122.

The responses are 19 Members voted yes and 4 Members voted no. That gives us 82 percent.

Co-Chair Morrison: Matt, next one?

MUC2021-121: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty

Dr. Pickering: So the next one up is MUC2021-121: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA).

So this is a risk standardized payment where previously, we saw the risk standardized complication rate. So this is the standardized payment associated with those episodes.

The description of the measure is as follows.

The measure estimates hospital level of risk-standardized payments for an elective primary total THA and TKA episode of care, starting with an inpatient admission to a short-term acute care facility, extending 90 days post-admission for Medicare fee-for-service patients who are 65 years

and older.

It's a facility-level measure. This measure receives conditional support for rulemaking as it's a fully developed contested measure, addressing risk standardized payment for elective THA and TKA.

The development does cite evidence that this risk standardized payment hospital level as a median of $22,408. There is variation as well that demonstrates a range of performance and opportunity for improvement.

No other measures in the hospital IQR program addresses payment for elective THA and TKA, and this measure is currently in use and has been expanded to include 26 codes for the mechanical complications definition.

So the conditional support here is pending NQF endorsement due to that expansion of those 26 codes and that's where the conditional support comes into play.

As far as the rural health and health equity, rural health was 3.9 on that 1 to 5 scale. It had mentioned some concern about rural patients being excluded due to transfers from rural health facilities.

And for health equity, it was 2.5 on that 1 to 5 scale. There was concern whether variation in payment has influenced by disparities in care.

This is a dynamic area. In moving from inpatient to outpatient and those in the outpatient settings are usually younger people. This measure should monitor equity over time.

There is also concern about pairing of this cost measure to a quality measure. This measure alone may not adequately reflect care received as some patients may not have access to these treatments.

For the public comment, there were three supportive comments encouraging CMS to update the testing

and achieve endorsement of these changes by NQF before implementing in any quality program.

So as a result, the commenters urged the MAP to consider the conditional support for rulemaking. With that, Sean, I'll turn it back to you for any clarifying comments.

Co-Chair Morrison: Clarifying comments, questions to the developers? I know we had an earlier measure around THA and TKAs but this is around risk standardized payments rather than complication rates.

I know Mary-Ellen's question just got answered. Other questions, thoughts, clarifying questions? Going once, twice? Okay, we will go to a vote.

The recommendation is conditional support for rulemaking, the condition being NQF endorsement.

Ms. Harding: The voting is now open for MUC2021-121: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA) for the hospital IQR program.

Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed for MUC2021-121.

The responses are 23 Members votes yes and 1 Member voted no. That gives us 96 percent. Co-Chair Morrison: Just before we jump one further, I wanted to just go briefly back at Dr. Schreiber's request to 21-106, which was the commitment to health equity.

We endorsed the Staff's recommendation on do not support for rulemaking based upon their conditions.

And Dr. Schreiber asked if there were additional concerns with this measure that were not reflected in the Staff review that people would like to share with

CMS.

Dr. Schreiber: If I may, thank you for allowing us to have a few minutes.

This is a measure that we had been working with our developer to look at and we think that it's actually important to look at and have hospitals attest -- this is an attestation of a structural measure -- that they're actually doing these actions to support equity across the hospitals.

The vote was quick without any comment from the Committee and CMS is interested in hearing feedback from the Committee, and if there are any questions to the measure developer.

But in particular, to see if there is feedback to the Committee about why such opposition and what could be improved.

Co-Chair Morrison: I'll take my Co-Chair hat off. I think speaking for myself and why I vote, this was a structural check box measure.

I can't imagine anybody saying no to this one and I'm not sure what value it brings in addition to all the conditions that Staff brought forward as do not recommend it.

Again, it's critically important we work on it, this is just not the measure to get at from my opinion.

Member Nolan: This is Sarah Nolan just echoing that. It seemed like if this is the goal then it's maybe better achieved through changes to Medicare conditions of participation or something like that.

Member Hatlie: This is Marty. I voted no here because I think measures like this are important. I think they send a signal to the field.

The risk is it's going to be check the boxes there, I get that but this is also setting expectations about what we expect hospitals to do.

I was glad to see the structural measure on maternal and child health was put into implementation because it seems similar to me to this one.

I think we need to be looking at structural measures like this more positively. So I'm glad Michelle brought this up because I wanted to make that comment and we didn't have time to do it earlier.

So thank you, Michelle, for bringing it up and giving me a chance to support it.

Co-Chair Morrison: And again, just to be very clear about the process, there's pretty unanimous decision that we're not going to spend time on a discussion after a vote because we will never get through the day.

Dr. Schreiber: I appreciate that, Sean, I just wanted to an opportunity to hear directly from the Committee.

Co-Chair Morrison: No problem, I get it.

Co-Chair Demehin: Hey, Sean, do you mind if I take my Co-Chair hat off for just a minute too?

Co-Chair Morrison: Go ahead.

Co-Chair Demehin: Michelle, when I took a look at this measure, I think I struggled a bit with do not support versus do not support with potential for mitigation.

And I think one of the challenges I have with this particular measure is it's awfully long and there's so many different components, that I would worry a little bit about whether you're capturing a consistent set of information across hospitals.

Because there's so much in there that I suspect could be somewhat subject to interpretation that I worry a little bit about collecting a consistent signal across hospitals.

The other thing that I worry a little bit about is, actually maybe even a little bit more than that question of details around how you interpret various components of the measure, how one might publicly report this.

I don't think that reporting as a percentage out of five makes a whole lot of sense in part because it says, well, as a hospital 20 percent committed to equity, 40 percent committed to equity.

Whereas, I think the underlying nuance of the measure is a lot more complex. Matt, I'm actually quite empathetic to Marty's perspective on this, which is there is a place for structural measures in quality reporting programs.

I think that place is very limited and we have to be very thoughtful about how we do it. So that's the thought process that I went through in trying to size up this measure.

There are certainly aspects and practices in here that I think are really worthy. If one were to go back and reconsider this measure in the future, maybe focusing on a shorter list of practices, especially those where you have data that shows gaps in terms of where hospital practices should be, I think that would be incredibly useful.

Member Hatlie: I'd welcome a discussion about this when we have more time about the role of structural measures in this whole process. At some appropriate time in the future, let's consider that.

Co-Chair Morrison: Okay, can we move on, guys? Matt, can you introduce the opioid-related adverse events?

Cross-Cutting Measure: MUC2021-084 Hospital Harm – Opioid-Related Adverse Events

Dr. Pickering: I certainly can, and I believe we say, thank you, Sean, for going through all those sets of

measures.

We'll now go to a team to facilitate the next measure, which is across two different programs, the hospital IQR as well as the Medicare Promoting Interoperability Program.

So I guess we'll turn it to you to see if there's any comments from the public from this measure in relation to those two programs. I think you're on mute.

Co-Chair Demehin: Sorry, as we have with prior public comment periods, we'd ask that you limit your comments to this particular measure. And if you're providing those comments live, please limit your comments to two minutes.

Dr. Pickering: Do members of the public have any comments to raise for the hospital harm opioid-related adverse events measure for IQR and Interoperability Program?

Please do now within the chat or raise your hand, or take yourself off mute. I'm not seeing any hands raised or any messages in the chat.

Co-Chair Demehin: In that case, I guess we can move on to talk about this measure and its preliminary analysis. We're considering this for both the IQR program and the promoting interoperability program, correct?

Dr. Pickering: That's correct.

Co-Chair Demehin: Take it away, Matt.

Dr. Pickering: First up is the IQR program, I won't read all of this on the slide, we've been through that in the previous section. So this measure is considered for the IQR program and we'll go to the next slide, which talks about the measure.

So the description of this measure is it assesses the proportion of patient-hospital encounters where

patients aged 18 years of age and older have been administered an opioid medication subsequently suffer from harm of an opioid-related adverse event.

Our administered opioid antagonist, naloxone specifically, within 12 hours. This excludes opioid antagonist administration occurring in the operating room setting.

It is at the facility level. This received a support from rulemaking. This measure is fully developed and specified at the level of analysis it's intended for.

This program does not currently include a measure that addresses opioid-related adverse event and subsequent administration of naloxone in the inpatient setting.

The measure has been submitted for endorsement this past spring of 2021, it was recommended for endorsement by the subsequent Standing Committee.

For rural and health equity, Rural Health Advisory Group rated this a 4.2 out of a 1 to 5 scale and noted this is a good measure and no adverse effect or issues identified for rural institutions.

For health equity rated as a 3.2, some of the comments there were lower resource hospitals may have some disadvantages. Consider the inequity from a systems perspective and not from a patient perspective.

So resources to address some of these issues. And this is a great quality measure, as stated by the Health Equity Members, but I'm not sure there's an equity component here, is the question on the table from them.

For going to public comment, we received one supportive comment that supports the adoption of this measure but recommends that CMS not move forward until it receives NQF endorsement, which it

just recently did, receive endorsement.

There were two non-supportive comments questioning whether this measure demonstrates a sufficient performance gap to support the use in the IQR program, noting some data that was reported for the performance gap, around six hospitals that ranged from 0.11 to 0.45.

Again, this information was reviewed by our Standing Committees who then recommended the measure for endorsement. The other non-supportive comment is it would encourage a do-not-support with the potential for mitigation or a do not support.

With that, I'll turn it back to you with any clarifying questions.

Co-Chair Demehin: Thanks, Matt. Let me start with a question that Christie raised in the chat that I think will be helpful to hear live.

That's the question of has this measure received final endorsement or is it recommended for endorsement by the Standing Committee? Could you clarify its endorsement status for us again?

Dr. Pickering: I can, yes, thanks, Christie.

For that clarification, it is final endorsement so this was a recent CSAC decision, which is our Consensus Standards Approval Committee, who pretty much agreed to uphold the endorsement recommendations by Standing Committees.

So that's the final recommendation of endorsement and that did happen this past spring for this measure. So it's a final recommendation for endorsement.

Co-Chair Demehin: Thanks, and the next one I think is one for the measure developer and that's from Jennifer.

That is why the 12-hour window of an opioid adverse event? Naloxone reverses opioid overdoses over 30

to 90 minutes.

Is there anybody from either the measure developer or CMS who wants to clarify that?

Dr. Pickering: Do we have anyone from the measure developer on the line in PAC? Are you on?

Dr. Hall: I'm sorry, I am here. So first of all, the majority of identified events, over 90 percent have an opioid administered within 12 hours of the naloxone.

We tested up to 24 hours to account for half-lives of long-acting opioids that found an overwhelming amount.

So we started off with the 24-hour period and then we revised that on our resubmission to NQF to bring it down to the 12-hour mark.

We also found those longer-acting half-life opioids were not prescribed as frequently so it made more sense to limit it to the 12-hour period and reduce the likelihood of false positives.

As far as exclusion for the OR, Chana, are you on the line? I'm just going to bring our testing lead and our ECQM.

Ms. West: The measure only excludes the administration of the naloxone within the ER. So if it was done in order to account for those naloxone administrations that may or may not be a part of the anesthesia plan.

We did look at operating room and also look at procedural areas to evaluate whether or not it would make sense to remove that.

We did not move forward with that, particularly related to procedural areas because of the inconsistency in the documentation there as well as the use of other locations, such as ICU and not being able to codify that information in order to be able to

pull it out accurately.

Dr. Pickering: Thanks for that. There's one other question in here that you also may want to tackle, this one is from Anna about naloxone administration that's in not entirely clear-cut space, like someone experiencing an overdose.

I know you just spoke to the OR exclusion piece a little bit but could you elaborate on that?

Ms. West: I'm sorry, could you repeat it? I'm looking at the chat questions and I'm trying to follow your example.

Dr. Pickering: It's the last question in the chat from Anna Legreid Dopp.

Dr. Hall: Chana, do you want me to take it? I'm happy to.

Ms. West: Sure.

Dr. Hall: So I think, Anna, the original measure did not need to have an opioid dose that preceded it. But what we've done is if you need to have an opioid as we just answered prior to the naloxone.

So if you had somebody coming into the DD with an overdose, that would not be picked up by our measure because they would not have had a hospital-administered opioid that would flag the numerator event.

Does that answer your question?

Member Legreid Dopp: Yes, it does, Dr. Hall, thanks for that. And what about the PCAs, patients with PCAs? Is that something that you discussed as well?

Dr. Hall: Yes, that would be also be included. So patients aren't PCAs.

Member Joseph: This is Vilma Joseph, I had another follow-up question regarding the procedural

sedation.

Frequently you have non-anesthesiologists performing procedural sedation for endoscopies, sometimes they're doing cardiac caths, so they will be using opioids and they sometimes would have to use naloxone.

So that is kind of similar to what's happening in the operating room where you're doing it for a painful procedure and sometimes you have to reverse it.

So I don't think that exactly fits what this measure is trying to get at. I was going to consider adding it to the exclusion criteria.

Dr. Hall: I think the main driver of the naloxone use in the ORs is going to be less and less part of the procedural sedation plan. If I recall correctly, the American Society, the ASA, does not recommend the use of naloxone as a reversal agent.

In the procedural areas, we had analyzed the data and I'll ask Beau to back me up on this, I believe it was around 80 to 95 percent of the cases where we looked had documented evidence that it was due to over-sedation, and that is why the naloxone was given.

And then some documentation post of the naloxone given that the patient became aroused.

Member Joseph: Yes, because ASA, they definitely don't want naloxone used routinely. So that's another thing, operating room or in the procedural area.

So is this really for patients who are on the floor who are taking opioids acutely or chronically, and then you're trying to see if they need naloxone?

Or is it truly for patients who are having procedures, either where they're getting some type of anesthesia from the anesthesiologist or non-anesthesiologist who is credentialed to provide sedation.

That's a little different.

(Simultaneous speaking.)

Member Joseph: I'm saying you already excluded the OR so it sounds like you should also exclude those who are doing procedural sedation because it's pretty similar to the OR.

Dr. Hall: Understandable, but the issue is that with electronic clinical quality measures, things have to be standardized and there's no current terminology to be able to identify all of those procedural areas.

Those things aren't being identified consistently. So it wouldn't be feasible, even if we were to say we wanted to go ahead and incorporate that.

From all of our feasibility assessments and evaluations, we determined that we aren't able to do it, both from a terminology standpoint and just the feasibility across hospitals altogether.

So that could be something that could be looked at at a later point as standards evolve, but at this current state, that's not a possibility.

Member Joseph: All right, I thought you were looking at CPT codes but okay, no problem.

Co-Chair Demehin: Any more clarifying questions or comments from the Committee? Seeing and hearing none, let's move to a vote on the Staff recommendation. And that Staff recommendation is support for rulemaking.

So kicking it over to Matt and Ivory?

Dr. Pickering: Great, thank you. Jean, no hands raised, no other questions in the chat. We'll move to vote.

We are voting to agree with the Staff recommendation of support for the rulemaking of hospital IQR program.

Go ahead, Ivory.

Ms. Harding: The voting is now open for MUC2021-84: Hospital Harm Opioid-Related Adverse Events for the Hospital IQR program. Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed for MUC2021-84 and the responses are 20 Members voted yes and 3 Members voted no. This gives us 87 percent.

Co-Chair Demehin: The next issue in front of us is to consider whether we want to uphold that same recommendation for the Medicare Promoting Interoperability Program for hospitals which includes an ECQM reporting component to it.

Let me open it up to the Committee to see if there are any objections or thoughts related to upholding that recommendation?

Dr. Pickering: I'll briefly introduce here just briefly but you are correct, this will be one of those carry-over vote situations for the Committee that I'll just briefly touch on.

As Akin mentioned, this is for the interoperability program.

As you can see listed there, it's a pay-for-reporting public reporting program in which eligible hospitals and critical access hospitals, if fail to meet the program requirements including meeting the clinical quality measure requirements receive a three-fourths reduction in the applicable percentage increases.

So the goal is really to in addition to interoperability using the certified electronic health record technology to improve patient and provider access to patient data.

If we go to the next slide it just lists a description of

the measure which I won't go through in detail as we've already done this before.

The description was the same, and this is an ECQM measure, which it has been tested as an ECQM measure and gone through NQF endorsement as an ECQM measure, which we discussed previously, that is a few endorsed.

So the decision category from NQF recommendation is support for rulemaking because of that endorsement and the testing that has happened and the alignment with the program.

For rural health and health equity, not too much different here, rural health was 4.2, again noting that it was a good measure. Health equity 3.3, just again, it was not sure if there was an equity component here.

The public comments for this measure were also similar, one supporting ending NQF endorsement, which it is endorsed as of recently, and the two non-supportive noting the performance gap issues as we had mentioned previously in the other program, and in encouraging a do not support or do not support with the potential for mitigation.

So as Akin mentioned, this is an opportunity since the decision categories are the same here. If the Committee would like to carry over their votes, we can do so.

So if anyone opposes that, it just takes one person. We'll vote separately on the measure. If anybody opposes that, please raise your hand. You can take yourself off mute and say you oppose carrying that over.

Or message directly to me in the chat if you oppose carrying over the votes. Please do so now.

Co-Chair Demehin: While folks are thinking about that, can I ask one more clarifying question? This

may be more one for CMs.

I'm assuming this is a measure that is similar to how it functions in the IQR program, and would be added to the menu of available measures.

It's not one that CMS would necessarily require for reporting but it is one they could potentially require for everybody in the future, right?

Dr. Schreiber: During the Promoting Interoperability Program but if it's a measure that's in a different program like IQR, then they have to report it.

The reason that we bring it forward for the Promoting Interoperability Program is because any ECQM that we use, we also put it in promoting the PI program so that we don't have misalignment of ECQMs.

Co-Chair Demehin: Got it, thank you.

Dr. Pickering: Thanks, Michelle and Akin.

Again, last opportunity here, if you oppose carrying over the votes from the IQR program to the Interoperability Program for this measure, please raise your hand, speak up, or directly message in the chat myself.

Akin, I don't have any messages and I don't see any hands raised or anyone in the chat.

Co-Chair Demehin: All right, we will carry over the votes for that measure. That was support for rulemaking, thank you all very much, and I believe now we go back to Sean.

Dr. Pickering: Sean, that was a short break for you.

Co-Chair Morrison: Way too short. We're going to the geriatrician to run the severe obstetric complications measure.

Dr. Pickering: That's right.

Co-Chair Morrison: Matt, can you tell us about severe obstetric complications and then I will do public comment?

Dr. Pickering: We could start with public comment and then --

Co-Chair Morrison: Why don't we start with public comment?

Dr. Pickering: Yes, that's good.

Co-Chair Morrison: Do we have public comment?

Dr. Pickering: Now is the opportunity for public comment, for MUC2021-104 Hospital Harm - Severe Obstetric Complications eCQM.

If anyone from the public would like to contribute or present, please raise your hand or use the chat feature and we will recognize you.

Co-Chair Morrison: Kelly, I think you wanted to make a public comment as speaking not in your role, is that correct?

Member Gibson: Yes. I just wanted to make a comment about the measure. I wasn't sure, since I'm also here representing SMFN, if I should wait to do that later?

Other members on my committee had also sent in comment.

Co-Chair Morrison: If you are representing SMFN, make the comment publicly. If not, if you're representing yourself, then make the comment during our time for conversation. Does that make sense?

Member Gibson: Yes. Representing SMFN, obviously this impacts us and we all agree that maternal severe morbidity is an important thing to track, as it gives

us more information to where we can look for evidence of increased maternal mortality.

Which, as everyone hopefully is aware, is rising in this country and has many disparities in it. I think it's important to evaluate that with the metric but some of the things included in here we had concerns about at SMFN.

Specifically, the inclusion of things like blood transfusion and ICU admissions, and really, just overall not risk-stratifying for patients who are coming into the hospital.

Are these all low-risk patients are are they higher-risk patients at the start of their hospitalization to the fact that they had maybe one of these morbidities doesn't necessarily reflect the care they received rather than their underlying health conditions.

Co-Chair Morrison: Terrific, thank you. Other public comment?

Matt, would you like to tell us about severe obstetrics complications?

Dr. Pickering: I would love to, Sean, thank you. So we're still talking about the IQR program so again, this measure is going to be considered.

It's another cross-cutting measure for IQR and also the Interoperability Program.

We'll start with IRQ first. So this measure, as you see the description there, assesses the proportion of patients with severe obstetrics complications, which occur during the inpatient delivery hospitalization. It's specified at the facility level. The NQF recommendation on this measure is conditional support for rulemaking. This is a newly developed measure, it's an outcome ECQM, or electronic clinical quality measure.

It's a high-priority are for hospital IQR and it addresses the meaningful measure area of patient

safety.

If included in the program this measure would be the only outcome measure in the IQR that directly measures maternal morbidity and obstetric complications.

Currently, it is not NQF-endorsed so the condition here is NQF endorsement. So the conditional support for rulemaking is contingent upon NQF endorsement.

As far as rural health and health equity, Rural Health evaluated this on a 1 to 5 scale with no concerns at 4.1. Health equity on a 1 to 5 scale at 4.4.

It comments here the measure is essential for reducing disparities in thinking about ways to stratify by certain subpopulations.

And there needs to be more appropriate access to care to prevent and address these complications. It's not really clear whether this measure with help elucidate these access issues.

Overall, the rating was 4.4 out of 5. As far as public comment, all supportive, 3 supportive comments here. It will measure severe maternal morbidity diagnoses and severe maternal morbidity procedures.

They're asking the MAP and the NQF Standing Committee to consider whether inclusion of some social risk factors should be considered here and there's a recommendation at the highest level of MAP recommendation be conditional support for rulemaking pending NQF endorsement.

It encourages CMS that in any maternal morbidity measures, maternal mental health should be incorporated.

For example, with this measure which focuses on severe obstetric complications psychosis, which can onset in the immediate postpartum, should also be considered.

So encouraging CMS to consider those within mental health within these types of measures.

There was one non-supportive comment that concerns measure specifications.

So mentioning that it's complicated, the ECQM is complicated and there are sometimes complications that are not the fault of patients or the healthcare system.

So these complications do happen. Also comments around the specifications were coding for maternal medical complications is not done as thoroughly by hospitals as is done for other conditions for various reasons.

It is also very biased against hospitals that get referred the most complicated patients, so those patients that are risky or at-risk patients are usually sent to hospitals that have higher levels of maternal care.

So those were the non-supportive comments. Again, that was largely just one comment, which was a summary of the concerns and then we had those supportive comments was well.

Sean, I'll turn it back to you for any clarifying questions.

Co-Chair Morrison: Thanks, clarifying questions for the developers?

Member Wisham: Sean, I did pose a question, this is Lindsay, to Katie in the chat, just asking from the measure developer perspective if they could just expand upon the risk adjustment methodology they would be applying to this ECQM?

I think that would be helpful and I know that was actually somewhat of the questions asked in the public comment as well.

Co-Chair Morrison: Thanks, Lindsay. Yes, I was just

reading up, I just got it, brilliant.

Dr. Balestracci: Hi, Dr. Katie Balestracci representing the measure developers.

So this is a risk-adjusted measure with a great deal of investigation into the literature and many other research projects that have been done in CRE.

We identified a number of risk factors that this measure adjusts for. They would be collected with the ECQM.

It does require that they are present on admission and there was very careful investigation to make sure there was not overlap with any potential codes that might be supporting any numerator events.

I do know there's a question specifically about the housing instability variable. We were certainly interested in looking at SDOH factors.

We are somewhat limited, as many of you may appreciate, in the variables that are available consistently in EHR systems.

So this might be something that we would be re-evaluating as we move forward and as EHR facilities are better about consistently collecting SDOH factors.

I will note that maternal complications show a particularly stunning disparity base, particularly on race among other things, and we are paying attention to that and considering ways to potentially stratify this variable on that.

If I may, I also just wanted to address very briefly two comments I heard during public comment. One is that I did hear a concern about ICU admission. This measure does not have ICU admission as a numerator event.

So I just want to be clear about that. And secondly, this measure does address some concerns about transfusion and has two outcomes. We measure an

outcome for severe obstetric complications that includes transfusion.

And we put forth a secondary outcome that excludes encounters for which transfusion is the only reason a patient might reach the numerator.

Co-Chair Morrison: Thanks for tackling all those, Katie, much appreciated. Anybody else?

Member Travis: This is Christie. If I could ask a question? Your comment regarding the significant disparities, especially by race, obviously is very important.

As you're looking at the risk adjustment methodology, I know you mentioned that some social drivers of health are difficult to come by, but it would seem to me that any stratification in order for it to be helpful for quality improvement might need to happen before those types of adjustments are made in the measure.

What is your thinking relative to the timing of stratification so that the disparities are visible? I may have a follow-up question.

Dr. Balestracci: Thank you for that question. It is in fact something we are currently considering.

We are looking at approaches that would consider stratification prior to and post-risk adjustment, understanding that when we are risk adjusting for clinical factors, race can be certainly associated with some of those.

The final approach to stratification is certainly something that CMS will determine but it is currently something we are looking at based on what I think are your concerns.

Member Travis: Thank you for that. And I guess just to put a plug in, we want to be sure that we're not masking, and I know there's a lot of debate around whether we're masking any of this.

Where even in the public reporting and other ways the measures are visible to the public and to others, those disparities shine through. Then how they get used in programs may be different but having that information be visible is very important to me.

Co-Chair Morrison: And I think to others, Christie. Other questions?

Member Guinan: Sean, can I jump in? Thanks, Katie, for the part about housing. Just to probe a little bit more, is that something that is collected? You said it's collected at a mission?

So it's not something in terms of coding or Z codes or something in terms of what we have available with housing instability?

Dr. Balestracci: As the measure is presently defined and specified, hospitals are provided the list of variables for which we are risk adjusting and we are requesting codes related to those risk factors.

So we are requesting that the hospital would provide that information to us per their EHR. Does that answer your question?

Member Guinan: It's something they're screening for and they are coding already for in terms of it has to be included as a field in their EHR already?

Dr. Balestracci: Thank you, yes, that's correct. I think we can all appreciate the hope is inclusion of this variable would mean that hospitals that aren't would continue or aim to do that.

But because this is one of the SDOH variables that was most consistently available, it was one that we chose and has prior evidence in other research.

Co-Chair Morrison: Thank you. Kelly then Akin.

Member Gibson: Thank you, just one other question in terms of the risk adjustment. Are you defining a subset of patients as clinical low risk, those who have

no comorbidities coming into the delivery encounter?

And would you look at those separately than those that come in with morbidities?

Dr. Balestracci: The risk model that is developed is developed to cover all risk factors. A patient who does not have any risk factors would not obviously be reflected in various comorbidities.

But we are not running a different risk model for patients that are low-risk versus high-risk. Does that answer your question?

Member Gibson: Yes. Is it possible to see what you're risk-adjusting for in the model, for things like an --

(Simultaneous speaking.)

Dr. Balestracci: We're risk-adjusting for a whole host of variables.

I'll name a few, anemia, asthma, autoimmune disease, hypertension, gestational diabetes, cardiac disease, BMI, pre-term birth, previous caesarian.

So a number of critical comorbidities, some prior pregnancy clinical issues and we are also, again, for housing instability identifying two lab results and two vital results, first resulted value on admission as clinical factors, clinical conditions that are unrelated to ICD10 codes.

Co-Chair Morrison: Akin?

Co-Chair Demehin: Thanks, my question is really about the use of the measure in the program.

I guess what's on my mind with this measure is if you look at the rate of occurrence of these complications, it's still any complication is worth measuring here but the rate occurrence is still pretty low.

So what that leads me to is a question about testing for sample size, what minimum sample size you need

to hit.

After you do that, are there still enough hospitals included that you're getting a good sample of hospitals to include in the measure?

Do you see the thrust of my question?

Dr. Balestracci: If that was a question for me, again, Dr. Balestracci, we tested this measure in eight health systems, which among them represented 25 hospitals and tested it with just over 60,000 delivery encounters.

A variety of hospitals with regards to size, rural versus urban, teaching versus not, et cetera.

Co-Chair Demehin: And do you have a sense of, as you would apply this measure to the broad swath of hospitals included in the IQR, are we going to get enough that meet the inclusion criteria?

I'm more thinking of if you put the measure in the program, are you going to have enough hospitals that can actually get a score on it?

Dr. Balestracci: I believe so.

I think what you're asking about is this can be a relatively rare outcome, however, we are certainly finding in the hospitals that we've tested in that these conditions are occurring.

They are occurring for delivery encounters, there could certainly be consideration implementation of the measurement period if that was a concern.

And that would be a CMS consideration. But we are confident that balancing the importance of this outcome, that implementation considerations can certainly be made that make this very important for hospitals across the country and one they could participate in.

Dr. Schreiber: Akin, Michelle, if I could answer that

for a moment?

It's true there are a certain number of hospitals who don't do deliveries at all and that's probably less than a third of hospitals in the country.

So right off the top you won't obviously have reporting from them. On the other hand, I think the measure developers have found these events do occur.

In part, this measure was developed because counting maternal mortality is a very rare event and we couldn't actually get data on just looking at maternal mortality.

But maternal morbidity, sadly because it's a composite with multiple different morbidities, actually, there seems to be enough data that I think we will have robust reporting.

Co-Chair Demehin: Thanks, that is really helpful context.

The one thing that I'll point out, just to draw a through line between the conversation we had last year and this one, as we were thinking about the structural measure related to maternal mortality and morbidity, I think a lot of us were thinking through can we come back with measures that are less structural and more outcome?

This certainly is it.

Dr. Schreiber: This is what we tried to produce, Akin.

Co-Chair Demehin: Thanks, guys. Matt, can we review again the Committee's recommendation and go to that vote?

Dr. Pickering: Sure, I'm happy to. So the NQF recommendation for preliminary analysis was conditional support for rulemaking.

That condition was NQF endorsement so that will be

what the Committee or the Workgroup is voting, to uphold that decision and that condition of NQF endorsement.

So if there's no other clarifying questions, we can move to vote.

Co-Chair Demehin: We can move to vote.

Dr. Pickering: Ivory, I'll turn it over to you.

Ms. Harding: Okay. The voting is now open for MUC2021-104: Hospital Harm - Severe Obstetric Complications eCQM .

Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed.

The results are 23 members voted yes, 1 member voted no, and that gives us 96 percent.

Co-Chair Morrison: Fantastic. And I think I turn things back to Akin now, right, Matt?

Dr. Pickering: Yes.

(Simultaneous speaking.)

Dr. Schreiber: -- have to get voted for promoting Interoperability.

Co-Chair Morrison: Thank you, Michelle.

Dr. Schreiber: You're not off the hook so fast, Sean.

Co-Chair Morrison: This is just not my comfort zone, obstetrics. Yes, let me ask if anybody has an objection to moving the vote to the promoting interoperability program?

Either private message Matt or I or speak aloud.

Dr. Pickering: Just to remind everyone, this is for the Interoperability Program, which we described

previously so I won't read off this slide.

Just for this program, the description of the measure is the same so we won't go too much into detail there, as well as the facility is the level of analysis.

This is an ECQM so the measure is aligned with that program for the Interoperability Program. It did also receive conditional support for rulemaking.

That condition is NQF endorsement so this measure is fully develop as an outcome ECQM. It's not NQF endorsed so the conditional support for rulemaking would be NQF endorsement.

And similar types of feedback for rural health and health equity as we receive from IQR. Rural health on the 1 to 5 scale was 4.1, no concerns in health equity, 4.4.

And then the same concerns about essential for reducing disparities and thinking about ways to stratify certain populations. Same comments from the public.

Three supportive comments recognizing the value of this measure so those were the very same comments as the IQR program.

And then the same comments for the non-supportive, which was one commenter being non-supportive really around the measure specifications, saying it was complicated, it may bias some of the hospitals, some of the coding challenges for maternal medical complications.

So the same comments for IQR. So as Sean had mentioned, we are now considering this for the Interoperability Program.

The decision category is the same, conditional support for rulemaking with the condition being NQF endorsement.

If anyone from the Workgroup opposes to carryover

the votes, please speak up now or message me directly and we will open it up for discussion and vote separately.

So, please, if you oppose, speak up or message me directly at this point. Sean, I don't have any --

(Simultaneous speaking.)

Co-Chair Morrison: I don't have anything either so I think we are good.

Dr. Pickering: Okay, we will carry over the votes for the obstetric complications measure, that's MUC 2021-104 for the hospital IQR program, which was conditional support for rulemaking pending NQF endorsement to the Interoperability Program.

Thank you all.

Cross-Cutting Measure: MUC2021-098 National Healthcare Safety Network Healthcare-associated Clostridioides difficile Infection Outcome Measure

Now we're going to MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides difficile Infection Outcome Measure.

This is also a cross-cutting measure. This measure was submitted to four programs, the hospital IQR, the Interoperability Program, the Hospital Acquired Condition Reduction Program, and the Prospective Payment System Exempt Cancer Hospital Quality Reporting Program.

So, Akin, I will turn it over to you. I believe we will go into public comment for this measure.

Co-Chair Demehin: Yes, indeed, thank you so much, Matt.

So let me open the floor for public comment, same ground rules as before in terms of limiting to two minutes. You're welcome to add public comments in

the chat function.

Dr. Pickering: I also want to see -- sorry, I know that we have the CDC on the call for these measures. I wanted to make sure, does the CDC have any comments they'd like to share at this time for the C. diff measure?

We'll also offer that opportunity up for the bacteremia/fungemia measure when we get to that. Does the CDC have any comments they would like to share for this measure?

Dr. Dantes: Yes, this is Ray Dantes. Thank you for the opportunity to discuss this measure that we're really excited to develop here.

So this measure represents an improvement over our existing Clostridioides difficile measure in that it defines healthcare associated C difficile with two requirements now.

One, a positive C difficile test, which is similar to our existing measure, and two, the presence of C difficile antibiotic treatment, which is the new component.

This new component serves as a proxy for provider judgment of a clinical infection. Our exploratory studies have shown that improved sensitivity and specificity of our new measure compared to our existing C difficile measure.

This is a additional quality measure that will leverage advances in data interoperability such as FHIR to streamline and automate reporting for users.

We will be doing risk adjustments as well for this measure using methods similar to our current measure.

And in 2022, we'll be applying for NQF endorsement and we'll begin to make this module available on our image-sending platform with the goal of increasing our user base into 2023.

Importantly, in the meantime we will continue to support our existing C difficile measure during this transition period with our eventual goal for this new measure to replace the existing measure.

Thank you.

Co-Chair Demehin: Thanks for the very concise overview, Ray, I really appreciate it.

Matt, I think I'm turning back to you for a minute to talk just a little bit about the program and then we will open it up for clarifying questions from the group.

Did I have that right?

Dr. Pickering: That's correct.

So it is for the hospital IQR program first, is what we'll be discussing so I'm not going to go into a lot of the details again for the IQR programs since we've talked about this for a series of measures.

So we're considering the IQR program first so we'll go to the next slide, which is the description of this measure, as CDC has articulated as well.

The measure does track the development of new C. diff infections among patients already admitted to healthcare facilities using algorithmic determinations from data sources that will be available through electronic health records.

It's specified at the facility level of analysis.

The NQF recommendation is conditional support for rulemaking so this updated measure is intended to capture healthcare-associated C. diff infections more precisely than the existing similar measure in other hospital programs by only counting those infections among patients that both have a positive laboratory test and evidence of treatment.

So this measure does not address any of the hospital inpatient quality reporting program measurement

priorities but it does correspond to the patient safety focus within CMS's meaningful measures 2.0.

So in that 2018 decision to reduce the number of members in the program, they saw the removal of this measure beginning in 2021. So the measure under consideration is conceptually very similar to the removed measure.

It currently is not NQF endorsed so thus the condition here is NQF endorsement. And also the resolution of any duplication that may concerns that originally why it was removed from the program originally.

So the condition again is NQF endorsement and any resolution on the duplication issues related to reintroducing the measure to the program.

For the rural health and health equity, rural health on the 1 to 5 scale rated this a 3.9, recognizing that healthcare-associated infections are important but low case volume is a potential challenge for this measure calculation and for its reporting.

For critical access hospitals, they do not participate in the IQR but this measure does apply to other hospitals like PPF hospitals. With health equity, it is a 3.5 from a 1 to 5 scale.

The comments received from the public, there were two supportive comments and zero non-supportive.

So for the two-supportive comments, they are in support but require NQF endorsement and CMS must address that duplication of reporting of this measure as these revisions are implemented in either program.

So with that, Akin, I'll turn it back to you for clarifying questions.

Co-Chair Demehin: I already see a couple in the chat function here. I see Marty's hand is up so let me start with the ones in the chat. The first comes from Denise.

What's the rationale for counting the antibiotic two days prior to the confirmed positive test? Ray do you want to take that one?

Dr. Dantes: Sure, this speaks to health and clarifies some of the inherent imprecision sometimes with C difficile diagnosis.

And so in this particular instance, if the patient has -- and also the fact that sometimes stool is not always available on demand when a patient has symptoms for various reasons.

So, for example, we wanted to avoid the situation where, say, a patient, actually, who is at a very high suspicion for C difficile upon admission or close to that time of admission, enough that the provider actually started treatment within what we usually call the community onset window, yet for reasons that were related to patient care, perhaps the C difficile test doesn't get sent until after that usual hospital Day 4 threshold.

Co-Chair Demehin: Thanks. Denise also asked a question about the data sources for this. It sounds like NHS will continue to be a part of it but there are pieces of the EHR that are coming into play too.

Could you elaborate a little bit?

Dr. Dantes: We do want a main focus of this measure to include advances in our data interoperability and so we're working with several partners here on smoothing out FHIRE reporting for this measure.

But we anticipate that we will also have more traditional methods of reporting this data to HSN as well.

Co-Chair Demehin: I'm going to combine a couple of questions from Denise and Lindsay before I circle back to Mary-Ellen's.

Lindsay asked the question, how many data elements will hospitals need to capture for this, the new

algorithm you're talking about, to be applied?

And from Denise, if the metric requires the captured dates of infection, would the confirmed positive be on Day 0 or would it be on the day the antibiotic started, if that makes sense?

And Denise, if I garbled that question, please do jump in and clarify.

Member Morse: I just want to make sure, when is the official infection started?

Is it the confirmed positive or if we're looking two days prior, would the two days prior, if they were on an antibiotic, would that count as infection start date, for example?

Dr. Dantes: I guess I hear the question there and I'll of course open it up to Andrea Benin, who is our Branch Chief who is also on the line as well.

I think we had talked about the measure primarily being in most cases based on the date of the test.

But we've also considered opening that window for antimicrobial treatment of patients on existing antimicrobial treatment, extending into the hospital onset period.

I may have just made that a little bit more confusing there.

Member Morse: A secondary question, what if the antimicrobials started prior to admission?

Dr. Dantes: If a patient was on an antimicrobial prior to admission we probably won't be able to collect that data electronically.

Member Morse: That makes me concerned about the hospital onset and how to capture that accurately.

Co-Chair Demehin: Let me also put together a couple of questions from Mary-Ellen and Christie because I

think they are somewhat related to one another.

Mary-Ellen's question is around asking for confirmation that there are different lab tests that actually can be used for this measure. And does this open the door to variation in what's captured?

Christie asked a really interesting question, too, around do you think this measure captures more or fewer infections? Any initial thoughts there?

Dr. Dantes: Yes, those are great questions.

So in our exploratory analysis, we found that the number of C difficile events with this new definition is a little bit smaller because it uses some of our existing rules about microbiology tests.

But then has the requirement they also have to be treated as a clinician on the ground encountered a few times a year a patient that will develop diarrhea.

I order a C difficile test and for reasons that are sometimes hard to explain or the fact that we forgot to take the patient off of stool softeners, their diarrhea will have stopped by the time we get the C difficile test back.

And so we see that adding this requirement of C difficile treatment serves as that proxy for clinical judgment.

It's hard to argue that you didn't think the patient had C diff when you were putting the patient on C difficile antibiotics.

Co-Chair Demehin: Thanks. Thank you for the comment, Lindsay, around the use of FHIR-based models and how that may potentially impact the need to update measure specifications.

Let me kick it over to Marty, I see your hand is up.

Member Hatlie: Dr. Dantes, I noticed right up there there was language to the effect that no input from

providers or patients was solicited as part of the process of the development of this measure.

And I'm just wondering why that was? I think often we now see a TEP of some sort, multi stakeholder convened to provide that kind of feedback.

And perhaps it was done earlier here?

Dr. Dantes: Yes, we've heard certainly feedback that our infection prevention is one to spend less time counting and we want these measures to be determined algorithmically.

And especially for a measure that's very simple like this one here, where you have the presence of an antimicrobial test and treatment within a particular window.

These are things that should be very feasible in what this period of transition that we're seeing is bringing on increased FIHR capabilities.

Dr. Benin: And Marty, this is Andre Benin.

We have a standing advisory group that is called the HICPAC Advisory Group, it's a standing advisory group of providers and we discuss this metric with them on a regular basis. We also have a handful of collaborations with providers who are deep in the weeds of improving care in the spaces we direct regularly over projects to gain their feedback on the existing C difficile metric in a regular and frequent ongoing fashion.

So there is feedback from providers. It is one of the main drivers, actually, of creating this revised measure because of a lot of interest in getting to the point where we can feel a little bit more confident that we're not measuring C difficile colonization in some of these settings and measuring what we think is actionable C difficile disease, if you will.

And so that's really the promise of this measure and it's based entirely on feedback from the provider

community.

Member Hatlie: I'll just encourage you to also include patients in this kind of feedback loop. Patients get infection more than they get some other hacks, they see it happening in one setting and not being caught, getting caught in another setting.

So that whole continuum of care, multi-setting piece, you could get some really interesting perspective, including patients and their family members as inputs to a process like this.

Co-Chair Demehin: Thanks, Marty. Lindsay has asked a couple of questions about the FHIR standard here and how it relates to the construction of this measure.

Lindsay, maybe I'll ask you to ask the question live just in case you have any additional follow-ups for right now?

Member Wisham: Ray, I guess my question is I know you mentioned that, obviously, we're looking at how to get efficiencies with the reporting on capture this important information.

And you mentioned FIHR and FIHR-based technologies. I just wanted to clarify that the submission or capture of the data related to this measure were not entertaining the FIHR portion of it?

The primary submission would be through the NHS Staff, is that correct? I just want to make sure I understood.

Dr. Benin: Lindsay, this is Andrea. I can go ahead, Ray, on that one.

We're in the process of setting up so that we would most likely be able to take this data into NHSN using multiple approaches to electronic data capture.

I think the FIHR-based standard and the FIHR-based approach is the most advanced, if you will, right now,

and it's an important priority for us to be able to work in that space.

But we're also in a situation of acknowledging where facilities are in their ability to provide electronic data in the options in that space.

And so we're looking at being able to make sure that we're able to accept electronic data across not just in a FIHR-based standard approach but also in other electronic formats so that it will be an ongoing activity to have, essentially, PAC compatible, if you will.

Member Wisham: I can appreciate I think it's developing the measure to keep in mind what FIHR-based resources or data models are going to best suit the data being collected here.

I completely think that is a wise move. I just think, obviously, this is being considered for the IQR program and that's an important consideration.

If FIHR-based measure reporting, I know there's been many conversations and presentations on digital quality measurement in the reporting of those, but that would not be considered one of the mechanisms for submission for this measure.

And you tell me when I'm wrong. That's how I understood the explanation.

Dr. Benin: I don't know if it would be in 2022.

But it will be ultimately one of the mechanisms for submission so we would be able to take this both as FIHR-based type of submissions as well as with CDA, which is how we currently take it, as well as with other --

We currently have about 60 percent of facilities that submit using CDA and then there are other folks who I think are manually entering a lot of data.

So the desire is to build it in a way that's compatible

across the platforms.

Member Wisham: And I guess my experience has been that measures that are specified where they're still coming from charters tracked or even using the current QRDA and CQL methods, that data does need to be measured, does need to be re-specified, and re-examined, really, more or less, and make sure that there aren't nuances in how the data models operate so that the measure is being calculated the same way.

So I think it's, again, extremely wise that you're looking at these efforts in parallel, but in my opinion, a FIHR-based ECQM or a FIHR-based data collection effort needs to be considered differently than what's being presented here, in the future.

Co-Chair Demehin: Thanks, really good, rich conversation and set of clarifications, I really appreciate that.

Let me pause one more time just to see if anyone on the Committee has further clarifying questions?

Hearing and seeing none, let's move to a vote on whether to uphold the Staff recommendation on this measure for the IQR program. And just a reminder, we are going to consider this measure for multiple programs but for right now, we're just talking IQR.

So let me kick it back over to Ivory and Matt.

Dr. Pickering: Thanks, we're upholding the recommendation of conditional support for rulemaking, the condition of NQF endorsement, and any of the resolution by CMS for potential duplication concerns for reintroducing the measure.

Ivory?

Ms. Harding: Voting is now open for MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides difficile Infection Outcome Measure for the hospital IQR

program.

Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed for MUC2021-098.

The results are 21 Members voted yes and 2 Members voted no, and that gives us 91 percent.

Co-Chair Demehin: So I think the next step here since we are considering this revised C diff measure for multiple programs as we talk about each of those programs. The first one we're going to talk about is promoting interoperability.

So let me kick it to Matt to tell us more about that.

Dr. Pickering: Thank you. This one is a little bit different because the NQF recommendation is different than the IQR program so we're not going to be asking to carry over the votes.

You see the interoperability program listed here, which we've talked about previously so I won't go into detail.

But if we go to the next slide, again, this measure that we're discussing here is 098, C diff measure, now we're talking about interoperability for that program.

You can see the description is the same and is at the facility level, and the NQF recommendation is do not support for rulemaking.

Recognizing this is an updated measure, for the measure to be incorporated into the Medicare Promoting Interoperability Program the measure must be both an ECQM and included in the hospital IQR.

The measure is not in ECQM, does not address any of the current hospital IQR measurement priorities and

the decision to reduce the number of measures in the program saw the removal of several infection surveillance measures including this one in 2021.

So the measure under consideration is conceptually very similar to that one that has to be removed. And based on the fact that it's not an ECQM and it's also why it's do not support for rulemaking.

And again, the measure is not NQF endorsed. The rural health and health equity, similar comments that I stated previously with the IQR program so I won't go into detail there, as well as the comments for this measure, public comments.

It's very similar to the IQR, supporting the measure pending NQF endorsement. With that, I'll turn it over to you, Akin, to see if there's any other clarifying questions from the Workgroup for this program.

Co-Chair Demehin: Thanks, Matt. Let me open it up to the Committee. So I'm going to take my chair hat for just a minute and ask one more clarifying question about this measure and how it relates to the Promoting Interoperability Program.

I think what I heard our colleagues from CDC say during the last part of our conversation was this is a measure that is designed to work in the NHSN tool.

There is a process underway to develop specifications that would enable the use of potentially something like FHIR and other EHR reporting capabilities.

The measure in front of us doesn't necessarily have all of those specifications yet and that's why we landed on the recommendation that we did.

So I guess that's more of a question for both Matt and for our colleagues at CDC.

Dr. Benin: Matt, maybe it makes most sense for you to take your part first because I don't know if I can --

Dr. Pickering: It is just that. Akin, is that the measure presented was not specified as an electronic clinical quality measure, which for this program that is a requirement for that measure.

So that's Assessment 1 of our preliminary analysis algorithm, if it's aligned with the program and in this case, it doesn't meet that requirement of the ECQM.

So it's a do not support because it did not meet that assessment. I'm sorry, go right ahead.

Dr. Benin: Akin, just to try to clarify, the NHSN metric that will come in via the NHSN surveillance system are not ECQMs in the capital letters, meaning not using the data specifications that have been created to make things officially what's called an ECQM, which is a very specific kind of electronic definition. But these measures will be digital, they will certainly be digital quality measures.

So I would defer on behalf of to the requirements for this rule and CMS's requirements around whether it is an after ECQM or not but these will be electronic with a small e, if you will.

They're going to be digital measures and are being specified in that fashion. So just to clarify that.

Co-Chair Demehin: Thank you, that is actually very helpful for me. Let me open it up for any other clarifying questions for this revised C diff measure with respect to the Promoting Interoperability Program.

All right, hearing and seeing none, let's go ahead and move to a vote on the Staff preliminary recommendation on this measure. Matt and Ivory, take it away.

Dr. Pickering: Again, you're voting to uphold the Staff or NQF recommendation of do not support for rulemaking for this measure for the Interoperability Program.

Ivory, I want to take it to you?

Ms. Harding: Voting is now open for MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides difficile Infection Outcome Measure for the Medicare Promoting Interoperability Program for hospitals.

Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds. Okay, voting is now closed for MUC2021-098.

The responses are 23 Members voted yes and 1 Member voted no. This gives us 96 percent.

Co-Chair Demehin: Thanks for that. Let's see, I think, Matt, is this the final program we're considering this measure for or are we considering it for BBP too? Can you remind me?

Dr. Pickering: Yes, there's this program and then the PPS exempt cancer hospital reporting program.

Co-Chair Demehin: Okay, it was PPS exempt cancer hospital reporting program. Why don't you tell us a little bit about this measure in relation to the HAC program?

Dr. Pickering: Sure, you'll see the program listed, this is the first time we're getting this program. It's a pay-for-performance and public reporting program.

It's a hospital-acquired condition reduction program.

The worst-performing 25 percent of hospitals in the program as determined by the measures in the program will have their Medicare payments reduced by 1 percent.

The goal of the program is to encourage hospitals to reduce these healthcare-associated infections through penalties and link Medicare payments to healthcare quality and inpatient hospital settings.

So going to the next slide, this measure was submitted to the program. The description is the same as you see listed there. It is at the facility level. It's conditional support here, the conditions are the same as the IQR program.

So there is alignment with this measure for this specific program and it may mitigate any unintended consequences from current measure design, counting a case based on a positive test only, which may have led to historical undercounting of a observed healthcare-associated C diff.

So this measure is consistent with the program's priority and aligns with the meaningful measure priority related to patient safety. It is not NQF-endorsed so the conditions here are to support for rulemaking pending NQF endorsement of this measure.

So the health equity and rural also evaluated this. Similar comments as we've experienced with the IQR program, rural health having a 3.6 out of 5 and health equity having a 3.4 out of 5.

The comments for this measure, similar to the IQR, are supportive pending NQF endorsement of the measure. So in this case, since it is a conditional support for rulemaking, it's the same decision category as we had for the IQR program.

We can offer up the carryover of the votes. And so the votes again for the IQR were 21 yes out of 1 no, so out of 23 that's 91 percent. Same conditional support for rulemaking in the IQR program.

We can carry over those votes to this program if there's no opposition from the Workgroup.

Co-Chair Demehin: Any objections or other comments or thoughts on the revised metric for the HAC program?

Hearing and seeing none, I think we can consider the

recommendation we gave on the IQR program to be the same one as it is for the HAC program.

Dr. Pickering: That's correct. So we will carry over those votes for the conditional support for rulemaking from the IQR program to the HAC program. Akin, the next program, I'll keep going.

This is the prospective payment system, PPS-exempt cancer hospital quality reporting program, or PCHQR. It's a pay-for-reporting public reporting program.

PCHQR is a voluntary quality reporting program and data was published on the hospital to compare. It provides information about the quality of care in cancer hospitals in particular.

11 cancer hospitals are exempt from the inpatient prospective payment system and the inpatient quality reporting program.

So it encourages hospitals and clinicians to improve the quality of their care to share information and learn from others experiences' in best practices.

So going to the next slide, again, the description of the measure is the same here, facility level of analysis. There is a conditional support for rulemaking on this measure as well.

So it would modify the existing healthcare-associated C diff surveillance measure in this program and it may mitigate potential unintended consequences from the current measure design, as we stated previously.

This updated measure is consistent with the Patient Safety Meaningful Measures 2.0 area. Again, not NQF endorsed so the condition here is NQF endorsement. Rural health and health equity, very similar comments.

Rural health evaluated this as a 4.0 for this program out of 5, health equity 3.6 out of 5. And for this program specifically, there were no public comments,

either supportive or non-supportive.

So no comments from the public for this measure in this program.

However, similarly, with IQR and the HAC program, since this is a conditional support for rulemaking and the NQF endorsement, if you do not wish to carry over the votes, you can speak up and we will not carry those over.

Akin, I'll turn it back to you to facilitate any discussion from the Workgroup.

Co-Chair Demehin: Thanks, Matt. Any comments, requests for clarification from the group?

Matt, the one general comment I'll offer here, not one that in my view would change the recommendation, I know one of the ongoing challenges with respect to measuring infections in PPS-exempt cancer hospitals is that the underlying patient population does work different and often is more severely ill.

So there are always questions of how you publicly report, how you generate meaningful comparisons and so forth.

I would say those apply here but again, that's just more general comment for implementation, not one that I think would change the recommendation here.

But I welcome the thoughts of others here. I see Denise.

Dr. Schreiber: Isn't that why, though, it gets compared amongst the cancer hospitals?

I recognize that the cancer patient may be very different than the general medical patient in a community hospital but the cancer patient in these particular hospitals have very similar characteristics of being very sick.

Co-Chair Demehin: I certainly agree with that. I know

Denise had a comment here in the chat function. Denise, do you want to add onto that?

Member Morse: Yes, and you are correct, I think comparing the other cancer centers to each other does help.

I think there are differences in the types of cancer, for example, the heme malignancy versus the solid tumor and the different patient categorizations and patient mix at each of the sites, which does create a problem that when we are calculating the risk adjustment based on the unit type, if that continues to be the model of risk adjustment versus individual patient characteristics.

And perhaps if it becomes something that can be a FIHR or ECQM-based measure, getting to that more patient-level characteristics might be a better risk adjustment in the future.

Co-Chair Demehin: One last call for comments or clarifications?

And any objection to carrying forward the recommendation as given to the IQR program? If you have an objection you can message me directly or speak up.

Hearing and seeing none, I think we can consider the Staff recommendation upheld.

Dr. Pickering: Confirming that I did not receive any chats about posing that carryover, we will go ahead and carry over the votes of that conditional support for rulemaking.

And I believe that concludes our evaluation of that measure for those programs. So the next up is the next NHSN measure, which is the bacteremia measure.

I do want to do a time-check, we are almost at 5:00 p.m. We have one more hour.

So just to remind folks, after these measures we have two more measures, which is the appropriate treatment for patients with Stage 1 through 3 HER2 positive cancer, and the end stage renal disease program, the standardized readmission rates measure.

So we could continue to power through and try to get this done and maybe leave a little early or if the group would like to take a break we can do so.

I'm trying to see if there's head nods. Are we okay to power through? If you're opposed to that and want to take a break, please message in the chat and we'll take five minutes.

If not, we can just power through. Thumbs-up to power through. Sean, are you good?

Co-Chair Morrison: Yes, I'm fine.

Dr. Pickering: We'll power through on this, thank you all very much, we'll keep going. Sean, I'll turn it to you for the next cross-cutting measure and this is also for four programs, the IQR, the Interoperability, the HAC program, and again, how to PCHQR for this bacteremia and fungemia measure.

Co-Chair Morrison: Bacteremia and fungemia, let me open for public comment?

Dr. Pickering: This is an opportunity for any member of the public, if you have anything you'd like to say, you can use the raise-hand feature or you can message in the chat.

We'll give it a few minutes and maybe we'll see if Ray has any comments. Not a few minutes but a few seconds, and we'll see if Ray has any comments.

Co-Chair Morrison: I don't see any hands. Let me turn things over to Ray to get just a couple minutes or two from CDC.

Dr. Dantes: All right, and thank you very much again

for this opportunity to discuss this exciting measure that we're developing that we think will help drive further reductions in healthcare-associated infections.

So this measure of Hospital-Onset Bacteremia & Fungemia measures bloodstream infections that develop after patients are admitted to hospitals.

We know that from our exploratory studies that about 25 percent of these patients do not survive the hospitalization regardless of whether a central line is present or not.

And therefore, we think looking at this broader measure of bloodstream infections is very patient-centered.

This is a new broader target for quality improvement and so we do note that not every hospital onset bacteremia and fungemia are HOB events will be considered preventable with current knowledge and practices.

However, this measure will be risk-adjusted and with a larger numerator compared to measures like CLABSI, and will produce more reliable results for facilities to facilitate comparisons.

We also anticipate that introducing this measure will spur innovation to prevent more of these bloodstream infections.

This measure will be algorithmically determined, it's digital quality measure that, again, we are looking towards advances in data transmission to CDC, including methods like FIHR.

In 2022, we are planning to apply for NQF endorsements and we'll begin to make this module available in our HSN platform as well with the goal of increasing our user base through 2023.

In the meantime, we will continue to support some of our measures that overlap with this, including

CLABSI and MRSA. I'll stop there, thank you.

Co-Chair Morrison: Thank you, Ray. Let me turn it back to Matt, then, to describe our measure.

Cross-Cutting Measure: MUC2021-100 National Healthcare Safety Network Hospital-Onset Bacteremia & Fungemia Outcome Measure

Dr. Pickering: Sounds good. So we have as this first program for this measure is the IQR program. I won't go into detail on the description here as we talked about this previously.

So just to keep in mind it's IQR first, and so we do have MUC2021-100 NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure.

So the measure, as you can see here, tracks the development of new bacteremia and fungemia among patients already admitted to acute-care hospitals using those algorithmic determinations from data sources widely available in electronic health records.

The measure includes many healthcare-associated infections not currently under surveillance by the CDC or the CDC's NHSN. So ongoing surveillance also requires minimal data collection burden for users.

It's at the facility level of analysis. The NQF recommendation here is conditional support for rulemaking.

This measure tracks the number of hospital onset bacteremia and fungemia infections indicated by positive test results among inpatients, but excluding those patients on admission for which a not treatment was administered.

Although this measure does not address any of the hospital inpatient quality reporting program measurement priorities, it does correspond with the patient safety focus of the Meaningful Measures 2.0.

So in 2020, there was the decision to reduce the number of measures in the program. On the removal of several infection surveillance measures, and this measure of consideration was conceptually similar to those that have been removed.

It's not NQF endorsed but as Ray had mentioned, there is planning to submit for endorsement.

So the conditional support here for rulemaking is pending that NQF endorsement and any resolution of the new patient concerns of reintroducing the measure that is similar to other measures that have been removed from the program previously.

For rural health and health equity, rural health was a 3.8 out of 5, their comments were again very similar to the C diff measure. Healthcare-associated infections are important.

There is concern for low case volume and the potential challenge for this measure calculating reporting due to lose case volume. And there are some critical access hospitals that do not participate in IQR but do participate in other programs applied to other PPS hospitals.

Health equity was a 3.5 out of 5 and for the public comment there was one supportive and one non-supportive. For the supportive comment, it was agreed that this measure addresses some healthcare-associated infections not currently under NSHN.

There was some concern that it has a duplication of a measure that was removed from the program and CMS would not move forward with this measure until it receives NQF endorsement.

The other comment here, non-supportive, the measure does not currently meet any of these measure requirements nor has it received endorsement by National Quality Forum.

So the recommendation is to move to do not support for the potential for mitigation. So with that, I'll turn it back to you, Sean, if you have any clarifying questions from the Committee?

Co-Chair Morrison: Yes, let me turn it over to everybody. Do we have clarifying questions for the developer?

I see already Ray wants to know whether counts the same patients already in the CLABSI and MRSA measures? Or would a patient only count for one of the two?

Dr. Dantes: Yes, so it would count in those four. If a patient had, say, an MRSA central line associated bloodstream infection, it would count towards all three measures.

But as I probably alluded to in our introduction, part of the interests that we actually had was actually interest that came from our users was that we do think that hospital onset bacteremia has potential benefits that may make it more favorable for use in some of these quality programs compared to CLABSI and MRSA.

But, of course, those decisions will depend on user uptake a little bit down the road. Did you have anything you wanted add there?

Dr. Benin: I would just add that there's been an evolution into understanding the overlap and making decisions collaboratively with groups about how whether or not over time the CLABSI and MRSA metrics get used differently or whether this metric ultimately takes over for it.

Co-Chair Morrison: Do I have other questions for the development team? If not, I think we'll go to Matt and Ivory to review the Staff's recommendation and a vote on whether we accept that for the discussion.

Dr. Pickering: That's right. The group is now voting

to uphold the recommendation of conditional support for rulemaking.

Again, the condition here pending NQF endorsement and any resolution of the potential duplication concerns of introducing the measure into the program.

So I'll turn it over to Ivory.

Ms. Harding: Voting is now open for MUC2021-100, the NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure for the hospital IQR program.

Do you vote to support the Staff recommendation as the Workgroup recommendation? A few more seconds. Okay, voting is now closed for MUC 2021-100.

The responses are 22 Members voted yes and 2 Members voted no. That brings us to 92 percent.

Co-Chair Morrison: Thanks, Ivory. Matt, can I move these through the next programs? Is there a pickup on these?

Dr. Pickering: For the last two programs it would be something of a carryover. This one, the interoperability, it's going to be a similar issue just because of the ECQM component and the concerns about the ECQ for this measure.

So if we go to the next slide, you'll see the description is the same, the facility is the same.

The issues here are for the decision category is the do not support for rulemaking and that is due to the ECQM issue that this measure must be both an ECQM and included in the hospital IQR.

The measure is not an ECQM, so similar concerns that we heard from the C diff measure, so it's not endorsed and not an ECQM, so do not support for rulemaking is the voting category.

The rural health and health equity votes and issues there were also similar for this program, and then the public comments as well were also similar. One supportive and one non-supportive.

As I mentioned, similar to the IQR program. So unfortunately we can't carry over the votes, we'd have to vote separately on this measure because of the do not support for rulemaking decision.

Co-Chair Morrison: That is what I anticipated. Let me just open it up for comments, questions to the developers or CMS?

Dr. Benin: Sean, it's Andrea, I can just clarify that in the same fashion as the C difficile measure.

The measure is a digital measure, it's being specified for electronic data collection but because it is an NHSN measure, it is not technically an ECQM in the capital ECQM. So just to clarify that.

Co-Chair Morrison: Thanks, Andrea, I really appreciate it. I'm not seeing any so, Ivory, we will move to a vote on the Staff's recommendation, which was do not support for rulemaking.

If we can pull that up?

Ms. Harding: Voting is now open for MUC 2021-100, NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure for the Medicare Promoting Interoperability Program for hospitals.

Do you vote to support the Staff recommendation as the Workgroup recommendation?

A few more seconds.

Okay, voting is now closed for MUC 2021-100 and the results are 21 Members voted yes and 2 Members voted no.

That brings us to 91 percent.

Co-Chair Morrison: Thanks, Ivory.

Now, I'm going to just ask if there are any objections to moving this forward into the hospital-acquired condition reduction program based upon the vote on the hospital IQR program.

If you have any objections, please speak up or just message Matt or I privately and we will move it forward for discussion.

Dr. Pickering: Thanks, Sean. If we can go to the next slide, again, this is conditional support for rulemaking.

Similar description, the condition here is NQF endorsement for this program, as it's not NQF endorsed but it is aligned with this program.

Similar rural health and health equity inputs and ratings as the IQR as well as the supportive and non-supportive comments that we have received for these measures.

So if the Committee has no clarifying questions, we can then ask if there's any opposition to carrying over the votes to the HAC program from IQR.

Co-Chair Morrison: And as said, just speak up and message Matt or I. I've got no objections here, Matt.

Dr. Pickering: I don't have any objections either.

Co-Chair Morrison: So I think we can move that forward on this program and if there are any objections to moving it forward on the PPS-exempt cancer hospital quality reporting program?

Dr. Pickering: Right. And so just to touch on this real briefly, same description as you see listed here of the program. So I won't go into detail there as we already described it.

If we go to the next slide, same description for this measure, for this program facility level, right? The

condition here is NQF endorsement for this program.

So there is an opportunity to carry over the votes as Sean has mentioned from IQR to this program. And again, the rural health and health equity similar concerns and similar ratings for this program.

Just like the C diff measure, there were no public comments for this measure for this program. So nothing to summarize there.

So if there's no clarifying questions from the Workgroup on this, we can then move to carrying over the votes if there's no opposition.

Co-Chair Morrison: And again, if you have any opposition, feel free to privately message Matt or I, or just speak up if you would like. I don't hear any objections and I don't have any, Matt, I don't know if you do?

Dr. Pickering: I have not received any from the chat.

Co-Chair Morrison: I think then we can move forward.

Dr. Pickering: So thank you all very much and we'll carry over those votes from IQR to that last program for that last measure for the last program of that measure.

So thank you, and thank you, Sean, for carrying us through there, getting back up to schedule. I wanted to just pause as well.

Dr. Schreiber, I didn't know if you had any comments you'd like to state based on interoperability?

Dr. Schreiber: Thank you, Matt. I think CMS will need to go back and review the statute for promoting interoperability, which we believe refers to electronic reporting of clinical quality measures.

So in point of fact, the CDC measures that can be electronically reported using EHR technology we

think falls into the realm of promoting interoperability, and that it's not specific to the ECQM, sort of in capital letters.

But we will verify the statute and we believe it does fit into PI, but we will verify.

Co-Chair Morrison: That would be good news, Michelle.

Dr. Pickering: Thank you. I know we're going to power through, we've got two measures remaining so I want to thank you, Sean, for carrying us through that last group set.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Measures

These last two measures, I'll turn it back to Akin. So we have now the PPS-exempt cancer hospital quality reporting PCQHR program measures here.

Akin, I'll turn it to you because we do have one measure remaining for this program.

There's a description of this program, I won't go into that. We've already mentioned this previously about the cancer hospitals.

So if we go to the next slide, Akin, I'll see if there's any public comment and I'll turn it to you for facilitation.

Co-Chair Demehin: Thanks. Same ground rules here, please make your comments applicable to this specific measure and if you're making them verbally, to two minutes or less.

And I'm happy to take them through the chat function as well. I'll give it a few seconds.

MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast

Dr. Pickering: And again, this is for MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer.

So members of the public can raise their hand or feel free to chime in through the chat.

Co-Chair Demehin: I am not seeing anything. Matt, do you have anything?

Dr. Pickering: I do not.

Co-Chair Demehin: Let's talk preliminary analysis.

Dr. Pickering: Okay, this measure is the percentage of female patients aged 18 to 70 with Stage 1 through 3 HER2 positive breast cancer for whom appropriate treatment has been initiated.

At the level of analysis, it's at the clinician on the slide because it was also submitted to the clinician group. It's also submitted here for facility level for this specific program.

So the NQF recommendation is conditional support for rulemaking as this measure does not align with the 2021 needs and priorities for the program.

However, this measure does align with the CMS meaningful measures framework in that it is an ECQM and may support greater access to life-saving diagnostic therapies during the COVID-19 public health emergency and beyond.

It currently is not NQF-endorsed so the condition here is pending NQF endorsement. It's conditional support and the condition is NQF endorsement. For the rural health and health equity inputs, rural health scored it a 3.4 out of 5.

It may not be applicable to rural providers as the program is for 11 participating cancer hospitals, however, from a rural perspective, this measure has

some importance for a rural provider such that they know whether treatment has been initiated for their patients.

For health equity it scored a 2.5 out of 5, concerned that the measure is not stratified by race and ethnicity or other social determinants of health, and collecting these data will be very important.

Concern that at any time that a measure has voluntary reporting, such as with this program, it may lend itself to some vulnerable cherry-pickings, one of the comments from health equity group.

For the public comments, there were two supportive supporting inclusion of the program. The measure could be used for quality improvement and certification and payment, et cetera.

So very supportive including the program. There was one comment in non support of this measure because it's unclear how the numerator of the measure is determined.

Appropriateness is conceptually attractive but extremely complex and difficult to implement.

Additionally, in the exclusions, patients with other contraindications seems to be very broad and it needs to tested for reliability and validity.

So those were the comments. Akin, I'll turn it back to you for any clarifying questions.

Co-Chair Demehin: Thanks so much. I do see in the chat that Denise had a good list of clarifying questions here. Is the measure developer on the line for this?

Ms. Drumheller: Yes, we have Staff from ASCO, the American Society of Clinical Oncology Available to Answer Questions.

Co-Chair Demehin: Wonderful. Do you want to walk through the questions that are here in the chat from

Denise? I'm happy to read them off.

Ms. Drumheller: Sure, was that question to me? This is Caitlin Drumheller from ASCO.

Co-Chair Demehin: Yes.

Ms. Drumheller: Sure, we'll walk through these and see if we can answer them as best as we can. I will also invite other ASCO Staff to chime in and keep me honest here. The first question is was this tested at only the PPS-exempt cancer centers?

And I think the answer to that question is that it was not tested exclusively with PPS-exempt cancer centers. We did have at least one included in testing so that's why we included it for potential inclusion in this program.

For the documented performance gap I'm going to just refer back to our testing document here.

Also, ASCO Staff please feel free to chime in here but I believe that for the ECQM submission method, the mean performance rate was just below 46 percent with the standard deviation of 0.299.

So the mean and standard deviation were calculated based on a sample of 27 patients across 6 sites. Let's see, is there a timeframe associated with when the treatment needs to initiated?

Great question. So, yes, we're really looking at the adjuvant treatment course here. The quality action of the measure was really focused on the appropriateness of treatment rather than the timeliness of treatment.

This is something that came up with a TEP during the amendment to the measure. But the timing of administration of HER2 targeted therapies is definitely expected to vary depending on what site or toxic agents are used.

So the numerator statement is really intended to

capture an adjuvant treatment course that is specified, it includes both chemotherapy and HER2 targeted therapy.

And to capture that independent of possible administration sequences which we think could vary. And then that adjuvant chemo is designed as a chemotherapy regimen initiated within six months of the cancer diagnosis.

And this is just kind of an aside but we do also include FDA-approved trazabio (phonetic) similars as an appropriate substitute for traza targeted therapies.

Is there a list of what is considered appropriate? I assume that is a question about the numerator and, yes, we do have a list of what is considered appropriate chemotherapy and HER2 targeted therapy for the measure.

It is in ECQM so we do have that codified. Is the performance gap due to patients not getting the right treatment or the lack of documentation?

That's a good question. I don't know if I can directly answer that. We do think that there is some gap because patients are not getting the right treatment. This is a little bit of a background information here.

So ECQM is an ECQM version that was developed new from an existing CQM that's currently used in MIPS by the same title. But that's QID 450 if anybody is curious.

But that registry measure underwent some pretty substantive updates that were deployed in the 2021 reporting year in MIPS that did expand the denominator-eligible population and also refined the numerator action as well.

So this ECQM does reflect the updated measure specifications. The old measure was topped out and when we took this measure through maintenance, we determined that there were some updates needed.

So initially the old version of the measure looked at HER2 positive breast cancer patients who are currently being treated with chemotherapy, and then the numerator action looked at walls and received chest using on top of that.

The TEP felt that the real quality action was that we needed to look at HER2 positive breast cancer patients who are eligible for treatment and then look to see whether in the numerator they received both chemotherapy and HER2 targeted therapy or trastuzumab.

So it did shift the specifications a little bit.

We think this is a little bit more of a precise way to determine, to answer this question, whether the performance gap is really due to not getting the right treatment, appropriate treatment or lack of documentation.

And let's see, just moving along in the question list, was the sample size only 27 patients for testing? Yes, that was our sample size.

We used all the available data that we had and did the best we could with that. Are all of these data elements truly electronically available discreetly? At our cancer center I can speak to the lack of these specifically.

That's great feedback. I think that I'll just refer back to our testing document here. Let's see, we did take a look, we did a work flow analysis with providers.

The feedback that we got was this would require a relatively low effort. We did do feasibility testing. So our feasibility testing indicated the measure presented a below-average burden to the providers.

So in our estimations we thought the benefits of the measure would outweigh the potential risk of burden to providers.

But definitely, if you have firsthand knowledge of

limited data element availability, I think we can definitely take that into consideration.

I'm just scrolling down the chat, it looks like there's another question about what happens if the definition of appropriate treatment changes, our new drug becomes appropriate?

We would continually update the measure based on any sort of new chemotherapy drugs or HER2 targeted therapies. So because this measure is in ECQM, we would look for updates to make in the value set and update the measure accordingly.

We do have a process for taking existing measures through our technical panels and maintenance. And I'm happy to answer any other questions.

Hopefully, that helped a little bit.

Co-Chair Demehin: Thank you for replying so systematically and succinctly. Denise, I do see your hand up? Is there any other follow-up you want to ask here?

Member Morse: I just wanted to echo the comment made in the public comments about the exclusion criteria for the denominator being very broad and ask from an ECQM perspective, how is that captured?

There are fields specific for other medical contraindications, for example?

Ms. Drumheller: That's a great question. I will definitely defer to ASCO colleagues if folks are on the line and able to chime in a little better than I am on that.

I think that was something that, at least when developing the measure narrative, the TEP did struggle with a little bit in making this an ECQM.

We were looking at compatic (phonetic) insufficiency and cardiac problems and how we could operationalize that as an ECQM.

That's part of the reason why we might have had more of a broader exclusion here for this, because of those things. So I'm not sure if we have other ASCO folks on the line who would like to chime in more specifically but that's as best as I can answer.

Co-Chair Demehin: Let me open it up for one last round of clarifying questions or comments before we move to voting on the Staff's preliminary recommendation?

I am not seeing or hearing any, Matt, anything on your end?

Dr. Pickering: No, I'm not seeing any hands or any other questions in the chat so I think we can move to a vote.

Co-Chair Demehin: All right.

Dr. Pickering: As Ivory pulls that up, again, as a reminder, we're voting on MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer for the PPS-exempt cancer hospital quality reporting program.

This is to uphold the conditional support for rulemaking with the condition being NQF endorsement. Ivory?

Ms. Harding: Thank you, voting is now open for MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer for the PCQHR program.

Do you vote to support the Staff recommendation as the Workgroup recommendation? A few more seconds.

Okay, voting is now closed for MUC2021-091 and the results are 19 Members voted yes and 3 Members voted no.

And that gives us 86 percent.

## End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measures

Okay, so we are going to move to the final measure that we have on the docket today which is for the End-Stage Renal Disease Quality Improvement Program.

And if we just go to the next slide, I'll just discuss the program briefly before opening it up for public comment on the measure. So this is the End-Stage Renal Disease Quality Improvement Program, or ESRD QIP.

It's a pay-for-performance and public reporting program. At the end of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance.

Payment reductions will be on a sliding scale, which could amount to a maximum of 2 percent per year. The goal is really to improve the quality of dialysis care and produce better outcomes for beneficiaries.

## MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities

So we'll go to the next slide. And this is the measure that's up under consideration is MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities.

And Akin, I'll turn it to you for any public comment.

Co-Chair Demehin: Thanks, last measure open for public comment. I would ask that if you have any comments over the phone, please limit them to two minutes and please limit them to this particular measure.

You are also welcome to submit public comments through the chat function.

Dr. McGonigal: This is Lisa McGonigal from Kidney Care Partners. We did submit a letter, an early letter

on this measure as well. But I just wanted to take a moment and speak.

First of all, KCP is coalition of members of the kidney care community.

It includes full spectrum of stakeholders related to dialysis care so patients, advocates, healthcare professionals, dialysis providers, researchers, and manufacturers and suppliers all organize to advanced policies and improve the quality of care for individuals with CKD and ESRD.

We took a look at this revised SRR measure. It had been previously endorsed as NQF 2496. We do have concerns with this measure, primarily, as was pointed out by Matt's Staff, that the NQF endorsement was withdrawn.

This was primarily from the Admissions Readmissions Standing Committee not passing the measure on validity because there was poor correlation with other outcome measures.

But what I really wanted to point out today because it wasn't discussed very much was that there were also pretty profound concerns around the reliability of this measure.

So the reliability assessment or estimate at this point in time was 0.35. This was actually a pretty significant drop from the prior iteration of the measure that was 0.55.

So we believe there was a pretty significant drop in reliability and we were concerned in particular that this might impact smaller facilities in general.

Results by facility size were not presented with the data and so we're not quite sure how this will impact it. So I did want to point that out as well.

That's the limit of my comments today, thank you.

Co-Chair Demehin: Thanks, Lisa. I really appreciate

you sticking around for the last conversation here.

One more opportunity for public comment? Hearing and seeing none, Matt, would you please walk us through the preliminary analysis?

Dr. Pickering: I certainly can.

So this measure, this standardized readmission ratio, SRR, for Dallas's facilities is a ratio of the number of observed index discharges from acute-care hospitals to that facility that resulted in an unplanned readmission to acute-care hospital within 4 to 30 days of discharge to the expected number of readmissions given to discharging hospitals and characteristics of patients and based on a national norm.

Note that the measure is based on Medicare-covered dialysis patients. It's a facility-level measure. The measure did receive a do not support for rulemaking as the NQF recommendation.

The measure is fully developed and specified. It's an updated version of NQF 2496. The NQF number 2496, which is currently included in the ESDR QIP, the measure addresses a high-priority area of care coordination in the ESRD QIP.

The program does not contain any other readmission measures, however, this measure was submitted to NQF endorsement in spring of 2020. It did not pass the scientific acceptability on validity.

It was not endorsed. So the endorsement was removed. The measure was fully developed and specified and it was submitted to the all-cause admissions and readmissions consensus development Standing Committee.

It passed on reliability and after raising some initial concerns regarding the differences in reliability, it did pass. However, for the validity assessment, the Scientific Methods Panel, which evaluates for

reliability and validity of complex measures had concerns related to the adequacy of the measure correlations presented for validity testing.

So while in the expected direction the correlations of the other outcome measures that it was correlated with were weak with correlation thresholds of 0.39, or correlation scores, excuse me, of 0.39 with the standardized hospitalization ratio, 0.10 with the standardized mortality ratio, and 0.4

So the higher and closer to 1 means more correlation. So these were lower correlations which is what raised concern with the Scientific Methods Panel.

And then also the all-cause admission and readmission Standing Committee which voted to not pass the measure on validity. Thus, the endorsement was removed.

So currently this measure is not endorsed and that is why they've received a do not support for rulemaking, because of those validity concerns and the removal for endorsement.

For the rural health and health equity inputs, for rural health it scored a 3.3 out of 5.

There is concern that the measure did not pass NQF endorsement due to validity and any measure that requires travel puts rural patients at a disadvantage, which can be the case in traveling to dialysis facilities.

For health equity, a 3.4 out of 5, concern the measure did not pass on validity for NQF endorsement, as well as a gap in equity in kidney care and outcomes.

As far as public comments, there was zero supportive comments, one non-supportive, which was from Kidney Care Partners, which we heard today so I won't go into too much detail there.

Raising concerns related to reliability and validity for this measure as well as variations in Medicare advantage patients. There's significant variation in

dialysis patients for Medicare advantage.

And that variation compromises the validity of the measure if Medicare advantage patients are not accurately counted or accounted for in the QIP metrics.

So, in addition, they encourage CMS to perform some sensitivity analyses with or without Medicare patients to make those results publicly available.

So that is the summary of the comments and Advisory Group inputs and the decision category of do not support for rulemaking. So, Akin, I'll turn it to you for any clarifying questions.

Co-Chair Demehin: Thank you so much.

Let me open it up to our group to see if there are any clarifying questions about the preliminary analysis or any questions about the measure more generally.

Hearing none, I wouldn't mind putting a broader question to -- I guess this is more a question for CMS than it is for the measure developer.

In light of the fact that this particular measure did not pass endorsement, I wonder if you could say just a little bit more about why you wanted to try to get it into the program.

It would be helpful to have that context as we think about this.

Dr. Agbenyikey: This is Will Agbenyikey, in charge of the measure. I think one of the measure reasons why we want to have it in the program is the idea that it's shared accountability.

It helps at most to actually be realistic to uphold hospitals accountable but to actually involve everybody that touches the patient after discharge and also the hospital. So this is one of the reasons why we feel strongly this should be part of the reasons why we engage in getting this measure into

the program.

Also we have this comprehensive ESRD care program and this measure would help us to evaluate and would help us in the evaluation of readmissions across programs, especially in the ESR.

Co-Chair Demehin: Thanks, Will.

Dr. Schreiber: As I was saying before, Akin, it was also through the Medicare advantage population.

Co-Chair Demehin: Because the previous version didn't include the VMA population? Okay.

Dr. Messana: This is Joe Messana representing the measure developer. If I could provide a point of clarification about that last statement?

Co-Chair Demehin: Sure.

Dr. Messana: The original version of the measure, which was approved 2014 to 2015, included index discharges, included patient discharges in the denominator for Medicare advantage patients.

This version corrects some biases that were inherent in the data collection. So both versions included Medicare advantage patients. This one includes an indicator covariate for Medicare advantage status and adjusts the definition of comorbidity so that Medicare advantage patients and fee-for-service patients, there's less bias in terms of identifying comorbidities in the prior 12 months.

So that's just a point of clarification. Medicare advantage patients are identified through the Medicare enrollment database, which I'm not aware of anyone identifying any major issues with it.

And this measure actually better accounts for Medicare advantage patients and puts an evaluation of facilities with a large number of Medicare advantage patients on more of an even partly ground than the original version, just to clarify that.

Dr. Schreiber: Thank you.

Co-Chair Demehin: Thank you. One last opportunity for clarifying questions or comments before we move to vote on the Staff preliminary recommendation?

Hearing and seeing none, let me kick it over to Matt and to Ivory to walk us through the vote.

Thanks, Akin. As Ivory pulls up the voting platform, again, we're voting on MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities.

The NQF recommendation that you're voting to uphold or not uphold is do not support for rulemaking due to the concerns we've previously presented.

So, Ivory, I'll turn it to you.

Ms. Harding: The voting is now open for MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities for the end-stage renal disease quality incentive program.

Do you vote to support the Staff recommendation as the Workgroup recommendation? A few more seconds. Okay, voting is now closed for MUC2021-101.

Voting is now closed for MUC2021-101 and the results are 19 Members voted yes and 1 Member voted no. That gives us 95 percent.

Co-Chair Demehin: All right, that was the final measure that was formally in front of the group for today. So hats off to this Committee for your focus and your hard work.

Many, many thanks to CMS and NQF Staff for participating in the conversation and to the measure developers as well for answering clarifying questions.

Opportunity for Public Comment

With the last few minutes that we have, we do want

to provide an opportunity for public comment on the day as a whole.

The previous commenting periods were focused on the measures specifically but this is an opportunity to provide any additional feedback on either the measures we considered today or anything else.

So I would again ask that you limit your comments to two minutes if you are making them verbally, and you are also welcome to make them through the chat function.

Dr. Pickering: Thanks, Akin.

Just one more time, this is members of the public, if they wish to speak up and voice their opinions or suggestions for the Workgroup, you can use the raised-hand feature or the chat feature as well.

We'll keep an eye on that and give it a few more seconds for the public.

Summary of Day and Next Steps

Co-Chair Demehin: Not seeing or hearing any, Matt, what I'll say as we move wrap up is we did put a potential placeholder for a conversation around gaps.

Seeing that we are at 5:45 p.m., I have my doubts that conversation would get very far. So I think that may be a little bit too ambitious.

But what are you thinking?

Dr. Pickering: I think it will be somewhat challenging considering we have just 15 minutes left and we still have to go through some next steps here.

I appreciate everyone's time and attention to all the measures we had to go through today and unfortunately, there were a series of program that we also didn't have gaps discussions with because of all the proceedings we have to go through.

So I think we most likely would need to move to some next steps, summary of next steps, and then we can follow up offline with any gaps discussions if needed.

So go ahead, I'll turn it over to Becky to summarize the next steps.

Ms. Payne: Thanks, Matt, and thanks everyone for sticking with us so far. We are fairly far into the MUC process for this year.

We have one remaining Workgroup meeting that will be tomorrow for the post-acute care and long-term care Workgroup. In January we will be convening our Map Coordinating Committee.

So we do have a couple of dates written down for you all just to help you with those. We also want to emphasize there will be a second public commenting period between December 30th and January 13th.

And of course, all of our Map Members are welcome to attend other Map meetings as members of the public. Finally, we just want to share some contact information with you all again.

We always appreciate your input and the time you all take to provide feedback. So please feel free to reach out to the team at any time.

I will turn it back to Akin and Sean, or I think just Akin is with us right now, to make some closing comments.

Adjourn

Co-Chair Morrison: I'm still here. I was just going to thank everybody in the Workgroup for really staying with us. A huge thanks to the NQF Staff.

I can't remember a Map meeting where the vote has consistently aligned with the Staff recommendations, and that's either we're getting smarter or NQF is continuing to be even better and better.

It's just terrific work. And a huge thanks to Matt and Akin. As I messaged them privately, I started developing myalgias and chills this afternoon and so Akin really took over.

I really appreciate that, and yes, I have been vaccinated and boosted, but the new exciting variant is in New York City. So thanks to you guys for taking over. I really, really appreciate it.

Let me turn it over to Akin.

Co-Chair Demehin: John, we're sending positive thoughts your way and you deserve an incredible amount of thanks for facilitating a very complex conversation around the health equity measures and the IQR measures.

That was a lot to get through and I think you did it in a way that really facilitated conversation. So I really really appreciate it and we're thinking of you.

Let me add my thanks to Sean's of the NQF team. Matt, Ivory, Becky, and everybody else involved in the preparation for this meeting, as always, you make it very easy for Sean and me to keep these conversations moving.

So thank you for the caliber of your work.

I would also like to thank again our colleagues from CMS who, as always, come to the table with just an incredible amount of engagement and thoughtfulness in talking through the measures with us, and candor in sharing with us what they're thinking.

So I just cannot thank you enough. The measure developers who are on the line today to walk through some pretty complicated conversations around measure specs, thank you for your engagement.

We really appreciate it.

I do see Michelle's hand raised. But before I turn it over to her, just a final thank you to all of you for

your tremendous work and conversation.

I always come away from these meetings feeling like I learned something new about how different stakeholders are perceiving quality measurement and what their names are.

That part of the conversation is hard to capture in words but, boy, is it ever valuable. So I really do appreciate it.

Michelle, let me kick it over to you.

Dr. Schreiber: This is a bit redundant but on behalf of CMS we wanted to extend the same thanks, certainly to the Committee Members for your really very engaging conversation sticking with it, and your thoughtful comments.

We really do consider them seriously. Akin and Sean, you guys did a wonderful job and, Sean, we obviously hope that you are fine. And again, to everybody else on the phone, NQF, CMS and our measure developers, thank you.

That's our same appreciation from us to all of you.

Dr. Pickering: I will just include my thanks. I won't go too far into it, as everyone else has mentioned so many thanks to all the stakeholders today.

I just want to emphasize my gratitude to the NQF team who have put a lot of tireless hours into the proceedings today. So thank you to this team at NQF, the leadership guidance, and getting all the materials ready for proceedings today.

We'll be following up offline but I will say that we're not at 11 minutes to end the call but we were technically a lot earlier ending previously from the map clinicians.

So way to go Workgroup, nice job, great job of ending early, I will say that we may have been ending a little early than intended but that's semantics, I guess.

Thank you, have a great holiday, we'll be following up offline and we'll be connecting with you on a future date. So thank you all very much. Have a safe and happy holiday.

Co-Chair Morrison: Take care, everybody.

(Whereupon, the above-entitled matter went off the record at 5:51 p.m.)