National Quality Forum
Measure Applications Partnership (MAP)
Health Equity Advisory Group 2022 Measure Set Review (MSR) Meeting
Wednesday, June 15, 2022

The Committee met via Video Teleconference, at 10:00 a.m. EDT, Rebekah Angove and Laurie Zephyrin, Co-Chairs, presiding.

Workgroup Members:

Rebekah Angove, PhD, Co-Chair
Laurie Zephyrin, MD, MPH, MBA, Co-Chair
Susannah Bernheim, MD, MHS, Individual Subject Matter Expert
Joy Bland, DBH, RN, CCM, CPHQ, Aetna
Heidi Bossley, MSN, American Medical Association
Damien Cabezas, MPH, MSW, Individual Subject Matter Expert
Stephanie Clouser, MS, Kentuckiana Health Collaborative
Irene Dankwa-Mullan, MD, MPH, IBM Watson Health
Leonor Fernandez, MD, Beth Israel Lahey Health
Mark Friedberg, MD, MPP, Individual Subject Matter Expert
Beth Godsey, MSPA, MBA, Vizient Inc.
Chris Grasso, MPH, Fenway Health
Malcolm John, MD, MPH, America's Essential Hospitals
David Machledt, PhD, National Health Law Program
Tala Mansi, Planned Parenthood Federation of America
Ekta Punwani, IBM Watson Health
Koryn Rubin, MHA, American Medical Association
Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM, Individual Subject Matter Expert
Mahil Senathirajah, IBM Watson Health
Sarah Shih, MPH, National Committee for Quality Assurance
Cardinale Smith, MD, PhD, Individual Subject Matter Expert
Melony Sorbero, PhD, MPH, Individual Subject Matter Expert
Jason Suh, MD, Individual Subject Matter

Expert
Sunny Todhunter, Individual Subject Matter Expert
Roberta Waite, EdD, PMHCNS, RN, MSN, ANEF, FAAN, American Nurses Association

Non-Voting Federal Liaisons:

Leslie Hausmann, Veterans Health Administration
(VHA)
Meagan Khau, CMS Office of Minority Health (OMH)
Michelle Schreiber, MD, Centers for Medicare and
Medicaid Services (CMS)

NQF Staff:

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

Also Present:

Ihsan Abdur-Rahman, MPH, CMS
Anita Bhatia, MPH, PhD, CMS
Greg Bocsi, DO, MS, College of American

Pathologists
Robert Dickerson, Mathematica Policy Research
Alrick Edwards, MPH, Abt Associates
Lisa Marie Gomez, CMS
Dan Green, Center for Clinical Standards and Quality, CMS
Maryellen Guinan, America's Essential Hospitals
Morris Hamilton, PhD, Abt Associates
Colleen Jeffrey, PIMMS
Kathleen Johnson, RN, CMS
Flora Lum, MD, American Academy of Ophthalmology
Shaili Patel, Hospital Outpatient Quality Reporting Program, CMS
Jessica Peterson, MD, MPH, MarsdenAdvisors
Gequincia Polk, Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), Interim TO COR, CCSQ, CMS
Mikhail Pyatigorsky, PhD, Acumen, LLC
Kimberly Rawlings, Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS

Contents

Welcome, Introductions, Overview of Agenda, Disclosures of Interest (DOIs), and Review of Meeting Objectives 9

CMS Opening Remarks 11

Review of MSR Process and Measure Review Criteria (MRC) 22

Opportunity for Public Comment 30

Hospital OQR Program Measures 36

00922-C-HOQR: Left Without Being Seen 36

00930-C-HOQR: Median time from ED Arrival to ED Departure for Discharged ED patients 48

00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain 58

02599-C-HOQR: Abdomen Computed Tomography (CT)-Use of Contrast Material 63

02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery 72

ASCQR Program Measures 82

Patient's Visual Function within 90 Days Following Cataract Surgery 82

Opportunity for Public Comment 82

02936-C-ASCQR: Normothermia Outcome 95

MSSP Measures 112

00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan 112

eCQM ID:CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM) 114

06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups 123

02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions 128

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey 131

01246-C-MSSP: Controlling High Blood Pressure 132

eCQM ID:CMS165v10: Controlling High Blood Pressure (eCQM) 134

Opportunity for Public Comment 140

MIPS Measures 142

00641-C-MIPS: Functional Outcome Assessment 142

01101-C-MIPS: Barrett's Esophagus 144

02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery 151

00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care 152

05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing

Ongoing Diabetes Care 155

05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report 156

05837-E-MIPS: Children Who Have Dental Decay or Cavities 161

Opportunity for Public Comment 169

HH QRP Measures 170

00185-C-HHQR: Improvement in Bathing 170

00187-C-HHQR: Improvement in Dyspnea 170

00189-C-HHQR: Improvement in Management of Oral Medications 170

Care (PAC) Home Health (HH) Quality Reporting Program (QRP) 175

03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) 177

Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function 180

00196-C-HHQR: Timely Initiation of Care 185

00212-C-HHQR: Influenza Immunization Received for Current Flu Season 187

01000-C-HHQR: Improvement in Bed Transferring 189

02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) - Post Acute Care (PAC) HHQRP 190

Opportunity for Public Comment 193

Next Steps 211

Adjourn 212

Proceedings

(10:04 a.m.)

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

Ms. Williams-Bader: All right, good morning, everyone, my name is Jenna Williams-Bader and I am Senior Director here for the measure applications partnership at NQF. We'll try this one more time, great, thank you all so much.

A couple of housekeeping reminders before we get started, you are able to mute and unmute yourself and you're welcome to turn on your video during the event. Please do keep yourself on mute when you're not speaking.

If you're a call-in user, please state your first and last name and feel free to use the chat feature to communicate with NQF Staff throughout the event. We can go to the next slide, please.

Meeting ground rules, also we have some meeting ground rules. Really, we're just asking for everyone to be respectful and allow others to contribute during this meeting.

We want all of you to share your experiences and we want to hear your perspectives, however, since we do have a number of people on the line, please do keep your comments concise and focused and please respect everyone on the line today.

Next slide. I'm sure many of you are familiar with the WebEx platform but we wanted to point out a couple of features here. You can mute and unmute yourself using the mute button at the very bottom of the screen.

Also, if you want to see the participants or chat, that's also along the bottom of the screen on the right-hand side and if you want to raise your hand

and we do encourage you to raise your hand if you'd like to speak, then you can use the reactions tab and raise hand should be there along the top.

Just remember to lower your hand when you're done speaking if you can, but we will have Staff keeping an eye on that as well. Why don't we go to the next slide?

As I said, welcome so much to the 2022 measure application partnership health equity advisory measure set review meeting. We truly appreciate that you all joined us today and that you are all prioritizing this work within your busy schedules.

Additionally, we'd like to thank CMS for funding this important work. Next slide, please. Here is an overview of the agenda, we'll start with a few welcomes and introductions as well as a run-through of disclosures of interest and review of the meeting objectives.

We will then have Michelle Schreiber give some opening remarks for CMS.

We'll do a quick review of the measure set review process and the measure review criteria and then the bulk of the meeting today we'll spend going through the programs listed here and the measures within those programs that were nominated for discussion.

There will be opportunities for public comment at the beginning of every program as well as one final public comment at the end of the day.

As long we have time, we'll also spend a little bit of time at the end of the meeting asking for your feedback on how the measure set review process has gone so far. And then we will end with next steps and closing comments.

Next slide, please. I'd now like to hand it over to Elizabeth Drye, our Chief Scientific Officer, who will

provide some opening remarks.

CMS Opening Remarks

Dr. Drye: Thanks, Jenna. Hi everybody, I'm really pleased to be able to welcome you today. I am new to this process like you, it's the same for all of us so we appreciate your engagement.

We're honored to partner with CMS to convene this special meeting of the measure application partnership to focus on measure set review and to focus on potential measures to retain or remove measures, thinking especially from the perspective of how those measures affect our goal of achieving better health equity and decreasing disparities.

As you all know, NQF and MAP bring together a multi-stakeholder group with representatives from broad perspectives including quality measurement and improvement, purchasers, public, community, and health agencies, professional health plans, consumers and suppliers.

Last year we collaborated with CMS and highlighted this measure set review process, focused on hospitals. That was in response to Congressional direction to HHS to implement this new multi-stakeholder process and consider measure-specific removal.

So, this is really an extension of that pilot, as you know. We're now extending this across the full scope of the map. The process will bring together this advisory group, a rural advisory group, and recommendations of the two advisory groups will inform three program-focused Committees.

Those Committees are focused on hospital measures, the first one, the second one on clinician measures, and the third on post-acute care and long-term care measures.

So, this is advisory but still really important.

What I would encourage you to do, we will poll you on whether you advise retaining each of the measures that we'll talk about, but I also encourage you just to talk about any observations you have about the measures and perspective, particularly as they relate to potential tools to advance health equity.

We'll carry those recommendations and thoughts forward beyond just the polling results. So, sometimes it's those specific insights that you can bring that can be most informative to the three Committees that will go program by program and review the full measure set and also go.

I wanted to thank you for participating in this process. There are a lot of measures in front of us in this process.

I know it takes a lot of effort but I wanted to give a special thank you to our Advisory Co-Chairs, Dr. Rebekah Angove, and Dr. Laurie Zephyrin.

We appreciate your leadership and we're here to support you as you facilitate the discussion today. Again, the review and discussion and details will inform the rest of the process.

I wanted to also just thank our CMS colleagues and the program leads in particular who have joined to provide important context to the discussion on today's calls about how the measures are used in particular programs and the rationale for having included them to date.

And they've been extremely helpful in setting up the discussions for today in subsequent Committee meetings.

So, we look forward to engaging you in the process and I'm going to hand this off to Jenna, our Senior Director, to orchestrate the whole day.

Ms. Williams-Bader: Thank you so much, Elizabeth,

and I think we might have a hand raised. Does someone have a question on what we've presented so far?

If you do have a question, feel free to put it into the chat or raise your hand, that might be an inadvertent hand raise.

If we could go to the next slide, please. We'll now have welcoming remarks from our health equity advisory group co-chairs and I will start with Rebekah Angove.

Co-Chair Angove: All right, sorry it took me a minute to unmute. Good morning, everybody, I will be on camera momentarily but I am Rebekah Angove, I am the VP of Patient Experience at Patient Advocate Foundation.

I'm so excited to be here with you today and have everybody participating in this important Advisory Committee.

As you all know, this is the first year of doing this and I just am really happy that CMS and this group has integrated health equity into the topics and areas of interest.

I'm really looking forward to today so I will not delay us any further. But welcome, and I am looking forward to having a productive and engaging day.

Ms. Williams-Bader: Thank you very much, Rebekah. Now I'll turn it over to Laurie Zephyrin.

Co-Chair Zephyrin: Sure, thanks, I just want to welcome everyone. My name is Laurie Zephyrin, Vice President for Advancing Health Equity at The Commonwealth Fund.

I just want to echo Rebekah's remarks, I'm really looking forward to today and just recognizing the importance of having this group and really thinking about these measures with the lens of equity.

I think this is a really important conversation and we'll have really great discussions today.

And again, thank you all for your time and I'm really looking forward to partnering with Rebekah and all of you on this.

Ms. Williams-Bader: Thank you so much. If we could go to the next slide, please? We'll now jump in a roll call and disclosures of interest. As a reminder, NQF is a non-partisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendos, or humor relating to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting.

While we encourage discussions that are open, constructive, and collaborative, let's all be mindful of how our language and opinions may be perceived by others. We'll combine disclosures with introductions.

We'll divide the disclosures of interests into two parts because we have two types of MAP Members, organizational members and subject-matter experts. We'll start with organizational members.

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 you only one question specific to you as an individual.

We ask you to disclose if you have an interest of $10,000 or more in an entity that is related to the work of this Committee. We'll go around the table beginning with organizational members only, please.

We will call on anyone in the meeting who is an organizational member.

When we call your organization's name, please unmute your line, state your name, your role at your organization, and anything you wish to disclose.

If you did not identify any conflict of interests after stating your name and title, you may add I have nothing to disclose.

If you represent an organization that is a measure steward or developer and if your organization developed and/or stewarded a measure under discussion today in the past five years, please disclose that now.

And then we ask you to recuse yourself from the discussion and poll for that measure later in the day. I will now turn it over Ivory who is going to run us through the organizational disclosures.

Ms. Harding: Thank you, Jenna. Let's start with Aetna?

Member Bland: Yes, I'm Joy Bland, I'm the Associate Vice President for quality at Aetna and I have no disclosures at this time.

Ms. Harding: The American Medical Association? The American Nurses Association?

Member Bland: Good morning, my name is Roberta Waite, I'm a member of the American Nursing Association and I have no conflicts to disclose.

Ms. Harding: Thank you. The American Society of Health System Pharmacists? America's Essential Hospitals?

Member John: Good morning, my name is Malcolm John, I am a representative for America's Essential Hospitals and I have nothing to disclose.

Ms. Harding: Beth Israel Lahey Health?

Member Fernandez: Good morning, I'm Leonor

Fernandez, I'm a primary care physician and medical director for health equity here and I have no disclosures.

Ms. Harding: Fenway Health?

Member Grasso: Good morning, I'm Chris Grasso, Chief Information Officer at Fenway Health and I have no disclosures.

Ms. Harding: IBM Watson Health?

Member Senathirajah: This is Mahil Senathirajah, I'm a Senior Director of IBM Watson Health, no disclosures.

Ms. Harding: Thank you. Kentuckiana Health Collaborative?

Member Clouser: Hi, this is Stephanie Clouser, Senior Director for Data Management Innovation here at the KHC and I have nothing to disclose.

Ms. Harding: National Committee for Quality Assurance?

Member Shih: Good morning, my name is Sarah Shih, I'm the Assistant VP for Research and Analysis at NCQA.

We are a measure stewards for controlling high blood pressure and I will recuse myself during that conversation and also we do have contracts with CMS who also has supported many of these measures, thank you.

Ms. Harding: National Health Law Program?

Member Machledt: Hello, my name is David Machledt, I'm a senior policy analyst with the National Health Law Program and I have nothing to disclose.

Ms. Harding: Patient Safety Action Network? Planned Parenthood Federation of America?

Member Mansi: Hello, this is Tala Mansi, I have nothing to disclose.

Ms. Harding: The SCAN Foundation? Vizient Incorporated?

Member Godsey: This is Beth Godsey, I'm the Senior Vice President of Data Science and Methodology at Vizient and have nothing to disclose.

Ms. Harding: Thank you. Are there any organizational that may have joined during roll call? Thank you. Back to you, Jenna.

Ms. Williams-Bader: thank you so much, Ivory. Thank you all for those disclosures. We'll now move on to disclosures for our subject-matter experts.

Because subject-matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume.

Instead, we are interested in your disclosure of activities that are related to the subject matter of the Work Groups or Advisory Groups' work.

We are especially interested in your disclosure of grants, consulting, or speaking arrangements but only if relevant to the Advisory Groups' work.

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

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

I also want to mention that we are not only

interested in your disclosures of activities where you were paid, you may have participated as a volunteer on a Committee where the work is relevant to the measures reviewed by MAP.

We're looking for you to disclose those types of activities as well. Finally, just because you disclose does not mean you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name, what organization you're with, and if you have anything to disclose and Ivory will be calling your name so that you can disclose.

We'll start with our Co-Chairs, and Ivory, I'll turn it back over to you.

Ms. Harding: Rebekah Angove?

Co-Chair Angove: Hello, I'm trying to turn on the computer, I'm sorry.

Ms. Harding: Anything to disclose?

Co-Chair Angove: No disclosures, thank you.

Ms. Harding: Laurie Zephyrin?

Co-Chair Zephyrin: I have nothing to disclose.

Ms. Harding: Emily Almeda-Lopez? Susannah Bernheim? Damien Cabezas?

Member Bernheim: I'm here, I was having a hard time getting off of mute.

Ms. Harding: Thank you, Susannah.

Member Cabezas: Good morning, nothing to disclose.

Ms. Harding: Thank you, Damien. And anything to disclose for you, Susannah?

Member Bernheim: I do but I was worried I was

causing the echo.

Ms. Harding: I can circle back.

Member Bernheim: I'll put it in the chat.

Ms. Harding: Mark Friedberg?

Member Friedberg: Yes, I'm Mark Friedberg, an employee of Blue Cross Blue Shield of Massachusetts and Brigham and Women's Hospital in Boston.

I sit on the Committee for performance measurement at NCQA, that's an unpaid position.

Ms. Harding: Jeff Huebner? Gerald Nebeker?

Member Todhunter: Yes, hi, this is Sunny Toddhunter, sitting in for Dr. Nebeker and I don't have anything to disclose.

Ms. Harding: Thank you. Nwando Olayiwola? Nneka Sederstrom?

Member Sederstrom: Hi, good morning, Nneka Sederstrom here and I have nothing to disclose.

Ms. Harding: Cardinale Smith? Melony Sorbero?

Member Sorbero: This is Melony Sorbero, I work on a CMS-funded contract related to the Medicare Advantage Star Rating Program.

Ms. Harding: Jason Suh?

Member Suh: Jason Suh, I'm a hospitalist with Peace Health, I'm the associate inpatient CMIO and I have nothing to disclose.

Ms. Harding: Thank you.

Ms. Williams-Bader: Thank you all so much for those disclosures. at this time, we'd like to invite our Federal Government participants to introduce themselves.

They are non-building liaisons of the Work Group so, Ivory, I'll turn it over to you to run through those.

Ms. Harding: First, we have the Centers for Medicare and Medicaid Services and the CMS Office of Minority Health?

Dr. Schreiber: Hi, this is Michelle Schreiber for CMS and there are a number of folks from CMS on the call. OMH, are you on as well?

Ms. Khau: This Meagan Khau from CMS, OMH, nothing to discuss.

Ms. Harding: Health Resources and Services Administration? Office of National Coordinator for Health Information Technology? The Veteran's Health Administration?

Dr. Hausmann: This is Leslie Hausmann, I'm representing VHA, thank you.

Ms. Harding: Are there any SMEs that I may have missed or that joined during roll call? Koryn, would you like come off mute? Are you an organizational rep?

Member Rubin: Yes, Koryn Rubin, American Medical Association.

Ms. Harding: Anything to disclose?

Member Rubin: No disclosures.

Ms. Harding: Back to you, Jenna.

Ms. Williams-Bader: Thank you so much, Ivory, and thank you all so much. I'd like to remind you that if you believe you might have a conflict of interests at any time during a meeting, please speak up.

You may do so in real time at the meeting, you can message your chair who will go to NQF Staff, or you can directly message the NQF Staff.

If you believe that a fellow Committee Member may have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting, approach the Chair, or go directly to NQF Staff.

Do you have any questions or anything you'd like to discuss based upon the disclosures made today? In that case, let's go ahead and move to the next slide.

I'd like to go ahead and introduce our MAP Advisory Group Staff as well.

We have Tricia Elliott, our Senior Managing Director, myself, Senior Director, Katie Berryman, who's our Director in the Project Management Department, Ivory Harding, and Susanne Young, who are managers, Ashlan Ruth, who is our Project Manager, and Jolencia LeFlore, and Gus Zimmerman, who are the associates supporting this work.

I'd also like to let you know that Chelsea Lynch, who is the Director of our Emerging Initiatives Department is on the line and will be helping to facilitate parts of this meeting today as well.

If we could go to the next slide, please? We also have on the line Kim Rawlings, who is our task order contracting officers representative from CMS as well as Gequincia Polk, who is our IDRQ contracting officers' representative.

And as you heard mentioned, we have a number of CMS program and measure leads on the line as well. Next slide, please.

So, the meeting objectives for today, the first will be we will be reviewing the 2022 MFR process and the measure review criteria.

The second, and where we will spend the majority of our time today is providing MAP Members with an opportunity to discuss and recommend measures for potential removal.

And then as I mentioned, we will be seeking feedback from you on the MSR process at the end of the meeting. Next slide, please. And then next slide.

I'd like to turn it over to Michelle Schreiber from CMS, who will be providing some opening remarks.

Review of MSR Process and Measure Review Criteria (MRC)

Dr. Schreiber: Jenna, thank you very much and good morning to everybody, it's a pleasure to be with you today. I am, as you heard, Dr. Michelle Schreiber, I'm a primary care physician by background and spent most of my career actually as a primary care in the City of Detroit.

So, the issue of equity is something that's near and dear to my heart and as you all know, is near and dear to this administration as well.

I am the Deputy Director for the Center for Clinical Standards and Quality and direct the group that really oversees most of these measures in our programs. So, the quality measures in value-based incentives group.

And we really welcome everybody here today.

As you've heard already, this is a relatively new process, Congress authorized the MAP to not only make recommendations to CMS about measures to be included in programs, and many of you have been part of those discussions over the years, but also to make recommendations to CMS regarding measures perhaps to be removed from programs.

We look forward to your particular input on that with an equity lens. I will say that when measures are put into programs, it's done hopefully with a lot of thought, a lot of scientific evidence behind it, many of the measures are endorsed by NQF but not all of them.

And we put measures into programs through public

rule-writing, as many of you are familiar with, and a period of public comment. So, there's always been a lot of opportunity for the public to comment on these measures as well.

But we recognize the concern there are in some cases perhaps too many measures or perhaps measures that aren't exactly the right ones or functioning the way we would like in terms of improving quality and safety and equity for individuals.

And so I think this process helped wrap up a more holistic approach to these value-based programs, recommendations for what should be in them and perhaps recommendations of ones that aren't functioning in the way we would intend or want as measures for removal.

I want to thank again NQF and the NQF Staff. This is a lot of work to put these meetings together and to facilitate them, to thank the CMS representatives as well as our measure developers who are on the phone.

And finally, of course, to thank each and every one of you for participating in this Committee.

To our Co-Chairs in particular, we recognize this is a lot of time you're dedicating to these important efforts and we really deeply appreciate it and deeply appreciate your comments as well.

It does have an impact as we look to rule-writing. Just to be clear, your recommendations this year will affect rule-writing next year.

So, you won't have the instance gratification perhaps of seeing a change in a measure in a rule this year but it will be for consideration for the subsequent IE next year. And again, thank you for all of your participation and your comments, and Jenna, I turn it back to you.

Ms. Williams-Bader: Thank you so much, Michelle. I really appreciate you being here and your opening remarks today.

If we could go to the next slide, please? I will be turning it over to Ivory Harding who will be reviewing the MSR process and measure review criteria.

Ms. Harding: Thank you, Jenna.

The charge of the Health Equity Advisory Group is to provide input on measures under consideration and measures under review with a lens to measurement issues impacting health disparities and made over 1000 United States critical access hospitals.

The Advisory Group also conducts their review with the goal to reduce health differences

closely linked with social, economic, or environmental disadvantages.

Next slide. The goal of the 2022 MSR process is to prioritize, survey, prepare, and discuss the measures for review with the output being a set of final recommendations and rationale for measures being provided to CMS.

So far, NQF has worked in collaboration with CMS and with Members of MAP to prioritize programs for discussion and narrow down the list of measures for review.

During completion of the survey, Advisory Group and Work Group Members nominated measures that they would like to discuss for potential removal and they selected the measure review criteria they used to nominate the measures.

However, they had limited information about the measures at the time they completed the survey so they were selecting criteria based on what they knew about the measures at the time.

Unless comments were left in the free text fields, we do not know why certain criteria were selected. These measures have been analyzed by members against measure review criteria and the results have been posted for public comment.

The rationale for nominations and notes from Survey Respondents within the MSS comes from this survey. Measures adopted into programs before 2011 may not have been reviewed by MAP as MAP did not exist before this time.

Today, Advisory Group Members will get to participate in a poll to determine the extent to which these measures advance health equity or contribute to difficulties in performance measures for a variety of reasons.

Feedback from the Advisory Group will be shared at each upcoming Work Group meeting for consideration in votes for measures for removal. More details on this process will be shared in the next slide.

Final recommendations will be published in September and these recommendations are one consideration that CMS uses when deciding whether to remove a measure from a program.

Next slide, please. Feedback from the Advisory Group will be shared with each setting-specific Work Group and the Coordinating Committee through volunteer reports at the Work Group and Coordinating Committee meetings.

Feedback from the Advisory Groups will also be in the incorporated into the measure summary sheets for review by the Coordinating Committee. Next slide, please.

Advisory Group Members were provided with 10 measure review criteria to use in their evaluation of measures for review during this survey process. The finalized criteria included feedback from the

Coordinating Committee and will continue to evolve.

The review criteria focus on measures that do not contribute to overall goals of the program our are duplicative, are not CBE-endorsed or have lost endorsement status, are in regard to patient outcomes, current evidence, performance variations, reporting burden and unintended consequences.

Next slide.

For measures that may have unintended negative consequences, the considerations will be different between the Advisory Groups and the Coordinating Committee.

Examples for the Health Equity Advisory Group consideration include race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, and geographical consideration.

Next slide. Each program will be introduced by NQF Staff before the public is given an opportunity to provide comment on each of the measures within that program.

For each measure, the lead discussants will provide their evaluation of the measure before the discussion is opened up to the entire group.

Advisory Group Members will then participate in a poll to express their support in retaining a measure within the program.

Next slide, please.

Are there any questions on the 2022 MSR process? I briefly saw a hand, is there still a hand raised?

Member Godsey: Yes, this is Beth Godsey from Vizient. I appreciate the overview of the criteria.

I think even looking at some of the process of the measures that we received and looking at them, I

think in the future it might be helpful for us to be able to start looking at these measures in a more stratified way, looking at those core aspects that were on that last criteria.

It can be difficult and challenging to be able to evaluate some of these measures when the lens of the outcome of those measures are not shown in that view.

So, I just wanted to make an overarching comment about the process and some of the criteria could potentially be expanded to account for some of those aspects that are really important when evaluating health equity.

Ms. Harding: Thank you for your comment, Beth.

As a reminder, at the end of the agenda there is a time where all the members will be able to participate in a poll on the process and then you will be guided on specific discussion questions by Jenna.

Thank you, that will be noted as well. Any other questions from members? If you're on the phone you can come off mute or leave a question in the chat.

Next slide, please. We will now transition to a test poll. Members were given instructions on where to find the links in this poll in an email yesterday. If you are unable to locate that information, please let a team member know and we can assist you.

I will now hand over the presentation to Susanne to continue leading you all in this activity.

Ms. Young: Thank you, Ivory. We are going to be pulling up a test poll question. Again, as a reminder, this was sent via email yesterday. This poll for today is to only be used for those voting members.

Please do not share. If you are having any trouble pulling up the poll or having trouble with the link, please feel free to chat or message NQF Staff and

we can help you with that.

The test poll question is now open to IT. I see we have some Members already answering our test poll question.

Once we open the poll, you can actually change your answer, so if you accidentally click on an answer you decide you want to change, once the poll is open you can actually clear out that first answer and repoll.

Please let us know if there is any problems, any difficulty finding that link or answering that test question.

I think we have at least 20 that we counted, is anybody having trouble pulling up that poll using that link?

We can send a link to you.

Member Bernheim: Can I just ask, does it tell you it's accepted it or you just click it and that's it?

Ms. Young: I believe, please correct me if I'm wrong, it changes color or it does indicate that your poll or your vote is there.

Member Bernheim: Yes, it just took a minute, thank you.

Ms. Young: If the poll is still open, you can change it until we lock it.

Member Suh: The bar turns blue and there are little words that says response recorded.

Ms. Young: Thank you, I appreciate that. I know we have a few that will need a link so we will do that. I just chatted a few more links, please let us know if you need assistance with those links.

While we are waiting to make sure everyone can access that poll, do we have any organizational

members or subject-matter experts who have joined since we went through our roll call and disclosures of interest earlier?

Member Smith: Hi, this is Dr. Cardinale Smith. I joined a couple minutes ago.

Ms. Young: Do you have anything to disclose?

Member Smith: I do not.

Ms. Young: Okay, I think we are up to our number. Please again let us know if you are having any trouble with that link, we can close the poll.

Once we close the poll today, we will be showing our numbers and we have 19 numbers on this call with IT. Thank you, team.

Ms. Williams-Bader: I think I'll be picking it up from here. If we could go to the next slide, please? We're going to start with our hospital programs today, next slide.

And the three hospital programs that were included in this year's measure set review were the hospital outpatient quality reporting program, the ambulatory surgical center quality reporting program, and the PPS-exempt cancer hospital quality reporting program.

Next slide, please. We'll be starting with the hospital outpatient quality reporting program. Next slide. This is a pay-for-reporting and public reporting program.

The incentive structure is the hospital's outpatient departments that do not participate or participate but fail to meet program requirements receive a 2-percentage point reduction of their annual payment update under the OPPS for not meeting program requirements.

And the goals of this program are to progress towards pain providers based on the quality rather

than the quantity of care they give patients and to provide consumers information about HOPD quality so they can make informed choices about their care.

Opportunity for Public Comment

Next slide, please. We'll now have an opportunity for public comment and I will turn it over to Rebekah.

Co-Chair Angove: Good morning, everybody, thank you. I want to open it up for public comment.

Just a reminder that, if you could please limit your response to two minutes. The easiest way is to raise your hands and I can get to everybody as the comments come in.

Towards the end, I will also open up space to make sure those on the phone or those in the chat have an opportunity for their comments to be heard.

If we have anybody that wants to comment, please raise your hand.

Ms. Williams-Bader: Rebekah, just to let you know, your voice is coming in a little muddled, a little quiet.

Co-Chair Angove: Is that better?

Ms. Williams-Bader: That is better, thank you.

Co-Chair Angove: My notebook was in the wrong spot. For those that may not have heard, we just request that keep public comments to two minutes and we're opening up this space to those that are on video.

Please raise your hand and then in a few minutes, once we get to all of those that raised their hand via the webinar, we will get to individuals that --

I'm not seeing any hands raised.

Ms. Williams-Bader: Rebekah, I'm sorry to do this to

you but you've gone really quiet again. I'm not sure if people are able to hear you.

Co-Chair Angove: I'll go back to the phone. Is that better?

Ms. Williams-Bader: I think it's still quite quiet. In the chat folks are saying they are having trouble hearing you. Rebekah, I think you were dialing in, are you rejoined yet?

Co-Chair Angove: I am rejoined but my phone won't unmute.

Ms. Williams-Bader: Yes, it's very quiet.

Ms. Young: We do have a hand raised.

Ms. Williams-Bader: While Rebecca is sorting out her sound, whoever has -

Dr. Hausmann: Good morning, this is Leslie Hausmann representing the Veteran's Health Administration.

I just had a process question while she's troubleshooting her audio.

Is the intent to discuss all of these as the collection or to comment on each one individually?

Ms. Williams-Bader: You may comment on an individual measure or the set of measures, either one.

Dr. Hausmann: I have another process question. Are the comments that are being submitted from this group today intended to be about if and how equity should be considered for each of these measures?

Are we past the point that it's important that equity be considered and you're looking for feedback on specifically how equity might be relevant to these various measures?

Co-Chair Zephyrin: Sure, I don't mind taking that but welcome others to speak as well.

This is the public comment portion of the meeting, just a reminder, we will start going through the measures one by one for the Advisory Group to comment on what we are hoping to get out of the conversation today.

Again, these are measures that have been nominated for discussion about their potential removal from programs.

So, the Health Equity Advisory Group can provide comments from two different perspectives, one would be that if the measure is kept in the program, do you have any concerns about that from a health equity perspective?

Would there be anything about the measure that you would want to see adjusted in order to better achieve our health equity goals? Or the Advisory Group might comment on how removing a measure can have an impact on health equity, perhaps it's a measure that is particularly useful at identifying health disparities so you'd want to see it stay in the program.

So, I hope that helps and again, if anyone else, our Co-Chairs or others would like to comment on that, please feel free.

Dr. Hausmann: This is Laurie Zephryin. I'd just like to add to that, just highlighting potential equity impacts, other impacts with leaving it and impacts with taking it out.

Can the measure address equity? Does it measure something that we know about disparities, for example, like are they disparity-sensitive conditions?

Probably not in this particular case but some of the other measures, does it address equitable access to

care? Are there unintended consequences?

And so those are part of the conversations that we can have as part of this group. Hopefully, this answers some of your questions, Leslie.

Co-Chair Zephyrin: Yes, it does, I appreciate that and I'll share my video. Now that I have some clarification, I'm not sure why, I do know why, hello, everyone, good morning.

I appreciate the clarification and I would like to offer my perspective that I do think that omitting the Left Without Being Seen could perhaps have implications if certain groups experience longer wait times in waiting rooms.

And it also may affect the denominator of who gets included in assessing emergency department experiences among patients that may disproportionately affect people who are either seeking care.

I would offer that particular measure may have important unintended equity impacts by being omitted.

Co-Chair Angove: Thank you, Leslie. Is that better?

Ms. Williams-Bader: Unfortunately, no.

Co-Chair Zephyrin: It's a little bit better.

Co-Chair Angove: I am on nine hours of Zoom calls a day, this is the first time anything like this has happened. So, I apologize to you guys.

Co-Chair Zephyrin: I can hear you, you just sound far away so why don't you continue? I don't know if others are okay with that. I can hear you, you just sound far away.

Co-Chair Angove: I think we just want to see if there are other comments.

I don't see any other hands up, maybe this is a good time if there are call-in users, if you want to come off of mute and share any comments you may have?

I think if we don't have any other comments, we can probably move on. I played with some settings so I'm going to be selfish and see if that helps at all, audio settings, yes, no?

I can hear you much more clearly now, Rebekah. I played with some of the WebEx audio settings so maybe that was the problem, thanks for the patience.

And since I don't hear anybody coming off of mute and I don't see anything coming into the chat and I don't see any hands up, so I think we can move on to our next section and close this public comment period on the hospital application quality reporting program measures.

Co-Chair Zephyrin: Thanks, Rebekah.

I do see a question from Jason Suh in the chat, which is more about process again and he asked shouldn't we be discussing the public comments after we discuss each individual subject?

So, we've put the public comment upfront because in the past we've gotten some feedback that when we have the public comment after the discussion, and particularly when we've had it after the vote when we're talking about the Work Groups, the comments may have influenced how either Work Groups or Advisory Groups thought about a measure.

And so we've now moved it upfront so those comments can be part of the discussion. We also have a question from Malcolm John, has the rationale for removal been vetted?

Are they from SME, CMS who have reviewed the

data? Malcolm, are you speaking about the measure review criteria that we are using?

Member John: Yes, just following up on the comment about left without being seen, I just reviewed in more detail the rationale for its removal include criteria for performance or improvement on the measure does not result in better patient outcomes.

And it just got me thinking about that statement landed there. Was there some data reviewed? Was there some clear history that it does not move the dial on outcomes?

I'm just wanting to understand if that's coming from that or is it from public comment?

Ms. Williams-Bader: The measure review criteria build off of the measure review criteria that were used in the pilot with the Coordinating Committee last year.

There were some meetings with the Coordinating Committee after the measure set review pilot and we got their feedback on the criteria and made some adjustments as a result.

We've also worked with our CMS colleagues to assess these criteria and to try to align them as much as we can with criteria that CMS uses for assessing measures as well.

This again is the first time we're doing this and so we are looking for feedback, we'll be looking for feedback later in the day, on how it was using these criteria for the review.

There are some where we have been able to provide some data, for example, with reporting and performance we've been able to provide some data in the measure summary sheets, but others where it is more challenging and I think you've pointed out one of them.

So, again, we're looking for feedback for how these criteria work and we'll be doing that at the end of the day. I hope that answers your question and welcome others to say anything if they would like as well.

Member John: Thank you very much and excuse my typos in the chat.

Ms. Williams-Bader: If we have no other questions or comment, I think we can go ahead and move to -- go ahead.

Member Machledt: This is Dave Machledt. I'm also just trying to understand the process here. We are as a group going to discuss all these measures individually after this public comment period?

Hospital OQR Program Measures

Ms. Williams-Bader: Correct, yes, that's what we're moving into next, we'll be walking through them one by one.

Member Machledt: Okay.

00922-C-HOQR: Left Without Being Seen

Ms. Williams-Bader: If we could go to the next slide, please? The first measure that we will be discussing today is 00922-C-HOQR: Left Without Being Seen.

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

The endorsement was removed for this measure and in the Advisory Group and Work Group survey that was completed in April, seven Advisory Group and Work Group Members selected this measure for discussion.

I'll now be turning it over to our lead discussants to talk about the criteria and rationale that the

Advisory Group and Work Group Members used when selecting the measure and to talk about their comments on the measures.

So, I'll be turning it over to the American Nurses Association and Vizient.

Co-Chair Angove:And we can start with a representative from the American Nurses Association if you are on and ready to discuss?

Member Waite: I'm just coming back, I had to use a biological break so I missed part of what you were asking. Can you repeat for me?

Co-Chair Angove: Absolutely, we are going to review the Left Without Being Seen measure and we are looking for the representative from the American Nurses Association as lead discussant to comment on this one.

Member Waite: As it relates to equity, this is one of the measures that from our perspective needs to be left in.

I think it has significant impact that we could look at some things that would contribute to looking at how somehow inequities play out with folks leaving, why they had to leave, would some of that rationale be not counted when assessing patients who were admitted?

So, I think we would lose a lot of data if we removed this and not counted these patients when we're thinking about Left Without Being Seen. I think it should be included.

Co-Chair Angove: Thanks, Roberta. Does the representative from Vizient have things to add as our second lead discussant?

Member Godsey: Sure, this is Beth from Vizient. A couple of the criteria that were highlighted for rationale for why this particular measure was recommended for removal included your measure

doesn't contribute to overall goals or objectives of the program.

Measure is not endorsed by the consensus-based entities.

Performance and improvement on the measure does not result in better patient outcomes and there's an additional criteria around measure performance.

It doesn't substantially differentiate between high and low. I think the reasons and rationale for why the endorsement was removed would be helpful to know. It may not have enough information at this particular moment to remove the measure.

From a health equity perspective, again, I just want to continue to highlight the criteria that we currently are evaluating or the information that was provided in order to evaluate it from a health equity perspective and healthcare access perspective I think is limited.

So, it makes it challenging to be able to recommend whether this particular measure should be officially removed or not.

Co-Chair Angove: Thank you so much, Beth. I want to open it up now to the group. If there are any clarifying questions, we're happy to field those or have a discussion about this measure.

Ms. Williams-Bader: And while we wait for hands, Rebekah, if we could also go to the next slide which covers the additional survey feedback we received? Thank you.

Co-Chair Angove: Jason has his hand up.

Member Suh: Good morning, I'm going to present the counterpoint, which is I work in a hospital, I'm a hospitalist, and my daughter has recently been a patient in an emergency during the middle of COVID-19.

She had to wait many hours. The reasons people leave are not tracked by us, it's really a huge variety of reasons why people leave. And it really has to do with the patients and understanding of the patient, rather than the health system.

Some people can wait 30 minutes and decide to get up and leave, some people can wait 12 hours.

Some of our busier hospitals in the middle of COVID-19 had waiting times of up to 12 hours and who decided to stay and who decided to leave really was dependent on the patient.

And so for us to measure it is sort of difficult. That would be my counterpoint to very good arguments of why we should keep this.

I understand those arguments but as stated in the thing, measures do not contribute to the overall goals and objectives of the program, I don't know if we get the right data asking this question.

That's my counterpoint, thanks.

Co-Chair Angove: Leonor has her hand raised.

Member Fernandez: Thank you. While I agree that it will be hard to discern why people have left, this measure I do believe could highlight certain important inequities, I'll give you just an example.

If a hospital basically is not providing interpreter services in a timely way and basically all those patients have to wait way longer before they have effective triage, you can totally see how that would very much increase the rates of leaving without being seen in that population.

So, if it's not being effective, that's a second-order thing as to how it's being used. But I do think this is probably, a strong hunch is that this is, an equity-sensitive measure that requires the subgroup analysis.

Thank you.

Co-Chair Angove: I see Dr. Sederstrom's hand is up?

Member Sederstrom: I was just going to concur with what the speaker said just before then there.

There are some very significant equity-based situations that we need to track even if we can't get all of the measurement for each patient specifically, we can see some trends in things like not having language services available and things like issues around job, needing to get to work or childcare or the lack of access for being able to hang in the ED for long because of other social determinant issues.

So, I think it's really an important measure to continue to try and get our arms around and improving it as we move forward makes sense.

I don't think removing it just because it's difficult makes sense because there's some very valuable information that is needed and necessary to address health equity.

Co-Chair Angove: I'm going to go to Mark Friedberg.

Member Friedberg: I think the statement about not knowing why an individual leaves is true but it's essentially just a reliability issue and if we do see a variation in hospital performance at the hospital level and between populations as far as disparities and sensitivities go at the population level, then we don't need to know why individual patients left.

What we're seeing is a true measure of hospital performance. So, I think it is aligned with the purpose of the program and I agree with comments about it being important for assessing disparities.

Co-Chair Angove: I'm going to go to Mahil next and I apologize, I don't want to attempt your last name. Please pronounce it for me for the next time.

Member Senathirajah: It's Senathirajah. I was just going to echo other comments. To the extent minority population may be using ERs as their access point to the healthcare system, this maybe evaluates the quality of that access.

But I would also say the fact that minority population may be using ERs for primary care sources outside the hospital is a factor that should be considered here.

So, I think it's a good evaluation of hospital performance, being able to serve those who show up in the ERs but there's also this other aspect about lack of access outside the hospital to primary care.

But overall I would support retaining the measure.

Co-Chair Angove: I'm going to go to Chris Grasso next.

Member Grasso: Hi, yes, I concur with a lot of previous comments and retaining this measure. I think it's not letting perfect be the enemy of good but I think it does get at health equity issues and I agree with Mahil in terms of it being an access point for some populations.

And particularly thinking about the sex and gender minority patients where people may be experiencing transphobia or homophobia to leave based on some of those initial experiences that they're having.

So, I would agree with keeping this measure.

Ms. Young: Rebekah, we have some comments in the chat.

Co-Chair Angove: Wonderful, I was just about to go there. Would you mind reading those out?

Ms. Young: From Koryn, the first comment, aren't we reviewing outpatient-specific setting programs?

And the second, I can imagine you could measure inpatient settings but I'm unclear if feasible to implement in outpatient setting.

Co-Chair Angove: Do we have clarification on exactly what this is measuring so we can respond to that comment?

Ms. Williams-Bader: I would ask do we have the CMS program lead for the HOQR program on the line?

Ms. Patel: Shaili, I'm online.

Ms. Williams-Bader: Do you think you could answer that question then, about how this measure works in the program?

Ms. Patel: Could you please clarify the question?

Ms. Williams-Bader: I think there's a question about since this is a hospital outpatient quality reporting program, how this particular measure fits in?

Ms. Patel: Inpatient side, is that the actual question or just within the outpatient side?

Ms. Williams-Bader: Within the outpatient setting, yes.

Ms. Patel: I'm not sure if I understand the question correctly but it fits into the program as in it's a chart-abstracted measure, the facilities would have to input information from the time the patient was logged into the ED and then discharged.

However, if they were admitted to inpatient, then it goes into the inpatient IQR program. I'm not sure if I answered the question here.

Dr. Schreiber: This is Michelle, thank you very much, let me take a stab at it. This is really a reflection of the time from when a patient arrives in the emergency department to when they obviously are discharged.

So, let me just clarify, Left Without Being Seen, are we on 22 or 30, because they're related?

Co-Chair Angove: 22 right now.

Dr. Schreiber: Because these are related. Left Without Being Seen obviously means the individual come to the emergency room and for whatever reason they weren't seen by a practitioner.

So, that generally implies either the wait time was too long or the individual felt like they weren't getting the service they needed.

I'm not sure that it necessarily implies access because there is access to the emergency room, but there may be long wait times and access within the emergency department.

The next one is the median time from arrival to departure. So, those are patients who are seen and then they are discharged from the emergency department.

So, both of these wait times get at whether or not patients feel that they are being seen in a timely manner, the first ones being those who just throw up their hands and leave without being seen.

The second is how long does it take to be seen and then to be discharged?

These are measures that are of the hospital outpatient department because emergency department visits are considered ambulatory visits. They're not considered inpatient visits.

And it is the hospital because these are hospital outpatient departments, these are emergency departments that are related to hospitals. It is the hospital then that has to report these measures.

These measures appear in public reporting but they're not specifically tied to any payment programs. So, a hospital's performance is not linked

to payment. Does that help answer it?

The intent of this is really whether or not patients are being seen timely in the emergency department for both of these.

Co-Chair Angove: The question came in via chat but I feel like I appreciate that clarification and the additional details.

Dr. Schreiber: I would say, I don't have the data on equity though, there are concerns this is an important issue around equity about whether or not patients are having to wait for long periods of time to get care in the emergency department.

And that could be reflected either in they're just leaving without being seen or those wait times until they're discharged are very long.

Co-Chair Angove: David Machledt, I see your hand up?

Member Machledt: That was very helpful clarification to understand, especially seeing that it's not tied to payment, one of the things just looking at these numbers I'm concerned about was you have an urban hospital with a really busy ED that isn't performing as well and that may be partly due to where it is and how many people are coming through.

And it's important to be able to track and so I could see this working back against if it was tied to payment, against those EDs that were serving lower-income populations or people who for whatever reason were using it more often as a primary care alternative.

So, I think knowing it's not tied to payment and you could look at a hospital doing better on its own, merits from your year would be helpful.

I saw the trend seems to be this has led to improving, getting fewer patients and the only thing

that I noted from the numbers, it seems like the number of patients who are leaving before getting care is really pretty small, it seemed like.

That's a good thing but it was 1.8 percent.

And I would love to also add the comment that reporting this by subpopulations and particularly language, if that was possible would make the measure I think much stronger than just the general measure that it is.

Dr. Schreiber: David, that gets to a point of ultimately, which of these measures are most appropriate for stratification, A)? And B) what do we use for stratification?

Because you can imagine there are many different variables that one could use for stratification.

And those are all conversations that are ongoing, not only at CMS, actually, but across any organization that uses measures.

In this one, no, it's not tied to payment, except if you don't report at all, but it is we think valuable information for patients to be able to see, whether or not this particular emergency room has long wait times, takes a long time before you're discharged, or that patients, individuals seem to be frustrated to the point they're leaving without even being offered, not offered services.

They're leaving before they get services. I suspect that does happen in some of the busier emergency departments or the larger ones, perhaps those that have less staffing. There's many reasons for that and I suspect that there are some underlying equity issues, although, as I said, I don't have the data for that so I'm not going to speak to that.

I'm going to apologize to you because in five minutes I have to hop off to lead another stakeholder call, but Shaili, I will leave this with you

and my Deputy Director will be joining shortly as well.

Tamyra Garcia will be joining within the next 20 minutes. Any last other questions you would like me to personally answer? I'm happy to.

Co-Chair Angove: Malcolm, I see your hand up.

Member John: I actually was going to say many of the comments that were just shared.

I did want to add, is there a way to standardized or stratify by population size so that we're comparing apples to apples in terms of acuity of ERs in reporting some of this data?

Would that be a possibility to augment or at least ameliorate some of the differences that might be associated with the community population that the ER serves?

That was one thought that I had for the disaggregation of data, because there seems to be some indication that ER wait time is associated with worse morbidity so disaggregating the data by some equity-related variables seems to make sense to me as well.

But in any case, I think the comments that were shared, I support them in general.

Dr. Schreiber: We'll take your comments in the recommendations so thank you.

Co-Chair Angove: There is a question in the chat from Beth asking if somebody can provide clarification as to why consensus-based entity CDE endorsement was removed?

Is that something we're going to cover in future spaces or do we want to address that here?

Ms. Williams-Bader: I think we would want to address it here and looking at the measure

summary sheet, we've seen that it was retired, an endorsement was removed but I'll ask if the program lead or if we have the measure steward or developer on the line and wants to speak to that?

And I will also see if we have more detail. Please jump in.

Mr. Dickerson: This is Bob Dickerson, I'm with Mathematica and we represent the measure developer on this.

The measure lost endorsement I believe it was back in 2012 and it was originally stewarded by a different organization that when it came time to renew endorsement did not pursue endorsement renewal.

So, that's pretty much what we know as far as why it lost endorsement.

It was more so that the original steward did not pursue endorsement and then CMS, we've recently worked with them to take on the stewardship of the measure.

Is that helpful?

Co-Chair Angove: Beth just chatted that was wonderful, thank you. Any other comments that anybody has for this measure before we move to polling? This has been a very robust conversation which I appreciate.

Ms. Young: Rebekah, I'm going to read out the comment by Roberta just for the record. Yes, I do agree reporting by a subpopulation is key.

Member Waite: Thank you, that was something I did place in the chat.

Co-Chair Angove: Just a point of process, do we need to be verbally reading all chats or are we putting chats as a part of the permanent record?

I guess my assumption was those would be included but if we need to be reading them out, I can try to manage that as well.

Ms. Young: We do try to read those out. Ms. Elliott: This is Tricia from NQF. We do capture the chat so for example, Shaili put some extended detail that was covered by Bob related to OP22 and what NQF has on the QPS site.

So, we will capture all of the chat but we bring forward any that may influence the discussion or make sure that folks see that. So, it's kind of a mixed bag. And I appreciate the support watching the chat as well.

I don't see any hands raised. Anybody on the phone that wants to come off of chat and add any comments, I'm just going to pause for you now. I feel like we can move to polling for this measure.

We will pull up the poll now. The poll is now open for measure 009-22-C-HOQR Left Without Being Seen.

Do you support retaining this measure in the program? Formal response choices are yes, no, or unsure.

I'll give it about 10 more seconds. I think we can close the poll. The poll is now closed for Measure 00922-C-HOQR. Responses are yes, 15, no, 1, and unsure, 2.

For percentage, yes, 83 percent, no, 6 percent, and unsure for 11 percent.

Co-Chair Angove: Thank you.

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

Ms. Young: Thank you so much, Susanne. We will go ahead and move to the next measure then. This is measure 00930-C-HOQR: Median time from ED

Arrival to ED Departure for Discharged ED patients.

The description is this measure calculates the median time for emergency department removal to time of department from the emergency room for patients discharged from the emergency department.

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

The measure has been publicly reported since 2013 as part of the ED throughput measure set of the CMS hospital outpatient quality reporting program. Endorsement was removed for this measure and five survey Respondents selected this measure.I will now turn it over America's essential hospitals as our lead discussant. Member John: I think that's me, Malcolm John. Unlike the last variable, I'm not convinced this provides sufficient data on the quality of care that the individual receives as it's currently stated.

It was hard to fully assess as the Vizient representative mentioned. I am in support of its removal at this time.

Co-Chair Angove: Thank you so much, Malcolm John, and I would like to open up the floor now for any clarifying questions and/or comments related to this measure.

Member John: Perhaps I should clarify one other point I made, I think the complexity of the cases aren't captured here. That was one of the main problems as well.

Co-Chair Angove: Dan Green, I see your hand up, why don't you jump in?

Dr. Green: This is Dan Green, I'm a medical associate at CMS. While this isn't my program, just a little bit of light I might shed on this.

Interestingly, ACEP was interested in these measures.

I remember when they first were presented to us in terms of throughput in the emergency room and I kind of was thinking as a clinician I wouldn't want to be responsible for that.

It seems like there are too many things out of my control that may delay a patient moving, being admitted, or in this case being discharged.

But they felt quite the opposite and felt fairly strongly about this. So, I'm just throwing it out there for consideration.

Member John: Did they say why they thought it was important to maintain?

Dr. Green: To be honest with you, this is going back a few years now to four or five and I don't recall but I do recall, I do remember being struck by the fact that I don't think I would want to be responsible but they were very adamant that they thought it was within their purview.

Member John: May I add a comment to that at this point?

Co-Chair Angove: Absolutely, Malcolm.

Member John: I know our ED has done extensive lean process evaluation of the flow issues and there are so many factors that involve potential stays.

I know for example there were people who were bordering in the ER who needed to go into our psychiatric hospital and the delay was really related to the flow to our regular institution. And not so much on the quality of service provided in the ED.

I feel this is one of those metrics that really needs a little bit more teasing out to add meaningful value because the possibilities are multiple for duration, including just a necessity but bordering patients due

to inpatient backlog or specialty, hospital backlog.

That may not be in the control of the ED so it really depends on what you're trying to measure here. Is it ED function or are you trying to measure the entire hospital system work flow?

Co-Chair Angove: Ekta Punwani, I see your hand up.

Member Punwani: Good morning, just a little bit of background, I've worked in hospitals for a number of years. I'm with IBM Watson Health right now leading the 100 top hospitals program.

That's just my frame of reference.

This is a really interesting measure, being responsible for improving this measure for a number of years. I do think there is a component of this, this is a big measure, I agree with what's been said.

However, I think we need this measure because it helps hospitals better understand the community need of what services may not be available or if people are holding on -- a lot of social services issues are where I see some of the really long meeting times.

So, I think from my perspective I think it is helpful from an ED and hospital and community perspective and I do think there's an aspect of health equity that we could learn if there was the right data collected with this measure.

Co-Chair Angove: Thank you, I'm going to go to David Machledt.

Member Machledt: Machledt like chocolate, thanks. My question, it's very different because it is a very complex measure with lots of different contributing factors potentially.

So, I could see for an individual ED it might not be a

great way of measuring that ED's performance but if this is a hospital outpatient performance in general, the question I have is is this one tied to payment like the last one?

Because I think if you tie it to payment, that's a separate question from this is very useful to know and if you see very high times or you're out of step with other EDs for something, it can identify a structural issue that might well have equity components for, I don't know, the psychiatric and mental health patients or something like that, that points to systemic problems with service availability and that kind of thing.

So, I could see it leading to actionable information but if it was used to ding a particular ED, it might be difficult.

Co-Chair Angove: Do we have clarity on if this is tied to payment?

Dr. Bhatia: Hello, this is Anita Bhatia with CMS and I did want to clarify a few things regarding this measure.

The answer to your question is the hospital outpatient quality reporting program is a pay-for-reporting program. There is no payment directly connected to performance, only to the reporting of data.

Two, in regard to the previous comment on psychiatric patients, the reporting measure for this particular measure, which is OP18, OP18 is stratified so the OP18B measure, which is the reporting measure does not include psychiatric patients.

There is a separate measure which is a stratification of this data, which is OP18C. That data is an available and downloadable file that is not the public reporting measure.

And then last is that this particular measure, it does

measure a lot of different factors that would contribute to the median time from ED arrival to ED departure.

But this is a meaningful measure for public reporting or our beneficiaries or other stakeholders. So, there are some merits to this measure.

Co-Chair Angove: Jason Suh, I see your hand up?

Member Suh: Hey, thanks. I'm going to talk about contact with two others for two seconds. I think we should keep this measure, first of all.

This is a good measure of what's happening in our hospitals, more so than the last one, less so than the other one that somebody else mentioned, which is arrival to admit.

That's a really good measure because it is related to morbidity and mortality. But this is about throughput into our EDs and how fast they get out.

Yes, things have gone topsy-turvy in our world with COVID-19 but I think it's a good measure to show what's happening in our EDs. It can't be gamed, that's the thing.

The last one actually can be gamed, you can just have somebody go out to the waiting room and say hello as a provider and say we've seen the patient.

But this one cannot be gamed and neither can the admit so I support keeping this measure.

Co-Chair Angove: Thanks, Jason. Beth Godsey?

Member Godsey: This is Beth from Vizient. I would agree with that comment related to the importance of this measure.

I do think, as mentioned previously, there are some complexities and lots of nuances to be thinking about which I think are relevant.

I do think it gives a lot of good insight into overall throughput within the organization, particularly for the arrival and departure patients. On an equity front I think it's important.

Knowing patients, how long they're waiting, stratifying that by critical strata that we've talked about already I think is important for organizations to understand and would support it from an equity evaluation perspective.

Co-Chair Angove: Shaili Patel?

Ms. Patel: One more thing I wanted to add, I added to the chat, this measure is also included to calculate the hospital Star Ratings, which provides the beneficiary of the overall performance and overall picture of the hospital.

Co-Chair Angove: Malcolm, I see your hand up?

Member John: I just want to say I do appreciate the comments about throughput as a hospital system. And I think if we're looking at it from that perspective, then, yes, that makes sense.

I just think it's important for us to have some clarity on what we're trying to measure. Is it the flow-through, the ED, and whether that in and of itself is associated with worse outcomes?

And then looking for inequities because that certain populations may be at risk or are we looking as a marker of the hospital throughput that some of the folks have mentioned? Which I agree with.

If you're looking at the entire system, it is part of that. So, I'm curious ,do we have a sense of what the goal is with this metric or desired goal when this metric was established? Maybe it doesn't matter, maybe the fact that it does look at the whole system is sufficient enough but I just wanted to -- it's my first time here so I'm just trying to understand. Thank you.

Co-Chair Angove: I appreciate you summarizing the chat, there's been a very robust chat around just that topic. Is there anybody on that that can speak to the ultimate goal of this measure and what they're hoping to capture?

Dr. Bhatia: This is Anita. What do you mean by ultimate goal? I don't think this measure was meant to directly speak to outcomes if that's the question.

Member John: Is it meant to measure the comments about the hospital or hospital system's throughput starting from ED and any barriers to exit from the ED so there may be barriers upstream or downstream rather, as opposed to just the efficiencies within the ER.

Because it may be that you have a very efficient ER but the barrier is not related to the ER but has a hospital system they need barriers in the ICU bed access or floor access.

So, some of the comments I think were relevant in that regard.

Dr. Bhatia: Perhaps the clinicians on the call could comment but I would think that would be something that the hospital would need to investigate on their own.

If they have a lengthy median time for this, they should use this as a quality metric to do a deep dive and determine their own root causes as to why they have maybe a long time for this particular measure.

Because this measure has been around in this program for a long time so prior to when there was a very strong focus on outcomes, on specific outcomes. So, there are other reasons to have measures other than to just look at outcomes.

This may be related to an outcome, I believe it was mentioned that a long time for this can be related to low outcome but that measure doesn't necessarily

directly speak to that.

This would be something that a facility could use to investigate what is going on with them.

Dr. Green: So, this is Dan Green from CMS also, I apologize, this isn't my program but in general, to Malcolm's point, I'm not sure you can really divide out the ED looking at their processes separately from the hospital system.

They're too interdependent but again, this is not used for payment unless they don't report it of course, but it is used in the Star Rating.

So, I think it's useful for the hospitals and of course, the emergency room as a contributor to see how they prepared other institutions, particularly in their geographic region.

And again, it's useful for the consumers if they're looking for a hospital system or an ER that they want to go to, obviously, unless it's a dire emergency unless which case hopefully they'll go to the closest place.

But even hospitals now, if you're driving in some of the major cities or even smaller cities, a lot of times they'll put the average wait time, again, it's a little different, but the average wait time up on billboards.

I know in Sarasota with Sarasota Memorial, they have the wait time and it's a digital thing that changes I guess depending on how busy the ER is.

Again, I know it's a little bit different than the measure but just in general for patient education.

Co-Chair Angove: I don't see any more hands and I do want to keep moving us along, we have a lot of measures to get to. Roberta wanted to jump in here, I just saw your hand go up?

Member Grasso: I had it up earlier and I put it down

but I just want to amplify and agree, I do think this is a really important measure, particularly when you're looking at it from a systems throughput perspective, looking at the system as a whole as well as the ED.

Because you can't disconnect it when you're looking at this measure and I really do think it has an impact on equity.

Co-Chair Angove: Thanks, I appreciate those comments.

I'm going to pause to see if there's anybody on the phone who would like to come off mute and share any comments? Because I know those on the phone cannot raise their hand.

Mr. Dickerson: This is Bob Dickerson from Mathematica. Again, we're representing the measure developer.

One of the things just in terms of what Dr. Green has added, and Anita, there is also a companion measure in the hospital inpatient quality reporting program.

So, when hospitals are using the data and looking at throughput, they have a bigger scope of information than just this single measure.

But again, as Anita pointed out, the measure itself is not designed to look at what the causes are of longer wait times and does not include an outcome.

But in the perspectives of how it can be used, it's one piece of a bigger picture.

Co-Chair Angove: Thank you. We've had a really robust conversation. I feel like we have heard from everybody that wanted to contribute so I move that we put this to our poll.

Ms. Young: Thank, Rebecca, we will bring up the poll. The poll is now open for Measure 009 through

0-C-HOQR median time from ED arrival to ED departure for discharged ED patients.

Do you support retaining this measure in the program? Full response choices are yes, no, or unsure. We're going to give it about 10 more seconds. We're going to close the poll. The poll is now closed for Measure 00930-C-HOQR.

Responses are yes, 13, no, 5, and unsure, 2. The percentages are yes, 65 percent, no, 25 percent, and unsure for 10 percent. Thank you.

Co-Chair Angove: And before we jump in the next one I just want to let everybody know we are following our agenda closely.

We were scheduled to break for lunch at 11:50 a.m. but we are going to try to get through the last three measures of the hospital outpatient quality reporting program before we take that break.

So, I just wanted to let everybody know in our agenda that we're running just a little bit behind.

00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain

Ms. Williams-Bader: Thank you so much Rebecca. We could go to the next slide, please. Our next measure is 00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain.

This measure evaluates the percentage of magnetic resonance imaging or MRI of the lumbar spine studies for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI.

Antecedent conservative therapy may include claims for physical therapy in the 60 days preceding the lumbar spine MRI, claims for chiropractic evaluation, and manipulative treatment, and the 60 days preceding the lumbar spine MRI and/or claims for

evaluation and management at least 28 days but no later than 60 days preceding the lumbar spine MRI.

The measure is calculated based on a one-year window of Medicare claims.

The measure has been publicly reported annually by the measure steward, the centers for Medicare and Medicaid services since 2009 as a component of its hospital outpatient quality reporting program.

Endorsement was removed for this measure and 7 survey Respondents selected this measure. I will now turn it over to our lead discussants and let's start with IBM Watson Health and then I also have Carnell Smith.

Member Senathirajah: This is Mihal, the Director for Watson Health and I'll be discussing this measure. It is essentially an inappropriate use, overuse measure that is again used in hospital inpatient quality reporting programs.

So, payments not driven by performance but there's payment for reporting. The rationale for the 7 members who identified this as a potential measure to consider for removal are on this slide.

So, the last endorsement performance on this measure does not result in better patient outcomes, largely I think because it gets an inappropriate use measure.

The measure does not contribute to the overall goals of the program, does not substantially differentiate between high and low performers, and there's a high level of recording burden.

In looking at the material provided by NCQA, the measure actually went through in terms of its losing endorsement a butchered path along that line.

It lost endorsement, was not initially endorsed by the Muscular Skeletal Committee based on validity criteria, largely concerns about inclusion of the

elderly population, 85 plus.

That's not the exclusions, not capturing all clinical criteria.

And the definition of antecedent conservative therapy maybe wasn't brought enough and wouldn't know how to capture things like telephone support, which are available in the claims data.

Also, in terms of the performance improvements, the measure in 2016 the average was 39.8 percent and dropped to 38.7 percent in 2018, so, a small half-percent improvement in 3 years. Because it hasn't moved much, although at 38 percent that indicates there's potentially a lot of overuse.

Also, material from NCQA which looked at whether there was performance differences, I think logistical significance in comparison to the white population.

And same with income, no difference in comparison to the high income population and also urban, rural, no performance difference compared to large central metro populations.

And then in terms of whether it's useful for health equity, I took a quick look to see if there was in the literature any differences in imaging utilization by minority populations.

And there were a couple of studies in radiology based on 2015 national health interview survey actually came to the conclusion that in black, Hispanic, and Asian patients less likely to report ever undergoing a CT in comparison to white participants, 26 percent less for the African American population and a much bigger differences, only 40 percent of the white population for the Hispanic population.

Also, the one in Canada looking at differences in emergency department diagnostic imaging at U.S. children hospitals, that also found a 20 to 30

percent difference so lower utilization amongst Hispanic and African American populations.

And another study that looked more comprehensively at Millbank and looked at 59 studies and come to the conclusion that a substantial proportion of studies found later overuse amongst white Asians.

So, our thinking was the equity problem may not be underuse or inappropriate use but maybe more underuse.

So, that basis thought this measure may not be useful in terms of equity as much, whether it's useful more broadly as part of the program is I think a bit of a different question.

To that my sense is that participants maybe find it not a terribly material measure, so the amount of dollars saved by eliminating the overuse or inappropriate use may not be that great.

So, that's our thoughts on the measure. Co-Chair Angove: thank you so much, I want to invite Dr. Smith to add any comments as well as our second lead discussant.

Member Smith: Yes, I think the only thing I would add to what was already said is first just emphasizing this is more about overuse I think than anything else.

If you look at the measure, it says for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI and antecedent conservative therapy would be things like physical therapy, chiropractors, et cetera.

I think we know that communities of color have less access or they utilize these all sorts of services less and I think there's a multitude of reasons why that is, access not being the only reason.

So, I think that also is something that contributes to a difference in this equity lens in addition to the points that were already made about not receiving MRIs at similar rates regardless of whether they are useful or not.

I think that's all I've got.

Co-Chair Angove: Thank you so much.

Before I open it up to comments, I just wanted to remind the group that while these have been really, really rich conversations that we've been having, I want to try to have everybody limit their comments to aspects specifically around health equity and the health equity impact of these measures.

There are Work Groups that are diving into some of the other pieces and I'm afraid we're veering a little bit out of the charge of our Advisory Group. But also we may never get through all of these measures, we may all be here until midnight.

So, let's try to keep focused in the health equity impact space as we move through these measures, I really appreciate it. I hate shutting down conversation but for the sake of time and focus, I think we need to be just a little more narrow.

I'm going to open up the floor for any clarifying questions and/or comments. Is there anybody on the phone who would like to come off mute and share any questions or comments related to this measure?

I don't see anything in the chat, I didn't mean to scare you all into silence. I want to thank our lead discussants for covering this so comprehensively.

I think that is reflected in the lack of clarifying questions and comments in the chat and hands raised. So, hearing no objections and seeing no last-minute hands, I am going to recommend that we move this to polling.

Ms. Young: Thank you, we will bring up the poll. The poll is now open for Measure 00140-C-HOQR Magnetic Resonance Imaging, MRI, lumbar spine for low back pain.

Do you support retaining this measure in the program? Full choices are yes, no, unsure. We're going to give that about 10 more seconds. We'll close the poll.

The poll is now closed for Measure 00140-C-HOQR. All responses are yes, 4, no, 6, unsure, 7. The percentages of yes, 24 percent, no, 35 percent, and unsure, 41 percent. Thank you.

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

Ms. Williams-Bader: Thank you very much, Susanne. Let's go ahead and go to the next slide. This measure is 02599-C-HOQR: Abdomen Computed Tomography (CT)-Use of Contrast Material.

This measure calculates the percentage of abdomen and abdominopelvic computed tomography studies that are performed without and with contrast. Out of all abdomen and abdominopelvic CT studies performed, those without contrast, those with contrast, and those with both at each facility.

The measure is calculated based on a one-year window of Medicare claims. The measure has been publicly reported annually by the measure steward, the Centers for Medicare and Medicaid services since 2009 as a component of its hospital outpatient quality reporting program.

This measure is not endorsed and six survey Respondents selected this measure. I will now turn it over to our lead discussants starting with Fenway Health.

Member Grasso: Yes, as you mentioned this measure was not endorsed.

There are some complexities that go into this measure that were not necessarily counted for, such as whether or not a scan was ordered in a trauma situation as well as whether there was an elegy to the contrast to the measure itself.

But more specifically, it's really unclear how this impacted patient outcomes, whether they improved or worsened as a result of this measure.

It's also based on claims data, which is often times coded by somebody other than the original person really having the information so they may not accurately capture the measure.

From some of the data that was available, it looks like there was some comparable findings across some of the demographic categories, however, there was a notable difference in terms of the healthcare access perspective where we did see some difference, geographical considerations, which are largely attributed to some of the probably available resources in smaller and rural areas. But also it didn't account for maybe some of the intersectionality that we might see, for example, an older black male, for example, might have different experiences.

So, it would be important to consider those.

And just overall, really from a health equity perspective, we know that original ethnic differences in terms of the treatment of pain, it would seem to me like a measure actually looking at whether or not a CT scan was ordered in these particular situations might more accurately get at some of those health equity issues.

Thank you.

Co-Chair Angove: Thank you so much. I want to

open it up to our second discussant from IBM Watson Health.

Member Punwani: This is Ekta Punwani, I will be talking about this measure from the IBM Watson Health perspective.

Very similar to the previous measure we just looked at, the MRI, this is also from my perspective an imaging overutilization measure and so we did look at this for a number of years and found that in this case, this measure, the way it's reported is percent of CTs that are ordered with and without contrast.

So, it's an overutilization of the testing. So, as we spoke before, from a health equity standpoint, overutilization of imaging, that measure specifically is not going to really give us a look into health equity because it's usually the reverse.

There's underutilization for some of our communities. So, from that perspective, and also looking at the actual results over the years, the measure is very small so the lower the better.

The variation has decreased and so I think it is tapped out looking at the dataset itself. So, our recommendation would be I don't think there really is a strong -- this would have a low impact on understanding and improving health equity.

So, we would probably recommend to remove this measure.

Co-Chair Angove: I want to open up the floor for any clarifying questions or comments related to the health equity and/or health equity impact of this measure. Anita, I see your hand up?

Dr. Bhatia: Just some clarification because whether or not a measure is useful for measuring equity is one thing and whether or not a measure is useful is another.

This measure has shown improvement with time,

showing that it has been effective in reducing inappropriate use, which is contrast material both with and without contrast material, which can indicate overuse.

It's still a quality issue. So, I would agree that it probably is not useful for measuring equity but it still is a fair measure to keep in the program.

So, let's be clear on what we're voting on, that's all.

Co-Chair Angove: And I appreciate that and I do just want to clarify that we want to hear and discuss aspects of equity not necessarily directly measuring equity but ways, removing or retaining the measures could impact negatively or positively equity as well.

So, it's not just direct measures but how either retaining or removing the measures could have a positive and/or negative impact on health equity.

(Simultaneous speaking)

Ms. Williams-Bader: This is Jenna from NQF. I just wanted to add to that a little bit more. I appreciate your comments, Rebekah, I think the one thing I would add as well is for those of you who aren't familiar, the Advisory Groups meet first.

We have a Rural Health Advisory Group and today we're obviously meeting with the Health Equity Advisory Group. Those comments from those groups are brought forward to our setting-specific Work Groups, clinician, hospital, and post-acute care and long-term care.

Those Work Groups will take a deeper dive into their setting-specific measures and they will consider the comments that are made by the Advisory Groups about these different perspectives of rural health and health equity perspectives.

And then they will vote more broadly on the measures as to whether they recommend retaining

or removing measures from programs. So, today we really want to hear from the Health Equity Advisory Group, as you said, Rebekah, about how these measures could impact health equity, could contribute to health inequity, and then those comments will then get brought forward to the Work Groups.

Co-Chair Angove: Jenna, this could be a challenge with awarding of the polls. I know in our previous meeting the polls were specific to will increase equity, will negatively impact equity, doesn't make a difference.

And today our polling really is about retention and/or removal but not specifically with that health equity lens.

And I think that's a challenge because then potentially individuals who may think this is a measure that should be retained but may not have an impact on equity either way, that's a challenging space, how do you vote?

Anita, am I kind of describing some of the feelings that you're feeling? Am I describing that correctly?

Dr. Bhatia: If that was directed to me, yes.

Co-Chair Angove: So, is there any clarity on when the polling takes place, what to do with a measure that somebody feels strongly about retaining, for example, but they don't feel like it has a strong impact on equity.

So, the recommendation for retention would be for reasons other than equity.

Ms. Williams-Bader: That's a very good question. Perhaps our team can huddle on that and we can circle back to that.

Ms. Elliott: Jenna, it's Tricia, I'll jump in and maybe add a couple comments here because it is a great question. There's a couple ways we can do that.

If folks wants to very briefly share that here, we would definitely capture that as part of the meeting, notes from this health equity discussion.

But there's also opportunities to participate in those Work Group discussions are listening in and providing verbal public comments during those meetings or also at different points in the process we do have the opportunity to do written public comments as well.

So, as an Advisory Group Member, you can also participate in those ways as a member and participant in public comments as well.

So, perhaps that helps a little bit and I think to speak to the slight shift in terms of the polling questions for this round with the measure set review process, we did streamline the polling questions to try and be a little bit more direct.

We found the polling questions when we were speaking about MUC list measures that it was always averaged around that. We had a scale of one to five and the measures always averaged around three.

So, we reviewed that and considered streamlining and making the polling a little bit simpler for this round. We would appreciate any feedback on that if that helps.

Ms. Williams-Bader: Thank you so much, Tricia. I think after huddling with the team, really, we're asking you to speak to it from the health equity perspective today.

So, like Tricia said, if there are Advisory Group Members who do think the measure is maybe not important or makes disparities -- sorry, I'm trying to phrase this the right way.

If it makes health disparities worse, you might still think the measure is important but you would vote

to remove.

We again welcome your comments and we can make that clear when we go forward to the Work Group that we are really asking you to consider it from that health equity perspective. It's not whether you think the measures are important overall but really from the health equity perspective how you feel about the measures, I think that would help as well and the Work Group can keep that in mind as they look at the measures more broadly.

Ms. Elliott: Just one more questioning clarifying question, if the measure is deemed health equity-neutral, if you will, would then you ask people to poll in that third category which says I think no opinion.

I've heard some comments that these may or may not use a couple of these comments that this feels a little neutral to have that but important other things.

Would you want people to respond to that third category?

Ms. Williams-Bader: Yes.

Member Machledt: First, I had a comment on this measure but I'm not really that comfortable with answering that's in a question that says a certain thing and having it mean something else.

Saying, no, we can't really change things right now but it feels very strange if I was going to say I think this is a measure that should stay on to then say, no, I think it shouldn't stay on.

And my question then related to how is the rest of this discussion being recorded and shared with the other group that's doing the actual voting and combining the input from rural and all that?

Our comments, the more detailed substantive comments, how is that being recorded and passed

on or are they just getting the poll results and basing most of their decisions on that?

Ms. Williams-Bader: We have Advisory Group volunteers. We've reached out to the entire Advisory Group ahead of this meeting and asked for volunteers to represent the health equity Advisory Group's discussion today at the Work Group meetings.

So, those people who kindly volunteered will be taking notes today and will be sharing a brief summary of the discussion as well as the poll results at the Work Group meetings.

As Tricia points out, there's also other opportunities for public comment for Advisory Group Members but we will have those volunteers present. I do think what's most important are the comments.

The poll can get a sense of how unanimously perhaps the Advisory Group might have felt in one direction.

I would warrant to say that it's really the comments that are going to be most important for those Work Groups to hear.

Member Machledt: My comment about this particular measure, and I know we have to move on, is that this is a measure of overuse and so in that sense I agree with other folks that this is not necessarily an equity issue in terms of standard of care or people getting the best possible care.

But it is a measure of overuse and if that overuse is directed at a particular group more than others, it also reflects a systemic problem and it means those resources might be better directed somewhere else.

If the measure is moving the ball and it's also disproportionately taking overused resources away from, for lack of a better word, a white probably more affluent population, then I think it is an equity

issue.

Anytime you have these big differences, it may not be a question of standard of care but there is a question of resource use and how those things are directed when they could have been directed somewhere else.

So, my sense on this issue is actually if there's a disparity like that and you're showing overuse, that's also important to correct and if the measure has been working to correct that, then it's actually improving health equity in a different way, just a different way than we normally think about it.

Co-Chair Angove: Thanks David. Mikil, I see your hand up as well?

Member Senathirajah: It was mainly about what the clarification of what the charge is, we're unclear of if we're just going to add the value of measure of understanding health equity or the value of the measure overall.

But I would say in response to David's comment, it could be that performance amongst minority populations on this measure is actually better because they generally have less utilization.

And reporting that may not be a fair thing for quality reporting but it may not address more pressing equity issues.

Co-Chair Angove: Anybody on the phone that can't raise their hands that want to provide additional, comments, questions, or thoughts? I want to thank everybody for the robust conversation around clarifying our charge.

I would recommend that everybody vote with their equity hat on, if you will, and this is our first year doing this so we are continuously trying to improve the process and how this group's perspective gets integrated into the larger process of the Work

Groups and the final decision-making.

So, all of these conversations are very helpful and we will go back to the drawing board and go better for our next meeting, I promise. Malcolm, I see your hand up.

Member John: I may be a little dense but I just want to make sure I got it right. If we feel the metric does not contribute to advancing health equity or addressing concerns like that, we would support its removal?

It's been recommend for removal, we don't think it impacts equity, then we would support its removal, is that the vote? If we think it actually is important for equity, we would vote to retain it.

I just want to make sure I got it.

Co-Chair Angove: I'm going to pass that off to my NQF partners to give a thumbs up or thumbs down if that's how you would like people to vote.

Ms. Williams-Bader: Yes, we think that's aligned with our thinking.

Co-Chair Angove: Let's move this one to polling.

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

Ms. Young: We will pull up the poll. The poll is now open for Measure 02599-C-HOQR outpatient computer tomography CT, use of contrast material. Do you support retaining this measure in the program?

Response choices are yes, no, unsure. We'll give it about 10 more seconds. We will close the poll. The poll is now closed for Measure 02599-C-HOQR. Poll responses are yes, six, no, seven, and unsure, 5.

Percentage equivalents are yes, 33 percent, no, 39 percent, and unsure, 28 percent. Thank you.

Ms. Williams-Bader: Our last measure in the HOQR program is 02930-C-HOQR:Hospital Visits after Hospital Outpatient Surgery.

This measure is at the facility level per surgical risk standardized hospital visit ratio of the predicted to expected number of all-cause unplanned hospital visits within seven days of a same-day surgery at a hospital outpatient department among Medicare fee for service patients aged 65 years and older.

This measure is endorsed and five survey Respondents selected this measure.

I will now turn it over to our lead discussants and the first is the American Medical Association.

Ms. Bossley: This is Heidi Bossley, I'm taking over for Koryn, she is away this afternoon so you get me, and just disclosures, I think you'll need that from me, I have nothing to disclose.

So, this measure, as Jenna pointed out

is endorsed, it actually was originally endorsed in 2015, went through re-endorsement two years ago in 2020, it's never been reviewed by the MAP based on what I see here.

There were several criteria selected on why this measure should be considered for removal, one being that it is duplicative of other measures within the same program.

The second one doesn't make sense to me and it says it's not endorsed or lost endorsement. So I think somebody might have been confused when they reviewed this.

And then the last being the performance does not substantially differentiate between high and low performers.

One group provided some input or at least those who put this forward for removal stating their

concern with the use of ratio measures and preference for risk-adjusted rates or year over year normalized rates.

And then they're saying since there is a similar measure endorsed by NQF, CMS should consider the endorsed measure. I guess it would be helpful for NQF Staff to clarify whether that's true.

I thought this was the same measure but perhaps I'm wrong. And then again, some confusion on endorsement, if it failed or if it wasn't endorsed, why?

Would it be helpful for NQF Staff to clarify that point? I'm personally confused now reviewing these comments. Happy to attempt to clarify those questions, Heidi.

Ms. Williams-Bader: Is the first one around endorsement of this measure?

Ms. Bossley: Yes, it's endorsed. It's 2687.

Ms. Williams-Bader: It is endorsed.

I will say when we were both creating a spreadsheet that accompanied the survey and when doing public comment and creating the measure summary sheets, we have had some back and forth with CMS program leads because it's not enough for us just to see if a measure with that title and description has been endorsed by NQF. Sometimes there might be some small differences in the measure but significant enough differences that CMS does not consider the measure to be endorsed.

So, I can go back and look but at the time the survey was distributed, this measure may have been identified as endorsed but I can confirm this measure is endorsed.

That's the first question. Was there another question in there?

Ms. Bossley: No, I think that was it and I see Shaili also confirmed this is the endorsed measure. That's what I thought.

Ms. Williams-Bader: So, just specifically to disparities, when I look at what was provided around the impact assessment, it does appear that there are some variations based on either age, income, dual eligibility.

You do see lower performance for those who are low-income, those who are dual-eligible. There's some variation across race and ethnicity to the extent it's statistically significant or meaningful in the variation. It's hard to tell because they're just statements.

But this is one measure that could very well show some disparities. It would be helpful if it was actually publicly reported that way. But I'll stop there and let my other colleague who has this measure assigned to them go forward.

Member Friedberg: Thanks, I agree with everything Heidi said.

I'll point out that none of the critiques had anything to do with disparities and they're not disparity-specific and this is one of the measures where at least we have some statements, although not the data, and that disparities are present.

Co-Chair Angove: Thank you, Susanne, I see your hand is up?

Member Bernheim: Yes, I'll comment on this measure, I was trying to sneak in on the voting question.

We can wait but I remain concerned that it will confuse the Committee that's getting our guidance if there's a measure that people on this call should be retained but not from an equity perspective, and they therefore vote to remove it, which is what I

think the final guidance was. So, I think before we do too much more voting, we should just come to a Committee consensus on what we do if we just don't think there's a strong equity argument in either direction.

And my recommendation would be then we use that third option. If we're really supposed to be representing the equity perspective, we certainly shouldn't vote to remove things that we think should stay in just because there's not an equity argument.

Which is what I thought was the final guidance. So, I'd ask that we revisit that before the next vote and be really clear so that we all know what we're doing.

Co-Chair Angove: I think there's two ways to look at this and earlier in the chat there was a comment that we need to re-word or possibly have a fourth option. I don't know if that's possible this late in the polling.

Would it be safe to say that the vote to -- there is no equity component to removing a measure, is that how we're thinking of it? I guess now that I'm saying this out loud, it made sense in my head, as it's coming out of my mouth it doesn't.

Does anybody at NQF have a way that we can get to a place that everybody feels comfortable for voting?

Because it sounds like the option given around asking to remove a measure or supporting to remove a measure just because there isn't an equity impact, even though it's a measure that people feel strongly about retaining for other reasons, isn't a good option.

We're doing a huddle around this at lunch.

Ms. Williams-Bader: That's what I would like to suggest.

I think especially given where we are in the agenda,

I think giving Staff and maybe, Rebekah, you and Laurie a chance to huddle at lunch would give us a chance to think through this and come up with something we can propose.

I'm a bit concerned about us spending too much time discussing it right now.

Co-Chair Angove: Maybe I recommend that we get through the hospital visits, 2930, get through all the comments, pause and vote on this right when we come back with hopefully clear guidance around the polling post-huddle.

Does that work for NQF and for the group?

Ms. Williams-Bader: That sounds good to me.

Co-Chair Angove: Let's get through this last measure.

Any equity impact, challenges, or clarifying questions around this particular measure? I also want to invite anybody on the phone to come off mute and share their thoughts.

I'm going to delay the voting, we will huddle at lunch and get some clarity.

The other piece that came up in the chat that I just wanted to share, we don't have time to talk about it here but potentially at the end of this meeting or in another space we can address it, is Tala's comments around using the same terminology when referring to populations of colors such as BIPOC instead of minority.

I know there are sensitivities and issues with the term BIPOC as well and that's why I don't think we have the space, I think we need to but we don't have the space today to discuss this topic.

But I do want to highlight it for everybody in attendance and kind of put a pin in that as something that the NQF team as well as the full

group and the Co-Chairs can address in some way at a future time and date.

I think because we're delaying polling I will pass it back off to the NQF team to break us for lunch.

Ms. Williams-Bader: Thank you so much, Rebekah. We will go ahead and take the planned 30-minute lunch break so we'll just say it starts at 12:40 p.m. and we will meet back at 1:10 p.m. Eastern Time.

And thank you all so much for the really rich discussion so far and the feedback on the polling. We will discuss and come forward with a suggestion after lunch.

(Whereupon, the above-entitled matter went off the record at 12:40 p.m. and resumed at 1:16 p.m.)

Ms. Williams-Bader: Okay, we are at 1:15.

Thank you all for giving us the extra 5 minutes. We appreciate that. You gave us the time to talk this through.

We will go ahead and get started. And we'll be going back to that last measure, the hospital visits after hospital outpatient surgery.

Thank you.

So after discussion with our co-chairs, and with a few of our CMS colleagues, what we will be moving forward with, is we will be actually not doing the poll moving forward.

And, the reason for this is a few reasons. One is that really, what's important as far as the output for these advisory group meetings, is the comments you have about the, whether or not these measures, either retaining them or removing them, will have an impact on health equity.

If there is harm in removing them, or harm in retaining them, or if you're uncertain. These are the

things that are really important for us to carry forward versus the numbers in, in those polls.

And, we do, because we have a lot of measures to get through, we do have to focus on that health equity perspective of the measures.

So, it felt hard to do a broader poll on the, on just retaining or removing the measures, because we're not having those full discussions of the measures today.

So, we will be moving forward and will not be doing a poll, but I, we definitely want to encourage you then, that if there, if you have comments that offer a different perspective than what's being said about a particular measure, please do speak up and share those comments.

Because I think that was one of the main reasons we wanted to do a poll, was just to see how, if the, if the advisory group was sort of leaning in one direction or another.

And, also please feel free to use the chat to just put, really to put brief, brief comments about whether you support what's being said, or, or not if you've got a counter-opinion.

But certainly you can say support that this has, and just something really brief so that we can collect that, as well.

Is there anything else that anyone who was in our little huddle, wanted to say?

Co-Chair Angove: Jenna, if I can just add, and you kind of said it, but I loved how you said it in our huddle, that those polls originally were really designed to understand the level of consensus in the group, not, and really those comments are the most important piece.

We just didn't want one very strong commenter to kind of overshadow a discussion. And, so that's why

we put the polls in place to really understand where, where consensus was, and the level of consensus.

So, if we can get that from comments, I think it's a great solution moving forward since we can't fix the poll for this meeting.

Ms. Williams-Bader: Thank you so much for that, Rebecca.

So, having said that, are there any additional comments then, that people would like to make about the hospital visits after hospital outpatient surgery measure?

And, I think I just stole your role there for a second, Rebecca. Sorry about that.

Co-Chair Angove: It takes a village.

Anita B., I see your hand went up.

Dr. Bhatia: Yes, this is Anita Bhatia (audio interference.)

Co-Chair Angove: Anita, you sound a little garbled to me. Are other people hearing that, or is that just on my side?

Yes, I see a couple nods.

(Pause.)

(No audible response.)

Co-Chair Angove: So maybe give Anita just a moment to get to a place where she has better coverage, maybe.

Webex audio is its Achilles heel today.

Dr. Bhatia: Am I back?

Co-Chair Angove: You're better, Anita. Not perfect, but better.

Dr. Bhatia: Internet. I hardwired it in.

Okay, I just simply want to add, I don't know if we've mentioned, but we are looking to stratify our Medicare claim space measures by rule eligibility.

Those would be provided in, for confidential hospital reports. So, that's an aspect that may not have been considered for this measure.

Co-Chair Angove: Thanks for sharing.

Anybody on the phones that can't raise their hand, want to share additional comments around this measure?

(Pause.)

And, Shaili, I see your name, your hand's raised.

Ms. Patel: Yes, to add what Anita said, we actually for this program, started providing confidential reporting of at least one measure, starting in May.

So, we've already started doing that.

Co-Chair Angove: All right, in the interest of time and seeing no other hands up, since we are not polling, I guess that I recommend we move to our next, our next section on the agenda.

Ms. Williams-Bader: Thank you so much, Rebecca.

So, if we could go to the next slide, we will now be, excuse me, we will now be looking at measures within the Ambulatory Surgical Center Quality Reporting Program.

Next slide.

This program is a quality payment program, and public reporting program. Ambulatory Surgical Centers that do not participate, or participate but fail to meet program requirements, receive a 2 percentage point reduction of their annual payment update, under the ASC Fee Schedule, for not

meeting program requirements.

And, the goals of this program are to progress towards pain providers based on the quality, rather than the quantity of care they give patients.

And, to provide consumer information about ASC quality, so they can make informed choices about their care.

We could go to the next slide, and then the next.

I'll turn it over to Laurie for the public comment.

ASCQR Program Measures

Co-Chair Zephyrin: Great, great, thank you. And, thanks, all. And, we'll try to make up some time in this section.

01049-C-ASCQR: Cataracts: Improvement in

Patient's Visual Function within 90 Days Following Cataract Surgery

This first set is focused on cataracts, improvement in patient's visual functioning within 90 days, 01049-C-ASCQR.

I guess who is the, I'll hand off to the NQF staff and lead discussants, and then we'll moderate the conversation.

Jenna, I may have taken your role in reading the title.

Ms. Williams-Bader: No, that's okay. We're going to do public comment first.

Co-Chair Zephyrin: Okay, fantastic.

Ms. Williams-Bader: So, yes.

Opportunity for Public Comment

Co-Chair Zephyrin: So, let's shift over to public

comment.

Ms. Williams-Bader: And, we have this slide up as it's, these are the two measures within the program that are up for public comment right now.

(Pause.)

Co-Chair Zephyrin: Looking to see if there are any comments.

(Pause.)

(No audible response.)

Co-Chair Zephyrin: Let me see if there's any hands raised. No, I don't see any.

Okay, all right, I haven't, I don't see any public comment at this time. And, why don't we give it a little bit longer.

(Pause.)

(No audible response.)

Co-Chair Zephyrin: Okay. Oh, Anita, you've raised your hand?

Dr. Bhatia: Yes, I did. Hey, I happen to be the program lead for this program.

Co-Chair Zephyrin: Oh, fabulous. Thank you.

Dr. Bhatia: I'm just curious why this was brought up for this discussion, because I mean this measure is in the program.

It's currently being reported on a voluntary basis, and it is reported by a small, avid group of facilities.

It is an aggregate data, so it would be difficult to discern equity issues with it, as it is currently being reported.

So, perhaps that's part of the concern with it.

Co-Chair Zephyrin: That's a great question. Thank you for bringing that up.

I'll turn it to NQF staff if they have any thoughts, or in response to this question, or others.

Ms. Williams-Bader: Yes, so again, clarification about the process. So, the measures within the programs we were discussing today, were nominated by advisory group, and work group members in the survey.

And, all the measures that got selected for discussion as part of this year's measure set review, are coming through both the rural health, and health equity advisory groups.

We did not make any decisions about a smaller list to take through both, we're bringing through both.

So, it's perfectly appropriate for the health equity advisory group, to determine that there are no health equity impacts for a particular measure.

But that's why they are here today.

Co-Chair Zephyrin: Okay, thank you.

Hopefully, I answered your question also in the larger document that was sent out. It has some additional context on, from public comments on whether people support keeping the measure or not.

This measure is being made mandatory for 2025. Thank you Jessica Peterson for providing that comment.

Okay. In the interest of time, should we, should I hand off to the next or the lead discussant?

Oh wait, Dr. Machledt, David Machledt. Hopefully I got that right.

Member Machledt: So, this is just a public comment.

And, are we doing, is this the full discussion on this, or is this just the --

Co-Chair Zephyrin: This is the public comment, not full discussion. But I'm not seeing any additional public comments.

So, Jenna, should we move on?

Member Machledt: We're talking about the cataracts measure?

Co-Chair Zephyrin: We are, yes, thank you.

Member Machledt: I did think that it's notable that this is the only patient reported outcome, and that's valuable.

But I know that that's not necessarily a, it could be an issue for disability, but it's not necessarily a equity component. So I'll stop there.

Co-Chair Zephyrin: Thank you, David.

Jenna, I see you posted a question for Jessica in the chat, in terms of which measure is being made mandatory.

Thank you for clarifying that question. Jessica, feel free to respond.

Dr. Peterson: Hi, yes, this is Jessica Peterson.

So the cataracts measure is being made mandatory as of the 2022 ASC final rule. So, for the 2025 ASCQR measure set, it will be mandatory reporting.

Since this is public comment, I will say that we at Marsden Advisors, have a lot of ophthalmic clients, and this measure has so many problems.

There's a reason very few people report it. It doesn't really have much of a health equity lens, but the problems with this measure include that ASCs often don't have this data. It's usually stored in the physician office.

And, there are walls between ASCs and physician offices, so they can't actually electronically access this data under current regulations.

So, this is actually a very problematic measure for us.

Co-Chair Zephyrin: Thank you.

(Pause.)

Co-Chair Zephyrin: Okay, any additional comments?

Dr. Lum: This is Dr. Flora Lum, from the American Academy of Ophthalmology, and I would just support what Dr. Peterson said.

Yes, the Academy has never supported this for ASCs, because you have patients are not followed up after the cataract surgery.

So it's really impossible, feasible, to collect this information on an ongoing basis. So, we have never supported it, it's inclusion in the ASC.

Co-Chair Zephyrin: Okay, thank you.

And, just I guess a quick question. I guess Jessica and David both said, mentioned, this doesn't have health equity implications.

Can you clarify what you mean by that? If you don't mind.

Dr. Peterson: Yes, sure. So, this measure really just looks at the cataracts that were done, and the patient visual function.

It doesn't really evaluate anything other than that. It doesn't look at socioeconomic status. It doesn't look at race. It just looks at outcome.

And also again, ASCs don't really have much of an impact on the outcome themselves. It's more the surgeon and the followup care, as well, which is again, this is a measure already for physicians, and

that data is again, stored in the physician system.

Co-Chair Zephyrin: Thank you.

David? I see you getting off camera, getting on camera, so I thought you wanted to say something.

Member Machledt: Yes. No, I don't have any. I just didn't see any obvious equity angle here.

So, that's, you know, I'm not nearly as familiar with this as some of the other folks who have spoken on it.

But it doesn't seem like its reported in a way that it would be, that it would lead to an identification of disparities, or some way that you can act to improve them.

But I would stand being corrected.

Co-Chair Zephyrin: Okay, thank you so much.

Beth Godsey? Hopefully I pronounced that correctly?

Member Godsey: You did, thank you.

I think I, from a health equity perspective, I think there's an opportunity here to explore this follow up, particularly the 90 days followup.

I disagree that it doesn't have an equity lens. I think part of the challenge, is making sure that followup care occurs for all patients.

And, sometimes that is not the case, depending on where that patient lives. Or how followup referrals are done.

So, I think that there's some opportunity here to consider.

Co-Chair Zephyrin: Thank you.

And, Jessica Peterson, I see you raising your hand.

Feel free --

(Simultaneous speaking)

Dr. Peterson: Yes, sorry to talk on so much --

Ms. Williams-Bader: Hey, Laurie, can I just pause here? It feels as if we are getting into a discussion of this measure, so --

(Simultaneous speaking)

Co-Chair Zephyrin: Okay.

Ms. Williams-Bader: -- we just need to officially, I think these are advisory group members who, correct me if I'm wrong, is it, are we, are these public comments we're getting at this time?

Dr. Peterson: I am not an advisory group member.

Ms. Williams-Bader: Okay, then go ahead, Jessica.

Dr. Peterson: I'll just respond that.

Co-Chair Zephyrin: And, then after this we'll close the public comment, but thank you.

Dr. Peterson: Sounds great.

Co-Chair Zephyrin: Great.

Dr. Peterson: So I just want to mention again, that this isn't measuring followup. Followup is included in the bundle already. This is just measuring visual function at 90 days following the surgery.

And, again, this is also a measure in the MIPS program for physicians. So, this is being evaluated in a more appropriate manner, since the ASC does not really have much of an impact on visual function. It's more the physician, the surgeon who does.

And again, that data is being stored in the physician's EHR, and the ASC cannot access that

directly.

Co-Chair Zephyrin: Great. Thank you.

Thank you for the public comment. Jenna, let's transition to the next section, please.

Great, thank you.

Ms. Williams-Bader: Great.

All right, so the first measure will be discussing in this program, is 04049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

This measures the percentage of patients age 18 years and older, who had cataract surgery, and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative, and post-operative visual function survey.

Endorsement was removed for this measure, and 5 survey respondents selected the measure.

I will now hand it over to our lead discussants. We have the National Committee for Quality Assurance, if you would like to go first.

Member Shih: Okay. This is Sarah Shih, hi.

When I reviewed this, I think the piece that I think Dave already kind of mentioned this, to see if it's a PROM.

So, it's a pre-post cataract surgery self-report visual function survey. And, as it's designed, it may not be equity sensitive because it doesn't identify who doesn't complete that survey.

So, as a PROM, it's looking at only those that completed both a pre- and a post- survey, and whether they had improvement in their visual functioning.

And, I think it's like a 20 or 25 question functioning survey.

So, that to me just the use of PROM always raises a flag for me, to be more attentive for potential equity considerations, especially of how it's fielded who is going to respond, or who is not responding to the surveys.

So, that's something to consider whether to continue to use this measure for accountability in the ambulo-surgical centers. I think that's been raised in the public comment.

It may not be at the level of accountability where the information is going to be useful, or actionable.

I also noticed that in the reports that NQF provided, it's a little topped out, all those that are reporting about 100 ambulo-surg centers are reporting this.

It's in the 90s, like mid-90s. And, out of a scale of 0 to 100, it's 92 to 100 percent in the past four years.

So those are considerations of whether you can really use this to detect health equity, or health disparities, or disparities in the process.

I think it's more of a measure design issue potentially, for health equity considerations.

I won't comment anymore on the retention piece, because that's hard for me to understand given the measure design.

I'll stop there so that Aetna can also comment.

Co-Chair Zephyrin: Great, thank you. Thank you very much.

I guess we can open it up for clarifying questions, and any discussion.

That was very helpful information. Thank you, Sarah.

Ms. Young: Anita has her hand raised.

Co-Chair Zephyrin: Oh good, Anita?

Dr. Bhatia: Can you hear me?

Co-Chair Zephyrin: Yes. You're a little muffled but let's try it.

Dr. Bhatia: (Audio interference).

Co-Chair Zephyrin: Sorry, can't hear you, Anita. It's coming out a bit garbled.

It may be agreeable to type in your question if it's not too long? Or?

Dr. Bhatia: (Audio interference).

Co-Chair Zephyrin: Sorry, can't hear you.

Dr. Bhatia: I'm sorry, too (audio interference).

Co-Chair Zephyrin: Okay, do you want to try again, Anita? I don't see anyone else's hands raised. Maybe if you tinker with your microphone.

Dr. Bhatia: (Audio interference) can you hear me?

Co-Chair Zephyrin: Let's try and see. Let's ask, maybe ask sort of half of the question and I can see if it's, if I can translate it.

Go ahead.

Dr. Bhatia: Okay. For this program, we only had (audio interference) level data for (audio interference) measures. And, then it was the (audio interference).

Co-Chair Zephyrin: I'm sorry, sorry, I'm not.

Okay.

Dr. Bhatia: I can't find the chat.

Co-Chair Zephyrin: Yes.

Dr. Bhatia: (Audio interference) chat and just type it.

Co-Chair Zephyrin: Okay. Sorry, Anita, it's not working.

Do others have questions, or comments, or clarifying questions or comments, for the discussion?

(No audible response.)

Co-Chair Zephyrin: Okay, seeing none, I'll turn it back to Jenna.

It looks like since we're not going to poll, Jenna, what do you, I'll turn it back to you unless there are other questions or clarifying comments.

Ms. Williams-Bader: Yes, I guess I'd like to give Anita a chance to put her comment into the chat.

And, then I would wonder if the, if other members agree with what NCQA, and what Sarah Shih from NCQA was saying about the measure, or if others are not sure about the equity impact here.

Co-Chair Zephyrin: Great. So, Anita puts her comment in the chat. Thank you, Anita.

So, the ASCQR program only has one aggregate level data for Medicare claims-based measures, due to burden consideration for facilities.

Thank you.

And, if people also as, okay, I see a question from Beth, and also if people want to enter in the chat whether they support or whether they have additional questions around the health equity implications.

Since we're not polling, you know, we'd love to have any, any thoughts from you as to what was just said by Sarah.

Beth Godsey?

Member Godsey: Yes. So, thanks for the additional information. I think it's helpful. I think it gets back to the question that we've been trying to address here today, which is, is the measure valuable to the program, or is the measure valuable to assessing health equity.

And, I think the comments made earlier about the challenges that ASCs are dealing with, are certainly real in this particular measure, and not necessarily the best approach for this.

I think in and of itself, the measure from an equity perspective, the comments that I made earlier, I think they continue to remain as far as being able to follow patients, and having access to those follow-ups.

And, even though being a patient reported outcome, certain demographics, certain individuals, have more challenges in that followup than others.

And, I think that those can be related to health inequities, in particular in access. So I don't know if that would show up in this particular measure or not, but I just want to go on the record to say that.

Co-Chair Zephyrin: Thank you, thank you, Beth.

Any additional thoughts or comments related, relating to health equity and the implications?

Anita, I see the second part of your, of your comments around stratification of claims-based measures by dual eligibility has been examined, but there are low numbers of these patients.

Thank you.

Member Shih: I just want to add that they only require a sampling of 30 patients, to be able to report this measure. So, it is a small sample.

I think if you were thinking about a program of whether this is improving care for a group of patients, you may not, you may artificially say they're doing well if you're only sampling 30.

And, again, sort of like who's missed in this PRO-PM, is a question of whether it's designed to be able to detect disparities.

And, so again, the way it's reported I'm not sure we're really going to benefit from the way, for understanding improvement.

Or I think there's less harm in removing it, like not reporting it. But should, other measures should be available to report on this aspect of followup care.

Co-Chair Zephyrin: Thank you.

Any other thoughts or questions in response to that?

It seems in terms of the health equity implications, it sounds like what you've mentioned, Sarah and others, that just in terms of the N is low and there's I guess who, who reports, and challenges what stratification.

And, then on the other hand, Beth raised questions of who's being, who could potentially be left out.

But it sounds like this may or may not be the right measure to address that.

Would love to hear if anyone has any thoughts, comments, or clarifying questions based on what was just said about this, these, this measure.

(No audible response.)

Co-Chair Zephyrin: Okay.

Again, if there, even if they're one word comments to, since we're not doing the polling, if you wanted to put something in the chat, feel free to so that we

can also have your questions, and thoughts, and comments for the record, as well, if there isn't a verbal comment you have.

(No audible response.)

Co-Chair Zephyrin: Jenna, I think we've discussed this one. Do you want to move on to the --

(Simultaneous speaking.)

Ms. Williams-Bader: Yes

Co-Chair Zephyrin: -- next one?

02936-C-ASCQR: Normothermia Outcome

Ms. Williams-Bader: Okay, the next measure is 02936-C-ASCQR: Normothermia Outcome.

This assesses the percentage of patients having surgical procedures under general or neuraxial anesthesia, of 60 minutes or more in duration, who are normothermic within 15 minutes of arrival in the post-anesthesia care unit or PACU.

This measure is not endorsed, and 6 survey respondents selected this measure.

I'll turn it over to our lead discussant Susanne Bernheim, for this measure.

Member Bernheim: Hi, can you hear me okay?

Co-Chair Zephyrin: Yes, perfectly. Thank you.

Member Bernheim: Great. I will be very brief. This is a measure that as it was described for patients getting procedures in ASCs, and whether or not they are normothermic when they get to the PACU, or within 15 minutes.

And, I think the main concern about this measure had to do with the burden of the data, that is needed to report this measure.

I see Anita has a note that I think relates to this measure, that it is voluntary reporting.

But from a health equity standpoint, I do not know of health equity concerns related to this measure, nor could I on a quick search, find anything.

So I don't have a strong opinion about this measure from the equity perspective.

Co-Chair Zephyrin: Thank you, thank you Susanne.

Member Bernheim: Oh, and Anita is correcting me. The note about voluntary reporting was for the cataracts measure. So, ignore that, that comment from me. I was late.

Co-Chair Zephyrin: Thank you. Thanks for that clarification, Anita.

Great, so any clarifying questions? Or any, oh, Anita, thank you. I see your hand up. Okay, now it's down.

Dr. Bhatia: Hello?

Co-Chair Zephyrin: Yes.

Dr. Bhatia: All right, I switched to the phone.

Just to clarify on this, we in the program, have never received complaints that this measure is burdensome for ASCs to collect the information.

The measure does only apply, only applies to procedures where there's anesthesia. So, it's not, obviously not for everything that ASCs do.

So, just to emphasize, no one has ever complained about the burden with this measure.

In comment, all the years that we've had it, we've never received comment to that effect. And we haven't received any current concerns about it either.

So, I do appreciate that there is a concern being voiced, but we haven't seen it.

Co-Chair Zephyrin: Thank you, Anita.

Any other clarifying questions, or comments for discussion?

(No audible response.)

Co-Chair Zephyrin: Any questions around, any thoughts or responses around potential health equity implications, or if not?

(No audible response.)

Co-Chair Zephyrin: Okay, great. Well, thank you, and I think we can probably save some time and move on to the next measure.

Jenna, back to you.

Ms. Williams-Bader: Great, thank you so much.

So now we'll be moving to the PPS-Exempt Cancer Hospital Quality Reporting Program.

Go to the next slide, please.

This is a quality reporting program. It is a voluntary reporting program. Data are reported on the provider data catalog. The program goals are to provide information about the quality of care in cancer hospitals.

In particular, the 11 cancer hospitals that are exempt from the in-patient prospective payment system, and the in-patient quality reporting program, and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

We will now move to a public comment for this program.

And, if we go to the next slide.

Thank you very much, and I will turn it over to Rebecca, for this public comment.

Co-Chair Angove: Hello, Good afternoon everybody.

So, same rules apply. For public comments we just request that you keep your comments brief, under 2 minutes, if possible.

And, you can do that by raising your hand to begin with, and then towards the end of this period, I will open up the floor to those calling in, or unable to raise their hand.

(No audible response.)

Co-Chair Angove: I don't see any hands shooting up, so maybe while people are considering this, I will open the floor to those on the phone or calling in, that are unable to raise their hand. You can come off mute and share any comments you have now.

Leonora, I see your hand up. Please, join us.

Member Fernandez: So I don't know if this is relevant. I was just going to comment that I can imagine, and have seen some literature on the importance of this with respect to equity, in terms of both access to hospice communication about the purpose of hospice, trust issues, et cetera, embedded in this.

So, I just wanted to comment that I do think it has equity dimensions.

Co-Chair Angove: I appreciate that. And, to keep us moving along, I'm trying to stall to see if there's any last minute hands that want to shoot up.

I think we can probably move to the, oh, I knew there was going to be one. Mahil?

Member Senathirajah: Sorry, this will be quick.

Yes, you know, I'm not sure if there is any data on whether there are disparities but just Google, and there's a study from Hopkins, saying that in fact, hospice use by African American patients is lower than white patients.

Oh, along the lines I think the measure is useful for equity purposes if, in fact, there are differences in, whatever the measure is measuring. So, in this case, hospice use.

Co-Chair Angove: Appreciate the quick Googling, and I think that is a good segue making sure there are not any other public comments, and then we can move to the formal review.

And, I know this is a confusing one because there's only one, so we kind of blurred those lines. But it's okay. We're getting everything in.

So, I'm going to hand it back off, or I'm going to officially close the public commenting period, and I will hand it back off to the NQF staff, to formally move us into review of this program measures.

Ms. Williams-Bader: Thank you very much.

So, this measure is 05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice.

It assesses the proportion of patients who died from cancer not admitted to hospice.

Endorsement was removed for this measure, and 5 survey respondents selected the measure.

Before I turn it over to our lead discussants, I do have a statement to read here.

This measure is a new claims-based measure developed by the Alliance for a Dedicated Cancer Centers, based on the concept of NQF 0215, with

the same measure name, which is a registry measure stewarded by the American Society of Clinical Oncology.

ASCO notified NQF it would no longer maintain the registry version of the measure in spring 2022, because the registry version of the measure had not been used in the CMS MIPS program since 2019. So, no data was available to retain NQF endorsement.

CMS approved this new claims-based version of the measure for the PCHQR Program, and is now working to implement the new version of the measure.

This will be the first year this measure will be implemented in the PCHQR Program. The Alliance for Dedicated Cancer Centers and ASCO, are in discussions about who will steward this claims-based version of the measure, with NQF moving forward.

ASCO also has a call scheduled with NQF on June 13, to discuss this measure, along with other ASCO stewarded end-of-life registry measures, which now have claims-based versions developed by the Alliance for Dedicated Cancer Centers for the PCHQR Program.

I will turn it over to our lead discussants. We have the Scan Foundation, and National Health Law Program, and I'll start with the Scan Foundation.

Co-Chair Angove: And, if the representative from the Scan Foundation is on and talking, you may be on mute.

Ms. Williams-Bader: It sounds like they might actually not be in attendance, so we could move to our second lead discussant, the National Health Law Program.

Member Machledt: Hi, thank you, yes, this Dave

Machledt, from National Health Law Program.

I'll give a little overview, in addition to what was good information that you shared there, about how new this information, or this measure is and that the data is sort of still rolling in, it sounded like.

Also, from evident from the comments from the new measure steward, the AADC.

So, the recommendations to remove this measure centered on the idea that the availability for, of hospice services, are not differentiated, or for cases where patients either denied wanting hospice care, or received palliative care and didn't need hospice.

I think again, it matters how you're looking at this, and whether, if it's at a systemic level, that information could still be used by a cancer center to see where it stands relative to other, say other rural programs or something like that.

So, I'm not sure that the availability of those services is a reason not to collect this measure.

It's actually, I think it could be instructive when you do that followup, of why is it that this particular place is lower than, has lower rates than other places.

This was added relatively recently to this program, and the comments like I said, noted that the initial data has not yet been shared with PCHs to allow them to act on it.

And, so it may be premature but we don't, there also wasn't any evidence that, there's no like clear evidence yet that there are disparities.

Except for the fact that we've already talked about, you know, it's not hard to see how access to hospice care can have a important, there's differential access, and that it's important to track that and to find out about it.

So, my sense is and I'll defer to others who might know more about this, but that this is a measure that it would be a little premature to recommend it to be removed.

And, that it could have, and has been observed to have, important equity implications for the access to hospice care in general.

So, I would sort of be in the wait and see category.

Co-Chair Angove: Thank you, David.

I will open it up to clarifying questions or comments, and let's start with I'm going to butcher your name probably, but Cardinale? Did I get close?

Member Smith: Close, close, Cardinale, Thank you.

So, I happen to be an oncologist and palliative medicine physician, and so I have clear thoughts on this measure.

I, in fact, am sad that it really only applies to the cancer exempt institutions, because I personally think that this is not a measure we should be tracking at all.

While others have pointed out the equity issues around hospice for communities of color, I think particularly this metric wants to track patients who died from cancer, who weren't admitted to hospice.

And, if that is a bad outcome, and it is okay if people don't want hospice. That is not necessarily aligned with everyone's goals.

Because the way in which we currently provide hospice in this country, doesn't meet the needs of all people in particular.

Doesn't meet the structural issues that many of our, many of those who are from communities of colors, face.

So, I think in terms of an equity lens, this does have pretty big implications.

Co-Chair Angove: Thank you for sharing. Beth?

Member Godsey: Yes, I would agree with that comment. It certainly having access to this type of resource is an important one, particularly for end-of-life management, and overall patient and family experience.

There's also been shown that there's significant challenges, and even for patients where English is not their primary language, where this is not particularly offered for them, or in a way with which they understand.

And, the cultural and ethnic components that need to be considered, and sometimes there are completely ignored in this area, and not dealt with in a sensitive way.

So, I agree with the comments that were made earlier that this should be included, or evaluated, from an equity lens.

Not just in addition to the racial/ethnic components, but also other aspects as well as related to language, and other types of areas that we need to focus on.

Co-Chair Angove: Thank you, and Susanne?

Member Bernheim: I really want to make sure that I understood what your feeling was about this measure, Cardinale.

Because I initially had approached this thinking we know that BIPOC populations often use hospice less.

And, if this encouraged making sure that that was available, that the equity lens might be to say that this is important to report and, potentially stratify.

But I think I understood something different from

your comments, so I just want to make sure the committee understood, as well.

Which was I think saying this assumes that hospice is a good, that this measure would assume that hospice is a good thing, and would promote potentially care that was not aligned with patients' values, and that you had concerns about this measure and did not like this measure.

So, can you just really clarify your perspective on this measure?

Member Smith: Yes, so I think your second comment is correct, which is that I think this assumes that hospice is the right outcome for all patients, you know, with cancer who are at the end of life.

And, as a hospice and palliative medicine physician, I can't say it's not appropriate. What I can say is that in its current state, it is not appropriate for everyone.

Therefore, in its current state, it doesn't meet the needs of all people, and in particular, BIPOC communities.

And, so therefore, those communities often are not accepting of hospice, and that is a core reason of why.

Member Bernheim: So really, there's an equity angle here that's important, but is a angle that supports removal of the measure?

I just want to make sure, because we're not voting, that I think we're hearing both sides so that I think when we go back to the main committee, this, that's a really important perspective.

So, thank you. I made you repeat it because I wanted to make sure we all heard what you were saying.

Thank you.

Member Smith: Thank you.

Co-Chair Angove: I appreciate that clarification, and spotlighting those comments.

Moving in order of hands up, so Malcolm, you are next.

Member John: Thank you, Susanna actually highlighted the bulk of my questions, which was clarification of Cardinale's point. So, thank you for that.

I did want to also ask maybe a process point that given the comment that was made, is it useful for us to suggest an alternative equity perspective for future consideration?

Obviously not for this year or anything, but, you know, to Cardinale's point, this is not a good equity metric,.

But perhaps a different one such as, you know, there, you know, when I think about health equity, obviously I think about access, patient experience, and clinical outcomes.

And, you know, palliative care consultation seems to be associated with, you know, good quality of life in patients with advance illness at that stage.

What direction goes really depends on the patient's needs, desires in consultation, I'm sure Cardinale can enlighten us.

But perhaps we could recommend that people, that the group think in the future, CMS think in the future, of a better equity lens towards palliative care.

Such as utilization of appropriate palliative care consultation, without an end point such as this.

And, I'm curious if we should be talking like that as well in our comments, and of course, Cardinale could expand on that.

But, that's it.

Co-Chair Angove: So, Malcolm, it's my understanding that this is not the space to suggest revisions, refinements, or new measures. But I will let NQF confirm or correct me on that one.

Member John: Or just make a comment that that's something for consideration in the future. Not as opposed to a formal recommendation.

Thanks.

Co-Chair Angove: I think it's a really valid point. I just don't want to take us down rabbit holes that we're not supposed to be going into today.

That's the only thing I'm trying to avoid.

Member John: Yes, thank you so much. Appreciate it.

Co-Chair Angove: Beth Godsey, I saw that your hand went up, and went back down. I just want to make sure that if you had something to share, that you had space to do it.

Member Godsey: Yes, I think, oh, thank you. I think I'm still confused about Cardinale's suggestion and recommendation.

And, so it sounded as if that the access to the resources was not the challenge, it was more the lack of personal choice to pursue hospice.

And, that because it's a personal choice, it therefore, is not an equity challenge?

So, they have, so patients who are end-of-life, have an opportunity from an equity perspective, have that opportunity to engage in hospice, and choose

not to.

And, full disclosure, I think that the measure itself is a bit confusing. There's a lot of double negatives in here as far as like patients who died from cancer not receiving, you know, a resource.

So, it is a bit of a challenge as far as the description is concerned, at least the way that I'm reading it.

But, you know, I think the other part around this measure is that not all hospitals have, or some of these organizations probably have more than others, particularly in the cancer space.

But hospice cannot always be available to all hospitals to refer to. So, that could also be a challenge for some organizations.

So, just a couple of comments and thoughts there.

Co-Chair Angove: And, it feels like there's been comments on both sides, both the equity implications of keeping this, as well as the equity implications of getting rid of it.

So, I think these are really rich comments to bring back to the larger work group to discuss.

And, I think back to Malcolm's point, there probably are suggestions to be made to improve this, or have additional quality measures related.

David, I see your hand up?

Member Machledt: Yes, I think going for the discussion, and it's helpful to hear that perspective.

Because in a sense, looking at just the outcome that is desirable, is that you have more people who had been in hospice when they died. That's the long and short of it.

And, so I understand that's what I understood from Cardinale's point is that if hospice is not designed

and responsive to the needs of the whole population, and is really designed to, and really falls short on those important cultural components, then that shouldn't be the desired goal is to have a high, the highest proportion of patients who died from cancer not admitted to hospice.

I understand that, you know, not having the choice in the first place because there was no hospice available, is a different question. And, is also equity implicated.

That's what I was talking about when I started. And, it seems like having a measure where you could distinguish those kind of things, you know, would be really useful to solve that equity problem, that paradox kind of.

Co-Chair Angove: Laurie, did I see your hand up? Oh yes, it's still up. Go head.

Co-Chair Zephyrin: Yes, it's been a rich conversation.

I just wanted to just highlight when we, my video's not working now, it's fine. I just wanted to highlight as we think about equity, it's really important to put it in the context of systems and structures, as opposed to personal choice.

Because choice becomes relative depending on where you live, and what your insurance status is, and whether you have a job that covers insurance.

And, so I also think just in the context of health equity implications, it's really important to also think about the systems and structures.

And, then I think what people have mentioned about just the, it sounds like the limitations of this particular measure.

And then there's the broader question of this would be important to measure if it measured it differently. And, I think it's, I appreciate that

nuance in the conversation.

Member John: May I follow up on that? It's Malcolm John, or am I jumping ahead of someone?

Co-Chair Angove: Absolutely, Malcolm.

Member John: Yes, so, you know, when we don't have clear disparity sensitive metrics, I'm wondering how as a group, we want to approach that.

So, you know, I think someone mentioned earlier that Google Base saw some difference in utilization of hospice care reported.

It's unclear to me how much hospice care is associated with improvements of experience, or quality of life, particularly among a range of traditionally minoritized patients and others as Cardinale points out, versus where we have a little bit more data say, on utilization of palliative care and its benefits more broadly.

And, so I'm just curious how we balance those considerations when there is an emerging knowledge, or gap and we're trying to learn more about equity within an emerging field or topic.

So hospice is associated, Cardinale, is saying, with improved quality of life. So, perhaps there's some data there that may support.

Okay, thank you.

Co-Chair Angove: Yes, and Malcolm, I think your point also gets to the idea of do we want to continue measuring it, because that data is going to be important even though it's not a health equity focus, or not a perfect measure.

Which we have had that conversation for previous measures, as well.

So, really, really great point.

Is there anybody on the phone that would like to unmute and contribute comments to this, this measure?

(No audible response.)

Co-Chair Angove: All right, so in lieu of the poll bringing us to a close, I am going to suggest that we move to our next set of measures.

And, I will pass it off to my NQF partners and colleagues, to take us to where we need to be in the agenda.

Ms. Williams-Bader: Thanks so much, Rebecca.

So, we're actually scheduled if you're following the agenda, for a break at 2:15 if I'm reading that correctly.

And, we are at 2:15 and at the end of a program. So I'd like to suggest we take a break, but let's only break for 10 minutes, because we do have a number of measures still to get through.

So, we will return at 2:25 Eastern time.

Thank you all.

(Whereupon, the above-entitled matter went off the record at 2:15 p.m. and resumed at 2:25 p.m.)

Ms. Lynch: So, good to see everyone again. I'm happy to spend the next few hours with you, but hopefully we'll power through.

So we're going to transition to the clinician program. Next slide, please. So there are two. We're looking at the Medicare Shared Savings Program, MSSP, and the Merit-Based Incentive Payment System, MIPS. Slide.

So I'll start with the Medicare Shared Savings Program, which is mandated by Section 3022 of the Affordable Care Act. The incentive structure is that

CMS assesses the Shared Savings Program accountable care organization, ACO, performance annually based on quality and financial performance to determine shared savings and losses.

Beginning with reform in tier 2021, the ACOs are required to report their quality data to CMS via the alternative payment model performance pathway. Reforms categories and weights under the APP used to calculate the ACO's fixed quality performance category score are quality 50%, cost 0%, and proven activities 20% and promoting interoperability 30%.

The program goals are to promote accountability for our patient population, coordinate items and services for the ACO's patient population Medicare fee-for-service beneficiaries, and encourage investment in high quality and efficient services. Next slide, please.

So we will be -- I'll turn it over to Laurie to open up public comment. Again, this is just for members of the public who have comments about the measures under this program. We will then discuss other work as an advisory group all of the measures individually. So for any advisory group members, let's just hold the discussion until we get to those measures.

So Laurie, over to you for public comment.

Co-Chair Zephyrin: Great, thank you so much. So I'll open it up for public comment. Again, this is for comments from the public, not necessarily advisory members, but comments from the public who have thoughts, questions, additional comments about these measures.

So, opening it up. I'm looking to see if anyone has their hand raised or if people want to put a comment in the chat, or if there's someone on the phone that wants to say something about these measures that are being discussed today.

Okay, no, I don't see anyone's hands raised, I don't hear any comments. I don't see anything from the chat. Apparently just confirming that with Chelsea, and --

Ms. Lynch: Yup.

Co-Chair Zephyrin: Great. Okay, okay, thank you. So we will close the public comment period, thank you. And let's turn it over to NQF and the lead discussant for.

MSSP Measures

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

Ms. Lynch: Thank you, so next slide, please. So our first measure for this program is 00515-C-MSS: Preventative Care and Screening: Screening for Depression and Follow-Up Plan.

This is the percentage of patients age 12 years and older screened for depression on the date of encounter, or 14 days prior to the date of the encounter, using an age-appropriate standardized depression screening tool and a positive followup plan is documented on the date of the eligible encounter.

This measure is not endorsed, and it was selected by three of our MAP members. We do want to note that CMS is planning to sunset this web interface-based measure starting with performance year 2025.

And our colleagues from the Patient Safety Action Network are available as our lead discussant. Are you on the line?

I'm not hearing her, so I will just briefly share the rationale for this measure selection, which was the respondents didn't think that the measure contributes to their overall goals or objectives of the program.

They knew that it was not endorsed by the consensus-based entity and that measure performance does not substantially differentiate between high in the performers, such that performance is mostly aggregated around the average and lax variation.

And I'll also note that the measure leads to a high level of reporting burden for reporting entities, but no additional survey feedback was there.

So I'll turn it over to you, Laurie, for the rest of the discussion.

Co-Chair Zephyrin: Excellent, thank you so much. Now let's open it up. I would love to hear if there are any clarifying questions or any discussions around this measure and health equity implications.

Member Mansi: Hi, this is Tala from Planned Parenthood. I'm happy to offer some thoughts.

I think, you know, considering the impact that covid-19 has had on adolescents and their mental health, I think this measure is critical to continue. We know that negative outcomes associated with depression make it crucial to screen in order to identify and treat depression at its early stages.

And while primary care providers serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients.

And you know, only 36-44% of children and adolescents with depression actually receive treatment, which suggests that the majority of depressed youth are undiagnosed and untreated, and that data is from 2010. I can only imagine, you know, what that looks like today. And we know that mental health services already are inaccessible.

This measure specifically addresses not only the screening but also the followup plan related to a

positive depression screening. So from, you know, a health equity lens, I think since this measure isn't duplicative of any other measure, I would argue for retaining it.

Co-Chair Zephyrin: Thank you, Tala. Thank you for highlighting those important points around the current burden we're seeing around mental health and the equity implications. And you've mentioned there's no -- there's no other measure like this.

Chelsea, you mentioned that this was going to be sunset. Is there -- is that, do you know the reason for that, or I'm just curious?

eCQM ID:CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)

Ms. Lynch: Jenna can correct me if I am wrong, but there is an eCQM version of the measure, so that measure would take its place.

Co-Chair Zephyrin: eCQM?

Ms. Lynch: Which is also the next things -- oh, sorry, an electronic clinical quality measure, for those, sorry.

Co-Chair Zephyrin: Okay. Got it, got it.

Ms. Lynch: An electronic version is on the horizon.

Co-Chair Zephyrin: Okay, that's why. Okay, thank you for that clarification, I appreciate that. Excellent.

Any other reactions or thoughts from the group, whether about health equity implications or in response what Tala and Chelsea just mentioned about the measure? Malcolm, thank you, you have your hand up.

Member John: Thank you so much. Just a clarification on the last piece of data. So if this is

now going to be electronic, an electronic data metric, I guess I'm struggling with how we should respond here if we're going to have the ability to track.

Because I think it is an equity issue for the reasons Tala - Tala, I hope I said her name correctly, Tala, Tala raised. It's just whether or not we need to support it here if it's being clearly tracked in another metric that will be able to document its utilization and planning.

Co-Chair Zephyrin: Thank you, that's a great question. Let me -- let's turn it over to our NQF colleagues to answer that.

Ms. Lynch: I'm not sure, Jenna, if you are aware. I know I think for this particular measure, because we did end up pulling the electronic version as well to talk about them at the same time. Or not at the same time but sequentially.

So for this measure, the plan is for it to be sunsetted. And I think then therefore it's essentially replaced with the electronic one. So we can have kind of that discussion.

But whether it's being captured in another aspect, I'm not sure, but I think the intent is for it -- there is a movement towards digital measures and using electronic -- electronic clinical quality measures going forward. So I think that's where some of that comes from.

And I did see Roberta have her hand raised, but I saw her take it down too, so I'm sorry about that.

Co-Chair Zephyrin: Thank you, Roberta, do you?

Member Waite: Yes, I just really just wanted to amplify what Malcolm and the other young lady was just stating, because I agree, this measure or a comparison, be it electronic, should be on there, for the reasons that were mentioned as it relates to

covid.

Even before covid there were huge inequities or disparities with mental health, and I would say that these are compounded now with the trauma that's exposed for our youth in violence that's happening. So I definitely think this needs to continue.

But if it's captured in electronic form, then you know, that would be good. I just want to make sure it's not missed in any way.

Co-Chair Zephyrin: Thank you. Thank you for --

Ms. Gomez: Hi, and --

Co-Chair Zephyrin: Hi.

Ms. Gomez: This is Lisa Marie Gomez with CMS.

Co-Chair Zephyrin: Hi, Lisa.

Ms. Gomez: I don't know if it's possible just to elaborate on what Chelsea had noted, just in terms of like the program aspect to address Malcolm's particular question. So I just want to provide one -- a couple clarifying points as you engage in the discussion that you have the full perspective and understanding of this measure and the electronic version of the measure.

So under the Shared Savings Program, this is a web interface measure. And the web interface measure is based on a sample of Medicare patients.

So for this measure, I know someone mentioned a comment about young individuals needing to ensure that they -- that they're -- that they have access to this type of care or a followup plan, or. I just want to highlight that for web interface, this measure is a sample of patients of the clinic patients and ACOs patients. And again, it's Medicare patients and just a sample.

Under the electronic version, which is a different

version, it's the pair data. So I just want to highlight that this measure here is different structurally in terms of what's being assessed in terms of patient data versus the electronic. And as Kathy noted, yes, the web interface is going to sunset for the Shared Savings Program in 2025.

So until then, this web interface measure, again, is assessing Medicare patients, and it's a sample of patients, whereas under the electronic version it's a payer. and it's 70% of your patient population that you report on.

Co-Chair Zephyrin: Thank you, thank you, that's a really helpful context, Lisa Marie.

Some comments in the chat from -- oh, we'll discuss the electronic -- oh, thank you, Jenna. We're discussing the electronic version of this measure next, so we'll have more to talk about.

And Malcolm, I agree with the equity aspect of this question. It can be here and electronic given the clarification, so possibly similar. Similar thoughts potentially for the next conversation around the electronic aspect of the electronic measure.

And then let's see, just noting a comment phenomenon, i.e., systems that have a higher proportion of patients with access to portals for digital screening, etc., will have a much easier time doing this than systems with less affluent patients, etc. It's important to do nonetheless. Thank you, Leonor, for making those, providing those comments.

Ms. Lynch: And Laurie, Heidi Bossly has her hand raised.

Co-Chair Zephyrin: Oh, hi, Heidi, thank you.

Member Bossley: Hi, I can't tell if you can see it.

Co-Chair Zephyrin: I, yeah, on my screen, it.

Member Bossley: Yeah, it disappeared. I know the person. I just want to make sure I under now which measure we're looking at. I thought this one was the vehicle was registry. It could have been interface.

Like interface is, that reporting option for MSSP and for MIPS will go away, that's going to be sunsetted. But I thought this was the one that is based on registry reporting, and then the second one is the eCQM. Is that -- I'm not seeing webinar interface in the materials we're sent, so I want to be sure I understand.

Co-Chair Zephyrin: Oh, thank you. I'll turn that question to our NQF or CMS colleagues.

Ms. Lynch: Yeah, Lisa Marie or even Jenna, if you have a little bit more clarity around the data source for this one.

Co-Chair Zephyrin: Thank you.

Ms. Gomez: I'm going to defer to my colleague, Kathleen. But I want to highlight, so I guess there's a couple of dynamics here. So in general, under like the MIPS program and SSP, but under SSP this measure is identified as under the web interface.

And I don't know what this version is. I'm not sure what this version is here, I'm actually not with the Shared Savings Program. I'm actually on the MIPS side, the web interface lead for that, which is why I can answer some of the questions.

But in terms of this measure just in general, they're, we're going to call them equivalents. So this measure does exist in the web interface which exists for the Shared Savings Program. This measure also does have a MIPS CQM equivalent, which be considered with like what you were saying with the registry. And it also does have an electronic equivalent, which is the eCQM version.

So with this measure in general, there are three ways in which it can be reported.

Co-Chair Zephyrin: Right, okay that's helpful, it's -- oh, I'm sorry, go ahead, yeah.

Ms. Gomez: Yeah, sorry. Kathleen, for this measure that you were given, that you're reviewing for this program, is this the -- I'm assuming this is the web interface version, correct, not the MIPS CQM, unless anyone from NQF can provide clarification on that.

But I don't know which version this measure is. Because again, there's three equivalents of this measure.

Ms. Johnson: Yeah, hi, Lisa Marie, hi, everyone. This is the web interface measure that we're discussing right now. The next one would be the eCQM measure if it's according to what's on the agenda. And I think we were asking you about the different kinds of reporting for web interface, or am I mistaken?

Member Bossley: No, sorry. So I guess I'm just trying to think how this will then cascade to the work group, right, the clinician work group and then the coordinating committee. And I want to make sure that the input we provide is useful.

There's, as you said, three versions. Web interface, to be honest, I don't think is worth anyone looking at and providing comments on because that's going away.

There's the CQM, which is the registry-based, and then the eCQM. And so those two as it currently is in the Shared Savings Program, correct me if I'm wrong, are the two vehicles the ACOs will be able to do, either registry or EHR, in the future.

I'm not sure that that makes a difference in our conversation today, because data sources will vary and I think the validity of the eCQM should be

discussed. I'm not sure that's going to -- what those issues are.

But I just, I guess I'm confused if we're going to vote -- provide, it's not a vote, but our preference for one or the other when both exist. It's just reporting vehicles, it's not -- I think the actual whether the measure is useful for disparities should apply to either one, I would assume.

I guess that's why I was -- I just wanted a little clarity on exactly what we're looking at to make sure it's clear.

Co-Chair Zephyrin: Right.

Member Bossley: I don't want to make us too delayed in our conversation, so I'll shut up now.

Ms. Johnson: Yeah, that's correct. Moving forward starting in performance year 2025 it will be reporting either on CQMs or the eCQMs, as you had mentioned. There will no longer be a web interface option.

Member Bossley: So this measure, if you're saying this is the web interface, this one's going to go away anyway.

Ms. Johnson: That's right.

Member Bossley: Okay, all right, I just wanted to make sure I had that right. Thank you.

Ms. Johnson: Sure, you're welcome.

Co-Chair Zephyrin: Mahil, thank you for your comment in the -- in the chat around you think the measure and/or eCQM version is useful for assessing equity given under-identification of depression in minority populations.

There also may be an intersectionality value given unidentification in women. Just want to make that comment. Oh, before I have to drop, okay, he had

to drop off.

So this has been a really great discussion. Maybe for time we can move to the next one, it's sounds like there's some overlap there in the conversation.

Jenna, Chelsea, are you okay with that?

Ms. Lynch: Yes, I think that sounds great.

Co-Chair Zephyrin: Okay.

Ms. Lynch: And the next slide, which will sound very familiar. So this is the eCQM ID: CMS 2v11: Preventative Care and Screening: Screening for Depression and Follow-Up Plan (eCQM).

Again, this assesses the percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented.

Again, this measure is not endorsed. And this measure was also of note not in the original survey. But since it's the eCQM version of the other -- the other measure presented, we wanted to share that with everyone.

Co-Chair Zephyrin: Excellent. And just a clarification. Are these the exact same measures, they're just ones -- they're just different modalities, is that? Chelsea, is that -- is that --

Ms. Lynch: I believe that's true. Jenna or our CMS colleagues, if that is incorrect and it's not just a data source, let me -- let us know.

Ms. Gomez: Yeah, this is Lisa Marie with CMS, and you are correct. It's just a different modality in terms of how it's reported, but the measure is the same.

Co-Chair Zephyrin: Thank you. So maybe since I

think we've had a robust discussion about the same measure but in a different modality, so any additional -- I think this, and Jenna and Chelsea, you know, maybe we can apply that last conversation also to this measure, measure too. But also I want to open it up to see if there's anything else that anyone wants to add.

Ms. Lynch: Yeah, Laurie, I think that makes sense. I think when it comes -- there's a few measures that are like this where there's like an original version and a eCQM, I think if there's just any equity implications of having an electronic version of a measure, that might be interesting to --

Co-Chair Zephyrin: Right.

Ms. Lynch: See if there's things there, but otherwise, then yeah, I agree that we can just pull those comments forward.

Co-Chair Zephyrin: Right, right. And I think your point about equity implications around the electronic aspect of the measure, definitely there's value in that. I think someone had mentioned something around access.

I think Leonor had mentioned about the systems option in terms of access to portals for digital screening and having, can also have some equity impacts. So I think Leonor's comments definitely also apply.

Any other comments or thoughts around this version of the measure and its additional aspect of being eCQM measure?

Okay, I'm just scrolling through to make sure I don't miss any hands and giving the opportunity for people on the phone to chime in since I can't see your hands. And great, okay.

I'll -- why don't -- maybe we can turn to the next one.

06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Ms. Lynch: Sounds great. Next slide, please. So our next measure is 06040-C-MSSP: Hospital-Wide 30-day All-Cause Unplanned Readmission Rate for MIPS Eligible Clinician Groups.

This measure is a respecified version of the measure Risk-Adjusted Readmission Rate of Unplanned Readmission Within 30 Days of Hospital Discharge for Any Condition, which is NQF No. 1789, which was developed for patients 65 years and older using Medicare claims.

This respecified measure attributes outcomes to MIPS-participating clinician groups and assesses each group through admission rate. The measure comprises a single summary score derived from the result of five models, one for each of the following specialty cohorts: groups of discharge conditions categories or procedure categories; medicine; surgery/gynecology; radio -- or cardiorespiratory, cardiovascular; and neurology.

This measure is not endorsed, but it is based on an endorsed measure, and it was selected by five MAP members. And I will turn it to over to Cardinale and America's Essential Hospitals as our lead discussants.

Co-Chair Zephyrin: Thank you. We're waiting for someone from American's Essential Hospitals. Maybe they're on mute.

Member John: It's Malcolm, I'm sorry, my video was giving me a little trouble.

Co-Chair Zephyrin: Oh, great, awesome.

Member John: Great, well, thank you. You know, I think obviously re-admissions is an important concern and a complicated quality indicator.

And I think the challenge here from an equity perspective is that while they've grouped it in terms of specialty cohorts, there still seems to be a need for greater specificity and sort of teasing out individual condition-specific measures, as opposed to a global readmission even by these specialty cohorts.

For example, we know that even within cardiovascular disease, there are differences between acute MI readmission versus congestive heart failure.

And there's some data in, you know, post-Obamacare, that has been published in reports like Health Affairs that you can see, you know, imposing these sort of re-admissions reduction program through the ACO actually led to some worse mortality in the heart failure as opposed to benefits in MI and worse outcomes, say, with pneumonia.

So again, I think it's a little bit too broad from a equity perspective. And you know, it's hard when you just have one opportunity to comment on a metric like this and perhaps not offer some suggestions for a better way of looking at it. But I think that that is one of the main concerns.

The other is that there should be some comprehensive risk adjustment beyond what was stated for socioeconomic, demographic, SDOH factors that we know can impact outcomes and that are unrelated to quality of care provided. And so that would be an encouragement to improve the metric as well.

So I think that's the position that we hold currently, and for brevity I'll stop there and can expand as needed. Since we're running late.

Member Smith: Hi, this is Cardi, Cardinale, you can call me Cardi. I think the only thing that I would add to that is for me, I'm sort of on the fence with this measure, probably because it's so ingrained to

everything I do every day.

But thinking about it through an equity lens, at least from my review of the literature, it looks like admissions post that first seven-day window is really, really related to more social determinants of health issues or structural determinant of health issues.

And so while I do think there is an equity component that exists here, I think the question is, you know, for 30 days, how much of that is appropriate for hospital systems to be responsible for sort of outside of that seven-day window.

Ms. Lynch: Beth, she has her hand raised.

Member Godsey: Hi, this is Beth. I couldn't agree more with the challenges that this measure brings in the -- in the sense of going beyond that seven-day mark. I think this measure is confounded, and I think a lot of people struggle with this measure, both from a measure development perspective, but also from a quality -- a quality outcome and improvement perspective.

There are so many things packed in here. You've got patients, you've got healthcare providers, you've got structural inequities, you've got social community needs, you've got, you know, lots of things that are really confounding this measure.

And while I think it's slightly insightful to be able to look at it from an equity lens, I think that it is riddled with opportunities to artificially put blame or measurement burden on, from a -- from an action perspective exclusively on providers, when there are so many things that go into this measure.

And so I have a, one, I have a challenge with the measure itself. The second part is that there's lots of components that need to be assessed from an equity perspective and unpacked from this measure before we could really understand what it is that we

need to do to focus to improve. So just a couple comments there.

Co-Chair Zephyrin: Thank you, thank you, Beth. Thank you, Cardi, thank you, Malcolm.

Any other -- Maryellen, did you have a comment? I see you're off mute.

Ms. Guinan: I am sorry, no, I'm not. Thank you.

Co-Chair Zephyrin: Oh, no, that's fine. I was just checking.

Ms. Guinan: Switching from phone to computer, multitasking.

Co-Chair Zephyrin: Totally understand, I've been there. Any other comments from anyone? Really great points around, just you know, really how potentially messy this measure is and some of the health equity implications and challenges, thank you for that.

Susannah Bernheim, you're clarifying that this is MIPS measure, not hospital measure. Was it a question or a statement? I'm assuming it's a statement because there's no question mark.

Member Bernheim: Yeah, it's just for people to know what version of the measure they're talking about.

Co-Chair Zephyrin: Okay, great. Thank you.

Ms. Williams-Bader: And to clarify, yeah, this is -- because this is the Shared Savings Program. So this would be for ACOs or there's another term that escapes me right now. And welcome CMS to clarify as well.

Ms. Gomez: Hi, this is Lisa Marie at CMS. So yes, so under the Shared Savings Program, this measure would specifically assess ACO performance and not individual groups, like, or individual KINS (phonetic)

underneath the ACO.

Kathleen, do you want to elaborate if I -- do you want to add anything?

Ms. Johnson: I don't believe I have anything additional to add, unless there's specific questions. Thank you, Lisa Marie.

Co-Chair Zephyrin: So this specifically is to assess ACO performance in some of the comments around the -- the social determinants of health. Because ACOs theoretically also should be addressing some of these community-based needs as well.

So if this is an ACO-specific measure, then some of the confounding factors that are -- that were brought up around what's happening in the community may be relevant, is that -- is that what I'm hearing?

Member Godsey: This is -- this is Beth. From my comments, it doesn't change.

Co-Chair Zephyrin: Okay.

Member Godsey: I think it's still -- it's still lots of components there that even if being a part of an ACO, there are factors there that are challenging to address.

Co-Chair Zephyrin: Okay, thank.

Member John: And I agree with that, and you could actually bury some issues if you're -- you know, I'm going to harp on heart failure because our institution has been looking at some of this. And in our city, it disproportionately affects Black, African American patients.

And sometimes you'll lose the fact that patients who should be readmitted are not coming and not getting readmitted. So it's a very complex, for all the reasons Beth mentioned, and others, and Cardinale. Very complex, and you can sometimes

actually cause harm if you're only focused on reduction.

Co-Chair Zephyrin: Great, okay, excellent. Thank you, thank you so much.

And Cardi put in the chat I also agree. Any other comments on this before we move on to the next measure? And also, again, feel free to enter a word, a sentence in the chat, as well as if you haven't had an opportunity to share some burning comments.

All righty, why don't we transition to the next measure. Chelsea or Jenna?

Ms. Gomez: Hi, this is Lisa.

Co-Chair Zephyrin: Oh, sorry.

Ms. Gomez: Sorry, just wanted to mention one thing. So I just want to note that, you know, we continue -- so this measure is a MIPS measure, but you know, it's being applied to ACOs, as you can see in this -- this display here.

But we -- I just want to note that we continuously monitor the literature related to the impact and unintended consequences of this particular measurement. And we found -- and it's found that like evidence that re-admission measurement has increased mortality rates as inconclusive. So I just wanted to point that out.

And so the Medicare Payment Advisory Commission completed an analysis on readmission measurement within the HRRRP (phonetic) and found no negative effect for mortality. So I just wanted to highlight that's what the research has shown so far.

Co-Chair Zephyrin: Thank you, thank you, that's very important. Thank you for sharing that, Lisa Marie.

Ms. Lynch: All right, can we go to the next slide. Oops, one more.

So the next measure is 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Chronic Multiple Conditions.

This is an annual risk-standardized rate of acute unplanned hospital admissions among Medicare Fee-for-Service patients aged 65 years and older with multiple chronic conditions. The measure is not endorsed but it is based on an endorsed measure, and it was selected by three MAP members.

Is the representative from Kentuckiana still on the call as our lead discussant?

Member Clouser: Yes, I'm here. Hey. Yeah, this is a really interesting measure. Some of the criteria selected for removal does not contribute to the overall goals, high burden for reporting entities, and negative unintended consequences.

Some of the specific survey feedback, one -- someone wondered how often it is being reported and does it have unintended consequences for the groups to take on a higher proportion of underserved populations. And someone pointed out that this not a quality measure, it is a utilization measure.

So looking at it from an equity perspective, some of my initial thought, we know that the management of chronic -- chronic conditions such as kidney disease, diabetes, heart disease, heart attacks, strokes that are included in this list do have equity differences. So I do think that that is very important, and it might be a utilization measure, but it is tied to quality.

Now, I think it was Beth in the last, similar to the

last -- the last measure, Beth pointed out that, you know, there are, you know, factors packed in there that might confound some of what's really going on. But management of chronic conditions related to equity is incredibly important.

Co-Chair Zephyrin: Excellent, thank you. And Chelsea, was there someone else to comment on it, or was it just?

Ms. Lynch: No, just one.

Co-Chair Zephyrin: Great, thank you. Let's open it up to any clarifying questions or discussions. Okay. Very important measure from an equity lens from Beth Godsey. Beth, I don't know if you want to say anything else in regards to that, but thank you.

Any other thoughts in terms of equity impacts or lens?

Member Godsey: I think that there's a lot of information that has been published --

Co-Chair Zephyrin: Beth, can't hear you that well, maybe come closer to your mic. Or it could be me.

Member Godsey: Can you hear me?

Co-Chair Zephyrin: Yes, perfect, okay.

Member Godsey: Okay. Sorry. I -- sorry, I was trying to figure that out as far as my audio. Apologies.

I think that there's certainly a lot of literature and information that showcases that the inequities that are highlighted in BIPOC populations related to chronic illness and chronic disease. And being able to look at this and evaluate it in that lens I think is critical and is extremely important for us to be able to continue to focus on that.

So all the measures that we have looking at at Vizient have this kind of lens from a chronic

condition perspective that not only speak to the ability of the provider to manage and maintain, from a -- from a access to care perspective, but also the structural and community challenges and inequities that exist that help -- that continue to make this challenge persist in the community.

So I think it's very important for us to look at, so hopefully that adds some clarification.

Co-Chair Zephyrin: Thank you, that was very helpful, Beth. Any other additional comments, questions? Okay, hearing none, over to Chelsea for the discussion of the next measure.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Ms. Lynch: Thank you, next slide. So this is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey.

This survey is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding six months.

This measure is endorsed and it was selected by three MAP members. However, the CAHPS for ACO survey was last administered on behalf of the Shared Savings Program ACOs for the 2019 performance year.

CMS waived the CAHPS for ACO surveys for the 2020 performance year. Beginning with the 2021 performance year, the Shared Savings Program ACOs were required to administer the CAHPS for MIPS survey as part of the APM performance pathway reporting. Their surveys are nearly identical, however, there are some scoring differences.

CMS has one year of CAHPS for MIPS date for

Shared Savings Program ACOs. Given that the Shared Savings Program is merely using the CAHPS for MIPS survey and there may have been some confusion during public with the list thinking of the CAHPS for ACO survey in the CMS measure inventory tool, NQF and CMS decided to remove this measure for discussion and voting during the -- during the reviews.

Are there any questions or concerns about this decision? So to summarize, not -- not discussing.

Co-Chair Zephyrin: Okay. Great, so Chelsea, we're not discussing it, we're just seeing if anyone has any issues with not discussing it?

Ms. Lynch: Exactly.

Co-Chair Zephyrin: Got it, okay, great. And Leonor, thank you, it will be in the future an important discussion, absolutely. Excellent. Next one.

01246-C-MSSP: Controlling High Blood Pressure

Ms. Lynch: All right, so next we have Measure 01246-C-MSSP: Controlling High Blood Pressure.

This measure assesses the percentage of patients 16-85 years of age who have a diagnosis of essential hypertension starting before or continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled, less than 140 over 90 during the measurement period.

This measure is not endorsed, and it was selected by six MAP members. Similar to the measure we started with, CMS will sunset this interface-based measure starting with performance in 2025, and we will be talking about the electronic one right after this.

And our lead discussants are the American Nurses Association, and our other person wasn't able to join.

Member Waite: Hi, so I can start. So we can see the concerns here for the controlling of high blood pressure was that it was endorsed by the consensus-based entity. That improvement on the measure does not result in better patient outcomes. And the measure has negative intended consequences, as well as the measure leads to a high level of reporting burden.

Some of the survey feedback was that it was considered to be a good measure, and individuals was wondering why it was not endorsed. And there was uncertainty as to the strength of data in those that were 75 years of age and older.

And as I reflected basically really on the public comments, there was a lot of concern over the lack of confirmation and documentation on the measure. As well as not being able to use readings that were obtained by self-monitoring and excluding very specific populations, such as health -- folks who were experiencing health failure. So it really targeted stage II folks who had high blood pressure.

An important thing, though, with this measure is that we know that a tremendous number of individuals who have high blood pressure or hypertension are impacted by equity or any of the issues. There are clear differences between racial, ethnic groups and socioeconomic disparities associated with high blood pressure.

So I do think it's important. I understand it's going to be sunset, but as was just discussed, the electronic version as well. So it's a measure that I do think is important, but if it's captured in another way, then I think that's -- that's good. So we can open it up for folks who have questions or want to add additional comments or thoughts.

Co-Chair Zephyrin: Thank you, thank you very much. Any clarifying questions or comments?

Member Shih: Hi, this is Sarah. I just wanted to let

folks know on the call this measure will be stratified by race, ethnicity at the health plan level. So that, sorry, update for the specifications to NQF will be coming soon.

Co-Chair Zephyrin: Fantastic. Thank you for that update. And any comments or questions? Should we move, maybe move on to the next one, since it's the same measure, and -- similar? It's -- wait, this is, is the electronic one next? Yes. Shall we move on to the next one since it's similar, and then what are your thoughts, Chelsea?

Ms. Lynch: Yes, that works for me.

Co-Chair Zephyrin: Okay, great, let's do that.

eCQM ID:CMS165v10: Controlling High Blood Pressure (eCQM)

Ms. Lynch: So this is Measure eCQM ID: CMS165v10: Controlling High Blood Pressure (eCQM).

Again, this assesses the percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before or continuing into or starting during the first six months of measurement period and whose most recent blood pressure was adequately controlled, less than 140 over 90 during the measurement period.

Again, this measure is not endorsed and was not presented in the original survey, but because it's the electronic version, we -- of the measure that was presented. So wanted to include it here.

And our lead discussant is the same, so if there's anything particular, Roberta, you can start here, or we can open it up.

Member Waite: Sure. I think we can open it up since basically a lot of it is repetitive from the initial one. Only as we identified, this one is electronic. But I think there's sort of a content, it's basically the

same.

Co-Chair Zephyrin: Excellent, thank you. Any clarifying questions or comments? Any additional equity questions relating to the electronic version of this compared to the last one?

I appreciate your comments, Roberta, around this affects disproportionately minoritized communities. And so there's potential opportunities there, though there -- there sounds like there's some challenges with the measurement. So thank you for highlighting those potential implications.

Member Waite: You're welcome.

Co-Chair Zephyrin: Chelsea.

Ms. Lynch: Susannah, yeah, Susannah has her hand raised.

Co-Chair Zephyrin: Oh, great, thanks. I can't even see that. Susannah.

Ms. Lynch: It's very tiny.

Member Bernheim: I just, I want to follow through on that comment, because I think it's an important one for controlling high blood pressure. And I'm still having a little bit of a disconnect making sure I understand how that will then feed into the committee that looking at removal of this measure.

So I just want to make sure I'm understanding therefore what our consensus might be if folks agree. So this is a measure --

Co-Chair Zephyrin: Is the removal of the measure for this one or for the last one, because I think --

Member Bernheim: For, well, for -- I mean, we're talking about both of them.

Co-Chair Zephyrin: Okay.

Member Bernheim: I think the idea is that the last

one's being replaced by this one.

Co-Chair Zephyrin: Okay, let's get some clarification maybe from NQF. That was my thought, but I could be wrong.

Ms. Lynch: So this should be very similar to the other measure that we talked about first where the non-eCQM version scheduled to be sunsetted in performance year 2025, switching over to this eCQM version.

So Jenna and my other NQF colleagues can correct me if my assumption is wrong, but it'd probably be more focused on the removal of the eCQM version, considering that the other one will be sunsetted anyway.

So I think thinking about how important is it to have controlling high blood pressure one of those measures in this program from a health equity perspective.

Co-Chair Zephyrin: Susannah, does that answer your question? Okay.

Member Bernheim: Yeah, that was my understanding, is that we're really talking about this measure concept. Because behind the scenes, it's going to -- this measure sounds like it's going to transition from being the version it is now to an eCQM, but there's consideration of removing this measure concept.

And I heard this is important from a disparities perspective, and I just want to connect the dots. Does that mean because of that, we think it's important to not remove it? Is that the suggestion?

Member Waite: That's what I was suggesting, yes.

Member Bernheim: Okay, great, okay, terrific. I -- then I will express agreement with you now that I understand what we're saying. Thanks.

Co-Chair Zephyrin: Okay, and does that -- we have two people with -- three people with their hands up, which is great. I just wanted to clarify with NQF team that what we're talking about, what Susannah had mentioned we're talking about, it's the idea of the concept of the measure, electronic or not, being removed. Because there's that possibility, right, is that? That's what --

Ms. Williams-Bader: Yeah, I think that it'll be useful -- so CMS did want us to include even the version that is being sunset because it's not set to sunset until 2025, and if there were serious concerns about a measure, then CMS would want to know about that.

But yes, the version of the measure that will persist as an eCQM, it will also be useful for CMS to obviously have comments about that measure as well.

Co-Chair Zephyrin: Okay, thank you. And Melanie, then Mark, then Beth. So Melony.

Member Sorbero: I just wanted to comment that not only does this measure disproportionately affect lower socioeconomic status populations, in what we've done for Medicare Advantage, we've also seen consistent disparities. So it's kind of doubly important from an equity perspective. We know there are disparities and we know it disproportionately affects these populations.

Co-Chair Zephyrin: Thank you. Thanks, Melony.

Mark.

Member Friedberg: Yeah, I just want to point out even in Massachusetts, which is a state that does pretty well on this measure and this measure concept generally, it's one of the most stark inequities that we see within provider systems and across our business, even in a fully commercially ensured population as far as racial and ethnic

inequities in care.

So I think this is a -- this has a lot going for it on an equity basis as a concept. Thanks.

Co-Chair Zephyrin: Thank you, thank you, Mark. And Beth.

Member Godsey: Yes, and to the prior folks who made comments, 100% agree that there's been known inequities related to this measure. It's a measure -- it's a measure that indicates that this can be improved and that it has a significant opportunity in certain populations, and that that should be the focus.

So I agree that we should continue to focus on this from an inequities perspective.

Co-Chair Zephyrin: Thank you, Beth. And Heidi, I think your hand was raised.

Member Bossley: Yeah, I agree with everyone, I think this is a really good measure from an equities perspective.

I would put in a request for staff, I don't think it needs to be solved now, but I -- there is still a registry reporting option, and there -- that is a CQM measure, which I don't see in front of us.

It's not an equity issue, so I don't think it needs to be discussed now, but it's got to be clarified before the clinician worker reviews this, because otherwise it's -- I think they will get very confused, because I personally am confused. So just a request that that get settled before the next meeting.

Co-Chair Zephyrin: And thank you, and was that -- I don't know if anyone from NQF or CMS wants to respond to that question.

Ms. Williams-Bader: Yeah, Heidi, thanks for that. We will clarify with CMS in between this and the clinician work group.

Co-Chair Zephyrin: And then additional comments around agreeing with -- thanks, Heidi. Agreeing with, from Malcolm, agreeing with equity relevance. From Leonor, very much agree with these observations and it's important to equity and pharmacoequity. And then Leslie, agree with comments about the importance of keeping this measure in some form.

Okay, any -- very robust discussion, thank you all. Any additional comments or clarifying questions before we transition to the next section through Jenna and Chelsea?

Okay, seeing none, unless I missed any, waiting a second for anyone on the phone, looking at any chats. Okay, I'll turn it back to Jenna and Chelsea. Thank you.

Ms. Lynch: Thanks, everyone. So our next measure, measure set program, excuse me, is the Merit-Based Incentives System, or MIPS.

So this is a quality payment program. It is pay for performance where there are four connected performance categories that affected clinicians' payment adjustment. And each performance category is scored independently and has a specific weight. And you can see there's cost at 30%, improvement activities at 15%, promoting interoperability at 25%, and quality at 30%.

The program goals are to improve quality of patient care and outcomes for Medicare Fee-for-Service, reward clinicians for innovative patient care, and drive fundamental improvement toward value in health care. Slide.

So I will turn it over to Rebekah to do public commenting on the MIPS measures, which, again, is all of the measures on the slide, and the advisory group will go measure by measure.

Co-Chair Angove: Thank you. Thank you, Chelsea. Absolutely want to open it up for public comments. If you are in the room, please raise your hand. Towards the end, we will open up for those on the phone. And please try to keep your comments to around two minutes.

And Flora, I see you have your hand up, so you can start us off.

Dr. Lum: Thank you so much, and I've really appreciated all the great discussion and thoughtfulness of the work group today.

So I'm Dr. Flora Lum, I'm Vice President of Quality and Data Science for the American Academy of Ophthalmology, and we represent 93% of the active practicing ophthalmologists in the United States, and we set the quality standards of care.

And three of our measures are on here, retinal detachment and the two diabetic retinopathy communication with the physician. And I know that there's limited time and it's going -- you're over time now. So I do, I just want to emphasize in terms of the equity discussion.

So we wanted to make sure that these -- that you knew that the Academy believes that these are very important for health equity, and they're important to the goal of CMS for health equity.

Blacks and Latinx individual have significantly higher rates of diabetes-related complications, namely blindness and diabetic retinopathy, more so than White individuals in the United States. Black patients also have higher odds of worse visual acuity outcomes after retinal detachment repair.

And we believe that visual acuity is a valid outcome and it measures function, right, patients who can't drive, they can't get around, they can't read. That's

all measured by their visual acuity outcome after retinal detachment repair. And so by maintaining these measures in the program, we believe that they contribute to the advancement of health equity in the country.

And in addition, the American Academy of Ophthalmology has launched a major initiative on DEI, and we are strongly encouraging our members to look at disadvantaged populations and under-represented minorities in terms of communication, care coordination and outcomes and try to address these in different ways in their practices in their community and as the Academy on the national level.

So having measurements in place will encourage that focus.

And I did want to mention we have the IRIS Registry, so we have 80% of the ophthalmologists participating in the IRIS Registry. And on these measures, they can go back and look at their patients lists and they can know if their patients are part of these under -- these minority populations and really track them closely in terms of their outcomes.

Thank you.

Co-Chair Angove: Flora, thank you so much for sharing. While I see if there are any more hands that are going to go up, maybe I'll open up the floor to those on the phone that are calling in and don't have the ability to raise their hands. And a reminder to go off mute if you want to contribute.

All right, I hate to speed us along, but I know time is of the essence. So seeing no hands raised and no voices coming onto the line, I am going to move us to the next section, where we're going to discuss each one of these individually.

Ms. Lynch: Thank you, Rebekah. Next slide.

00641-C-MIPS: Functional Outcome Assessment

So we'll start with Measure 00641-C-MIPS: Functional Outcome Assessment.

This measure assesses the percentage of visits for patients age 18 years and older with the documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter and documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

Endorsement has been removed, and this measure was selected by four MAPS members. Our lead discussants are Vizient and Jason Suh.

Member Suh: Hey there. So I reviewed all the stuff sent to me. This is a very vague -- I even talked to some primary care docs, and our problems are that all eight patients over the age of 18 without a specific goals in mind. There's similar measures for the elderly.

There's, you know, there is equity issues when it comes to recovery from stroke and other significant events. But this is so wide-based, blanket coverage of all patients over 18, I tend to agree with some of the people who commented rationale for removal that it's not getting us what want and it's just too broad to measure, and it's also not being measured.

The people who are responding to this is infinitesimally small numbers, reporting rates of less than one percent. This is a good idea, but I think it just needs to go back to the drawing board. That's what I got out of my review of all the literature that was sent to me, and also doing a Google search.

Co-Chair Angove: Thank you, Jason. Does Vizient

have a representative on the line that wants --

Member Godsey: Yeah, I'm here, this is Beth.

Co-Chair Angove: Great, let me pass it over to you, Beth.

Member Godsey: Absolutely, thank you. You know, I agree with the comments around the measure itself, just on the merits of the measure, I think there's some concerns about, as mentioned already, the broad sort of generic application.

Assuming that the framework of the measure itself is more refined and more actionable, where there could be, if we were thinking of it from an inequities perspective, where it could land, it would be almost the absence of this, the absence of functional outcome assessments in certain populations.

And that being stratified could give some insight into it, but I think that there's some -- there's some structural components around this measure that need to be considered before we go down that path.

But if we were take it on its merit today, being able to see are we representing our patient population with this functional assessment from an equity lens and stratification would be informative, but I don't know that it would drive us to really clear action.

Co-Chair Angove: Thanks, Beth. I'm going to open it up for clarifying questions or comments, or a number focused on the health equity impact or implications of this measure.

And maybe while we're waiting for hands to go up, since I don't see any, we'll use this time to see if there's anybody on the line that would like to unmute and share thoughts, or clarifying questions.

Ms. Gomez: Hi, this is Lisa Marie Gomez with CMS, and I just want to highlight, I know that, you know, there's comments about this measure being very, very broad. I just want to know at least in terms of

why this included in our program.

So you know, this measure is in its second year of topped out lifecycle, however, this type of measure can be more broadly applicable and can help reduce the overall number of measures in our program. Because right now, we have 200 measures in our program.

It also allows for care comparison across multiple clinician types. While the measure does look to see the functional assessment was documented, which may be defined as, you know, a checkbox measure, it does require that a plan of care be completed for those patients with a positive functional outcome assessment which supports optimal patient care.

I also just want to note that the denominator does state every visit in order to ensure continuity of care throughout the patient's treatment. However, the measure does go on to indicate that the intent is to ensure utilization of functional outcome assessment tool at a minimum every 30 days. So in these instances, the clinician makes performance of the measure.

So I just wanted to provide that -- that perspective.

Co-Chair Angove: Appreciate that information. Anybody else have comments that they want to share?

All right, I think I'm comfortable moving to the next one. It feels very anticlimactic not to have the poll in place, but I will pass it over to my colleagues to move this to our next measure.

01101-C-MIPS: Barrett's Esophagus

Ms. Lynch: Thank you. So the next measure is 01101-C-MIPS: Barrett's Esophagus.

This measure assesses the percentage of esophageal biopsy reports that documents the presence of Barrett's mucosa that also include the

statement about dysplasia. Endorsement has been removed, and this measure was selected by four MAPS members. And lead discussants are NCQA and Aetna.

Member Shih: Hi, this is Sarah Shih from NCQA. So when I reviewed this measure, it took me a while to understand what it was trying to surface. And it is essentially folks that have already been screened for Barrett's esophagus, which is I guess a cancer screen. But that cancer screen report should include a statement about dysplasia.

So it's very, very specific to how a pathologist's report is whether includes the dysplasia statement, because high dysplasia versus low dysplasia has implications for actionability for preventing the esophageal cancer.

As the measure is specified, it's hard to understand if there's an equity implication, because it's really topped out. If you'll see in the report from NQF, it's at 99% or almost like, almost 100% of the reports are showing this dysplasia statement, and also very few participants in MIPS are reporting this specific measure.

The question is maybe outside of this particular purview, but it is important to screen for Barrett's esophagus, the type of cancer, especially for people who have symptoms of GERD, the gastro -- I forgot what the E stood for, but it's redux, you know, the gastro-intestinal redux disorder.

And so that could have equity implications in terms of the screening. But as this measure is specified, it may not have equity impact. So that's -- that was where I was able to land with information available. And defer to Aetna if they have other information, or those that have more understanding of this particular measure.

Member Bland: Hi, I'm sorry, I'm finding my voice from being sick. This is Joy, representing Aetna.

I felt your statement was very similar to what we found. We also had some providers within Aetna with the percentage being high, and what the treatment wouldn't be different. So we were unclear as to what the benefit of the measure was.

But some of the concerns were, you know, I don't know that this data, being as high as it is and it's tapping out according to CMS, if we had opportunity if the data was parsed out by, you know, health equity. Or did we think that we wouldn't have this high a rate with people of diverse backgrounds.

But with the current data, we couldn't identify that as being the reason the measure was being proposed. So we were in support of this measure not moving -- moving forward as it - as it reads today.

Co-Chair Angove: Thanks so much, Joy. I'm going to move over to Greg, who has his hand up.

Dr. Bocsi: Hi, my name is Greg Bocsi, I'm a anatomic and clinical pathologist and a member of the College of American Pathologists Quality and Clinical Data Registry Affairs Committee.

So I just wanted to add some perspective on this measure. You know, we feel this is a very important measure to retain in the program. Very surprised that it was nominated for this process. And if you refer to our written comments that were already submitted, you'll see sort of our thoughts on, you know, its importance to maintain in the program, its relevance to the program.

And you know, with regards to it not being endorsed, you know, that's -- that's always a hard call. At the time, we didn't have the resources to submit it for endorsement. And I guess we would encourage people not to take that as an indication that there was an act of determination that it wasn't worthwhile for lack of endorsement.

You know, in terms of understanding the role of the measure, you know, it is focused at pathologists, and you know, that's part of the reason that you don't see enormous numbers of people reporting the measure, is that pathology is a comparatively small specialty.

But amongst pathologists, this is a very important measure because we have a limited number of measures that we're able to report the program. And so retaining it is very helpful for the specialty of pathology.

And just, you know, from the equity lens, there are concerns that a perfect surveillance intervals are perhaps not observed based on one's race or ethnicity. But the pathologist, you know, cannot directly impact the decisions that are made by the gastroenterologist or the physicians, you know, directly treating the patients.

But having this information in the report is critically important because the, you know, criteria for followup and potential interventions to treat the patient are based on the specifics of the dysplasia, as described by the pathologist in the report.

So as I said, you know, we think this is very important to retain in the program and would encourage you to think likewise. So if there's any other questions or any other perspective I can provide, just please let me know.

Member Bland: I have a question. This is Joy from Aetna, and I did feel that there was a very good writeup to -- that you're referring to. My question is do you feel if it wasn't a -- do feel the measure's performing well because it's part of the program and the education and the work that's gone around coaching and training pathologists to capture this? And that if it wasn't part of the program, you would project that there would be a decrease in this identification? Just from a quality perspective.

Dr. Bocsi: Yeah, well, I mean I can tell you that if you look at pathology reports where, you know, there is upper endoscopy done with a concern for Barrett's, you will find descriptions of what the pathologist saw on that biopsy that range from very precise to confusing to other pathologists.

And so you know, that's part of the underlying intent of a measure like this is to provide guidance for pathologists, you know, how to -- how to crisply report their findings in a way that is meaningful and understandable to all gastroenterologists following the guidelines for followup.

And you know, of course it's impossible to predict if you remove the measure if adherence would, you know, recede. But I guess, you know, it's hard, because we don't actually see the distribution of the performance, we just have a mean performance score, which does make it look like it's, you know, quite good. But oftentimes there's a long tail.

And so you know, if you're in the tail, even though most patients are getting very high quality reports, if you're among those whose report doesn't have the information captured quite precisely, then it makes it more challenging, I mean, and potentially impossible to determine appropriate followup intervals and intervention without the pathologist, you know, specifying it precisely in the report.

Co-Chair Angove: So, Greg, I appreciate that. I just want to bring us back into focus and remind everybody that just due to the nature of our committee, what we're going to be reporting out on and time, which is really the most pressing piece, if we could limit all of our comments around health equity and kind of move away from more of the performance-focused aspects.

I know they're really, really important, we're just not going to have time to get through everything today. And more likely our committee is not going to be asked to comment on those pieces anyway.

So if we could just stay focused on equity and the impacts to equity, I'd be much appreciated.

And again, I've scared people into silence, hands went down.

Dan, I see your hand up. Give you the floor.

Dr. Green: Well, since you said you scared me, then I felt to make a comment. Just real quick, I want to echo what Greg said. I mean, just remind folks about the program briefly.

Pathologists have a very limited number of measures, and there are a bunch of different kinds of pathologists. There's lab pathologists, there's clinical pathologists that are looking at tissue and what have you.

And you know, for better or for worse, the way the program is constructed, again, if they don't have enough measures to report on, it really does unfortunately affect them in a negative way potentially.

The other thing I would like to mention and remind folks is just because the performance rate is high, it doesn't mean all the docs that could be reporting it are necessarily reporting it.

I agree with the statement by a few folks that in terms of the equity, I'm not sure. I mean, you know, when you're looking at a glass slide, I'm not sure that health disparities really necessarily plays a role. Followup, yes, but not actually interpreting a slide. So I'm not sure it really is in the purview for the committee to hear if we're focusing solely on equity. Thank you.

Co-Chair Angove: Thanks, Dan. Beth, I'm going to go to you next.

Member Godsey: Yeah, I think it's certainly, the comments made, I think it would be helpful to have from an equity perspective given, even though it's

topped out, it's hard to determine whether it should be removed when we're not stratifying this measure.

I would hate for us to remove a measure when we're seeing -- when there's potentially hidden aspects, whether we shine some light related to inequities. So, want to make that comment.

Co-Chair Angove: Thanks, Beth. All right, I want to just give an opportunity for those on the phone calling in to unmute and share any thoughts that they have on the impact to equity that this measure would have.

Ms. Gomez: Hi, this is Lisa Marie Gomez with CMS, I just want to just highlight one element that Dr. Green just noted. So in the program with MIPS, as he indicated, there's a limited number of these types of measures for the specialty. Right now we have a total of six measure. If this measure was removed, there'd be a total a five.

And under our program, we do require a reporting of at least a minimum of six measures. In the event that there are less measures, they're put in all measures. But again, as Dr. Green noted, there are different types of specialties under pathologist, and if let's say a measure is removed, it may impact their ability to report or have their performance assessed.

Co-Chair Angove: Great, thank you. All right, let's move on to the next -- the next measure, and again, I do appreciate the conversation around performance. We're not going to have much influence in that space at the larger meeting, and so let's keep our comments laser-focused on equity, because those are the insights that we're expected to bring to the larger group.

So thank you, everybody. We can move to the next slide.

02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Ms. Lynch: Okay, the next measure is 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery.

This measure assesses patients age 18 years and old who had surgery for primary rhegmatogenous retinal detachment and received an improvement in their visual acuity from their perioptic level 90 days of surgery in the operative eye. This measure is not endorsed and was selected by three MAPS members.

And Melony, if you're still on, you're our lead discussant.

Member Sorbero: Yeah, so I think as noted here, the main concern with the measure was the low volume. And because -- because it's a low incidence event. And because of that it's going to be really hard for there to be any kind of assessment of equity issues specific to this measure. Because in all likelihood, providers aren't going to have enough patients in any different subgroups to be able to report subgroups separately.

Though I do want to acknowledge that Flora noted earlier that outcomes for certain groups do tend to be worse following retinal detachments. So I think from an equity perspective, that kind of summarizes the key issues.

Co-Chair Angove: I appreciate those comments. And we only one lead discussant for this measures, so we can open up the floor to any clarifying questions or comments. And while we wait for hands to come up, maybe I will open up a space for those on the phone or dialing in to unmute themselves and share.

All right, I'm not hearing any voices, and I don't see any hands. Susannah shared in the chat that she agrees with the equity aspect being important for this measure, so I appreciate the utilization of the chat. And seeing no last-minute hands raised, let's -- let's move to our next measure.

00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Ms. Lynch: Our next measure is 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.

This measure assesses the percentage of patients age 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with the documented communication to the physician who manages the ongoing care with the patient diabetes mellitus regarding the findings of the macular or fundus exam at least once within the 12 months.

Endorsement has been removed, and this was selected by three MAP members. I don't believe either lead discussant is on, so if we could go to the next slide.

The criteria the MAP members selected when selecting this measure were performance or improvement of the measure does not result in better patient outcomes, the measure is not endorsed or lost endorsement, and the measure leads to a high level of reporting burden for reporting entities.

Additional survey feedback was that this measure is information exchange, not necessarily care coordination, and the primary care clinician or endocrinologist may not be able to influence this outcome from a patient vision standpoint.

And also noted it has to be performed by a

specialist and should be covered under the specialty referral communication measure and requires significant efforts to track down the records and meet this requirement. A high burden and a high cost. Strong performance could indicate better resource organization rather than a higher standard of care.

Co-Chair Angove: All right, I think we can pass it over to our first discussant from the Patient Safety Action Network for this one.

And I don't have names, only organizations, so if you are on and if you are talking, you may be muted. All right, let's go to our discussant two, Emily Alemda-Lopez. Are you available?

Ms. Lynch: I don't believe Emily was able to join us.

Co-Chair Angove: And I know we're running behind, so people might have reserved time and are not available. If we don't have discussants, do we want and/or need to open up for comment?

Ms. Lynch: We can open it up to comment. And of note, there is an electronic version of this one as well that is right after this. So we could have a general conversation in general about any concerns with diabetic retinopathy and health equity concerns there.

Co-Chair Angove: That sounds great, and those discussants are the same.

Ms. Lynch: They are.

Co-Chair Angove: Let's, yeah, let's do that. Let's open up any comments or clarifying questions for both this measure as well as 05796, the electronic version of this.

And while people are thinking about whether not they want to raise their hands, I'll open up the floor to those dialing in, calling in to come off mute and share any thoughts they may have.

Leonor, I see your hand up.

Member Fernandez: Thank you. I just was confused about how the -- how this is being documented. Is it primarily that EHRs are showing that it's accessible to the other one? Is it that the person documents that they sent it in their note? Is -- I just didn't understand how this is being proven that it occurred.

Ms. Gomez: So to just that question, I'm going to turn it over to Colleen -- to Colleen. Would you be able to address like exactly how documentation for this measure is -- perfect, okay, thanks.

Ms. Jeffrey: Yeah, not a problem. So within the measure's numerator, there is definition for communication and what must be included in order to meet that clinical quality action that's being looked for.

So the definition for communication is may include documentation in the medical record indicating that the findings of dilated macular or fundus were communicated, for example, verbally, by letter, with the clinician managing the patient's diabetic care, or a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

And then the findings need to include the level of severity of retinopathy and the presence or absence of macular edema.

So in order to be numerator compliant for this measure, all of that information would have to be included within the medical record for the patient to ensure that that communication is happening from the ophthalmologist to the physician managing that patient healthcare.

Member Fernandez: Thank you. I just feel like the comment that this is going to -- a strong

performance could indicate a better resourced organization in the bottom comment rings true, that it may be measuring more information systems than measuring what is truly happening.

Co-Chair Angove: Thanks, I'm going to go to Mahil.

Member Senathirajah: Yeah, I am just speaking in terms of the value of the measure to understanding inequities. I think this would be very valuable, both because of the substantially higher prevalence of diabetes amongst the African American and Hispanic populations and known disparities in the diabetes quality measures in general.

Co-Chair Angove: And Mahil, before Dan dropped off, he shared similar sentiments in that chat about the diabetes measure being very important from an equity standpoint, so I appreciate those comments.

Member Senathirajah: Great.

Co-Chair Angove: I do not see any other hands. A couple agreements in the chat, so I appreciate that there's some consensus around the importance of these diabetes measures.

I am going to move us to our next measure in the interest of time. And remember, we're skipping the next one, which is actually the electronic version of this one, so we'll go two ahead.

Ms. Lynch: Although I do think for the record, Rebekah, I should have read that, so let me read it really quickly and then we can agree to move that on.

Co-Chair Angove: Got it.

05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Ms. Lynch: So, sorry about that. So this is Measure 05796-E-MIPS: Diabetic Retinonpathy:

Communication with the Physician Managing Ongoing Diabetes Care eCQM.

Again, this is the percentage of patients age 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with the diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Endorsement has been removed and it was selected by three MAP members. But we will forward the same comment that we just had, so we can go ahead to the next measure.

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

Which is Measure 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report eCQM.

This measure assesses the percentage of patients with referrals regardless of age who forward the referring provider receives a report from the provider to whom the patient was referred. This measure is not endorsed and was selected by three MAP members.

And I believe our lead discussants are the American Nurses Association and Beth Israel Lahey Health.

Member Waite: Yes, this is Roberta from the American Nursing Association. So we can see that this measure as far as concerns, it leads to high level of reporting burden, it doesn't contribute to the overall goals and objectives of the program. It's not endorsed by a consensus-based entity. And performance on the measure does not result in better patient outcomes.

Extra feedback identified that it was redundant from 02527-C-MIPS, which I'm not clear on what that --

what it is, so maybe we could have insight. But also, it penalizes those not in systems of care and benefits those who are in systems in care for reporting.

As I reflected and continued to look at, you know, other data, I definitely see that coordination, I believe that coordination really helps with communication between providers. But when I look at it from an equity standpoint, I can't say that there's anything outstanding from an endorsement standpoint, even though it's important to have the communication.

A big gap for me was this specific one doesn't outline sort of a timeframe or an interval for when those referrals of that loop have to be closed. I think that has significant implications. But I do leave it open. So I want to -- as it relates to this one is not one that I strongly endorse. But we can hear from our next reviewer as well.

Co-Chair Angove: And the next reviewer is -- all right, here, beautiful.

Member Fernandez: Oh, I'm sorry, thank you, Rebekah. Yeah, I want to point out Mark's very helpful comments, and basically about the validity of these data. Because I think we're all in agreement or we may be in agreement that closing the loop -- that coordinating care is incredibly important, and particularly important with populations have less access to healthcare, etc., etc.

So however, it's not totally clear this is more a validity and reliability of the measure issue. It's not clear that it is going to capture coordination of care as much as information systems and availability of the information in certain systems compared to others.

Co-Chair Angove: Thank you. And Leonor, I have on my list that Beth Israel Lahey Health was supposed

to comment. Are you affiliated? I just want to make sure that we're not skipping any of our lead discussants.

Member Fernandez: Yeah, I am from Beth Israel Lahey Health.

Co-Chair Angove: Beautiful. Okay, I assumed, but like I said, I only have organizations and not names, so. All right, well, thank you to both of our lead discussants.

I'm going to open up the floor to those that are on calls or dialing in. Please come off mute if you have any thoughts, questions, or comments while the others in the room have a minute to get their hand up.

Ms. Gomez: And if it's possible, I know that Leonor's question in terms of just that dynamic, Colleen, are you able to address her question or at least the uncertainty about like is it -- how --what this measure is like measuring, like the validity of that? Because I think that would address some of the comments that we're seeing in the chat, at least in terms of that dynamic.

Ms. Jeffrey: Yeah, so with this measure -- and I should note that this measure is also available from multiple collection sites, so it's not only within this as an eCQM, but it is also available as a MIPS CQM.

So different clinicians have the choice to choose the different collection types that fit best within their practice. This measure is looking at, it's attributable to the physician who is referring the patient. So it's just making sure that there is that full feedback loop as opposed to just ensuring that a specialist report was sent.

The referring clinician needs to ensure that they have received the specialty report from the -- from the specialist. So it would be part of their process to be held accountable if they don't receive that

specialist report. And that's why this measure is different than a lot of the other care and communication measures, as it's ensuring that that full feedback loop is completed.

So I'm not sure if that helps.

Co-Chair Angove: No, thanks for that clarification. And let's go to Susannah, who has her hand up.

Member Bernheim: I just want to take one second to pick up on Mark's comment in the chat and apply it to this measure, because I think it's a valuable distinction and helps me think about where I am on equity on this measure.

So if I am understanding correctly, you know, the point Mark's making is that if systems with more resources, because of those resources, are able to provide better care, then that reflects a true difference in the care patients are receiving in two different systems.

And that would be an equity concern that might promote the use of that measure, because there's an inequity in patients who are going and the quality of care for patients who are going to the lower resource systems.

If systems that have more resources do better on a measure because their EHR makes it easier to check a box, but you know, the box would have been checked had it been available in another system, then you're not really noticing a quality difference, you're noticing a documentation difference and the equity concern is a little bit different.

So first let me just pause and make sure, Mark, I'm roughly kind of reiterating --

Member Friedberg: Yeah, you said it better than I did, that was great.

Member Bernheim: I think you said it better. But so then in this care, it feels to me, as opposed to the

one that was about really ensuring that there was communication, this feels to me, and see if you agree, like the problem might be just that it's not as easy to like check the box. And it might not really reflect whether or not the loop is being closed.

And so I -- my summation is that I feel less like there's a real equity focus for this measure, that those differences may be not as reflective of differences in quality. And so I feel less strongly about what happens with this measure from an equity lens.

Ms. Jeffrey: Just, and I know this isn't definitive or anything -- sorry, this is Colleen from PIMMS. Just kind of to give a frame of reference as we do create different performance benchmarks for the different collection types.

I will say that the eCQM which would be using that EHR system has a lower, has a much lower performance rate than does the MIPS CQM, which is, you know, all payer data that can be collected in any manner that the clinician would like to do.

So for instance, the historical benchmark for 2022 for the MIPS CQM is 81.25%, whereas for the eCQM where you might think it's easier just to check a box, the performance rate is only 34.98%.

Co-Chair Angove: Beth, I see your hand up, why don't you jump in.

Member Godsey: Sorry, I thought I was stuck on. Anyway, I want to make a comment related to the referral and the specialist, referring to the specialist. I think we're talking a lot about the mechanics and the wiring in organizations that might have resources or don't have resources to do that.

But I think if you were stratify this by race, you're going to see that there's going to be a lot of White patients in this group, and you're not going to see a lot of Black patients or people of color in this group.

And I think that in and of itself should be highlighted in some form or fashion, whether it be in this measure or not, that there's been known inequities related to referrals from primary care specialists in ongoing communications throughout the care continuum, and I think that that should be highlighted.

Co-Chair Angove: Thanks, Beth. I don't seen any more hands up. I'm stalling just a moment to see in anybody wants to come off mute and share. But I feel like we've had a robust conversation about this, and so let's -- let's move to the next one.

05837-E-MIPS: Children Who Have Dental Decay or Cavities

Ms. Lynch: Next slide, please. So our final measure for the MIPS program is Measure 05837-E-MIPS: Children Who Have Dental Decay or Cavities eCQM.

This is a measure that assesses the percentage of children six months to 20 years of age at the start of the measurement period who have tooth decay or cavities during the measurement period. The measure is not endorsed and it was selected by three MAP members.

Apologies, let me look back at our notes. Our lead discussants are Susannah and IBM Watson Health if they're still on.

Member Bernheim: Hi, this is Susannah, I'm here, I will try to be brief.

I think this measure is -- you heard what it is, it has to do with presence of tooth decay or cavities. And some of the concerns about it had to do with who was being measured. When I dug in, I'm pretty sure that the measure is of the primary care physician.

And there's not a tremendous amount that primary care physicians can do, but there are things we can do to educate patients, to ensure they're getting

fluoride, to ensure people know about the dangers of certain kinds of food and beverages to ensure families -- kids, with young kids are getting their teeth brushed.

And there's a huge equity issue here. Oral health care is a big area of inequity, and it starts in childhood and has lifetime effects. So I would argue from an equity lens that this remains a really important measure and that there's enough evidence that primary care physicians can probably influence it that it's a reasonable measure to retain.

Co-Chair Angove: Appreciate that. Is our discussant from IBM Watson Health available?

Member Dankwa-Mullan: Yes, I'm here. This is Irene Dankwa-Mullen. And I'm so glad you said that, Susannah.

So I'm also will be quick here, and I don't even have anything to add. That's exactly what I was going to say. I think this is a really high priority measure for the primary care, primary dental community as well.

What I was also going to suggest was that, you know, perhaps because -- I would also like to see this measure stay. And maybe also add that, you know, because percentage of children -- the first part is, you know, six months to 20 years of age at the start of the measurement period who have had tooth decay during the measurement period and receive a followup care.

I think maybe that's where there was concern that there was not action and it was just looking at prevalence. But I do understand that they are recommended measures by the Dental Quality Alliance that looks at, you know, actionable. So receiving -- receiving comprehensive or periodic evaluation.

But I do -- I do think that this needs to stay. It

drives fundamental value movement toward value healthcare. We talk about holistic healthcare, and oral healthcare is very much a part of it, just like mental health, physical health, social health. So I wouldn't go too much into it, but I thought this was an important measure to retain.

Co-Chair Angove: Thanks, Irene. Beth, I see your hand up, we'll start with you.

Member Godsey: Just a quick comment. I think that overall this is, this measure is an important measure.

I think a couple things to be thinking about, and part of our discussion that we had internally related to this measure is that does it disincentivize -- or dentists to take care of patients who are from communities where all they have is -- or lack of food availability to them or where they can actually get health opportunities for teeth and care and overall health.

We want to be able -- I think what we want to hope for is that, one, that dentists are -- can and should be incentivized to help support these patients. But the other aspect is that I think this is an example of a measure where there are many upstream components that impact this from a community perspective and a structural and equity perspective that need to be considered.

But just wanted to make those couple comments.

Co-Chair Angove: I don't see any other hands. Is there anybody on the phone dialing in?

Member John: I actually have a question, I'm sorry, Rebekah.

Co-Chair Angove: Yeah.

Member John: Yeah, just to follow up on Beth's question. I'm sorry, are people -- are organizations penalized if they have a high degree of -- of children

that do have tooth decay or cavities?

Co-Chair Angove: Can somebody come on and clarify? Lisa shared in that chat that this measure applies to dental professionals only. Does anybody know about the cost, the payment implication?

Ms. Gomez: Is that Malcolm's question?

Member John: Yeah --

Ms. Gomez: Sorry --

Member John: That's Malcolm's question because I do agree that it's important to, you know, shed a light on this and for practitioners to know how they are doing and how they can care and take action as needed, whether it's reflective of their patient population for the reasons Beth outlined, or whether it reflects perhaps not effective interventions on their part.

But to account for some of the concerns that were raised, I was curious about the consequences for payment.

Ms. Gomez: Okay, so performance. So let me just make sure I understand. So you're saying that let's say for example that if a dentist has a higher population where their patients have cavities, are they going to penalized as a result of that. Is that --

Member John: Correct.

Ms. Gomez: What I'm understanding? Okay, so Colleen, are you able to discuss like the risk adjustment of the measure, and the elements to that? Because I know our measures are not structured in a way to where it would it say there is a clinician population that would have a higher percentage of patients with a certain -- with a condition, that they would -- they wouldn't be adversely affected by that.

So Colleen, I don't know if you're able to address

this dynamic with risk adjustment and other things for this measure.

Ms. Jeffrey: So this measure is an inverse outcome measure, so it would be looking at the percentage of patients with cavities or dental -- dental decay. So a lower score or a lower percentage is better for this measure.

And that performance rate would be placed within the deciles that are made with a historic benchmark and a clinician's payment adjustment. That would be one of the measures that would be looked at for a clinician's payment adjustment within MIPS.

Member John: And would they -- and is it adjusted, you know, for patient population?

Ms. Jeffrey: I don't not believe this -- no, this one does not have any risk adjustment variables. But we could definitely confirm that with the developers of the actual eCQM project.

Member John: Yeah, I mean, I think for a lot of these metrics that have a large contribution of social determinants of health, it seems like it will be, particularly if there's payment consequences that would benefit from adjusting according to patient population, for a period of time anyway.

At some point we have to hold people accountable to moving the dial, even if you have a complex or traditionally disadvantaged community population where social determinants are impacting their health beyond your control or affecting their health predominantly and you have to do more to intervene.

But that may be something for us to talk about at the end as we think about processes and future ways we can contribute. Anyway, just a thought.

Member Dankwa-Mullan: Yeah, I just wanted to say good point, Malcolm, about thinking of broader risk

adjustment. Because for, you know, this is a similar for all disease or conditions with similar large disparities and limited resources.

And you know, I think -- thinking about a risk adjustment is good, and but probably by ignoring and not including this, it may not also be the right thing to do for health equity.

Member John: Correct, because paradoxically those -- those organizations may actually need the resources to serve the community.

Member Dankwa-Mullan: Yeah.

Member John: And they're going to be penalized. And at some point, you do want to hold them accountable to moving the dial, but --

Member Dankwa-Mullan: Yeah.

Member John: You know, initially you want to shed a light and support.

Member Dankwa-Mullan: Yeah, thanks.

Member Godsey: Yeah, this is -- this is Beth, that is my comment related to how it -- although it doesn't say anything around 30-day readmissions or it has that same component of it as far as upstream social and community components to be thinking about that have an influence.

And so while it's certainly an important measure, having it -- having the responsibility solely on the way of the provider seems to be a bit far-reaching.

Co-Chair Angove: Susannah, I see your hand is up.

Member Bernheim: Yeah, no, I just, I'm responding to Lisa's note that this applies to dental professionals only. And I clearly, when I presented it, had misunderstood that. I thought I had read that it was a primary care provider, which had surprised me but then intrigued me.

So I think these concerns about choices that providers have about what patients they care for and the risk of incentives to not care for populations that are at high risk are real concerns.

I wouldn't want to see this measure disappear in reaction to that. But these issues around -- I think it is important to think about the broader provider community and incentives for caring for a representative population so that you don't create disincentives in this program.

Co-Chair Angove: Great, and I do not see any other hands up. This has been a really great conversation. So I think we should close this measure, as well as the entire measures section that we've been discussing. So I'll hand it back over to my colleagues to take us to the next section in our agenda.

Ms. Lynch: I'm actually happy to say we're going to take a quick, five-minute break. We've been going for quite a while, so just a quick break, five minutes. We'll come back at 4:20, and then we'll provide an update on kind of the plan for the rest of the meeting as well.

So see you at 4:20 Eastern time.

(Whereupon, the above-entitled matter went off the record at 4:15 p.m. and resumed at 4:22 p.m.)

Ms. Williams-Bader: Hi, everyone. We'll go ahead and get started, but I wanted to see if Laurie is on?

Co-Chair Zephyrin: Yes. Hi, everyone.

Ms. Williams-Bader: Okay, great. Thanks, Laurie. So, in these last couple of hours, we are going to reorganize just a little bit and we really appreciate everyone's flexibility here.

We are going to start talking about the Home Health Quality Reporting Program. We will be grouping the first three measures together, so we'll have a

discussion about all three of those, and we will run through the measure descriptions, then have our lead discussants speak, and then we'll do a discussion of all three.

And then we'll also try to get to the discharge to community measure and the application of percent of residents experiencing one or more falls, but at 5:10, we would like to break for public comment, so we'll stop where we are and do public comment.

And then because I think one thing we've really realized today is that as this is a new process, it's going to be really important for us to get your feedback on how the process has gone, so after public comment, we ask you to please stay if you can to talk to us about how this process has gone and any suggestions you have for the future, and then we will end the meeting.

Before the end of the meeting, we will send out an email with a survey for you to provide feedback on any measures we did not get through today. So, any questions about that? Okay, great, then Chelsea, I'll turn it back to you.

Ms. Lynch: Wonderful, thank you. So, I'll be talking about the post-acute care/long-term care programs. Next slide?

So, we'll be, as Jenna said, focusing on the home health --

(Audio interference.)

Ms. Lynch: Okay, sorry about that, the Home Health Quality Reporting Program. Please note that the Hospice Quality Reporting Program was also included on this year's measures at review. However, none of the measures in this group received enough votes from the survey for us to include them in the review meeting, so again, we're just focusing on the home health. So, next slide? And next slide?

So, an overview of the Home Health Quality Reporting Program, this is a pay for performing program.

The incentive structure is the Section 484.225(i)of Part 42 of the Code of Federal Regulations provides that HHAs that meet the quality data reporting requirements are eligible to receive the full home health market basket percentage increase.

HHAs that do not meet the reporting requirements are subject to a two percent percentage point reduction to the HH market basket increase.

The program goals are to align with the mission of the National Academy of Medicine which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness. Next slide?

So, we will pause for an opportunity for public comments on all of the measures that are in the Home Health Quality Reporting Program, so I'll turn it over to you, Laurie, to do that.

We won't be talking about all of them, but we do offer that opportunity for members of the public before we get into the advisory group discussion on each of the individual measures.

Opportunity for Public Comment

Co-Chair Zephyrin: Fantastic, thank you, Chelsea. Again, we're opening it up for public comment for members of the public. We'll have our discussion with the advisory group members afterwards. Any questions, comments, thoughts on any of the measures from the public? Anyone on the phone?

(Pause.)

Co-Chair Zephyrin: Okay, I don't see any hands raised or comments in the chat or hear anyone on the phone, so why don't we move along? I'll hand it back to Chelsea to go through the measures.

Ms. Lynch: Thanks, Laurie. Like Jenna said, I'll be reading through these three measures consecutively and then we will follow back up with the lead discussants. So, all of these are functional improvements, so we thought it made sense to talk about them together.

00185-C-HHQR: Improvement in Bathing

So, the first measure is 00185-C-HHQR: Improvement in Bathing. This measure assesses the percentage of home health quality episodes of care during which the patient got better at bathing self. This measure is endorsed and was selected by five MAP members. Next slide?

00187-C-HHQR: Improvement in Dyspnea

The next measure is 00187-C-HHQR: Improvement in Dyspnea. This measure assesses the percentage of home health episodes of care during which the patient became less short of breath or dyspneic. Endorsement has been removed and this measure was selected by six MAP members. Next slide? And one more?

00189-C-HHQR: Improvement in Management of Oral Medications

And the next measure for this discussion is measure 00189-C-HHQR: Improvement in Management of Oral Medications. It assesses the percentage of home health episodes of care during which the patient improved in ability to take their own medicines correctly by mouth. This measure is endorsed and was selected by four MAP members.

Our discussants for these two measures are going to be Beth Israel Lahey Health and Mark Friedberg. I believe Fenway had to step away and we didn't have a lead discussant for the last one. So, maybe Mark --

(Simultaneous speaking.)

Co-Chair Zephyrin: Are our lead discussants on? Maybe they're on mute? Oh, wait, I see Mark.

Member Friedberg: I thought I was doing the next one.

Ms. Lynch: We're going to talk about them together, so --

Member Friedberg: Okay, yeah, I can talk about dyspnea, so --

Co-Chair Zephyrin: Great, thank you.

Member Friedberg: Yeah, no specific equity, you know, data in the documents that were shared with this group, so, and there's no basis to believe one way or another that this is going to be affected by equity. I think the validity concerns with the measure are sort of separate from today's discussion. Thanks.

Co-Chair Zephyrin: Great, thank you, Mark. And Chelsea, you mentioned our other lead discussants had to drop out?

Ms. Lynch: Just for the dyspnea measure. Beth Israel Lahey is the lead discussant for the improvement in bathing, but we did not have a lead discussant for the management of oral medications.

Member Fernandez: Should I go ahead? I'm sorry.

Co-Chair Zephyrin: Yes.

Member Fernandez: Okay.

Co-Chair Zephyrin: Please.

Member Fernandez: Thank you. So, the improvement in bathing, ability to bath is part of the OASIS measures, I believe, and discussing this with home care, I sit in primary care and hospital medicine, so I had less personal familiarity, it is well

assessed or more reliably assessed when it's done by PT. There's a little bit more variability when done by other clinicians.

The reason I raise that is because there is some discretionary aspect to whether, how someone assesses whether the patient has improved in their ability to bathe during the episode of home care.

That discretion and the fact that when there are patients with whom communication is impaired due to language or other barriers, I would imagine leads to uneven ways that this measure gets reported, and so I wonder about some of its validity.

Clearly, the disability portion of intersection of social determinants of health and disability is an important one, so seeing an improvement occurring in those rates would be an important equity dimension.

How well this measure captures that and how much agency home care has in improving those will vary. So, I'll stop there.

Co-Chair Zephyrin: Thank you. Why don't we open it up for questions and conversation from the group? Any clarifying questions or just general discussion? Beth?

Member Godsey: Yeah, one comment I'd make about this is related to equity and overall inequities is looking again at the stratification of these measures by race.

I think you're going to see fewer folks get referred for home health in general who live in communities that have been historically marginalized or groups that have had cultural differences compared to their providers.

And so, while I think the measure is certainly important, I think it's the absence of what we're looking at that is going to highlight some disparities, so I just wanted to call that out and make a

comment related to that.

Co-Chair Zephyrin: Thank you for bringing that up. Any additional thoughts or comments? Does anyone want to react to that?

Member Bernheim: I have a similar thought as that, but I'm just trying to think what it means for use of these measures overall.

Co-Chair Zephyrin: Can you expand on that a little bit?

Member Bernheim: Just that there's more of a sort of programmatic access problem. You know, I'm not sure how to think about that in the context of individual sort of kind of narrow measures within a program because you may just have a limited population that it applies to.

So, I guess if I was giving advice to the post-acute committee, I wouldn't necessarily flag it as an equity concern for this measure, but more for the program.

Mr. Edwards: This is Alrick Edwards from Abt, one of the measure developers for the home health measures.

I just want to note that we are certainly aware of some of the access issues in general and are looking at measures that more broadly address these issues of both access and appropriate plans in place for HHAs to address social determinants of health issues in home health.

So, I just wanted to note that we are aware of these issues and are looking at measures to address those concerns.

Co-Chair Zephyrin: Thank you.

Mr. Edwards: The only other thing I would note is with these measures that are critically important for home care in the sense that together as a whole,

these measures have been useful in a sense tracking outcomes for those who are in the program, and it's quite large.

Home care is -- we have more than probably 11,000 home health providers, well over 12 million episodes in a given year, so we're dealing with a very large program that cuts across swaths of the national population and every group affected.

So, do we have some access issues? Yes. Do we need these measures to be able to address and properly ensure that HHAs are providing care equitably across the populations? Absolutely.

And we actually do monitor and track the results by indicators of social determinants of health as much as we have them, so regularly, every quarter, we actually are looking at these indicators by race, urban/rural status --

(Audio interference.)

Mr. Edwards: -- lots of different indicators that are actually more available on assessment tools than they are in some other scenarios.

Co-Chair Zephyrin: Thank you for providing that further comment, appreciate that. Any other comments or thoughts from others on the bathing, the dyspnea, and the management of oral medication?

It seems like some important conversation went around, at least for the dyspnea measure, not necessarily specific equity implication regarding these, but also the access issues that essentially potentially limit access to this, and so the numbers are small and also make the equity evaluation issues challenging as well. Any other thoughts?

Member Fernandez: I was just going to add that it feels -- I know we're not here to propose different ones, but it feels like understanding what

percentage of the patients have difficulty bathing is a very important part of the piece of the equity dimensions of this piece.

And then the improvement is -- we want to incentivize that, but the improvement may capture a different angle on equity than the very important how many have difficulty with bathing to begin with.

Co-Chair Zephyrin: Thank you. Thank you for raising that, Leonor. Any other comments before we move onto the next set of measures? Okay, just checking to make sure no one has their hands up. And, okay, Chelsea, should we transition to the next set?

02944-C-HHQR: Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

Ms. Lynch: Yes, that sounds great. So, we are going to move forward just a little bit on the agenda and go to, I think it's slide 106. Perfect.

So, this is measure 02944-C-HHQR: Discharge to Community - Post-acute Care Home Health Quality Reporting Program. This measure assesses successful discharge to the community from HHA, with successful discharge to the community including no unplanned hospitalizations and no death within the 30 days following discharge.

It assesses a HHA's risk-standardized rate of Medicare fee-for-service patients who are discharged to the community following a home health episode, and do not have an unplanned admission to an acute care hospital or long-term care facility in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community.

Community, for this measure, is defined as

home/self-care without HH services, based on Patient Discharge Status Codes 01 and 81 of the Medicare FFS claims.

Endorsement status is this is endorsed and four MAP members did select this, and yes, this was intentional. We will be circling back to those measures as we have time, so sorry for any confusion there.

I do want to acknowledge that this measure is required by statute, and our lead discussants are Melony and Edna.

Member Sorbero: So, I just wanted to note for this one that there's -- many concerns were raised for this measure, but some of them were inconsistent with the actual information on the measure that we were presented.

So, it's unclear to me whether, the extent to whether even the concerns around equity were really meant for this measure or meant for something else given the inconsistency in some of the other concerns raised.

But I do think with any of these measures that are focused on either, like, discharge to the community or readmission to a hospital or a nursing home, that the resources available in the community are probably going to be very important in terms of whether you're able to have folks stay at home once they finish home health care.

And so, I do think that there's a potential for equity concerns with rural communities and how that could affect rural providers that is completely outside the control of the providers.

And beyond that, I think there are likely equity concerns related to ensuring that people are put in touch with the resources they're going to need to be maintained in their home, and so I think there are kind of potentially competing equity issues related

to this particular measure.

Co-Chair Zephyrin: Thank you. Our next discussant?

Member Bland: This is Joy from Aetna. I agree there is health equity possibilities here, I think, with rural communities, and from a health plan perspective, we're also noticing that not even in rural areas, we even have identified health equity concerns in the community by zip code and demographics in many different states.

My assumption, this would be, from what I read, that this would be something the health plans would be tracking similar to follow-up after hospitalization is how I read this.

I don't know if I'm completely, if we're completely correct on that assumption, but I did see possibilities of inequities getting the resources people need, and find value and found the equities from a health plan perspective.

Co-Chair Zephyrin: Thank you. Thank you for both of those perspectives. Opening it up to the group of advisors, any comments or additional clarifying questions? Any equity implications or unintended consequences or what was sent previously?

Okay, why don't -- I don't see any comments or anyone raising their hand. I think maybe you're all talked out. If you have any additional comments, you know, let your fingers do the talking in the chat. Chelsea, I'll turn it back to you.

03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Ms. Lynch: Sounds good. So, the next measure is 03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury, Long Stay.

This measure assesses the percentage of quality

episodes in which the patient experiences one or more falls with major injury defined as bone fractures, joint dislocations, and closed-head injuries with altered consciousness, or subdural hematoma during the home health episode.

This measure is not endorsed and was selected by five MAP members. Our lead discussants are Jason Suh and the American Medical Association.

Member Suh: So, I was all over the place on this one, which is who to say it belongs to? The PCP is often involved. You know, patients on home care, the home care, you know, agency, the patients are going to McDonald's with their family in a wheelchair.

So, A, there is a quality component, which we should be prescribing less medications that would cause falls. We should make sure that they get PT and OT, et cetera, but to measure falls in a patient who is primary at home and attended to by multiple different people, I just found that very difficult to kind of marry those two ends.

And then from an equity point of view, I think there's equity issues on patients getting home health, but once they have home health, falling within it, I'm not so sure that's an equity issue, so those are my comments.

Ms. Lynch: And my apologies. I just wanted to also share that I forgot to mention that this measure is also required by statute.

Member Suh: Thank you.

Co-Chair Zephyrin: Great, thank you, Jason, and who was --

Member Bossley: I think it's me, then Laurie.

Co-Chair Zephyrin: Okay, great, go for it.

Member Bossley: Okay, yeah, I mean, this one, if I

remember how this is captured, it captures if a fall happens at home, but it would be good probably to have that clarified.

I mean, most of the falls, as far as I'm aware, occur in the home, so this really is going to capture that piece of this in a way that we won't get it if it's looking at in the hospital, et cetera.

And I tried to look around for any data to show disparities just because the rates are so low when I look at what was provided in general, so it's hard to tell if there's true differences based on race or geographic location, et cetera.

So, I feel like there is. I think this is one that can really get at some inequities in the fact that if an individual is living at home alone and he doesn't have social supports, those pieces, but -- I'm sorry. I just saw Jason's comment. It is falls at home. Thank you.

So, to me, I think it is, but I'd love to see what others think as well. I do think this has a definite ability to look at some inequities in care potentially or distinguish them at least, identify them.

Co-Chair Zephyrin: Great, thank you. Thank you for those comments.

Member Suh: Specific definition, it's falls at home and it's also self-reported. It's not -- I think. That's what I read.

Member Bossley: Yeah, I think you're right. Yeah, I think so.

Mr. Edwards: That's correct.

Co-Chair Zephyrin: And so, okay, great, thank you. And I guess we had discussed earlier some of the challenges around patient-reported measures.

Any other thoughts around equity, around equity implications, concerns around disparities? I think

everyone's just done for the day. Okay, if you have any additional thoughts or comments, please enter them in the chat. Why don't we just, for the sake of time, let's move onto the next one.

05853-C-HHQR: Application of Percent of

Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

Ms. Lynch: Sound great, and we can go to the slide. So, this is measure 05853-C-HHQR: Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.

This measure is the percentage of home health quality episodes in which patient mobility and self-care functional status was documented and at least one discharge goal was recorded.

This measure is not endorsed and it was selected by four MAP members. Our lead discussants and Fenway Health and NCQA, and I know Fenway had to step away, but they might be back.

Co-Chair Zephyrin: Great, thank you. Why don't we open it up for our lead discussants? If you're on mute, you may need to unmute.

Member Shih: Did you want NCQA to go or -- I was waiting to see if Fenway was --

Co-Chair Zephyrin: Please, go. You can go, NCQA. Please go, NCQA. I think Fenway might have stepped off of the call for a few minutes. Why don't we get started, please? Thank you.

Member Shih: I'll admit this was a tough one to understand from an equity perspective. I was trying to look for a little bit more specification of how the information is collected.

Because again, if this is a self-report, Laurie, I think

you mentioned this on the last measure and my antenna always goes up when this are self-reported measures or require a patient-reported, you know, dependent on a patient report for the data source.

But briefly, I think what the measure is trying to capture is whether a functional assessment had taken place and it addresses whether the functional need was addressed if someone was discharged, or passed away, or like a series of events that took place during long-term care hospital.

So, it's a large measure, I think, from an equity perspective. Again, I always worry about who is missing from the report because you can't assess for disparities or inequities there.

The way it looks like it's reported, you don't have the strata or bifurcation to understand who might be left behind, and then I'm unclear of how it would impact the entity.

Because, again, it doesn't have any information in the report of how it's being reported and what type of entities can or can't report on a specific measure. So, that was the best I could do with the information provided.

Ms. Lynch: And my apologies for jumping in again. I also forgot to share that this measure is also required by statute. And you are on mute, Laurie.

Co-Chair Zephyrin: Thank you, Sarah, and thank you, Chelsea. I was just checking to see if our colleague from Fenway Health is back on the call. I don't see them, so why don't we just open it up to any conversations or questions around this measure or reaction to what Sarah was just talking about?

Okay, so no comments on this measure? Susannah, what happens -- is this relating to this? What happens -- oh, what happens if MAP recommends dropping a measure, but it is required by statute? I'll turn that over to the NQF team for a response to

that.

(Simultaneous speaking.)

Co-Chair Zephyrin: It's a note in the chat.

Ms. Lynch: Go for it, Jenna.

Ms. Williams-Bader: Yeah, I was actually just pausing to see if Michelle Schreiber was still on. Michelle, did you -- I see your name on here.

Dr. Schreiber: I'm here.

Ms. Williams-Bader: Did you want to speak to that? Okay.

Dr. Schreiber: Can you rephrase the question for me, please? And I'm happy to.

Co-Chair Zephyrin: Sure, there's a question from Susannah Bernheim around what happens if MAP recommends dropping a measure, but it is required by statute?

Dr. Schreiber: The reality is if it's required by statute, we don't have a choice. We can't drop it unless we get congressional up chain, literally an act of Congress. We would have to go through, you know, getting -- there is a process to do it, but getting permission from Congress to change the statutory legislation.

Now, that being said, I mean, if there really is a ground swell of saying this measure is something that we don't think is addressing an issue correctly, or importantly, or it should be something else, we all, including everybody on this call, have the ability to kind of lobby Congress in our various advocacy capacities to try to get it to change, but CMS does not have the authority to change a statutory regulation without specific congressional intervention.

Ms. Abdur-Rahman: And this is Ihsan. I'm the Home

Health Quality Reporting Program Measure lead. I do want to note that we are working on a more robust outcome function measure to replace this measure.

Mr. Edwards: So, you can replace a measure, but you can't get rid of it typically?

Dr. Schreiber: We can amend a measure. We can modernize a measure. We can probably, depending on how the statute is written, we can frequently, you know, update a measure. What we can't do if it's mandated is eliminate it.

And in some cases, I don't think that's the case here, but there are some, like in the ESRD program, that are very prescriptive, or the HRRP, the readmissions program, they are very prescriptive that we probably couldn't even change either.

Mr. Edwards: I just want to note is that in this area, we probably have the luxury of doing this measure domain of function instead of the specific measure, so there's some flexibility here.

Co-Chair Zephyrin: Thank you, and I think David has his hand raised? Is that David Machledt? Oh, was that you, David? Okay, great.

Member Machledt: I've had to switch platforms, so hopefully this --

Co-Chair Zephyrin: Okay.

Member Machledt: I don't have a specific thing about this measure. It obviously sounds like there's not much to do about it, so I don't know how much discussion is important, but I will say that in general when you think about equity, I think considering equity along the lines of disability is also really important.

And while this is Medicare and a lot of it is tied to rehab, there are generally a dearth of these measures, and one thing about this measure that I

noted, and it's very important for people who are working on HCBS measures, is that it notes a discharge goal, and that collection of information and person centered orientation around what outcomes are and what an individual actually wants for those outcomes is really important.

I don't know how much that applies to this measure because I'm not that familiar with the Medicare side of the home health things, but I did want to make that note, and also that when we're thinking about equity, we want to keep our equity definition broad and not just -- you know, we tend to focus on race and ethnicity language a lot, but there's other areas too.

Co-Chair Zephyrin: Absolutely, thank you. Any other comments from the group? Let me see if there's any hands I'm missing. Okay, and on the phone?

Ms. Lynch: There is another comment from Susannah in the chat. I think that would be --

Co-Chair Zephyrin: There is another comment? Oh, let me see here. Okay, thanks for the information from Susannah Bernheim. That is helpful. So, question for Matt. It may be slightly different in these cases in order to make recommendations. That will be useful for CMS.

Member Bernheim: Just I was trying to figure out what our goal can be that's functional and where the measure --

(Audio interference.)

Co-Chair Zephyrin: I don't know. Who is that talking? Oh, Susannah, you're breaking up a bit and we can't hear you.

Member Bernheim: Oh, sorry. All I was saying is I think in cases where there has to be a measure retained in the program, then, you know, David's

point, for instance, about how you might update it, since CMS is thinking about updating it anyway to be a stronger measure, is probably more useful feedback than just remove because CMS can't just remove.

Co-Chair Zephyrin: Great, thank you. Okay, thank you, and I'm not seeing any comments in the chat or hands raised. Thank you for this conversation. I'll turn it back to Chelsea.

00196-C-HHQR: Timely Initiation of Care

Ms. Lynch: Okay, I think we have ten minutes left. We can do one. We'll see if we can get through two just to limit the amount of work on the back end. So, we are going to be going back to measure 00196-C-HHQR: Timely Initiation of Care.

This measure is the percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date, if provided, otherwise was within two days of the referral date or inpatient discharge date, whichever is later.

Endorsement has been removed and this measure was selected by five MAP members, and let me just check my notes. Kentuckiana, if you are still on the line, I believe you are the discussant.

Member Clouser: Hey, yeah, so this is one that I don't know that I have too much to add from an equity standpoint. Now, someone did put some questions in the criteria and the survey feedback about being topped out or unintended consequences.

In our materials, there was a reference to some of that performance data, so the overall performance for this measure is 95.6, so about 96 percent, and if you look at some subgroups, overall, 96.6, Black, 94.8, and other race, 94.4, so, you know, similar numbers there.

I would like to hear any more thoughts on unintended negative consequences, but I don't know that I have much more to add beyond that.

Co-Chair Angove: Just to clarify, was this on Laurie's list of ones --

Co-Chair Zephyrin: I was just looking back. I think we circled back to the --

(Simultaneous speaking.)

Ms. Lynch: Yeah, we're still in the home health -- sorry about that.

Co-Chair Zephyrin: Yeah, we circled back to timely -- yeah, thank you.

Ms. Lynch: Yeah, sorry about that.

Co-Chair Zephyrin: No, that's okay. Excellent. Thank you for the discussion on this measure. Shall we open it up to any questions, comments, feedback, thoughts around equity implications?

Member Machledt: I mean, this is David. It does seem like the concept, timely initiation of care, is certainly something that has big equity implications and is really important for measuring quality and potential troubles in that transition.

So, but if it's 95 or 96 percent, it makes me wonder, you know, maybe the bar is set too low or maybe this isn't, like, capturing -- I mean, it seems like there's often issues with timeliness of care, so it makes me wonder what else is missing and it's hard to know just from a short discussion what that is.

Co-Chair Zephyrin: Right, right.

Dr. Hamilton: Hi, this is Morris Hamilton from Abt. I don't have a distribution by race or other characteristics. However, I can say that one of the aspects of the distribution that matters when we're looking at it is the low end of the distribution.

We agree that the measure is topped out at 97 percent or so, but if we look at the bottom tenth percentile, we find that ten percent of home health agencies are unable to initiate timely care about 17 percent of the time, and so that's an area of concern that we investigate.

Co-Chair Zephyrin: Thank you. Thanks, Morris, for that perspective. That's an excellent point. Stephanie also agrees that's a great point. Any other comments or thoughts? Great, thanks, Beth agreed. Why don't we -- let me see, no hands up or additional comments -- move onto the next one, Chelsea?

00212-C-HHQR: Influenza Immunization Received for Current Flu Season

Ms. Lynch: Wonderful, so we have three measures left, so we're going to try to push through. The next is measure 00212-C-HHQR: Influenza Immunization Received for Current Flu Season.

This measure assesses the percentage of home health quality episodes of care during which patients received influenza immunization for the current flu season. Endorsement status has been removed and six MAP members selected this measure, and our lead discussants are, I think we just have one for this, is the National Health Law Program, so David.

Member Machledt: Hi, everyone. Suddenly I'm talking a lot again, sorry. So, you know, this is the only -- there are no similar measures to this that are listed in HHQR.

The comments, again, some of them talked about being topped out and it has lost its NQF endorsement after it wasn't resubmitted for maintenance review in 2016.

If you look at the numbers, the shifting in flu vaccination rates between 2019 and 2021 were very limited. It stayed around 79 percent. I think it

increased by half a percent over that time.

But in the packet, they do provide some information about Black and other race categories that had lower rates, which I imagine over the whole population is significant. The Black rate was 73.9 percent and racial other was 74.6. So, you know, it looks like there's stagnation, but I don't know if that means that this is topped out.

And I will say that in light of the COVID epidemic and the issues that we've had with vaccinations, different access, I think that this is clearly an equity -- that there's clearly an equity focus to this measure, that there may be a lot of complications that have happened recently because people have had trouble accessing care, and so flu vaccinations --

I know some childhood vaccinations really went, like other vaccinations besides COVID went off. People missed their scheduled vaccinations. I could imagine that is also something that's been happening with flu.

So, I think that, you know, on the surface, it seems like this isn't a timely time to not be measuring vaccination rates, and there is a documented disparity there.

I think it's worth thinking about what the stagnation -- you know, why that's happening and ways to improve it, so that's something. And other folks may know more about this measure and its specifics than I do, but those are just my observations from the materials that we have.

Co-Chair Zephyrin: Excellent, thank you. Thank you so much. Any thoughts or reactions to this or any questions or comments around health equity, health equity implications or not?

Ms. Young: Melony has her hand raised.

Co-Chair Zephyrin: Okay, I can't see that. Melony, go right ahead.

Member Sorbero: Yeah, I just wanted to agree that there are definitely health equity issues related to this measure. Within Medicare Advantage, we consistently see over the years disparities on this one.

Co-Chair Zephyrin: Thank you, Melony, appreciate that. And Malcolm also agrees this has strong equity implications historically and should continue.

Anyone else that has any additional comments or questions, clarifying questions? Okay, Dr. Schreiber, okay, thank you. Thank you, Dr. Schreiber. All right, Chelsea, let's move onto the next set.

01000-C-HHQR: Improvement in Bed Transferring

Ms. Lynch: Okay, this is our penultimate one, so we're so close. The next measure is 01000-C-HHQR: Improvement in Bed Transferring.

This assesses the percentage of home health quality episodes of care during which the patient improved in the ability to get in and out of bed.

This measure is endorsed and was selected by five MAP members, and I do not believe our lead discussant was able to join, so I can quickly move onto the next slide, please, for that criteria.

So, quite a few criteria here around negative unintended consequences, including potential negative impacts to the rural population and possible contribution to health disparities, maybe some issues related to low volume or entity not having data, not reflecting current evidence, and performance or improvement not resulting in better patient outcomes and potentially being duplicative of other measures in the program.

Additional survey feedback was related to issues with skilled maintenance and examined the

pros/cons of targeted functional measures, composite measures rather than separate measures of functional outcomes, and then other person who liked this measure. So, I think we can just open it up, Laurie, since there is no lead discussant.

Co-Chair Zephyrin: Fantastic, thank you. Let's just open it up. Any thoughts or comments around equity, equity implications for this measure? I think a lot of what we discussed previously can apply. I don't know if anyone has any specific questions about this measure.

Member Machledt: This is maybe a very minor point and I don't know how applicable it is to this issue, but in general, I know that this is, in Medicare, it's more focused on a sort of rehab approach, but if you have a person with a disability who already, you know, can't transfer from the bed by themselves, them improvement is not the right standard. You know, it may be maintenance of current functionality and things like that.

And I'm not positive how that fits in with this particular measure, but I wonder about, you know, the notion of, you know, having to improve might be leaving out some people with disabilities and have an equity implication there.

Mr. Edwards: I think that's a great point. I just wanted to note that one of the factors we mentioned earlier about introducing other robust outcome measures, those measures do actually account for both maintenance and improvement, so it is something that we have in mind in the home health program.

Co-Chair Zephyrin: Thank you. Thank you, both. Any other additional thoughts or comments regarding this? Okay, Chelsea, let's move onto the next one.

02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) - Post Acute Care (PAC)

Ms. Lynch: Our next and final one, which is very exciting, so the next measure is 02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary - Post-acute Care HHQRP. The measure assesses the Medicare spending of a home health agency's MSPB-PAC HH episodes, relative to the Medicare spending of the national median home health agency's MSPB-PAC HH episodes across the same performance period.

Note, an MSPB-PAC HH measure score of less than one indicates that a given home health agency's resource use is less than that of the national median home health agency during the same performance period.

This measure is not endorsed and was selected by seven MAP members. Similar to our previous measures, this is a measure that is required by statute. And I don't believe The SCAN Foundation was able to join, so our lead discussant is from Vizient.

Member Godsey: Last, but not least, for our measures today, so let's go ahead and knock this one out. From our perspective, you know, I think there was some concern or some discussion about being incentivized to spend less on certain patient populations if we were to stratify this and incentivizing in the wrong way.

We want to make sure that we are creating measures that are reflective of and address the patient needs versus simply reducing spend, and so there could be some equity components.

So, if you were to look to stratify this measure and we're spending less on certain populations than others, this would be -- I would consider this to be a challenge for us to be thinking about, but again, those were our comments that we had from Vizient, so thank you.

Co-Chair Zephyrin: Thank you for those comments. Any clarifying questions or additional discussion regarding this or questions in response to Beth's summary? It's our last one. Well, is this our last one? Yes, this is our last one.

Mr. Edwards: Just one note that the relationship isn't as we all may assume, so spending more doesn't always necessarily result in better outcomes is what we found when we looked at the measure.

So, we will have a process in place to look at specific outcomes to kind of get a sense of where the relationship is between spending and outcomes. I just wanted to highlight that. So, it may seem like across the board that if you spend more, you get better outcomes, but that's not necessarily the case.

Dr. Pyatigorsky: And just to add one more point, this is Mikhail Pyatigorsky from Acumen, that the measure includes spending on associated services, not so much as spending by home health agencies, but any Medicare spending during the episode window. So, if a patient has a negative outcome such as readmission, that is also captured here.

Co-Chair Zephyrin: Thank you.

Member Machledt: So, is this measure then often tied to other outcome measures? Is that -- because I could see it being useful, but if it's just a measure of spending per beneficiary, it seems like it could have -- it has little value also for equity.

Co-Chair Zephyrin: That's an excellent point. Anyone from NQF want to respond to that or -- was it Mikhail that was talking previously or Alrick?

Mr. Edwards: I think that the idea that we would use this in our arsenal of tools to try to address health equity issues is important, so certainly we are concerned with value and quality of care, so I think it's a tool. It's not something by itself, as you said, the answer.

Co-Chair Zephyrin: Right, but it did mention there was a concern about this on looking at fee-for-service costs, and so I did have a question around, just since you mentioned value, Alrick, you know, what are the impacts around the value-based payment and other types of alternate payment models as well, but --

Mr. Edwards: Nothing presently, and I think in general across claims-based measures, there's a goal to try to broaden that to include Medicare Advantage patients, obviously, but for this measure presently, there is no value-based purchasing implications at the moment.

Co-Chair Zephyrin: Interesting, thank you. Great, any last comments for the last measure discussed today before I turn it back to Chelsea and Jenna? Okay, back to Chelsea and Jenna. Thank you, all.

Ms. Lynch: All right, thank you all so much. I'll be turning it over to Rebekah to do a final public commenting period, but I do encourage the advisory group members to stay on so we can do some lessons learned and additional opportunities for improvement of the process, and just evaluate how everything has gone. So, if you're able to, please stay on, and until then, Rebekah, over to you.

Opportunity for Public Comment

Co-Chair Angove: Thank you so much. I'm proud of this team for hanging in there and getting us through the measures. I am excited to open it up for the second time globally for public comment. Just a reminder that we ask that you keep your comments to two minutes or less.

And I do not see any hands raised in our participant list, so while I'm waiting for hands to go up, I am going to open the floor to those who are dialing in or on phones, or are unable to figure out or find how to raise their hands, if you could come

off mute and share if you have any comments related to what we've talked about today.

(Pause.)

Co-Chair Angove: I'll give you just a few more minutes to raise your hands if you have something to share. I feel like the silence may be indicative of the comprehensive public comment before each of the measures, but I don't want to close this prematurely if individuals from the public have things they want to add, share, contribute to our conversation.

So, I'm going to be watching for chat raised hands, and if you can't do either of those, please feel free to come off of mute and share your comments.

(Pause.)

Co-Chair Angove: All right, I feel like we can probably move to our next section if my colleagues at NQF feel appropriate, great.

Ms. Williams-Bader: Yes, thank you so much, Rebekah. And again, I really want to thank the advisory group for sticking with us today.

We know there's a lot of measures to discuss and there's a lot of robust discussion, and also really appreciate your flexibility as we've tried to adjust this process so that it works and we get the most out of this discussion today.

So, we have three quick poll questions, but then we definitely want to have some discussion with you as well on how the measure set review has gone up until this point. Let's go ahead and do the poll first and then we will dive into the discussion questions.

So, the first question, is the survey, the measure set review survey that we sent to advisory group and work group members to nominate measures for discussion worked well, from one, strongly disagree, to five, strongly agree.

(Pause.)

Ms. Williams-Bader: Jason, I see you have a question in the chat, but I'm not sure. Could you expand on that, on what your question is?

Member Suh: A lot of the measures said, you know, number of members who recommended removal of this, three, four. Out of what number is that is the question?

Ms. Williams-Bader: Okay.

Member Suh: I think that would be good data to have on the next time we do this, which is three out of ten, right, three out of 100. That does give a different flavor. If it's three out of three, that's different than, you know -- does that make sense?

Ms. Williams-Bader: Got it, okay, yes, that makes a lot more sense. Thank you.

Member Suh: Yeah.

Ms. Williams-Bader: Okay, let's go ahead and close the poll. You'll definitely have an opportunity to provide feedback. This is just to give us a sense for how this has worked.

Okay, so we're seeing some disagree and strongly disagree, a few neutral, and then a few of you agree and strongly agree that it worked well, okay.

Let's do all three poll questions and then we'll circle back for feedback. So, the next question is, I had what I needed to respond to the survey.

(Pause.)

Ms. Williams-Bader: Okay, why don't we go ahead and close? All right, so about a mix or about a split here with a little more than half either disagreeing or strongly disagreeing, one neutral, and a little less than half agreeing. Okay, we'll definitely circle back to that.

And then the last question, the advisory group review of the measures under review worked well. So, the discussion today and the materials in preparation for today, did that work well?

(Pause.)

Ms. Williams-Bader: Okay, and I think we can close. Okay, and again, about a split as far as disagree and agree, so about, again, half disagreeing and half either neutral, agree, or strongly agree, so we'll dive into all of that.

So, thank you all so much for your responses there. That certainly gives us an idea of where you all are. So, I think if we can move forward one more slide, we do have some discussion questions, but we'll add to this as we go.

So, thinking back to the survey, what worked well during the survey and what didn't work well? And we've had one suggestion about the survey results, but what else worked well or would you suggest changing for the future?

Ms. Young: Beth has her hand raised.

Ms. Williams-Bader: Thank you, Susanne.

Member Godsey: Yeah, I would just -- I think, you know, the experience that we had earlier in the day where, particularly for some of the survey questions, we weren't clear what it is that we were polling on, or the poll questions I should say, what it is that we were trying to assess, and so some clarity around specifically what is it that we're evaluating and what question would you like for us to address, I think that would be helpful.

Ms. Williams-Bader: Thank you so much, Beth, and are you talking about the survey back in April or the polling questions specifically today?

Member Godsey: Oh, I was referring to the polling questions.

Ms. Williams-Bader: Okay.

Member Godsey: I was looking at the first main bullet that says polling questions.

Ms. Williams-Bader: Oh, sorry, those were the actual polling questions we just did.

Member Godsey: Oh, oh, oh.

Ms. Williams-Bader: Yeah.

Member Godsey: So, you're asking about the -- oh, I see, at the bottom here.

Ms. Williams-Bader: Yeah.

Member Godsey: Got you.

Ms. Williams-Bader: Yeah.

Member Godsey: So, related to the survey, I would say that the turnaround time was a challenge. I think that there was some recognition of that. I think the materials related to support answering the survey, I think there's some opportunity.

The actual mechanism itself of the survey, you know, like the interface and that kind of stuff, I thought that worked fine. That seemed to be pretty straightforward, but just some of the getting ready to and the process of working our teams to get clarity on how we wanted to respond, I think, there were some opportunities there.

Ms. Williams-Bader: Do you want to expand on what opportunities you see? And you don't have to have solutions, but the things you'd like to see improved?

Member Godsey: Yeah, so many of the times we were having conversations about the measures, similar to what we went through when we found ourselves sort of dealing with as we did today, was that we were mostly focused on the merit of the measure and lost focus a lot about the equity

component of the measure.

So, there was a quite a bit of discussion about, is this a good measure? Does this fit for this program versus, which I think the overarching goal of this group was really, you know, we had to really put effort into putting intended discussion about equity components where that wasn't necessarily called out or information wasn't necessarily provided to help address that question.

So, for instance, some information was stratified, many were not. There weren't comprehensive representation of the different types of aspects around healthcare inequities that we wanted to address.

So, obviously we talk a lot about race, we talk a lot about ethnicity, but there are many other components and dimensions that I think, if not explicitly called out in reviewing the materials and reviewing the measures, will be missed and we won't be able to provide as comprehensive assessment.

So, I think the materials themselves, if they were more focused on helping the reviewers think of the measures and evaluate the measures from an equity perspective, that would be really helpful, and I think that presupposes that there's going to be a need for how equity measures should be assessed.

I think there's some challenges today in the industry that need to be understood or need to be understood and addressed, and put forth, but those were some of our comments and some of the discussions that we had, so hopefully that provides some insight, some clarity.

Ms. Williams-Bader: Yeah, thank you, and I have some follow-up questions, but I also see hands raised, so I'll come back to that if we have time. Let's see, Mahil?

Member Senathirajah: Yeah, this sort of picks up on what Beth was saying, and so I think what worked well is that you end up with a nice, clean list of measures and how many people voted to consider their removal.

But one of the questions sort of parallel to the discussion today, I think we really don't care about whether we should just think about removal due to equity concerns or removal due to other concerns about the measure.

And, you know, through the discussion today, it may be useful to reframe the polling questions as, you know, maybe does the measure potentially -- is the measure potentially detrimental to health equity, or is it sort of neutral, or maybe beneficial?

But I guess if you're looking to nominate measures for removal, you know, maybe is there the potential that the measure is detrimental, but leaving aside, you know, the other, you know, importance to report the measure, and scientific acceptability, and feasibility.

So, maybe if it's not really the charge of this workgroup to consider those aspects of the measure, then maybe that's a way to reframe the poll.

Ms. Williams-Bader: Thank you so much for that. Okay, so let me go to Melony next.

Member Sorbero: Yeah, I just want to say I completely agree with the previous comment and I think additional information to the -- and you probably just gave us all of the information that was available that would support our thinking about equity for the measures.

But I think we need to continue to push for more information on the measures so that we can give a very considered response around that rather than, you know, having to go search through the

literature, or take what we know from our own work, or, you know, our exposure to the literature to be commenting on equity so we can be a little more thoughtful and consistent in how we --

(Audio interference.)

Ms. Williams-Bader: And, Melony, I lost the end of what you said, but I heard you say that having more information would allow the group --

(Simultaneous speaking.)

Ms. Williams-Bader: Melony, I think you're speaking and we can't hear you. I heard part of your response.

Member Sorbero: -- which may be outside of providers -- sorry, I think maybe my connection isn't good.

Ms. Williams-Bader: Yeah.

Member Sorbero: Can you hear me now?

Ms. Williams-Bader: I can hear you. The problem, I can hear you, and then when I can't, I can't, but --

Member Sorbero: Got it. I'll put it in the chat.

Ms. Williams-Bader: Okay, thank you, appreciate that. Leonor?

Member Fernandez: Just first, a big thanks to all of you for the way you've done this, the thoughtfulness, the inclusiveness, the way you invite questions has been wonderful.

I think, yeah, more base in literature, I think, would be helpful. Now, that's a large piece of work. I almost wonder about ways of crowdsourcing that and inviting comments for a longer period of time from a broader sector of sort of the interested public and scholarly community.

And people could put in under certain frameworks of

how we think of, you know, setting up a framework of how we think the criteria for equity. One is does it measure equity and the other would be what impact would it have policy wise?

Those are two different questions, whether it measures equity and is sensitive to equity, and then for like the MIPS and other things, how would using it affect, you know, policy outcomes?

So, I think it's hard to mix those two questions together and I agree with the person who suggested that it's a two-point question, so that's it, but thank you.

Ms. Williams-Bader: Great, thank you so much. David?

Member Machledt: Yeah, I want to plus one on Leonor's comment there. I really think, well, you know, the time constraint has been a challenge. I think the sort of bounds --

Well, first, let me just say I think the facilitation of this meeting has been really, really good. I like how you were able to change on the fly and be responsive to the concerns. I think that that's, you know, it helps the meeting to go.

And from the other folks who were on this group, I learn a whole lot from just sitting and listening during these and getting a great perspective from the expertise that's on this call.

What makes me sad is that it feels like the charge, like what we're actually doing, is very limited, and a lot of the information, and the expertise, and the insight isn't going to end up -- like it may be on, you know, what is --

You know, there's a lot of commentary on how a current measure is designed and how it -- you know, that's really meant to go to a steward or something like that. This is not quite working right

or something, and isn't really necessarily something for, you know, for this process of deciding whether or not this particular measure should be removed or not.

So, that's one comment is that I wish that there was a way that we could have a sort of input or feedback that goes to the measure steward or something like that in addition to just the simple recommendation about whether we think this measure should stay or should not stay.

And this reminds me of the meeting in December when we talked about, you know, issues with, say, risk adjustment, or issues with stratification that were sort of outside of that process, but are so integral to health equity and using quality measures to evaluate health equity, so that's been a little bit of a challenge and I wish that we could be used.

With regard to the sort of process here and sort of more specific recommendations, it would have been helpful to know a little bit more about the statute. Like, so I felt overwhelmed by all of the measures. I'm fairly new to some of these Medicare measures.

Knowing ones that are statutory and that really can't be removed anyway would have helped me to streamline my reviewing process to know that, you know, there's probably not much going to be happening with this one, so I can maybe spend a little less time on that.

Secondly, I often miss the context for where a particular measure sits within the whole context. So, if a measure is transitioning from one form to another, like we've talked about with some of the measures today, that's really important to know because that's very different than, say, like just eliminating a measure on, you know, tracking influenza shots and not having some kind of different thing that's coming in the way.

So, I think that for people who don't have a lot of

time and we don't have a lot of review of things, having those, if there's any way of sort of prioritizing or showing like how the things sit within the context, how each measure sits within the context of all of the measures in that program, that would be really helpful.

And I do endorse all of the other comments about, you know, using it for payment, whether a measure should stay or go, and whether it's, like, not ideal, how you might tweak it and make an improvement. Those are three kind of separate things and it would be nice to be able to weigh in on those individually.

Ms. Williams-Bader: Thank you so much for that, David. All right, let me go to Susannah next.

Member Bernheim: I think much of what I was going to say relates to the last few comments from David, Leonor, and from Melony, sorry, which is -- and one thing I just want to clarify, my impression was that the initial survey was not really an equity lens.

That was here are some reasons we might pull measures out of the program. You are all part of the MAP and you can suggest certain measures should be pulled out of the program.

But in this discussion, our job was to address potential removals with an equity lens, and so in that context, I think a number of the things that were just said were helpful. What we ended up doing today was kind of recreating the concept of disparity sensitive measures, right?

These measures seem more disparity sensitive and these seem less, but depending on the measured entity, the program and the payment, the outcome, what we might want to see happen because of that and where the disparity issue lies, there are different pathways, right?

So, I heard in one case a concern that continued

use of the measure might worsen disparity. So, the disparity concept may suggest and even stronger reason for removal, which is very different than a measure where we think there's a really important disparity, but it's completely outside a provider's control and we're worried that it's more of a risk adjustment issue, or a measure where we think there's a real important disparity that needs to be eliminated by stratification.

So, I think, again, I'm giving a slightly different framework, but it falls in line with what you were saying before. I think we could do a little work as a committee to come up with some categories that help refine the idea that this is --

Equity is important in this measure, but I feel like we didn't quite get past equity is important to a little bit of what that means for this measure and this program.

Anyway, I'll stop there because I think other people are saying very similar things, but I will pause to just reiterate what many have said which is co-chairs and NQF staff, this was a long meeting and you were super agile, and patient, and facilitating of a productive conversation, so thank you.

Ms. Williams-Bader: Thank you so much, Susannah. I do see that there are comments in the chat as well. Of course, if you would like to verbalize any of those, please feel free, but we are also capturing those, so don't worry about that. We're capturing all of the comments. Is there anyone on the line who hasn't been able to raise their hand who would like to speak? And then perhaps we'll ask some follow-up questions. Okay, so to follow up on some of -- oh, sorry, go ahead.

Member John: Yeah, this is Malcolm and I just wanted to also thank you all for your flexibility and responsiveness today. I know it was a challenge. The first year is always the toughest, so I look forward to its evolution.

And I think for me as new to this process, I still echo what others have said completely and, you know, is the input to just say yes/no, this is really having an equity impact, or yes/no, it has an equity impact and we think it should be removed?

Well, I won't rehash that, but that obviously was a standout for me if it's just adding additional information or making a decision in the context of that additional information.

I do also wonder how do we know what we know about some of the metrics in terms of whether or not they truly impact equity, and so in that context, it's sometimes hard to really understand or give the appropriate guidance.

You know, it seems not all of the metrics had aggregated data in their additional information. Some did and some didn't, and where those were there, it was mainly around race and ethnicity. That was also limited in scope and I think we have to acknowledge the limitations around that.

And as we talked about getting more information, providing like, you know, there's known inequity here, health inequities here, or a health equity sensitive metric here versus what might be emerging, versus what is really unknown and may be a priority for other reasons.

And so, I even want to take a step back sometimes and say, like, are we all thinking the same thing when we talk about equity? You know, it may seem very fundamental, but we may be actually approaching it from different aspects.

And so, understanding what CMS and NQF really wants in terms of that definition, are we talking about access outcomes, experience, social determinants and other, or all of the above and its impact? So, are we trying to impact structures? Are we trying to impact process or outcomes, access, experience, et cetera?

So, where we could put some framework around what is most useful to you all, and understanding that there's going to be some variability there, I think, would be helpful.

What I found challenging is that some of the information, like some of the metrics were being sunset, but then they had this potential companion piece sitting out there somewhere, or not the electronic, but other similar metrics, and it wasn't clear, like, if we kept this, even though we think there's some value here, is it really essential or are we capturing that value elsewhere? And I don't know how to resolve that, but I found myself thinking that on a few of the items.

So, those were just some of my general thoughts, but on a global scale, lastly, I'll say that I do worry that we're trying to fit a square peg in a round hole because, you know, some of these metrics, if we're really concerned --

I mean, will there be an opportunity to give feedback around how we might do better in capturing equity in some of these metrics? Because I think that's really where I see the real value added down the road, but it may not be what you need or want, but over time, I would hope that that's the direction that we go.

Ms. Williams-Bader: Thank you so much for those comments. I believe that Mark might have his hand raised.

Member Friedberg: Yeah, I just want to say first off that I agree with many of the comments already made. I've been thinking about even at the conclusion of this process, I'm still a little unclear on some of the ask for this group and I think, you know, that makes sense for the first time out, but maybe it would make sense for this group or something like it to create a checklist that's a little more specific about what we mean by the equity ramifications of a given measure.

You know, the kind of things that come to mind are, are we talking about the measure itself or certain uses of the measure, right? That seems like a useful distinction, or are we talking about hypothetical situations in which a measure might be used or where we, you know, lack data on, for example, whether, you know, a system with more resources is going to be able to game the measure more effectively than a system with fewer resources or if that's a true difference in care. I just think articulating those identifiable unknowns is useful.

Then the other thing is there are things that are directly about the measure as well and I think it would be worth calling those out. For example, it's possible for a measure to be topped out, and for somebody, not based on an equity consideration, to say, well, this measure is topped out and therefore it's suitable for retirement.

And, you know, you can find sometimes that that seems reasonable until you stratify the measure, and then you find out, oh, it's not topped out for everybody and this actually has some real value as an equity measure even though it might not be quite so valuable as an overall performance measure, and that might be a real value add.

So, these are just some ideas for a checklist, but by no means are they fully formed or exhaustive, but I think, you know, during that kind of an exercise, moving that in front of the group discussion could be really helpful next time around. Thanks.

Ms. Williams-Bader: Thank you so much, Mark. I'm not seeing any more hands raised. Susanne, do you see any?

Ms. Young: I do not.

Ms. Williams-Bader: I do see -- and we're continuing to get comments in the chat, so thank you all for sharing those. So, I want to try to circle back to a couple of things, but also welcome others

at NQF to follow up as well.

So, one of the big differences obviously with this process compared to MUC is that these measures are not -- we have a much larger universe of measures to start with, and even when we narrowed it down to just a few programs for this year, we have hundreds of measures within those programs.

So, I'll start back again with this survey. Realistically, how much information would you be interested in looking through at that point when completing the survey?

And also, we did give -- the same survey went out to advisory group and workgroup members, but do you think the kinds of questions we should be asking when doing the survey should be different?

Because I also -- if we were able, if it was feasible to pull together a lot of information at the point of the survey, which I'm not promising, but would you be able to look through that much information for, you know, a couple hundred measures?

(Pause.)

Ms. Williams-Bader: I see lots of people in the chat liking the idea of a checklist, so I'm making a mental note of that and an actual note of that. Go ahead, yeah.

Member Senathirajah: I was going to say I kind of want to thank NQF for even having this committee, like having equity be a part of the consideration of the removal process, I think, is a great thing, and thanks for all of the materials. It's a lot of measures to go through and you corralled a lot of it.

In terms of, you know, so I kind of think of, and I don't know if this is the right way to think of it, but if, you know, that there would be stratified reporting potentially around these measures and therefore, I

think, oh, would that stratified reporting, you know, help identify and close equity gaps?

And then that leads me to think, oh, well, are there any known disparities across, you know, racial, ethnic, other groups, and then think about is there anything known about the measure as a supportive, any information about stratified rates, and then sort of is there information in the literature about differences in whatever the measure is measuring, so, you know, for example, looking at MRI rates.

And so, it may be useful, and, you know, it's a lot to look at if there's a search and it's a lot to undertake, but if measures that did have either known differences based on the measure's reporting rates or differences in the literature, that may be useful to bring forward and highlight.

Ms. Williams-Bader: And are you saying at the time of the survey?

Member Senathirajah: No, sorry, that's more, you know, during this process.

Ms. Williams-Bader: Okay, yeah, and I will say the data we provided was the data that is available for these measures as far as the actual performance data, so if you saw -- measures that didn't have stratified rates means that that data is not publicly available. It really, it varies by program and even perhaps by measure within a program.

Member Senathirajah: Right, yeah, so then that's, you know, can anything be drawn from the literature?

Ms. Williams-Bader: I thought I saw one other hand raised. I'm not seeing it now.

Ms. Young: Beth's hand is raised.

Member Godsey: Yeah, I just wanted to follow up on that comment, Jenna, around the -- having that information, I think, is useful. I know that, from an

NQF perspective, that might be more challenging for you if you're not given that information.

I think it might be a request instead from CMS or the measure steward to, moving forward, set the standard to say in order for us to assess the validity of the measure from an equity perspective, that we would need that information from them and that they provide that and support that, so recognizing, you know, NQF has some limitations in that, but that there are others that could provide more of a stratified look for us to take a look at.

Ms. Williams-Bader: Thank you for that. And then, Sarah, did you have your hand raised? Oh, okay.

Member Shih: I did, but I just ended up tying it in. Thanks.

Ms. Williams-Bader: Okay, thank you. Let me turn to my NQF team and see if anyone has questions that you'd like to ask in follow up?

Well, thank you all so much. I feel like we've gotten a lot of information. I guess, actually, let me pause. Is there anyone from our CMS team who would like to ask any follow-up questions?

Okay, well, thank you all so much for staying with this, with the meeting and providing this feedback. Yes, this is definitely a learning year. I imagine the next couple of years will be learning years as we continue to flesh out this process.

The MUC process has been around for a while now, but this one is new, so, and there are differences between this and MUC, so your feedback on this has been really helpful.

It definitely seems like there is a lot of interest in a potential checklist and I definitely hear a request for more information on performance data, in particular either the disparities from performance data or potentially from the literature. We'd have to see

what's possible there as far as what we can provide, but thank you for that feedback.

And then it definitely seems like with or without a checklist, there needs to be more clarity around what specifically is the ask of the group and potentially maybe -- we definitely need to rethink the polling questions, but there might be opportunities to think about what specific categories we could have as far as the actual equity issues at play.

So, we'll take all of this feedback back to the team and we'll discuss and see what we might be able to think of for the future. Any last comments before I turn it over to, I believe it's Joelencia who is going to do our next steps? Okay, Joelencia, I'll turn it over to you.

Next Steps

Ms. LeFlore: Thanks, Jenna. I will now provide an overview of the upcoming activities. Next slide?

We have now completed the final advisory group meeting. Next, the workgroups will meet to discuss their respective measure sets. The hospital workgroup will convene June 22. The clinician workgroup will convene June 27. The PAC/LTC workgroup will convene June 30. Additionally, the coordinating committee will convene in late August.

Once all of the MSR meetings are completed, there will be a public comment on the final recommendations occurring July 22 through August 5. To conclude, the final recommendations report will be issued to CMS in September. Next slide?

This slide provides an illustration of the timeline that was previously stated. Again, the respective workgroups will convene and then the coordinating committee and public commenting will occur, and the final recommendations report will be sent to CMS. Next slide, please?

Finally, this slide provides the contact information for the MAP health equity team. I will now turn it back to Jenna.

Ms. Williams-Bader: Thank you. And I believe I have given my closing comments here, but I will turn it to Rebekah and Laurie to see if they'd like to make any closing remarks.

Co-Chair Angove: I don't have anything to substantial to add. I do not want to stand in between everybody and the end of their day, so just thank you for being here with us, being so engaged and so passionate about these measures and making sure that we're aligning them to advance health equity. It's been a really rewarding day and I appreciate all of you.

Co-Chair Zephyrin: Yes, I just want to echo that. Thank you all for all of your time.

Adjourn

Ms. Williams-Bader: All right, well, thank you all, and thank you to our health equity volunteers who will be sitting in and summarizing the conversations for the workgroups as well. We really appreciate that. And if you have any questions about that, please feel free to reach out to us. Thank you all and have a great evening.

(Whereupon, the above-entitled matter went off the record at 6:00 p.m.)