National Quality Forum
Measure Applications Partnership (MAP)
Health Equity Advisory Group Review Web Meeting
Thursday, December 9, 2021

The Advisory Group met via Videoconference at 10:00 a.m. EST, Rebekah Angove and Laurie Zephyrin, Co-Chairs, presiding.

Present:

Rebekah Angove, PhD, Co-Chair
Laurie Zephyrin, MD, MPH, MBA, Co-Chair

NQF Staff:

Tricia Elliott, MBA, CPHQ, FNAHQ, Managing Director
Chelsea Lynch, MPH, MSN, RN, CIC Director
Katie Berryman, MPAP, PMP, Senior Project Manager
Ivory Harding, MS, Manager
Amy Guo, MS, Manager
Victoria Freire, MPH, CHES, Analyst
Joelencia LeFlore, Coordinator
Matthew Pickering, PharmD, Senior Director, Quality Measurement

Organizational Members (Voting):

Joy Bland, DBH, RN, CCM, CPHQ, Aetna
Karthik Sivashanker, MD, MPH, CPPS, American Medical Association
Katie Boston-Leary, PhD, MBA, MHA, RN, NEA-BC, CCTP, American Nurses Association
Lanita White, PharmD, American Society of Health-System Pharmacists
Kirsten Bibbins-Domingo, PhD, MD, MAS, America's Essential Hospitals
Leonor Fernandez, MD, Beth Israel Lahey Health
Chris Grasso, MPH, Fenway Health
Irene Dankwa-Mullan, MD, MPH, IBM Watson Health
Mahil Senathirajah, MBA, IBM Watson Health
Stephanie Clouser, MS, Kentuckiana Health Collaborative
Sarah Shih, MPH, National Committee for Quality Assurance

David Machledt, PhD, National Health Law Program
Alicia Cole, Patient Safety Action Network
Tala Mansi, MPA, Planned Parenthood Federation of America
Sarita A. Mohanty, MD, MPH, MBA, The SCAN Foundation
Beth Godsey, MBA, MSPA, Vizient Inc.

Individual Subject Matter Experts (Voting):

Susannah Bernheim, MD, MHS
Damien Cabezas, MPH, MSW
Mark Friedberg, MD, MPP
Jeff Huebner, MD
Gerald Nebeker, PhD, FAAIDD
J. Nwando Olayiwola, MD, MPH, FAAFP
Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM
Cardinale Smith, MD, PHD
Melony Sorbero, PhD, MPH
Jason Suh, MD

Federal Government Liaisons (Non-Voting):

Michelle Schreiber, MD, Centers for Medicare & Medicaid Services
Alan Levitt, MD, Centers for Medicare & Medicaid Services
Meagan Khau, Centers for Medicare & Medicaid Services
Girma Alemu, MD, MPH, Health Resources and Services Administration
David Hunt, MD, FACS, Office of National Coordinator for Health Information Technology
Leslie Hausmann, PhD, Veterans Health Administration

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Proceedings

(10:03 a.m.)

Welcome and Introductions

Ms. Lynch: Good morning.

My name is Chelsea Lynch, and I'm a Director in the Emerging Initiative at the National Quality Forum.

I'd like to welcome all of you to our web meeting for the Measure Application Partnership Health Equity Advisory Group Review Meeting for the 2021-2022 pre-rulemaking cycle.

We truly appreciate that all of you joined us today and that all of you are prioritizing this work within your busy schedules.

Before we begin, I'd like to share a couple of housekeeping items with the group.

We're using the Webex platform, which has audio and video capabilities. Please put yourself on mute when you're not speaking, and we encourage you to keep your video on, especially when you are speaking.

Please use the chat box to communicate with NQF staff and with each other. During our discussion, we'll be using the Hand Raise feature and we'll put instructions in the chat box on how to do that throughout the meeting.

The material for today's meeting can be found as attachments on the calendar invitation and are also posted on the project website.

Please note we are recording this meeting, and the recording, transcript, and meeting summary will be posted on the project web page when available.

Finally, for members of the MAP Health Equity Advisory Group, we sent an email with a link to Poll

Everywhere yesterday evening, and this is the link that we will be using to answer the polling question for each measure under consideration. Please let us know if you have any problems accessing the link, and we'll do a test question before we start our discussions on the measures under consideration.

I'll briefly go over our very full agenda for today. We'll start with welcoming remarks, introductions, and disclosures of interest, followed by some opening remarks from the Centers for Medicare & Medicaid Services. We'll provide an overview of the pre-rulemaking approach and instruction for today's discussion.

We'll, then, transition into our discussions on the measures under consideration. As a reminder, we will be discussing measures under consideration for clinician, hospital, and post-acute and long-term care programs, as well as measures that are being considered for multiple programs.

After a discussion, if we have time, we'd like to spend a little time assessing the review process we're using today to see if there are any modifications we'd like to make in the future.

As always, there will be an opportunity for public comment. This is scheduled for approximately 5:45 p.m., and we're requesting that comments from the public be held until the designated commenting period.

And finally, we'll end today's meeting with an overview of next steps and some closing remarks.

Just I want to see if Kathleen Giblin was able to join us this morning from NQF.

It does not sound like it. So, I believe I am introducing our Senior Managing Director, Tricia Elliott, to provide some welcoming remarks from NQF.

Ms. Elliott: Thank you so much, Chelsea.

Can you hear me okay?

Ms. Lynch: Yes.

Ms. Elliott: Perfect. Thank you.

So, it's my pleasure to welcome all of you to the Inaugural Review Meeting of the Measure Application Partnership Health Equity Advisory Group. We're very excited.

So, we are very pleased to continue our partnership with the Centers for Medicare & Medicaid Services in convening the Measure Application Partner to provide input on performance measures being considered for use in public reporting and performance payment programs.

For the first time during the 2021-2022 MAP cycle, NQF and CMS have convened this MAP Health Equity Advisory Group to provide feedback on the measures under consideration with a lens to measurement issues that impact health disparities. The ultimate goal is to reduce health differences closely linked with social determinants of health, which have been highlighted during the ongoing COVID-19 pandemic. Your discussion today poses an incredible opportunity to provide input on measures that drive toward NQF's vision of consistent, high-quality care for every person in every community by 2030, regardless of socioeconomic, culture, or geographic factors.

We would like to thank Advisory Group members and federal liaisons for taking time out of your busy schedules to provide this important input as part of the pre-rulemaking process.

We'd also like to thank you in advance for providing feedback that will help us hone the MAP health equity activities and discussions, so that we continue to improve the process as we continue into

next year.

Finally, a special thank you to our Co-Chairs Rebekah Angove from the Patient Advocate Foundation and Laurie Zephyrin from the Commonwealth Fund for their leadership of the MAP Health Equity Advisory Group.

We look forward to working with you all day today and hearing your discussion.

Chelsea, I'll hand things back to you.

Ms. Lynch: Thank you, Tricia.

I'd now like to invite Co-Chairs, Dr. Rebekah Angove and Dr. Laurie Zephyrin, to share some welcoming remarks as well. And why don't we get started with Rebekah?

Co-Chair Angove: Thank you so much. I'm really excited to be here. Great to see some new and also familiar faces and to spend a day with you focused on making sure that these measures have aspects of health equity and that we're really looking at this important issue. I'm actually really excited that this is the first meeting, and I am hopeful that this is a long tradition that is integrated into the MAP work.

I'm specifically kind of excited to be here and share this with you because my entire career has been focused on addressing social needs of patients and integrating patient and caregiver voices into research, care, and policy. And so, I'm happy to be here to further this conversation, to help facilitate and to provide some of the insights that I have gathered over my career.

So, I'm going to hand it over to Laurie.

Co-Chair Zephyrin: Thanks, Rebekah.

I'm so excited to partner with Rebekah and the MAP team and others on this work.

Again, welcome, everyone, today.

You know, this work is really important to me personally. My career has been focused on really thinking about systems transformation and how to advance health equity, as a clinician in the field and working nationally across health systems, and now, working at a foundation really helping to drive policy change and systems change to ensure that we are thinking about health equity in a meaningful way and advancing health equity, particularly for those most marginalized.

I'm excited to be here with all of you and just the multidisciplinary representation on this group. I'm really looking forward to the conversation.

We measure what we value, and measures matter. And as Rebekah mentioned, I see this as a beginning, hopefully, of a long tradition. I think there will be some questions that come out of this that we'll learn to be able to apply to the consideration of future measures as well.

So, looking forward to partnering with all of you in this conversation today.

Ms. Lynch: Thank you both. Really looking forward to today as well.

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

We'll combine disclosures with introductions. We'll divide the disclosures of interest into two parts because we have two types of MAP members,

organizational members and subject matter experts. We'll start with organizational members on the next slide. Our Co-Chairs are considered subject matter experts, so we will get their introductions and disclosures when we get to that group.

Organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests. Because of your status as an organizational representative, we ask 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.

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

Ms. Freire: So, thank you, Chelsea. Yes, thank you, Chelsea.

I will now go ahead and call on our organizational members. If you are on the line, please unmute yourself and go ahead and disclose your -- or let us know that you are here.

I'll start with Aetna.

Member Bland: Hi. My name is Joy Bland. I am the Associate Vice President of Quality, and I have nothing to disclose. Thank you.

Ms. Freire: Thank you, Joy.

Next, the American Medical Association.

Member Sivashanker: Hi. My name is Karthik

Sivashanker, Vice President of Equitable Health Systems, and I have nothing to disclose.

Ms. Freire: Okay. Thank you.

And next, we'll go to the American Nurses Association.

Member Boston-Leary: Hello. Katie Boston-Leary, Executive Director of Nursing Practice and Work Environment and Nursing Programs at the American Nurses Association. And I have nothing to disclose.

Ms. Freire: Thank you, Katie.

Next, the American Society of Health System Pharmacists.

Member White: Hello. My name is Lanita White. I'm Assistant Dean of Student Affairs at the University of Arkansas for Medical Sciences and a member of ASHP, and I have nothing to disclose.

Ms. Freire: Thank you.

Next, America's Essential Hospitals.

Member Bibbins-Domingo: Hi. I'm Kirsten Bibbins-Domingo. I'm a general internist and professor and a Vice Dean at the University of California San Francisco, where I also practice at San Francisco General Hospital, and I have nothing to disclose.

Ms. Freire: Thank you.

Next, Beth Israel Lahey Health.

Member Fernandez: Hi. I'm Leonor Fernandez, and I am Beth Israel Lahey Health's Health Equity Advisor, and I have nothing to disclose. Thank you.

Ms. Freire: Thank you.

Fenway Health.

Member Grasso: Chris Grasso, nothing to disclose.

Ms. Freire: Thank you, Chris.

Next, IBM Watson Health.

Member Dankwa-Mullan: Hi. Good morning, everyone.

Irene Dankwa-Mullan from IBM Watson Health. I am the Deputy Chief Health Officer and Chief Health Equity Officer. Nothing to disclose.

Ms. Freire: Thank you, Irene.

Next, Kentuckiana Health Collaborative.

Member Clouser: Hi, everyone. My name is Stephanie Clouser. I am the Data Scientist for the Kentuckiana Health Collaborative, and I have nothing to disclose.

Ms. Freire: Thank you, Stephanie.

Next, the National Committee for Quality Assurance.

Member Shih: Good morning. My name is Sarah Shih, Assistant Vice President for Research and Analysis, and I have nothing to disclose.

Ms. Freire: Thank you, Sarah.

Next, we have the National Health Law Program.

Member Machledt: Hi. I'm David Machledt, Senior Policy Analyst for the National Health Law Program, and I have nothing to disclose.

Ms. Freire: Thank you, David.

Next, the Patient Safety Action Network.

Member Cole: Good morning. I'm Alicia Cole, and I'm a Patient Safety Advocate with the Patient Safety Action Network, and I have nothing to disclose. Thank you.

Ms. Freire: Thank you, Alicia.

Next, the Planned Parenthood Federation of America.

Member Mansi: Good morning. Can you hear me?

Ms. Freire: Yes, we can hear you.

Member Mansi: Hi. This is Tala Mansi. I'm the Associate Director of Health Equity Metrics and Improvement, Planned Parenthood Federation of America. And I have nothing to disclose.

And I'm sorry, that's my dog in the background.

Ms. Freire: Thank you, Tala.

Next, the SCAN Foundation.

Member Mohanty: Hi. Good morning. This is Dr. Sarita Mohanty. I am with the SCAN Foundation, President and CEO, and I have nothing to disclose.

Ms. Freire: Thank you, Sarita.

And last, we have Vizient, Inc.

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

Ms. Freire: Thank you.

Chelsea?

Ms. Lynch: Yes, thank you, everyone, for those disclosures.

We will now move on to the disclosures for subject matter experts. Because subject matter experts sit as individuals, we ask you to say 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 Advisory Group's work. We're

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

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

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

Finally, just because you disclose does not mean that you 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.

Victoria will now go through this roll as well.

Ms. Freire: Thank you, Chelsea.

I will start with the Co-Chairs. Rebekah Angove.

Co-Chair Angove: I am Rebekah Angove. I am VP of Patient Experience and Program Evaluation at Patient Advocate Foundation. I'm also the Director of PAS, Patient Insight Institution. And I have nothing to disclose.

Ms. Freire: Thank you, Rebekah.

Laurie Zephyrin.

Co-Chair Zephyrin: Hi. I'm Laurie Zephyrin, Vice President, Advancing Health Equity, at the Commonwealth Fund. I'm also, a clinical assistant professor, NYU Langone School of Medicine. I have nothing to disclose.

Ms. Freire: Thank you.

I'll move on with our other subject matter experts.

Emily Almeda-Lopez.

(No audible response.)

All right. Susannah Bernheim.

Member Bernheim: Good morning. I'm sorry, I'm having trouble getting my video to work.

I'm a Senior Director of Quality Measurement at the Yale Center for Outcomes Research and Evaluation and associate professor at Yale.

The only thing that I should disclose is that there are some measures that our team has developed that are on the list that will be discussed today, and my assumption is that I will keep quiet while those measures are being discussed.

And I sent you a note. Unfortunately, I was asked to review one of the measures that actually was developed by my team. So, I'll excuse myself from that discussion.

Ms. Freire: Thank you, Susannah.

Next, Damien Cabezas.

Member Cabezas: Hi. Good morning. I'm Damien Cabezas. I'm President of Mercy Care, which is a Federally Qualified Health Center in Atlanta, Georgia, and I have nothing to disclose.

Ms. Freire: Thank you.

Next, Mark Friedberg.

Member Friedberg: Hi. Mark Friedberg, Senior Vice President of Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts. Also, a part-time general internist at Brigham and Women's Hospital. I'm on the

Committee on Performance Measurement at NCQA, and I'm part of the Board of Directors at the Massachusetts Health Quality Partners. Thank you.

Ms. Freire: Thank you.

Next, we have Jeff Huebner.

Member Huebner: Good morning, everybody. I'm Jeff Huebner from Madison, Wisconsin. I'm a family physician here. I work at our UW Health System and, also, serve as Medical Director for Population Health at our Health System. And I serve on the Board of Directors for a nonprofit, the Doctors for America, working to improve health care for all Americans. And I have no disclosures.

Ms. Freire: Thank you, Jeff.

Next, Gerald Nebeker.

Member Nebeker: Yes. I'm the President of RISE, Incorporated, a multistate nonprofit organization supporting people with intellectual and developmental disabilities. I'm also an advocate for the same national, as well as locally. And I have nothing to disclose.

Ms. Freire: Thank you, Gerald.

Next, we have Jacqueline Nwando Olayiwola.

Member Olayiwola: Good morning. My name is Dr. Nwando Olayiwola. I'm Chief Health Equity Officer and Senior Vice President at Humana and, also, adjunct professor at the Ohio State University College of Medicine and College of Public Health. I have nothing to disclose.

Ms. Freire: Thank you.

Next, we have Nneka Sederstrom.

Member Sederstrom: Hi. Good morning. I'm actually in the car. So, that's why I'm off-video.

But I am Nneka Sederstrom. I'm the Chief Health Equity Officer for Hennepin Healthcare, which is our safety net hospital in downtown Minneapolis, the only safety net hospital in Minnesota. And I have nothing to disclose.

Ms. Freire: Thank you.

Next, we have Cardinale Smith.

Member Smith: Yes. Hello. Good morning, everyone. I am Cardinale Smith, but most people call me Cardi, like Cardi B. So, you can feel free to do the same. My middle initial is actually B.

I am an associate professor of medicine and thoracic oncologist and palliative medicine physician at Mount Sinai in New York City. I'm also the Chief Quality Officer for Cancer here for our health system. And then, I have nothing to disclose.

Ms. Freire: Thank you.

Next, we have Melony Sorbero.

Member Sorbero: Hi. I am Melony Sorbero. I am a Policy Researcher at the RAND Corporation, and I work on a contract for CMS for the Star Ratings Project for Medicare Advantage and Part D, where we're working to identify approaches to identify issues of equity within the program and ways to address them.

Ms. Freire: Thank you, Melony.

Do you have anything to disclose other than that?

Member Sorbero: No, that's it.

Ms. Freire: Okay. Thank you.

And lastly, Jason Suh.

(No audible response.)

Okay. At this time, I'm like to invite our federal

government participants to introduce themselves. They are non-voting liaisons of the Advisory Group.

I will start for the Centers for Medicare & Medicaid Services, CMS.

Member Suh: I guess my computer wasn't working correctly. I'm sorry about that.

Ms. Freire: Okay.

Member Suh: Can you hear me now?

Ms. Freire: Yes, we can, Jason.

Member Suh: I was talking on mute.

Hi. I'm Jason Suh. I'm a hospitalist in Longview, Washington, working for PeaceHealth. And I'm the Inpatient Medical Director of Informatics for PeaceHealth. I have nothing to disclose.

Ms. Freire: Thank you, Jason.

I will now move back to our federal government liaisons.

CMS.

Member Schreiber: I'll start. I'm Dr. Michelle Schreiber. You'll hear from me in a moment.

I am the Deputy Director for the Centers for Clinical Standards and Quality and the Director of Quality Measurement and Value-Based Incentive Programs at CMS.

And I believe we have others from CMS on the line, including OMH.

Member Khau: Yes. Hi. This is Meagan Khau. I am the Director for the Data Policy Analytics Group within CMS, Office of Minority Health.

Ms. Freire: Okay. Thank you both.

Next, the Health Resources and Services Administration.

Member Alemu: Hi. I am Girma Alemu, representing Sarah Hatter for the next couple of hours. She will be joining the meeting at 12:00. And I have nothing to disclose.

Ms. Freire: Thank you.

The Office of the National Coordinator for Health Information Technology.

Member Hunt: Hi. I'm David Hunt. I'm Medical Director for Patient Safety at ONC, and I have nothing to disclose.

And I'm having problems with my virtual background. I no longer sit in front of a large portrait of myself.

Ms. Freire: Thank you.

And lastly, we have the Veterans Health Administration.

Member Hausmann: Good morning. My name is Leslie Hausmann. I'm an investigator at the VA Center for Health Equity Research and Promotion, where I also direct the Equity Capacity Building Corps. And at the University of Pittsburgh, I'm an associate professor of medicine and Assistant Dean for Medical Student Research. And I have no disclosures.

Ms. Freire: Thank you, Leslie.

I will turn it back over to you, Chelsea.

Ms. Lynch: Okay. Thank you, everyone.

I'd like to remind you that, if you believe that you have a conflict of interest at any time during the meeting, please speak up. You may do so in real time at the meeting. You can message our Chairs,

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

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

Does anybody have any questions or anything they would like to discuss, based upon the disclosures made today?

Okay. I thank you all for sitting through that very lengthy process. We appreciate it.

I am very fortunate to be joined by a great team here working on the MAP Health Equity Advisory Group, and would like to thank Katie, Ivory, Amy, Victoria, and Joelencia for all of their hard work.

And I'd like to also acknowledge and thank Kim Rawlings and Gequincia Polk from CMS for their support on this project.

And it's now my pleasure to hand it over to Dr. Michelle Schreiber, the Deputy Director of Quality and Value at CMS, to provide some welcoming remarks to the Advisory Group.

Dr. Schreiber?

Member Schreiber: Thank you, Chelsea.

First of all, a sound check. Can you hear me okay?

Ms. Lynch: Yes.

CMS Opening Remarks

Member Schreiber: Okay. Wonderful. Thank you. After several years of all of us doing these by remote, you can never be too careful.

It is an absolute pleasure to welcome all of you today to the Health Equity Advisory Group. We are really looking forward to your comments. As you

know, this is the first such meeting and the first such Committee to address the measures under consideration from an equity point of view. So, we're very excited.

I introduced to you my role in my very opening remarks, but let me just paint a little background as well. I'm a primary care physician by training. In the majority of my career, I was a primary care physician in the City of Detroit. I've also been a Chief Quality Officer, both of Henry Ford Health System in Detroit Medical Center and a Chief Medical Officer. So, these issues are very personal to me, to our practice, to my patients, to our systems, because this affected really everything that we did with our patient population.

As all of you know, the Biden administration is deeply committed to the issues of equity, and we are very really thrilled with the fact that this is coming to the forefront. All centers of the government, all centers across CMS, are really dedicated to looking at how we can enact programs that help close the disparities gap and ensure equity in terms of access to outcomes for everybody. So, we are really very pleased and just thrilled with the group that is here today. So, thank you very much.

Let me send my thanks, also, to NQF, Chelsea, to you and your staff. There's a lot of work that goes on in putting these meetings together, and we appreciate that, including the pre-review.

There are many staff on from CMS. I do want to acknowledge, of course, Time and Gequincia, but there are others on the line as well, again, because this takes a long time to put these measures together and to bring them forward for you.

I want to specifically call out Dr. Alan Levitt, who's the Medical Director for the Post-Acute Care Group in the Quality Measures Group. I may have to step away from time to time on today's meeting, and Alan will, however, be on the line. So, Alan, thanks

and a shout-out to you.

We recognized in the COVID pandemic the grave disparities that we've seen in the outcomes and the care for persons of color, persons of different ethnic backgrounds, persons of other minorities; that it's no longer something that can be ignored. And it's not like we didn't know this before, but this is something that must be addressed. And again, as I said, across the Biden administration, there is a cross-government approach to really try to improve and to enact programs that will be permanent and able to make significant impact and change.

Overview of Pre-Rulemaking Approach

Today, your role is to review the measures that we have under consideration that have been developed probably in some cases over the past several years that we are considering implementing in the value-based programs. So, you'll hear about the value-based programs. There are those for hospitals, for practitioners, for post-acute care settings, for Medicare Part C and D. And your role today is to comment on the equity aspect of those measures, how it would influence one way or another.

But we'll also be listening closely to any of your recommendations for what are those programs, what are those action steps that CMS or others in the government could take, from your perspective. And we'll take those back as recommendations as well.

So, once again, I thank you all for your participation. In advance, if I don't talk to you beforehand, I wish all of you the happiest of holidays. I have to get that upfront and include it, and look forward to today's discussion.

Thank you.

Well, I do want to make one other note. We have a number of measure stewards on the phone today

for each of the measures. So, they are happy to answer your questions, if you have them.

And again, look forward to a great discussion today.

Thank you, Chelsea. Back to you.

Ms. Lynch: Okay. Thank you so much, Dr. Schreiber.

I will turn it over to Amy to go through our process for today.

Ms. Guo: Thank you, Chelsea.

So, as Chelsea previously mentioned, we will start off today with a brief refresher on the role of the MAP Health Equity Advisory Group in the pre-rulemaking process.

And if you were able to attend our orientation session in October, most of this is going to look pretty familiar, but it will be a helpful reminder of our overall goals, so that we're all on the same page before we get into the bulk of our discussion today.

As part of this section, we will also review the process that we follow to discuss each measure under consideration, again, just so we're on the same page about what to expect during today's meeting.

As a reminder, the MAP Health Equity Advisory Group is intended to provide perspectives that are related to health equity as part of the pre-rulemaking process. When we use the term health equity here, we're referring to the goal of attaining the highest level of health for all people by reducing or eliminating health disparities that adversely affect vulnerable populations.

During our discussion today, Advisory Group members will review each of the measures in the 2021 measures under consideration, or MUC, list. And for each of those measures, we are going to

discuss any measurement issues that are related to health disparities at critical access hospitals that should be considered if these measures are used in credible programs. In particular, we are going to look at the measures and discuss whether they support the overall goal to reduce health disparities that are closely linked with socioeconomic or environmental disadvantages.

As we review each of the measures that are on the MUC list, we're hoping to gather feedback, including the following:

We'd like to hear members' thoughts on the importance of each measure in terms of advancing health equity, as well as any major flags on data collection, reporting challenges, methodological challenges, potential unintended consequences, or unaddressed gap areas that can be identified in the programs that are being discussed.

Our discussion from today will be shared with the setting-specific groups prior to their meetings and discussion next week. So, those groups include the MAP Clinician, MAP Hospital, and the MAP Post-Acute Care, and the Long-term Care Work Groups.

The input from the Health Equity Advisory Group is provided to those setting-specific work groups in a couple of ways.

First off, your feedback is going to be incorporated into the Preliminary Analysis, or PAs, that describe each measure. You will recall that, after the release of the MUC list last week, our team had circulated a list of initial Preliminary Analyses for the Advisory Group's review. Those were the very long documents that contained the specifications submitted by each measure developer, as well as short written analyses of each measure that were developed by NQF staff.

Based off of discussion from today, those PA documents will be updated. We'll also include the

results of any polling questions that we hold today. And those updated versions of the PA documents will be shared around with the setting-specific work groups, so that members of those work groups can reference our discussion before their review meetings.

In addition to the written content in the PAs, we'll also have NQF staff attending the work group meetings, and they will be sure to summarize our discussion for each measure under consideration during those meetings.

In these ways, the Advisory Group's input will help lay some of the groundwork for the more detailed measure-by-measure discussion that is going to happen at the setting-specific work group level. The Advisory Group's input will, then, help inform the overall recommendations that come out of the meetings next week.

Now that we've had a chance to review how the Health Equity Advisory Group fits into the larger MAP structure, we do want to take a moment and talk through the process for today's discussion. We'll try to follow the same five-step process when discussing each of the measures under consideration today.

First, we'll start off with NQF staff, who will provide a description of the federal program where the measure is being proposed. And to reintroduce the measure, we will have lead discussants summarize the measure and say their initial thoughts on whether the measure should be included in the proposed program or flag if there are any additional concerns or questions that they have.

After the lead discussants offer their first thoughts, we, then, open up discussion to the full Advisory Group. And in a few minutes, we will review some specific discussion questions for consideration, but at hall level we, again, will want to discuss items related to priority, data collection or reporting

challenges, methodological problems, and any unintended consequences.

After the discussion comes to a close, we'll, then, ask the group to participate in an online poll. This is the Poll Everywhere platform that Chelsea had flagged at the beginning of the meeting.

This poll will help us get a quantitative idea of the Advisory Group's perception of the measure and of the potential impact on health disparities, if the measure is included in a program. The polling will use a five-point scale ranging from high potential to have negative impact to high potential to have a positive impact.

And then, after the polling, we will conclude with discussion on gap areas for the specific program that are related to health disparities in critical access hospitals.

Before we continue and go through specific discussion questions, we did want to pause here and run a test question, just to make sure that Advisory Group members are able to access and utilize the polling platform.

So, if you are a member of the Advisory Group, you should have received an email yesterday evening around 6:00 p.m. Eastern with instructions for using the Poll Everywhere platform. There is a link in that email, and then, instructions to enter your name and get ready to poll. If you didn't receive that email, please reach out to our team and we can get the link to you, so that you're able to participate.

Warning: please don't put the link in the public Webex chat. We only want it to go to Advisory Group members for purposes of this meeting.

So, at this time, I will hand it over to Ivory, if you would like to run through a test poll and make sure that folks are able to use the platform and see how the responses will be shown.

Ms. Harding: Yes. Thank you, Amy.

So, the test poll question is now open, and we would like you to respond to this question: what region of the U.S. do you call home? The answer choices are: the Northeast, the Southwest, the West, the Southeast, and the Midwest.

Okay. At the end of every poll, we will show the responses and we will go through and explain how many members chose the provided answer selections.

And I will now turn it back over. Thank you.

Ms. Guo: Thank you, Ivory.

Victoria, if you can go to the next slide, we can run through the discussion questions that we want to consider before we jump in.

So, this is the final, very important item that we want to review before proceeding with the discussion for today. This is the list of the suggested discussion questions that we'd like you to consider.

We have a list of six equity-related questions here that we think will be helpful for the group to consider for each measure that we discuss today. Again, we're looking for the Advisory Group to provide high-level input on health equity considerations that are specific to the measure being discussed.

First, we would like the group to consider what aspects of health equity each measure has the potential to advance. We'd also like the group to consider what social determinants of health should be considered related to the measure. If the measure includes stratification or risk adjustments, whether there are any concerns about how the measure is stratified or risk-adjusted, based on a health equity lens, and whether or not there are any suggestions for additional information related to

stratification or risk adjustment.

We'd like to hear your thoughts on whether it would be beneficial to provide stratification when performing performance feedback for the measure; whether or not the group thinks there are any ways that the measure could make disparities worse or have any unintended consequences.

And then, finally, if there are any measurement gaps related to health disparities in critical access hospitals in the program that's being discussed.

With that, I will hand it back to Chelsea for any final questions on today's process or discussion before we start jumping into specific measures.

Ms. Lynch: All right. Thank you, Amy.

So, are there any questions from the Advisory Group about the approach or any issues with the Poll Everywhere link?

Okay. And we did just share how to raise hands with the little smiley face towards the bottom, but we will go ahead and get started with our discussion.

Discuss Measures Under Consideration

So, we're going to start a review of the measures under consideration for clinician programs. Please note the review of the measures under consideration for clinician programs is split into two parts, and the second part will be later this afternoon.

Merit-Based Incentive Payment System Program Measures

We'll first review measures under consideration for the Merit-Based Incentive Payment Program, or MIPS. So, MIPS is a quality payment program with a pay-for-performance incentive structure.

There are four connected performance categories: quality, promoting interoperability, improvement activities, and cost. Each of these categories is scored independently and has a specific weight. The final score, out of 100 percent, will be used to adjust payment for eligible clinicians. This is intended to improve patient outcomes for a fee-for-service Medicare and reward innovative, high-value patient care.

MUC2021-125: Psoriasis – Improvement in Patient Reported Itch Severity

Our first measure under consideration is MUC2021-125: Psoriasis - Improvement in Patient-Reported Itch Severity.

This is a fully developed, patient-reported outcome measure that assesses the percentage of patients age 18 years and older with a diagnosis of psoriasis; for an initial visit, has a patient-reported itch severity assessment performed with a score greater than or equal to 4 and who achieve a score reduction of two or more points at a followup visit.

This measure is at the clinician level of analysis; is not endorsed by NQF, and is not risk-adjusted or stratified.

Member Shih: Thank you, Chelsea.

And I am new to this. So, I didn't realize that I would be the first person to provide the discussion.

Ms. Lynch: That's okay.

Member Shih: Did you want us to dive in?

Co-Chair Angove: Yes, I was just about to come on and ask you, our lead discussants, to kind of be ready to jump into this one. So, absolutely, why don't you start us off?

Member Shih: Okay. Great.

When I was reviewing this measure, because it's a patient-reported scale, the first thing -- and the summary didn't describe it -- the first thing I would wonder about is the comprehension and whether it was designed to be available for people with limited either comprehension or language issues. That is a concern.

And culturally, also, because this is a followup measure, are patients who are administered this instrument comfortable in describing their condition, so that they don't feel like they're non-compliant if they are not able to follow the treatment?

So, because this is an outcome measure, I know it's sort of there's multiple stages for whether a population could inadvertently be biased to look like they're performing better or not. It's worth considering at least stratifying the measure because it's not stratified. And also, to consider, if someone is using this for quality improvement as a physician, what population may not be reporting the followup? And so, potentially, socially needs to be considered in this, especially for housing, understanding that populations of housing insecurity or, potentially, other socioeconomic needs may be at a disadvantage and exacerbated by these conditions.

By the way, I wanted to note that this measure is very similar to the MUC Measure No. 129 for psoriasis. The only difference is the denominator, but both of them are very similar, in that the idea is to improve on a scale of self-reported itchiness for those that have been diagnosed either with dermatitis or psoriasis.

But I think because this is a patient-reported tool, we really need to pay attention of like how that tool is used and how it's being provided to a patient, especially if there are language or comprehension issues.

Co-Chair Angove: Great. Thank you so much.

And I'm going to have Gerald Nebeker also provide some remarks on this measure.

Member Nebeker: You know, I think that's a good point. Many people with intellectual and developmental disabilities may have this condition, but may not be able to self-report itching. And their discomfort level might be manifest in behavioral incidences, as opposed to, hey, my severity is difficult.

So, that said, I think there might need to be some ability for a caregiver or parent of a person with an intellectual disability to do the best they can at reporting this, but knowing that, you know, they're not going to really be able to get in the person's head to know exactly the measure.

So, I don't have a problem with it. I'm just thinking that, from a practical standpoint, a self-report from a person with severe intellectual disability might be challenging.

And that's my only feedback.

Co-Chair Angove: Well, thank you. Thank you.

So, I'm going to open it up to the group. A reminder: please raise your hands and we will call on you. Focus on what aspects of health equity do you see this measure advancing and what social determinants of health should be considered related to this measure. Let's start there.

Member Cole: Hi. This is Alicia Cole. I can't figure out how to raise my hand yet.

Co-Chair Angove: Yes, I saw you go off mute. Go ahead.

Member Cole: So, I'm just curious and I'm trying to get my bearings here, because I'm thinking about this in terms of self-reporting, but, then, I'm also thinking in terms of socioeconomic ability to pay for certain medications and how that might affect

what's being used and how good the product may be, the quality.

And it makes me think about, you know, I had wound care for many, many years. And one of the products that I was given to use, my copay was $600. And, yes, it worked, although later on it had a cancer risk attached to it. So, we had to stop using it.

But, you know, not everyone can afford a product for psoriasis or wound care, or what have you, that has a $600 copay. So, if you are dealing with a population that can afford products that are more expensive, or if they have insurance, that is a factor.

So, I'm wondering how that aspect of it can be incorporated into this. Just my quick thoughts.

Thank you.

Co-Chair Angove: No, thank you for those.

Dr. Sederstrom, I see your hand is raised.

Member Sederstrom: Yes. Hi. My only question, because of the issue of self-reporting, is there any incorporation on how to address language proficiency, whether or not a person is an English as a second language learner, or has any sort of health literacy needs? How is that going to be incorporated if self-reporting is going to be the measure?

Co-Chair Angove: So, I'm sorry, guys, I'm trying to see all the hands coming up. Let's go to Leonor Fernandez, please. Thank you.

Member Fernandez: Thank you.

I am (telephonic interference), but I just think it's great that there's a patient-reported measure here. I guess I'd raise just that it begs the question of whether there are other conditions that will be considered, given that psoriasis is, in fact, a little bit

more -- well, twice as common at least as reported in the white population than in black and Latino populations. I'm less clear on Asian. So, it just raises the question of equity which we may have thought of. But I didn't have something, otherwise, against it.

Co-Chair Angove: I saw some hands go down. Maybe that was the point that they were going to make?

Yes, thanks, David. David in the chat said, It's an excellent point.

Maybe we could just ask one more of these questions around if this measure could exacerbate disparities or any unintended consequences.

Yes, go ahead, Beth.

Member Godsey: I think, from thinking about this particular measure, that there is some potential of not only capturing the patient information or the social determinant of health challenges within this particular measure. So that it could be providing a signal that there may not be challenges or disparities occurring when, in fact, we may not have the underlying data or information about the person to warrant that this is being done more equitable across the patient population.

So, I just want to make sure that, if we are to leverage this measure, that we're capturing the important social determinant data elements in an accurate way, as well as SOGIE and real-based attributes. So that, when we report it out, that we're reporting as accurately as possible and it doesn't provide any bias in the assessment.

Co-Chair Angove: That's a really good point.

Mahil, I'm going to go to you next.

Member Senathirajah: Yes, this is Mahil from IBM.

I was really gaggling that point, on the lookout for response bias to see if particular groups are not participating in certain -- in addition to how they may interpret the survey cognitively and the language.

Co-Chair Angove: And, Mark?

Member Friedberg: Yes. Hi.

I guess I have a question about how we should be thinking about these in the context of equity. Are we thinking about these as measures that would be stratified and used in some kind of pay-for-equity or reporting equity program? Or on a population basis, as they currently are? And just thinking about how that use might affect the equity of care that's received.

Co-Chair Angove: It's a great question. I think we absolutely want to talk through what stratification would be beneficial when providing performance feedback for the measures.

So, absolutely, for most of these, there isn't stratification laid out. At least that's what I believe. Somebody can correct me if I'm mistaken. But we definitely want to make suggestions on what that stratification could look like as it would relate to health equity and disparities.

Member Schreiber: I'm sorry, this is Michelle, CMS.

I would ask that maybe we could contain that is a separate conversation rather than talking about stratification measure by measure, because that's really a global issue that we're looking at for CMS, about what to stratify; what would we use to stratify. And we would really welcome the comments of this Committee, but probably as a topic, rather than doing it measure by measure.

Member Friedberg: Thanks.

Co-Chair Angove: Yes, I think you're right. We're

going to have -- I think, every measure, we could say there are equity challenges or unintended consequences, depending on how and if you stratify. And so, that's a great suggestion, Michelle. Maybe we can put a pin in that and make some time at some point in the meeting today.

Member Schreiber: That would be wonderful. Thank you, Rebekah.

Co-Chair Angove: All right. Anything else that we're missing? Anything that we haven't heard?

I see, Mahil, that your hand is up.

Ms. Lynch: Rebekah, this is Chelsea.

I'm sorry, Mahil. I just wanted to point out a couple of comments from Jeff and Jason in the chat to reference after Mahil.

Member Senathirajah: Oh, sorry, I have a more general question, which is, you know, all of this sort of begs the question, are there observed disparities in these measures? I imagine that's something we don't know yet, but is there any information that the NQF staff or others have been able to pull together around these measures?

Ms. Lynch: So, the information that we have available for each of the measures is what is submitted by the measure steward and developers while they're applying to the MUC list. So, that will vary by measure. So, sometimes we may have more information than others, just kind of depending on how the measure was done, and like at what point. Is it fully developed or still under development, as well as just, is it included in something that they were looking for?

Member Senathirajah: Okay. So, everything we've got is in the packet, essentially?

Ms. Lynch: Yes.

Member Senathirajah: Okay. Sounds good.

Member Suh: Hi. It's Jason answering your question in the chat.

So, as a Native Korean speaker and having helped my father through a terrible battle with cancer for four years, subjective questions, when translated to another language, are difficult.

So, my dad asked, when he was short of breath, he's tired. And so, there are cultural differences and some stereotypes, and stuff like that, in other cultures which doesn't like to report clinical symptoms.

But I don't see a scale that the patient reports in which there's such cultural diversity in America, leading to a lot of health equity. It could actually make the answers worse, you know, certain cultures answering it one way versus another. Does that make sense?

Co-Chair Angove: Yes, it absolutely does. And I know in the chat Susannah did talk about, in addition, capturing the disparity in diagnosis and the importance of response bias, which would be related to English as a second language, non-native English speakers, and a variety of other challenges with response.

I wonder if somebody on the CMS side can take some notes around some of these issues that are more global. Because I see, even in the chat, that there's a lot of talk around, you know, these are great points and they're probably going to come up with every single measure. So, global issues that should be raised around equity. It might be helpful to start a running list that we can talk about more globally, similar to the stratification question.

Member Schreiber: This is Michelle.

Not only is NQF taking notes, I am assured by that,

and they will have a transcript, but we at CMS are taking notes of the overall themes as well. And frankly, this is part of what we were hoping to get out of the group as well, are some overall comments. So, thank you. I guarantee you we're taking notes.

Co-Chair Angove: Beautiful. Beautiful. Okay.

David, why don't I jump over to you?

Member Machledt: Thank you.

I just was wondering, along these lines, you know, I know we're not supposed to talk about stratification by particular measures, but since someone had already mentioned the socioeconomic consequences of this, if there's a thought of stratifying this by dual eligibility, if that's something that wouldn't be such a challenge? Would that help to get at maybe some of the issues? Not with the diagnosis issue, but the question of whether people are able to afford their treatment. And that is just something I think also will come up a lot in the rest of the measures when we talk about stratification.

Co-Chair Zephyrin: And, Rebekah, I'd just like to add, I think -- this is Laurie Zephyrin -- I think most of the comments were covered.

I think because, for psoriasis, just sort of putting on the clinical hat, it tends to be undertreated, and people of color are not diagnosed as well. And so, then, the questions are in terms of, in what ways could the measure exacerbate disparities or have unintended consequences? And the considerations that have been raised as part of the conversation in terms of lack of stratification, you know, that in itself can contribute to unintended consequences. So, definitely, we should put a pin in that as well.

Co-Chair Angove: Thanks, Laurie. Absolutely agree.

Susannah? Susannah? If you're talking, we can't

hear you. You might be muted on your phone set.

Member Bernheim: Thank you. Can you hear me? Sorry about that.

Co-Chair Angove: Yes.

Member Bernheim: I just wanted to say, because I know we're going to soon be asked to vote, and I raised some concerns in the chat, but I just wanted to think globally about how I'm thinking about this. And I think we'll find our way as we're getting used to these conversations.

But, you know, I think, when I think about this measure, I'm thinking, is this an area that I think about a particular focus for certain kinds of disparities? Or do I think there is a particular likelihood of unintended consequences if this is pushed forward?

And what I would say is, psoriasis is important. This measure will not help with the thing that I'm most concerned about, which is that we do a terrible job diagnosing skin disease in skin of color, but I don't think that it's going to hurt that issue.

I think that patient-report is both a really important kind of measurement to make sure we're steering some people and has, as has been raised by this group, some really important disparities or sensitive issues around language and bias in who responds. But that's global to patient-reported measures, and I think patient-reported measures are really important to be moving forward.

And so, when I think globally about voting on this, you know, I'm trying to think about what I would most -- you know, would that turn me away from a measure like this? And I would say that, the way I would pull this together is, this is an important area that's not going to, in my mind, address one of the most important disparities. But the single thing that I would want to pay the most attention to is these

issues of sort of whether the tools -- I would want CMS to pay attention to -- whether the tool is, you know, thoughtfully interpreted and whether we're monitoring for bias in the response. But it wouldn't keep me from supporting the use of this measure.

But I'm still trying to pull a lot of this together, to the extent that that's helpful.

Co-Chair Angove: Yes. And let me provide just a little bit of clarity. So, this body is an advisory body. We're not a decision-making body. Whatever we talk about today and the polling that we do will be shared with the larger decision-making group as a recommendation.

And we also will not be -- we're not here to decide on whether or not this is a good measure or not. We're really here to inform around the equity implications, the disparity challenges, and things of that nature. And the polling questions will reflect that.

So, I think that's a hard -- we just have to pull back a little bit and remember we're not saying whether or not this is a good or bad measure. And even if we say there are some equity flags for this, if you will, that may not mean that they won't pass it, right, in the decision-making, the larger group.

So, if we can kind of keep that lens, that hat on today, I think it will make our job a little easier. We really want to pass recommendations back to them with that equity lens.

So, Laurie, your hand is up, and then, next, we'll go to Leslie Hausmann.

Co-Chair Zephyrin: No, I already spoke. I've been trying to figure out to put it down. Thank you.

Co-Chair Angove: All right. Leslie?

Member Hausmann: Yes, thank you.

So, in the spirit of this board playing more of an advisory role, one thing that struck me about this particular measure is the fact that patients do have to come back twice and get assessed twice. And just given the engagement disparities in any skin-related care, I'm guessing the drop-off in having that followup visit is also going to be inequitable.

And so, I would advise the group that is making the ultimate decision on this measure to explore whether there are other ways that -- the selection bias that might be introduced by requiring two visits to calculate this particular measure, I just think would be important.

Co-Chair Angove: Thank you.

So, we're supposed to spend about 10 minutes on each. We've, I think, already spent our allotted time and more on this one.

Really, really great points raised, and I think a lot of global points that are going to continue to be raised throughout the day for nearly every measure.

Maybe we can now go on to the polling question, if there are not any burning comments that need to happen before we do our vote.

Ms. Carter: Hi. Good morning. My name is Stephanie Carter, and this measure is stewarded by AAD. And I just wanted to, hopefully, maybe respond to a few of the questions that were brought up prior to the voting.

So, first, I wanted to say thank you for the feedback and the comments.

Someone earlier had mentioned about maybe, for patients that may not be able to do the assessment tool, that maybe a caregiver or a proxy be introduced into the measure. And I think that was helpful feedback, and I think that's something that we could add to the measure.

Additionally, I wanted to bring up that this measure has three tools in it that can be used to assess for itchiness. And at least with one of them, it is available in different languages. It's validated to be in different languages, and hopefully, that can help with maybe language barriers and being able to use the tool.

The third thing I kind of wanted to touch on was there were comments in regards to patients being able to come back for a followup visit. This measure does include telehealth codes that can, hopefully, help with being able to see the patient virtually, so they don't have to physically come back into the practice, and they can see their provider and can be assessed again for this symptom of psoriasis.

And then, lastly, there was mention about the medication and how that can affect the outcome of itch. And thank you for that feedback as well.

We are in the process of developing a shared decision-making measure which I hope would complement this measure, for the provider and the patients to kind of come to a decision-making plan on treatment that works for them, and that can positively affect this health outcome as well.

So, I just wanted to add that. Thank you.

Co-Chair Angove: That was very helpful. Thank you, Stephanie.

All right. I don't see any more hands up. The chat is very active, which is great.

Maybe we can start the polling, so we can stay on schedule?

Ms. Lynch: Ivory will do that. Yes, thanks, Ivory.

Ms. Harding: The poll is now open for MUC2021-125, Psoriasis - Improvement in Patient-Reported Itch Severity, to be included in the Merit-Based Incentive Payment System, or MIPS, Program.

Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

Okay, the poll is now closed. We will now review the responses.

Zero members have voted that this measure has a high potential to have a negative impact by increasing health disparities.

Eleven members have voted that this measure has the potential to have a negative impact by increasing health disparities.

Seven members have voted that this measure will not have an impact on health disparities.

Four members voted this measure has a potential to have positive impact by decreasing health disparities.

And zero members voted that this measure has a high potential to have a positive impact by decreasing health disparities.

Thank you for your participation, and I will now turn it back over.

MUC2021-135: Dermatitis – Improvement in Patient-Reported Itch Severity

Ms. Lynch: Thank you, Ivory.

So, we will move on to the next measure under consideration, which is MUC2021-135: Dermatitis - Improvement in Patient-Reported Itch Severity. So, it's very similar to the measure we just reviewed.

So, this is a fully developed, patient-reported outcome measure that assesses the percentage of patients age 18 years and older with a diagnosis of dermatitis, where an initial has a patient-reported itch severity assessment performed that is for greater than or equal to 4 and who achieved a score

reduction of two or more points at a followup visit.

This measure is the clinician level of analysis and not endorsed by NQF, and is not risk-adjusted or stratified.

Member Shih: Thank you, Chelsea.

And I guess what I wanted to ask the Chairs is whether we need to have this discussion. I am not a physician. So, I don't know how different the diagnosis is for dermatitis versus psoriasis. But the instrument and the denominator is almost identical, except for the diagnosis.

Co-Chair Angove: So, it's a great point, and I was going to raise it. I think just, in the essence of time and having a productive day, if the group -- I would love to hear from the group, both you, Sarah, and Gerald as well, our lead discussants, if they feel this is a very similar measure, which it sounds like you do.

And then, I think what we would want to do is just make space to either, very briefly, have individuals on the Advisory Group just say that it is like the one we just measured, kind of just take those notes, and put them over here. And then, also, if there's anything additional that we need to cover, but I agree, I don't think we need to have the exact same conversation.

Member Nebeker: My feedback would be exactly the same on this one.

Member Shih: Mine as well, Alicia.

Co-Chair Zephyrin: This is Laurie Zephyrin.

I think the one difference potential difference could be around the end, right, the population? There's probably more, there might be more among the dermatitis diagnosis than the psoriasis diagnosis.

Was someone else talking?

Co-Chair Angove: Yes. Grace, were you trying to jump in?

Co-Chair Zephyrin: I think she may have accidentally gone off mute.

Are you there?

Ms. Snyder: Oh, apologies. I'm not on mute.

Co-Chair Angove: Laurie, you raise a really good point.

Anybody else have anything? I see in the chat people are kind of saying, yes, more of the same.

Maybe I can open the floor to anybody that feels that there's a unique comment or challenge or equity issue that we need to discuss for this one.

Member Friedberg: I think this is an example of where the only thing that's different is the denominator, right, the denominator condition? And now, there's been some chat about how that might be important in determining the overall measurement space and making sure that's equitable.

So, the same concern, I think, as for psoriasis really. It's just that this is probably some information that in future meetings we should ask measure developers to provide.

Co-Chair Angove: Great. Thank you, Mark.

And I feel like, with the chat and the comments I've heard, it feels like consensus to me.

All right. Maybe we can pull up the poll, and we can do the poll for this one?

Ms. Harding: Getting to the poll.

The poll is now open for MUC2021-135: Dermatitis - Improvement in Patient-Reported Itch Severity, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparity if this measure is included within the proposed program.

Okay, the poll is now closed.

Zero members responded that this measure has a high potential to have a negative impact by increasing health disparities.

Eleven members responded that this measure has a potential to have a negative impact by increasing health disparities.

Six members responded that this measure will not have an impact on health disparities.

Four members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And one member voted that this measure has a high potential to have a positive impact by decreasing health disparities.

Thank you.

Member Sederstrom: I accidentally hit the wrong vote, and I couldn't clear it in time. So, I don't know if that can be changed or erased, or anything.

Ms. Harding: Yes, I believe if you can email the team your correct vote, we will make sure to have that recorded properly.

Ms. Lynch: Okay. So, we will move on to the next measure under consideration -- oh, actually, our apologies.

Just to update that, let's so a revote. So, we're able to capture in the minutes and in the transcript the appropriate voting. So, we'll run that vote one more time, please, Ivory.

Ms. Harding: Okay, I'll get that set up.

Co-Chair Angove: And while she's doing that, why don't we, moving forward -- there's a lot of really rich conversation about these global aspects that we definitely want to have time for. So, maybe for individual measures, moving forward, we can try to focus more on the specific health equity implications of the measures themselves.

That will save us a little bit of discussion time, so we're not rehashing these global issues and topic areas for every measure. And then, hopefully, that time saved will give us some time at the end of the meeting where we can really talk through the global, some of these global issues and equity concerns.

So, that's going to be my request for future measures, and I'll get out of the way and let you all do your poll.

Ms. Harding: Okay, the poll is now reopened for MUC2021-135: Dermatitis - Improvement in Patient-Reported Itch Severity, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included within the proposed program.

We'll give everyone a few more minutes.

Okay, the poll is now closed.

Zero members responded that this measure has a high potential to have a negative impact by increasing health disparities.

Eleven members responded that this measure has a potential to have a negative impact by increasing health disparities.

Eight members responded that this measure will have no impact on health disparities.

Five members responded that this measure has the

potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has a high potential to have a positive impact by decreasing health disparities.

Thank you.

MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty or Total Knee Arthroplasty

Ms. Lynch: Okay. Thank you, everyone.

So, we will move on to MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty or Total Knee Arthroplasty.

This is a fully developed patient-reported outcome measure that assesses the percentage of patients aged 18 years and older who had an elective primary total hip or total knee arthroplasty during the performance period and who completed both a pre- and post-surgical care goal achievement survey, and demonstrated that 75 percent or more of the patients' expectations from surgery were not met or exceeded.

This measure is at the clinician group level of analysis. It is not endorsed by NQF, and the measure will be reported as two risk-adjusted rates stratified by procedure.

Co-Chair Angove: Thanks.

And, Jeff, I'm going to have you jump in as our lead discussant.

Member Huebner: Great. I'll try to kick it off.

So, this is a patient-reported outcome measure with the goal of trying to provide the best post-acute care for patients that leads to improved outcomes in regards to pain and function and quality of life.

And I think, as the prior discussion highlighted, many of us see the benefit of having more patient-reported outcome measures.

The social determinants considerations I think are very similar to the prior discussion, as a patient-reported outcome measure, especially in regards to language and, potentially, cultural background in regards to answering the questions that would be on the questionnaire.

This one is a little bit more, I guess, intensive compared to the last measure, in that it requires that pre-surgical assessment, the surgery to occur, and then, the post-surgical patient-reported assessment, which happens over several months.

And I think the measure -- and I see we have an expert in the chat who is going to be able to help talk us through this.

There are some concerns about the burden in regards to coming back for certain patient populations perhaps, and being able to fulfill this measure and be included in the denominator.

The measure is risk-adjusted by age, gender, and BMI, which would be very much biological factors, and shown in the literature to affect the potential measurement outcome. But there was no comment that I could find in my brief review of the literature in regards to how this would be impacted by other factors that could potentially be considered for risk adjustment, such as socioeconomic outcome or background.

It is not going to be stratified by race, ethnicity, or other factors. And I think stratification would be beneficial to help in monitoring for disparities that might occur in this measure and potentially inform efforts to prevent those disparities or address them as they're occurring.

And then, in regards to unintended outcomes, I

think we addressed the part about the denominator potentially not including people of backgrounds that aren't able to fulfill the full course and complete the post-survey.

And perhaps this is my own bias as a clinician, but knowing already that there is a disparity in who gets THAs and TKAs by race, ethnicity, and other factors, and seeing that it's a difficult procedure for many people to obtain, based on access and their background, there is the potential as well that this measure could foster trying to select patients that would potentially do well with the measure from the clinician's view.

Co-Chair Angove: Thanks, Jeff.

The one thing that -- oh, I'll kick us off, because I had a couple of thoughts on this one, and then, I'll open up the floor.

The one other thing that I thought of as I was reading through and reviewing these was, not necessarily this measure, but related to the measures, the patient-centeredness of the pre- and post-surgical surveys. I work in a field around patient experience, and often, a lot of these surveys and assessing patients' needs, patients' care goals, aren't patient-centered.

And so, you know, a question that was flagged -- and it may be irrelevant -- was just what these goals and expectations are. Is it a predetermined list? Is this part of that clinical (telephonic interference) they're having, very sensitive to things that include both clinical and non-clinical aspects of the patient experience. And so, this just kind of brought up that thought in my mind.

Dr. Rozenblum: So, this is Ronen, the developer. Whenever you want me to respond -- I don't want to interfere with the process -- I would be happy to address some of the stuff here.

Co-Chair Angove: Yes, absolutely. I'm trying to watch and see if we have any hands raised for this one.

I do not see any right now. So, if you want to jump in and respond to what you've heard so far, that would be great.

Dr. Rozenblum: Great. So, first, thank you for the consideration and the feedback. I think I really appreciate that.

So, for the record, just to state that the proposed PRO-PM was developed as part of the grant that we received from CMS. So, it was monitored by the CMS. And consistent with that, with this notion, we followed the CMS guidelines and NQF blueprint regarding potential issues and challenges related to health equity and specific needs of this patient relation.

Specifically, we considered throughout the measure developing various individual risk factors, social risk factors. So, we did the comprehensive work, and I will not get into the details, but we did the comprehensive literature review about the potential effect of the concept in the measure around care goal achievement regarding a specific relation.

Jeff, to your point, we reviewed really the measure's -- we did the comprehensive, qualitative interviews and focus group program, including cognitive testing with patients, providers, and peers, and including these focus groups and interviews, the various populations to get their perspective. They all show a lot of appreciation on the value of the measure, and in interviews, you know, didn't recognize any potential risk when it's coming to the various population and equity.

We did quantitative testing around social determinants and equality and cross-sectional and prospective testing, looking at the performance measure. And we checked if there is differences in

terms of the performance of the measure regarding race, you know, ethnicity, and education as a surrogate for socioeconomic, and we didn't find any difference between them. This is supported, also, by the literature, that there is not, and if there is anything, and we worked with measure experts.

So, based on all this input, we concluded a few things.

So, first, we, as mentioned in the slides, we did stratify the measure by hip and knee because we saw different expectation, and it is well-described in the literature that patients have different types and levels of expectation and roles regarding hip surgery and knee surgery.

And as Jeff mentioned, we risk-adjusted for race, ethnicity, and education. We did conclude that, based on all this input, that the treatment PRO-PM will advance health equity by addressing some of the key domains of health equity.

The first one is health care access and quality of health care, which focused on health communication. So, the aim of this domain, as you all know -- you're experts -- is to decrease the proportion of adults who report broken communication.

And this measure, just to get clear, is not assessing the patients' really methods for things that are not extreme. The aim is to enhance communication between providers and patient, patient and providers, regarding their goals and expectations, which there's huge gaps today in the field.

By the way, another thing that we identified in terms of measure gap, there's no existing measure. You know, (telephonic interference) PRO-PM.

We also, in terms of the second domain in social determinants, which is increased proportion of adults whose health care providers involved them in

the decision as much as they wanted. As you all know, our measure is definitely enhancing patient engagement in the process and involving them in that.

And the last thing that I will say in terms of, you know, all this input for everything that we, quantitative and qualitative, this mixed method, we concluded that there is a minimal negative effect on social determinant. So, this was also supported by measure developers and a lot of patients, as you mentioned, working with patients.

Now, Rebekah, to your point, which this is my area also, patient-centered care, patient experience. So, I'm very sensitive. So, the question there is cognitive testing. I think that the burden, we actually tested the burden. From qualitative, we asked payers, providers, and patients. They didn't see any burden, additional burden. In terms of quantitative testing, it took them like two to three minutes in terms of burden.

In terms of methods, you know, any PRO-PM, it's pretty important to compare data, but we tested the different modalities like EHR and paper-based, and people can use it like in both ways.

And the mechanism of calculating is very, very simple. In fact, again, to your point, it's very simple serving a question, tackling, you know, three domains, main domains, in total hip and total knee with physical function, pain, and wellness, which asked not about a list of expectations. We didn't want to go there, and we didn't develop that. It is, basically, asking the level of expectation regarding pain from the surgery, and then, later on, we addressed that.

And we are not trying to improve patients' satisfaction here. That's why there's no issues with selection bias. We just want to see a patient comparing patient to himself in terms of if the expectation was low. We addressed expectations

without trying to do that.

So, we feel very confident that our measure, actually, will promote patient-centered care and social determinants.

Sorry for being long.

Co-Chair Angove: No, thanks, Ronen.

Yes, we do need to jump in and give our Advisory Group some time to discuss.

And, Beth, I'm going to go to you.

Member Godsey: Yes, I think one clarifying question and this was actually in the chat. You know, did you mention that the measure's risk-adjusted for race?

Dr. Rozenblum: I didn't understand the question. If you want to restate --

Member Godsey: Is the measure risk-adjusted for race?

Dr. Rozenblum: No, it's not. It's just --

Member Godsey: Did you state, Ronen, is the measure risk-adjusted for race?

Dr. Rozenblum: No, the measure is risk-adjusted for age, gender, and BMI.

Member Godsey: Okay.

Dr. Rozenblum: We considered the way we did the analysis race, ethnicity, and education as a surrogate for socioeconomic, and we made a decision based on the results and input from, you know, qualitative input, not to include that because it will do the opposite, basically.

Member Godsey: Sure. Okay. Thanks for the clarification.

And the reason why I asked, and someone else

brought it up, too -- and I think Jeff's comment earlier when he introduced his --

Co-Chair Angove: Beth, I'm sorry to interrupt.

Member Godsey: -- perspective I thought was very telling. And this is a measure that -- can you hear me?

Co-Chair Angove: No, Beth, I'm sorry to interrupt. I just want to make sure that we hear what you want to say. You are breaking up just a little bit. So, is there a way you can get to a place with maybe a stronger signal?

Member Godsey: Sure. Can you hear me okay now?

Co-Chair Angove: Yes. Yes, you sound good now. I did not mean to interrupt.

Member Godsey: No, no, I'm glad you did, so to make sure that you can hear me. So, apologies for that. Maybe if I talk a little slower.

I think part of the comments that Jeff made related to access to elective procedures, such as total hip and knee, for certain patient populations who may have challenges in actually getting this procedure may showcase what Ronen was saying, that race and ethnicity did not show up as a risk factor, a significant factor, because those patients aren't actually getting into the measure because they can't get access to this particular care.

And so, I think that, in some ways, there could be a potential concern that this measure is somewhat self-selecting out certain patient populations who might have less resources or access to care or because (telephonic interference) may have other social hardships that they need to prioritize over their health.

Hopefully, that was clear, and I will certainly move around.

Dr. Rozenblum: May I reply for that? Or there's no time for that?

Co-Chair Angove: If you have a brief reply, absolutely.

Dr. Rozenblum: Very, very brief. So, we actually think, based on the input of stakeholders, patients, and providers, that this will improve access, just because, first, you know, for a certain population, that the issue of communication with the providers, it's going to enhance that.

But, in terms of access, our measure is not dependent on another measure, and it does not require any group or any objective measures. So, patients can fill out -- you know, we incorporate our measure into applicant. A patient could do that from this, I mean patient portal or paper. So, it's actually there is no issue, from our perspective at least, with respect to comment, that there's not going to be any issues comparing it to other measures that you need to go to the clinic and to measure yourself.

Co-Chair Angove: So, I really appreciate the measure developers that are on and offering some clarity and some details. I just want to kind of remind everybody, don't feel the need to defend the measures. We actually brought this group together to provide critical and external insights into equity implications. And so, I appreciate all the comments, but we don't want you to feel like you're having to defend what you did or why you did it.

I think everybody that develops measures does a great job and follows guidelines and does what they think is right. And this is just that kind of external, third-party way of making sure there weren't any blind spots or gaps, because we're not as close to the development as you and your team were.

So, thank you for the details.

Dr. Rozenblum: Thank you.

Co-Chair Angove: I see Alicia. Yes?

Member Cole: Yes. So, I'm thinking about just the component of this, of the pre- and the post-, and the expectations. And I'm thinking in terms of, you know, my dad's two total knee replacements and my aunt's and other patients that I've navigated through the process.

And I'm thinking about the differences in the way their expectations were even presented to them, of whether they were a young athlete who was concerned about being able to play a sport again or whether it was my aunt who was concerned about being able to do ballroom dancing again.

I'm thinking about things like age and how culture can affect that because I've had elderly patients who said, well, you know, I'm getting older and pain is pain. And I'm just going to always have this pain. No, you shouldn't have the same degree of pain afterwards that you had before.

And I look at the difference in who received a CPM machine and who didn't. And I think about things, people not understanding that, when you're evaluating the after care and your progress, walking is very different from full range of motion. Yes, you can walk and you're not using a cane anymore, but do you have full and total range of motion? Have you done all the bends that you're supposed to do?

So, these are very subjective things that, if a patient, you know -- I think about my Guatemalan neighbor who, months later, was having a lot of swelling with her knee and a lot of pain, after doing quite well for the first month, and she didn't want to complain because her doctor was nice. And so, her whole evaluation, then, became based on the niceness and kindness of her doctor rather than the fact her knee was swelling and she was still in pain.

So, you've got a lot of subjective things going on here when you start dealing with age and culture

and what is discussed as a good outcome prior to the surgery. I don't know; I just have so many questions about this one. I really do.

So, thank you.

Co-Chair Angove: Yes, Alicia, you raise some really insightful points. As you were talking, I was even thinking this could impact how providers set up what the expectations are, either positively or negatively, almost teaching to the test, if you will, knowing that this is a quality measure and that followup is going to be important, right, that those two match?

So, really, really great points.

Leonor, we're going to go to you next.

Member Fernandez: Thank you, Rebekah.

Yes, I just wanted to ask sort of a procedural question relating to this for all of our voting. So, it feels to me, from listening to the group and just, in general, the literature, that we're going to want stratification in all measures.

And so, I was a little confused in the previous voting, you know, how to answer because I would answer one way if it is stratified and another if it weren't.

In terms of risk adjustment, it's going to come up over and over again in terms of the specific details of how that risk adjustment is done and based on what -- will be exactly what determines for many of us whether we think it promotes equity or bakes it in.

And then, how we deal with the denominator. So, whether a person not answering or those folks not included, how we deal with that and whether that is included in the measure, forcing a system to try and deal with that or not.

So, these things are going to come up with every single measure, and it's hard to vote without knowing how they figured.

Co-Chair Angove: So, Leonor, I think I would respond that we need to vote on and discuss the measures as they are. So, if there isn't stratification, you need to vote assuming that this measure is going to be pushed through as is with no stratification and vote accordingly.

I think if we can save some time for the end of our meeting, we can talk about, you know, potentially, for the majority of these, there's an asterisk, right? Like it may increase disparities without stratification, right? So, I think that's where that bigger conversation comes in. But, for voting, I think we need to assume that this is going to go to the bigger committee as is, and what recommendations do we need to give them around approval, or I don't know if they're going to recommend modifications. That would be great. But that's how I would approach it.

CMS and all the leaders on this call, would you agree?

Okay. Karthik, I'm going to go to you next.

Member Sivashanker: Hi, all. Yes, I'm really appreciating the discussion.

And as it relates to this particular measure, I'll mention that I believe it was tested just at Mass General Brigham, is that correct?

Dr. Rozenblum: Just, yes, it's in one department in a sense, yes.

Member Sivashanker: Sorry, say that again, Ronen?

Dr. Rozenblum: Yes, like six sites at the department system, which is six hospitals.

Member Sivashanker: Okay. Got it.

So, I just happened to be, you know, kind of getting back to some of the broader concerns raised about access, you know, I just happen to be in the Mass General Brigham system. So, I know something about it.

And I'll say that, for example, in my hospital, which I'll leave unnamed, although you could probably figure it out pretty easily, the vast majority of the patients in our ortho clinic are white. It's not even close to being representative of the demographics of greater Boston. So, who's responding to this is going to be very different than who we should be caring for in the community.

So, I'm just going to bring that up, and then, just like thinking about the possible limitations of the Mass General Brigham the only tested metric.

Dr. Rozenblum: Yes. So, I appreciate that. So, that's why I highlight that, basically, part of the testing, quantitative and qualitative, we included diverse groups and we included, also, their perspective, as well as quantitative testing, to see if there is a different opinion.

And just I see a few comments about age. We did; we are risk-adjusting for age. So, age is there.

And I think, Alicia, you raise a lot of good points which really is like talking about the value of the measure. The measure is actually patient-centric here, and taking into account the subjective thing of any concerns and goals and expectations. And basically, even if the measure is the perceived conversation between the patients and the providers, that's what the measure is doing, because they are not doing that so well.

And he's talking about a lot of my studies which I'm not going to talk about here. You know, going back to what you said, it cannot manipulate the provider stuff because we're asking the patient about their expectation. It can be low, high, or whatever. And

then, we are asking them after that. It's all about managing the unrealistic expectation, that we know that we have consequences on outcomes later on in theories.

Co-Chair Angove: All right. Thank you.

So, I'm going to keep us moving forward. Otherwise, we are going to be here until 10 o'clock at night, and we didn't budget in a dinnertime break. So, we're going to get us moving.

I don't see any hands up. So, I'm going to take that as a sign that we don't have anything new. The chat is very active, and I appreciate everybody putting comments and thoughts in there.

If there aren't any pressing issues that need to be raised about this before we vote, I'm going to suggest that we pull up the polling.

Ms. Lynch: Ivory, you're in mute.

Ms. Harding: Thank you. Can you hear me now?

Ms. Lynch: Yes. I think people were following along anyway, but we just wanted --

Ms. Harding: Okay. MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty or Total Knee Arthroplasty, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

Okay, the poll is now closed for MUC2021-063, and the responses are as follows:

Two members responded that this measure has high potential to have a negative impact by increasing health disparities.

Nine members responded that this measure has the

potential to have a negative impact by increasing health disparities.

Nine members voted that this measure will have no impact on health disparities.

Four members responded that this measure will have the potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has the high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: Thank you.

Thank you all.

MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure

So, we will move on to the next measure under consideration, which is MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure, (PRO-PM).

This is a fully developed patient-reported outcome measure that estimates a clinician- and clinician-group-level risk standardized improvement rate for patient-reported outcomes following elective primary total hip or total knee arthroplasty for Medicare fee-for-service patients 65 years of age or older.

The substantial clinical benefit improvement will be measured by the change in score on the joint specific patient-reported outcome measure instruments measuring hip or knee pain and functioning from the perioperative assessment to the post-operative assessment.

The measure has not been endorsed by NQF, but is slated to be evaluated for endorsement in the fall 2021 cycle.

Co-Chair Angove: Thank you.

And, Karthik, I'm going to have you start us off, as our first lead discussant.

Member Sivashanker: Great. So, I'll try to keep it brief, since we're, I'm assuming, over time.

So, there's some things we like about this metric on the AMA side, and there's some concerns that we have. I'll just focus in on the concerns for the moment.

One is just in terms of the burden to collect all of this data. So, the practice and the clinician have to collect the data for the measure 90 days pre-op up to 425 days post-op. And my concern might be that this burden would be unevenly distributed across clinicians and practices, based on their resources and the complexity of the patients that they're caring for. For example, if you're taking care of more non-English-speaking patients, that's a very different burden than if you're not.

My understanding is there is no adjustment for stratification by race, ethnicity, language, et cetera. And kind of going back to the last measure, there's that same question about potential selection bias in terms of who's being offered the procedure in the first place and who is not, and as a result, who's reporting on this measure or not?

So, I'll pause there and hand it over to the group.

Co-Chair Angove: Thank you so much.

And we are going to skip Susannah because she is part of the development team. So, she won't be a lead discussant on this one.

So, yes, let's open it up to the group for thoughts

and comments.

Go ahead, Mahil.

Member Senathirajah: Yes, thanks. This is Mahil from IBM.

You know, with respect to the access issue and selection bias, my thought is, yes, it may impair the measure, but maybe there's another measure that needs to be developed to assess access. Because I think we might face selection bias on a lot of this, but the measure itself is constructive, you know, reflecting those that did get a THA or a TKA. It may be structurally sound as is. So, I just wanted to parse out those two things.

Co-Chair Angove: And, Jeff, go ahead.

Member Huebner: Yes, with both this one and the last one -- and I'm saying my opinion more on this one since I'm not the lead discussant -- but just from my vantage point as a practicing primary care physician in multiple regions of the country, access to these procedures for low-income populations, patients from more diverse backgrounds, is incredibly challenging.

And I'm just concerned that adding more quality measures that will lead to higher payment will steer orthopedic surgeons to accepting patients for surgery that they think are going to be successful, in their view. And that's subject to a lot of bias, and it's also subject to inadequate support in regards to the social determinants concerns that we're familiar with.

That said, I totally applaud the direction of patient-report outcomes measures and all the work that's going into them. I do want to say that.

Co-Chair Angove: Yes, and there's some chat activity around this topic, too. And it's interesting, this is our first clinician level of analysis, too. Is

there anything specific that we want to add about the level of analysis on this one? Either a global issue that we can raise and pin for later or specific to this measure?

Dr. Balestracci: If I may, this is Dr. Katie Balestracci. I am representing the measure developer for this measure.

I can respond to a concern here, too, or, first, let your Committee finish discussing.

Co-Chair Angove: Katie, just give us one more minute to make sure kind of everything's out on the table.

Dr. Balestracci: Absolutely.

Co-Chair Angove: And then, if you can just keep those comments very brief and kind of laser-focused on clarity, as opposed to --

Dr. Balestracci: Absolutely.

Co-Chair Angove: Yes, just a large, descriptive comment.

So, does anybody have additional thoughts or comments before I let Katie offer some thoughts on this one?

And I don't see hands, but feel free to unmute as well, if you can't find the hand raise.

All right. We're trying to make up time. Katie, go ahead if you have some brief things to add.

Dr. Balestracci: Absolutely. I just wanted to note a really important aspect of this measure, which is the measure of improvement and the approach taken to measure improvement. So, rather than evaluate a patient's post-operative status alone, this measure looks at a threshold level of improvement.

And what that does is it actually works to

disincentivize surgeons from not treating patients with greater severity or patients with social risk factors that might suggest more challenging improvement. These patients with greater severity actually have, statistically, a greater opportunity for improvement because of this threshold approach to improvement. We're looking for substantial clinical benefit. So, if they start with a lower baseline score, they actually have a greater statistically opportunity to reach improvement. So, in terms of the surgeon's approach to selection, I believe that this threshold improvement actually works against that danger or that concern.

The other thing I simply wanted to mention briefly is that an important aspect of this measure is the approach to response bias or potential response bias. I think we know that PRO-PMs, as measures with voluntary data collection, can be challenging. And we have included a number of social risk factors in our response by this approach to try to really address concerns around the fact that folks that may be of non-white race, dual-eligible, or have low SES may be slightly less likely to respond. And we want to make sure that our outcomes are reflecting their improvement.

Co-Chair Angove: Thank you so much, Katie.

And I don't see any new chats or any hands up. So, I am going to suggest that we move to the polling to keep us moving forward.

Ms. Harding: Okay, the poll is now open for MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (PRO-PM), to be included in the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

Okay, the poll is now closed for MUC2021-107, to

be included within the MIPS program.

The responses are as follows:

Three members responded that this measure has high potential to have a negative impact by increasing health disparities.

Eight members responded that this measure has a potential to have a negative impact by increasing health disparities.

Six members responded that this measure will have no impact on health disparities.

Five members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has a high potential to have a positive impact by decreasing health disparities.

Thank you.

Co-Chair Angove: If we can all make sure we are muted? Thank you.

Before we jump to the next one, I saw this question in the chat and I just wanted to clarify. So, these poll questions are great because it gives us a bit of quantitative way to talk about the implications for disparities/inequity. But we are also taking detailed notes, as well as a transcript is being created from this conversation. Those comments and thoughts and notes will be shared, in addition to the polling questions, with the larger decision-making body.

So, they are not just going to share the poll, in and of itself. The conversation we're having will also be shared with that group next week.

Ms. Lynch: Yes, that's wonderful. Thank you for sharing that, Rebekah. I was about to say the same. We will definitely give context to the voting results

and make sure people kind of understand the thought process of the Advisory Group when they're reviewing the measures.

MUC2021-090: Kidney Health Evaluation

So, our next measure under consideration is MUC2021-090: Kidney Health Evaluation.

This is a fully developed process measure that assesses the percentage of patients 18 to 75 years of age with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate and a Urine Albumin-Creatinine Ratio within the 12-month measurement period.

This measure is at the clinician group level of analysis. It is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: All right. I'm going to hand it over to Jason, as our first lead discussant.

Member Suh: I have to double unmute. Can you guys hear me?

Can you guys hear me?

Ms. Lynch: Yes.

Member Suh: Oh, okay. Great.

Co-Chair Angove: Yes, you're not on video. We all gave you the nod and the thumbs-up.

(Laughter.)

Please go ahead.

Member Suh: How about that? Okay. All right.

So, one of the subjects that we took on for kidney health was the GFR is currently viewed by most lab companies as black and non-black GFR. And it has this racial bias in the actual calculation itself.

And we found that, with the studies that we did, that it actually can delay dialysis and rating of patients when we do it this way. There's actually no medical evidence that that's supported. It's kind of old medicine that we're undergoing.

And in that effort, we eliminated the calculation of GFR, black and non-black, and we went with eGFR, which is officially the non-black number. And it's done really quite well. So, that's what we've done.

And I can also turn it over to the next subject matter expert.

And I think, from all of our nephrologists in our systems, this has been widely endorsed as, why didn't we do this sooner?

Co-Chair Angove: Thanks, Jason.

Emily?

Chelsea, I see you're kind of -- she may not be on the call.

So, let's open it up, and if she does jump on, we can give her the floor.

Any additional thoughts or concerns related to unintended consequences or the potential for this measure to advance health equity?

Co-Chair Zephyrin: This is Laurie.

I wonder if, can Jason speak -- Jason, can you speak a little bit more to what you're saying in terms of using the non-black eGFR? I mean, obviously, there's the data around the new eGFR equation, but I wonder if we want to talk a little bit more about that.

I see Sri Lekha -- I'm sorry if I pronounced your name wrong -- put some additional information in the chat.

Member Suh: Let me look at my chat.

Yes. So, I'm sorry, the question again?

Co-Chair Zephyrin: If you just wanted to just provide some additional context, either you, or I see there's someone from the National Kidney Foundation as well. Or Sri from the American Society of Nephrology, if possible, can just talk more about the change in GFR and how that's represented in this measure here, just from an equity perspective.

Member Suh: So, it eliminates racial bias, is the simplest equation that I can talk about, which is it delayed dialysis recommendations. It ranked African-Americans as less severe in kidney disease. And there's no science behind it.

Our nephrologists dove into the data. So did the Lab Stewardship Committee, led by a pathologist, and said, look, we just should go with the eGFR, making it equitable for all.

Co-Chair Zephyrin: Thank you.

Ms. Godwin: I'm from the National Kidney Foundation. Is it okay if I just chime in and give two sentences of context about --

Member Suh: Yes, please.

Ms. Godwin: Okay. So, thank you for raising this point.

I did want to just briefly clarify that, over the past approximately two years, the National Kidney Foundation and the American Society of Nephrology have convened a task force of experts on this issue to discuss recommendations for removing race from the reporting of eGFR. As you said, there's no clinical science to support the use of race, a social construct in the use of clinical medicine.

So, those task force recommendations actually just

came out this fall. So, they have recommended the use of a raceless version of the estimating equation that's used to measure eGFR. There was a concurrent New England Journal of Medicine paper that also published that new estimating equation.

There is an ongoing (telephonic interference) that that equation is implemented in all of the major national labs who have been partnered with the National Kidney Foundation since the beginning of this effort. And although the implementation of nothing happens quickly, I will say that the implementation of this is moving forward very, very rapidly.

So, we already have the LOINC codes, which will ensure that these lab tests can be reported by the labs. And so, if this measure is endorsed by NQF, and ultimately, adopted into MIPS for the year beginning 2023, I would very strongly suspect that all the reporting on this measure will be with the raceless version of the GFR estimating equation.

And I do know that one of the physician experts from the American Society of Nephrology is on, and she can certainly speak to any of your more clinical questions about GFR reporting.

Co-Chair Angove: And I'm going to jump over to Paul to make sure we get all the Committee questions and comments out.

So, Paul?

Dr. Palevsky: Are you referring to Paul Palevsky?

Co-Chair Angove: Yes. I am sorry. Paul Palevsky.

Dr. Palevsky: I was actually going to comment, Miriam. I am President of the National Kidney Foundation. So, Miriam Godwin, who is from the NKF as well, has already commented on the fact.

(A) Merely removing race from a calculation of eGFR has actually been shown to increase issues related

to disparities. Therefore, we now have this new raceless equation, as was just referred to.

The other key point to recognize here is that this is a measure based on both eGFR and the other half of identification of kidney disease, which is urine albumin-to-creatinine ratio testing, which is an underutilized test. We know that there are disparities in kidney disease, and identification of patients based on albuminuria may actually move us towards less disparity in diagnosis among a population where there is marked overrepresentation of patients with kidney disease in the end stage kidney disease population.

Co-Chair Angove: Great. Thank you so much, Paul. It's very, very helpful.

I don't see any additional hands up. We have a little bit of chat activity. I'm just going to pause to see if anybody wants to pop their hand up or pop anything into the chat before we move to the polling question.

Co-Chair Zephyrin: There's a great question in the chat, I guess, Jeff, around -- and I think Miriam mentioned it -- around, is everyone going to be using this, the new eGFR? So, I think that's an important point to note, because that's a significant aspect in ensuring that it's measuring appropriately from an equity standpoint. So, maybe that's something we can note.

Dr. Palevsky: Can I comment on the implementation?

Co-Chair Zephyrin: Great. Yes.

Dr. Palevsky: It's already been referred to, but there's already a strong commitment from Lab Corps and Quest. Major other regional labs are implementing it. I mean, it is unusual to see changes implemented after a task force or a guideline comes out within a relatively short period

of time. But the community has been primed for this.

We certainly can't talk -- there are over 5,000 labs in the United States that report serum creatinine in an eGFR. So, we certainly can't have data on all those labs, but the large labs and many of the smaller labs have been out in front of this. We're waiting for the new equation and have committed. There will actually be a document coming out from the lab community calling for immediate implementation of the new, race-free eGFR equation. So, the lab community is strongly behind moving away from the older MDRD and CKD-EPI equations that included race in the calculation.

Co-Chair Angove: Wonderful. Thank you so much for that clarity and those details.

Member Cole: I have a quick question, just to piggyback on that, because I love what Paul was talking about. Is there a way to marry -- like you talked about moving away from the eG -- I'm so bad with acronyms -- but the eGFR? That's what it is, the eGFR. And also, putting it in conjunction with the lab testing, the serum creatinine, and all of that?

As we have this, are those two things married in the evaluation? Are we having them go hand-in-hand or is it just the one, and we're hoping that they'll follow up and do the other? So, that's my question, because I like what he said. It's not just going raceless, but it's also the labs. So, are we incorporating both of those like in tandem, or incentivizes that those things are done in tandem?

Thank you.

Dr. Palevsky: So, this is a measure for patients with diabetes that they have both an eGFR measure and the urine albumin-to-creatinine ratio measured at least once within the 12-month measurement period. Doing an eGFR alone doesn't meet the

measure. Doing a UACR alone doesn't meet the measure. You need both done within the 12-month measurement period to meet this measure. So, this is trying to drive the appropriate testing for kidney disease in a population, patients with diabetes, who are at highest risk for development of kidney disease.

Member Cole: Perfect. That answered my -- that clarified it for me perfectly. That's what I was hoping.

Thank you.

Co-Chair Angove: All right. I think we're probably ready to poll on this one.

Lots of great information. I appreciate it.

Ms. Harding: The poll is now open for MUC2021-090, Kidney Health Evaluation, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is to be included within the proposed program.

The poll is now closed for MUC2021-090, and the responses are as follows:

Zero members responded that this measure has a high potential to have a negative impact by increasing health disparities.

One member responded that this measure has a potential to have a negative impact by increasing health disparities.

Three members responded that this measure will have no impact on health disparities.

Thirteen members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And eight members responded that this measure has the high potential to have a positive impact by decreasing health disparities.

Thank you.

Co-Chair Angove: It looks like we may have to revote. In the chat, we had somebody that miss-clicked again.

Ms. Harding: Okay, I'll reset.

Co-Chair Angove: Thanks, Ivory.

And she apologizes.

As you're resetting, we have three left after this one. We have 11 minutes until lunch. We can go a little late. But I want to get everyone's comments and thoroughly review, everyone, but I also don't want to stand between everybody and a much-deserved break. So, I'm going to move us quickly, once we're done polling here and we get to the next one.

Ms. Harding: Okay, the poll is now open for MUC2021-090, Kidney Health Evaluation, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included within the proposed program.

Okay, the poll is now closed for MUC2021-090, and the responses are as follows:

Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

Zero members responded that this measure has a potential to have a negative impact by increasing health disparities.

Two members responded that this measure will

have no impact on health disparities.

Fifteen members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And eight members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Thank you.

MUC2021-127: Adult Kidney Disease: Angiotensin Converting Enzyme Inhibitor or Angiotensin Receptor Blocker Therapy

Ms. Lynch: Yes, thank you, everyone.

We will move on to the next measure under consideration, which is MUC2021-127: Adult Kidney Disease: Ace Inhibitor or ARB Therapy.

This is a fully developed process measure that assesses the percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease, stages 1 through 5, not receiving renal replacement therapy and proteinuria who were prescribed an ACE inhibitor or ARB therapy within a 12-month period.

This measure is at the clinician level of analysis. It is endorsed by NQF and is not risk-adjusted or stratified.

Co-Chair Angove: Thank you so much.

And Susannah? Susannah? You have to tell me how to pronounce your name because I keep mispronouncing it.

Member Bernheim: Susannah is great, although either is fine.

I will try to be brief. I think, quickly, this is an important clinical area. The kidney disease and

treatment of kidney disease is an important focus for disparities, especially disparities by race and ethnicity.

The two concerns that I would raise about this measure are:

It is, I think, a more burdensome measure than most. It's just in a registry. So, participants in that registry, you know, sort of have the ability to provide this, but it requires a fair amount of detail out of the chart to understand exclusions, and things like that. And so, I always worry with high-burden measures that providers who have fewer resources may be less able to provide the information.

But, nonetheless, I think it's an important measure because of the focus on kidney disease and important treatment in kidney disease. And per the information we got, not very impressive rates of performance on this measure currently. So, a lot of room to improve.

The little bit that I could find in the literature, it's not clear to me that, on this particular measure, there's a lot of actual disparities in -- sort of nobody gets this often enough -- it's not clear there's a lot of disparities, but I don't know that information deeply, because that may or may not argue in the future for stratification. But I think it's important just for the overall need-to-improve rate and that's for kidney diseases, an area of critical disparities.

So, I'll cut it short.

Co-Chair Angove: Thanks, Susannah.

Jeff?

Member Huebner: Yes, it's a great summary. I would just add, I mean, this is an area where we know that there are disparities, both in the level of chronic kidney disease by race and ethnicity, as well

as the complications leading to end stage renal disease and poor cardiovascular outcomes. So, it is an important intervention that's very evidence-based.

My concern relates back to the prior conversation until we have a better way that's been fully implemented across our country to have raceless diagnosis of chronic kidney disease. This measure could lead to exacerbation of disparities and earlier treatment for white populations.

And I'll just add to it, Susannah's point perhaps was related to this, but when clinicians are focused on getting patients medicated when they're not -- and I think in this case there's tremendous evidence that we should be doing this. But, to the exclusion aspect of it, there is the unintended consequences, perhaps overtreatment as well, and it will lead to side effects and additional visits and followup that's necessary for patients that have those side effects.

Co-Chair Angove: Great. Thank you.

Let's it up to the group around what aspects of health equity this measure may advance or not advance, and then, what determinants of health should be considered related to this measure. So, let's start there.

So, a little bit of activity in the chat. I don't see any hands going up. So, you're all probably reading and typing.

Is there anybody that wants to add any points to what the lead discussants have already said or raise additional concerns?

All right. We all want to get to lunch.

Oh, Susannah, yes, jump in.

Member Bernheim: I just want to say one quick word because I think this actual question is so important. And I actually know that there is some

good work going on in this area.

So, just on our list of things we discuss later, how to think about measures where the measure may be important, but it may be influenced by outside issues, but it's coming up over and over. So, I just want to make sure we come back to it. It's really critical.

Co-Chair Angove: Yes, and I think that also makes our job a little harder, right? And so, we're not necessarily talking about the value of the measure; we're talking about the equity piece. So, yes, absolutely, let's put a pin on that. Somebody put a note, and we'll add it to the end of the day.

All right. Let's move to the poll on this one.

Ms. Harding: Okay, the poll is now open for MUC2021-127: Adult Kidney Disease: ACE Inhibitor or ARB Therapy, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is to be included within the proposed program.

I would also like to clarify that you can change your answers by just selecting on your preferred choice before I lock the poll, and I'll give a slight warning for everyone.

Okay, about 30 more seconds.

Okay, the poll is now closed for MUC2021-127, and the responses are as follows:

Zero members responded that this measure has a high potential to have a negative impact by increasing health disparities.

Five members responded that this measure has potential to have a negative impact by increasing health disparities.

Ten members responded that this measure will have no impact on health disparities.

Seven members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Thank you.

MUC2021-105: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Ms. Lynch: Thank you, everyone.

We will move on to the next measure under consideration, which is MUC2021-105: Mismatch Repair or Microsatellite Instability Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma.

This is a fully developed process measure that assesses the percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal, or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair by immunohistochemistry, biomarkers MLH1, MSH2, MSH6, and PMS2, or microsatellite instability by DNA-based testing status, or both.

This measure is at the clinician group level of analysis, is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: Thanks.

Irene, can you lead us off?

Member Dankwa-Mullan: Yes, absolutely. Can you

hear me? When I'm about to speak, my next-door neighbor landscaping is going on. So, I hope you don't hear background noise.

Co-Chair Angove: No, we hear you very clear.

Member Dankwa-Mullan: Okay. Okay, perfect.

So, I'm a physician, not an oncologist, but I've had some personal experience with this in the family.

So, we know immunotherapies. This is another measure that also has to do with access issues. We know immunotherapies have led to substantial changes in cancer treatment, because they can tremendously improve the efficacy of treatment and survival.

But only a small proportion of patients are sensitive to immunotherapy. And so, these specific value markers, MMR and MSI, are usually used to separate those that will respond from non-respondents.

So, mismatch repair pathways, they start sort of, like I said, they can play a vital role in merely looking at cancer treatment, especially in this new era of therapeutic agents and looking at prognostic significance for a disease, for these cancer types.

So, I would say that there are a lot of disparities in terms of access to this measure. There's been, for Fox Chase Cancer, steady that looked at, found out older-age black race, lack of insurance. And even the Medicaid/Medicare dual-eligibility coverage, and as well Medicare-academic or research facility center, were all independently associated with not receiving this biomarker testing.

So, as is, you know, I mean, that's, basically, the huge independent associations of race. And insurance coverage and the care center and geography -- and so, there are all these inherent structural barriers to biomarker testing that we

need to address for equitable access.

But, other than that, this is, you know, a good metric, except that we're also looking at a small proportion that will be sensitive to these immunotherapies.

I will stop here, and if Joy has anything to add?

Member Bland: No, I don't have anything to add. Thank you.

Co-Chair Angove: Diana, go ahead.

Dr. Cardona: Hi. Good afternoon. My name is Diana Cardona. I'm a pathologist at Duke, and I'm here representing the CAP, the steward of this measure.

So, just a couple of clarifications. This measure is not just looking at performance of the testing, because all your points are spot-on. Access to this testing has been an issue in the past. So, this one is really just looking at pathologists are documenting in their reports that they recommend the testing.

Now that patients have access to their reports, essentially, immediately, we're hoping that this enables that discussion between the patient and the oncologist. If it wasn't requested or if it wasn't ordered, it allows that dialog. So, the patient feels empowered to say, hey, this was recommended by my pathologist; is it going to be done, yes or no? Because, like you mentioned, access and payment issues have definitely been something that has impacted pathologists' ability to do some of the testing that they want to do.

And also, the access, we're seeing that actually improving now with these updated guidelines. Pathologists in small, rural communities and small access-type hospitals are bringing in this type of testing, especially the immunohistochemistry, which is a little bit more budget-sensitive, so that they can provide this testing. So, we're seeing that, as the

measures and these guidelines are updating, that access is actually improving. And so, that's kind of the other goal of this measure.

Co-Chair Angove: Thanks for that clarity.

Cardi, I see your hand is up.

Member Smith: Yes. Hi, and thank you for that. That's actually one of the things that caught my eye, is that this is for a recommendation, which, to me, as an oncologist, I totally understand the financial challenges to this, but it's almost giving it a bit of a pass and saying, well, you know, it was recommended, and therefore, sort of responsibility has stopped.

I just think that, you know, a lot of this is like jargon to people, right? And so, I'm not really sure that folks who may have lower literacy, or we know that there are whole populations that don't actually access open notes or look at their MyChart portals, but that's not necessarily going to help them.

I almost feel like it's stronger -- I understand I'm not going to change the measure -- but it feels like it's stronger to say that the testing should be done. And I do like that it includes immunohistochemistry because that's at least a surrogate marker and is more available than the DNA-based testing.

So, I guess to summarize my thought, it is that I'm not sure that there is an impact on this equity negatively or positively, and wonder if it may be skewing a bit towards negative because there could be a bit of a, well, we've recommended it. So, we've done our part.

Dr. Cardona: Yes, spot-on agree. Trust me, we wanted it to be that they had to do the testing, but, then, access becomes an issue and you could be negatively impacting a pathologist for something that, honestly, is not in their direct control always.

Co-Chair Angove: Some interesting comments in the chat as well. So, I see our chat is active. I do not see any other hands raised. I'm just going to pause a moment and see if anybody wants to raise their hand or add anything into the chat before we vote -- or not vote, poll. I guess it's a poll.

All right. Well, that was a rich discussion.

Let's go to the polling for this, and then, we have one more.

Ms. Harding: The poll is now open for MUC2021-105: MMR or MSI Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

Okay, a few more seconds.

The poll is now closed for MUC2021-105, and the responses are as follows:

One member responded that this measure has high potential to have a negative impact by increasing health disparities.

Eight members responded that this measure has potential to have a negative impact by increasing health disparities.

Ten members responded that this measure will have no impact on health disparities.

Two members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And one member responded that this measure has high potential to have a positive impact by decreasing health disparities.

Thank you.

Chelsea, you're on mute. We can't hear you.

Ms. Lynch: I sure was. Thank you. Sorry about that.

MUC2021-058: Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors

So, our last measure before our break is MUC2021-058: Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors.

This is a fully developed process measure that assesses the percentage of patients aged 18 years and older with a diagnosis of cancer on immune checkpoint inhibitor therapy, and grade 2 or above diarrhea and/or grade 2 or above colitis, who have immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered.

This measure is at the clinician group level of analysis. It is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: Thanks.

And, Mark Friedberg, can you get us started?

Member Friedberg: Sure. Thank you.

So, this measure probably applies to a pretty small denominator. You know, it's folks on active cancer treatment who are treated with a particular drug and who have a particular complication of those drugs.

And, you know, that sort of bears out in the submitted materials. I think there were a total of around 75 patients in the reliability testing at seven sites. So, there might be some concerns about how representative those 75 patients were, but no

information is provided on that either way. And I don't even know if that was recorded.

In the absence of some kind of clinical concern about the appropriate treatment varying by race and ethnicity, I don't really see any particular equity implications of this one in either direction.

Co-Chair Angove: Thank you.

And, Jason, anything to add?

Member Suh: I actually don't. That was a really good analysis, Mark.

Co-Chair Angove: I'm going to open it up to the floor, pause to see if anybody wants to put their hands up.

I also realize that there's a few call-in people, and it's taken me this long to realize it. But you may not have the ability to raise your hand if you're a call-in-only and not on the mobile app.

So, I'm also just going to be silent for a moment and create some space for any of the call-in participants that may need to jump in and haven't been able to. And we'll do a better job moving forward to create that space.

Dr. Pai: This is Sara Pai. I'm at Mass General Hospital, but I'm a representative of SITC, who developed this measure.

I just want to state that there is an increasing trend for using immune checkpoint inhibitors therapy, and we're hoping that it can, given its significant benefits in cancer patients. And we certainly hope that all cancer patients will have equal access to this type of therapy.

And really, this measure is really to assess for safety, making sure that the patients who do receive the drug are given it in a very safe environment, and that there is feedback on the

second-most-common adverse event associated with this drug, which is colitis and diarrhea.

Co-Chair Angove: Thanks, Sara.

Cardi, I see your hand up.

Member Smith: Yes. So, I like this. I like this a lot, as someone who prescribes a lot of immunotherapy.

I think the one thing that I'm just thinking about or wondering about is that there are still a lot of, in community settings there's a lack of knowledge still about the appropriate management for these immune-related -- I mean really the toxicity, but also, specifically, diarrhea.

And so, I guess I'm trying to think of whether this will be more in the potential to improve outcomes because it's sort of forcing clinicians to, or forcing an environment in which clinicians are better educated about what these toxicities are and how to manage it, or if we are penalizing clinicians who are in systems or settings where these drugs aren't used that commonly, and aren't as familiar with it. I don't really know that I have an answer to that. Just in case someone else can help me think about that.

Dr. Pai: Yes, that's a great question. And really, you're right, this measure is really trying to increase awareness about these side effects and trying to make sure that providers or prescribers are aware of it.

One of the requirements for really an oncologist who would be measured by this measure is that they would have, the patient has to be on ICI. So, as ICIs continue to be more used outside of the major academic centers, which we're seeing that trend already, we believe that the impact of this measure will continue to increase over time.

Co-Chair Angove: Any other thoughts anybody wants to add? Please raise your hand, or if you're

on the phone, feel free to unmute and jump in.

All right. I am not going to stand between anybody and their well-deserved break. So, let's move this forward to the polling.

I appreciate the great discussion on this one.

Ms. Harding: The poll is now open for MUC2021-058: Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors, to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities if this measure is included within the proposed program.

Ten more seconds.

The poll is now closed for MUC2021-058, and the responses are as follows:

Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

Zero members responded that this measure has the potential to have a negative impact by increasing health disparities.

Fourteen members responded that this measure will have no impact on health disparities.

Nine members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Thank you.

Ms. Lynch: All right. Thank you, everyone.

Such a wonderful discussion so far. I know we have a lot more to come.

So, we will go ahead and come back at 1:10. So, just about 27 minutes or so for lunch. I don't want to get too far behind, but I certainly want to make sure everyone gets some nourishment for the rest of the afternoon. So, we will see you all at 1:10, where we will start on measures for the PAC/LTC programs.

And this wonderful discussion that I know we're all really looking forward to having, we will likely just do that, instead of the process improvement, unless we end up having time for both, but we definitely want to make sure we get those perspectives done.

So, enjoy your lunch and we'll see you back at 1:10.

(Whereupon, the above-entitled matter went off the record at 12:43 p.m. and resumed at 1:10 p.m.)

Ms. Lynch: Okay. So, we will go ahead and get started. Welcome back everyone. I do want to just take a quick minute to have Dr. Alan Levitt from CMS & MS come talk to the advisory group.

Member Levitt: Well, thank you very much. For those who don't know me, my name is Alan Levitt. And I'm the Medical Officer in the Division of Chronic and Post-Acute Care at CMS.

For the past nine years I've been the federal liaison to the MAP in the Post-Acute Care/Long Term Care Workgroup.

I've been an interested observer here this morning, and wanted to thank the Advisory Group for the quality of the conversation and chat we've had here so far.

And so, for those of us on East Coast time, and for those in the Central time zone, as well Beth, it's onto the afternoon. Thank you again.

Ms. Lynch: Wonderful. Thank you. So, we are going to transition now to discussing measures under consideration for the post-acute care and long term care program.

In this section, we'll discuss measures under consider for the Skilled Nursing Facility Quality Reporting Program and he Skilled Nursing Facility Value-Based Purchasing Program.

Please note that there will be additional PAC/LTC programs discussed in a later section with measures that are under consideration for multiple programs.

Skilled Nursing Facility Quality Reporting Program

So, the first program that we'll talk about, is the Skilled Nursing -- excuse me, the first program that we'll talk about for measures under consideration is the Skilled Nursing Facility Quality Reporting Program.

This is a pay for reporting and public reporting program for skilled nursing facilities that do not submit the required quality data, will have their annual payment update reduced by 2 percent.

The goal of this program is to increase transparency so patients are able to make informed choices.

MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel

The first measure under consideration for this program is MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel.

This is a fully developed process measure that accesses the percentage of healthcare personnel who received the influenza vaccination.

The measure is at the facility level, is endorsed by NQF, and does not include risk adjustment or stratification.

Member Sivashanker: So, should I get started?

Ms. Lynch: Yeah, go ahead. I think Laurie might have gotten disconnected and is signing back in.

So yes, please go ahead.

Member Sivashanker: Okay.

Co-Chair Zephyrin: Yes, perfect. Please don't wait.

Member Sivashanker: Yes, so I don't have a lot to say on this one. My understanding is that it's a longstanding measure.

And it's a public health priority, which is even more important in light of COVID-19 pandemic.

So, I'd be interested to see if there's any equity concerns that are being flagged by the rest of the group. But, I'm not sure if I'm seeing anything at the moment.

Co-Chair Zephyrin: Great. Thanks Karthik. Stephanie, do you want to add anything?

Member Clouser: No. I think you kind of hit the points. You know, this is like he said, a public health concern.

And we know that black and indigenous populations have higher rates of hospitalization and death, and lower rates of vaccination coverage.

So obviously, healthcare personnel getting vaccinated is very important to those populations.

One of -- thing of interest to know is that in the numerator, a declined vaccination -- a decline to get vaccinated is included in the numerator, which providers like for people who -- for vaccine refusal.

But, not always great there.

Co-Chair Zephyrin: Great. Thank you. We'll just open up to the group. Maybe we can see if there's

any additional comments around the -- the first two questions around aspects of how effectively you see this measure advancing.

I think that Karthik and Stephanie touched upon it in terms of -- of just the importance of vaccination rates. And then the public health implications, but also the social determinant of how this should be considered related to this measure.

I don't think we need to spend that much time on it. But, I just wanted to make sure we are hearing from everyone.

Co-Chair Angove: Stephanie, I just want to clarify. Did you say that the numerator includes those that refuse vaccination?

So, publically it could seem that there's 100 percent vaccination rate in a facility, but that is actually not true?

Or did I interpret you wrong?

Member Clouser: You interpreted me correctly. And that was the impression that I was on.

But, I see under -- but I think that Megan put something slightly different in the chat.

Co-Chair Zephyrin: Yeah. Megan, do you want to -- and do you want to chime in? You said the data reported CMS only for vaccination coverage.

The clinician is measured separately, but not reported as compliant.

Ms. Lindley: Correct. I'm having some audio issues. Can you hear me?

Co-Chair Zephyrin: Yes. We can hear you. Thank you.

Ms. Lindley: Okay. Wonderful. Yes, Stephanie, you're correct. We measure, there are three

different numerator categories.

One is for vaccination received at or outside the facility. One is for a true medical contraindication, and one is for declination.

So, those are measured separately kind of for process use within the facilities. But, the data that reported to CMS for the other programs in which this measure is in use, are strictly vaccination coverage.

So, the vaccination coverage you see does not include declination.

Member Clouser: Thanks Megan. Thank you for clarifying that for me.

Co-Chair Zephyrin: Awesome. Thank you. Thanks Megan. Thanks Stephanie.

Any other thoughts or comments? Those -- great, we know this measure is still critically important.

So, I think we can probably make up some time and --

Co-Chair Angove: David has his hand up. Does that --

Co-Chair Zephyrin: Yeah. Oh good, thank you. David, you had a quick?

Member Machledt: Yeah. I just had a quick question sort of more broadly about this program.

But, the distinction about what's public -- what and how things are publically reported versus reported to CMS.

And you know, if this is about helping people decide, you know, on the quality of a scope in a nursing facility. If there's a difference in how -- if that's made clear in every measure?

I didn't see that difference noted in the measure

that I reviewed. And so, I just -- if someone could clarify that, it would be helpful for me.

Co-Chair Zephyrin: So, a clarification in terms of the location of that?

Member Machledt: The difference between public rep -- like what's available as public reporting, versus what is maybe just reported to CMS anytime.

Co-Chair Zephyrin: Fantastic. Megan, I don't know if you wanted to chime in on that based on your last comment?

But, this has three different denominators, and so want to get a sense of, are there other measures also where it is what's publically reported versus what's just reported to CMS, versus what's just a process measure internally?

Ms. Lindley: So, I don't know how broadly I can speak to what CMS does, or other measures, because I don't know SME for flu. But, I know there are other colleagues from NHSN on the phone.

For this, what we send to CMS is the compliance data. And it is, I see there's a question on the chat, stratification by personnel, yes.

It's employees versus credentialed non-employees, who are essentially physicians and advanced practice nurses, versus students, trainees, and volunteers.

And what CMS compiles for publication on the, for example, on hospital compare for the inpatient quality reporting program, is simply an overall compliance.

So, the data are available to each individual facility and NHSN. And they can look at all those different categories, including by personnel and by the different compliance or noncompliance statuses.

And then CDC, we also publish some data on our

website at the state level. Which are broken down, or again vaccination coverage only, but are broken down by those three different categories of healthcare personnel in addition to the overall compliance.

And then yes, declinations are in the denominator. Every -- the numerator -- the measure is designed so that the numerator sums to the denominator so that there's exclusion and nobody is not accounted for.

Co-Chair Zephyrin: Great. Thank you. Any additional thoughts around specific equity implications?

For stratification, other stratification concerns around race and ethnicity? Let me see, any other?

Great. Well, I think for this one, why don't we jump to the voting. I mean, I agree in terms of just population served and people that may tend to be published and sort of like having healthcare providers vaccinated.

Or having a sense of the percentage of healthcare vaccinated and have significant equity implications in a positive way.

And so, if there's any additional feedback, please let us know. Otherwise, I think we can vote. Ivory?

You have everything. So, Ivory has the poll up. She's on mute, and she can --

Ms. Harding: Hi, can you guys hear me?

Co-Chair Zephyrin: Yes.

Ms. Harding: Okay. So, poll is now open for MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel to be Included Within the Skilled Nursing Facility Quality Reporting Program.

Please submit your response to share the potential impact on health disparity if this measure is included in the proposed program.

A few more seconds. Okay. The poll is now closed. And the responses are as follows for MUC2021-123:

Zero members responded that this measure will have high potential to have a negative impact by increasing health disparity.

Zero members responded that this measure has the potential to have a negative impact by increasing health disparities.

Seven members responded that this measure will have no impact on health disparity.

Fifteen members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And two members responded that this measure had a high potential to have a positive impact by decreasing health disparities. Thank you.

Co-Chair Zephyrin: Okay. Thank you.

Skilled Nursing Facility Value-Based Purchasing Program

Ms. Lynch: Okay. Thank you everyone. So, we are going to transition to a different program.

It is the Skilled Nursing Facility Value-Based Purchasing Program. This is a value-based purchasing program that awards incentive payments to skilled nursing facilities based on a single all-cause readmission measure that was mandated by the Protecting Access to Medicare Act of 2014.

The SNF's performance period risk standardized readmission rates are compared to both their past performance to calculate an improvement score, and the national SNF performance score during the

baseline period to calculate an achievement score.

And the higher achievement scores become the SNF performance score. If the SNF has less than 25 eligible stays during the baseline period, only the achievement score will be calculated.

If the SNF has less than 25 eligible stays during the performance period, they will be held harmless.

The goals of this program are to transform how care is paid for, moving increasingly towards rewarding better value, outcomes and innovations, instead of merely volume and the containment performance on a single readmission measure.

As I mentioned, the SNF VBP program was authorized by the Protecting Access to Medicare Act in 2014. Per the Act, the all-cause measure will be replaced as soon as practical with a potentially preventable readmission measure.

CMS will withhold 2 percent of SNF Medicare fee for service payments to fund the program. And 60 percent of the withheld funds are redistributed as incentive payments.

These incentive payments to SNFs -- sorry, totally lost my place. Sorry about that.

So, the incentive payments begin on October 1, 2018. In 2021, the Consolidated Appropriations Act allows the Secretary to apply up to nine additional measures, such as measures focusing on functional status, patient safety, care coordination, or patient experience for patients or services furnished on or after October 1, 2023.

MUC2021-095: CoreQ: Short Stay Discharge Measure

So, the first measure under consideration for this program is MUC2021-095: CoreQ Short Stay Discharge Measure.

This is a fully developed patient engagement and experience measure that accesses the percentage of individuals discharged in a six month period from an SNF within 100 days of admission who are satisfied.

This is accessed using an average satisfaction score equal to or greater than three for four of the questions on a CoreQ Short Stay Questionnaire.

This measure is both at the facility and resident level of analysis, is endorsed by NQF, and does not have risk adjustment or stratification.

Co-Chair Zephyrin: Great. Thanks Chelsea. Sarita Mohanty, you start.

Member Mohanty: Yes. Can you hear me okay?

Co-Chair Zephyrin: Yes. We can hear you perfectly. Thank you.

Member Mohanty: That is great. Great, good afternoon. So, yeah, so this one is, I'll just be brief and I will look forward to hearing from David as well.

This is an important person-centered measure. You know, it really is, as mentioned, a satisfaction measure post-discharge from SNF., for the electronic and patient reported data and surveys.

And I think when it comes to looking at this measure, you know, again, speaks to be person-centered.

You know, it's associated with value-based payments, so there's incentive to collection this information and identify the satisfaction levels.

And particularly, so there's always a concern that -- about the disparities that exist in completing these surveys among those who don't have access post-discharge. You know, having language barriers.

So, I think we just need to be mindful as we're

thinking, you know, as we've talked about in other kind of patient reported type of outcome measurement.

But, we do know that there are racial/ethnic disparities in nursing home quality of life, and even post-discharge.

And even just as we think about state by state and Medicaid payments, and how that may influence nursing home quality and thereby satisfaction.

So, you know, I think if we think about more subgroup analysis and stratification, you know, that could be very important in this work to see what the differences in satisfaction would look like across payer types and racial/ethnic backgrounds for examples.

I think the one thing I wanted to ask or to kind of think about as, you know, about the input of this measure, I know it was endorsed, I guess the question about caregivers' input into this measure was a question.

I know one of the ex -- we should be mindful as we look at this measure about the exclusion. There's actually multiple exclusion criterion for this measure.

One of them is that, you know, -- and I understand that, you know, patients whose responses were filled out by someone else. But, you know, in these instances when caregivers are taking care of individuals post-discharge, you know, the question always remains about how their input is included or not.

And so, I know that -- I just wonder how much caregiver input was put into the creation of this measure.

So, I'll stop there and see if David has anything else to add. And look forward to the discussion.

Co-Chair Zephyrin: Yeah. He's on Sarita. David?

Member Machledt: Okay. Thank you, Sarita. I think that you hit on a lot of the same points that I had noted.

There was a question about, you know, I think the question of response bias that we've already discussed before, especially with regard to the race/ethnicity language.

Maybe also by payer, since this is an all payer measure. It would be really ripe for looking at by stratification.

I realize that it says it's the only measure of patient experience. Although I would say that satisfaction is maybe on the vaguer terms that maybe harder to act on, to find actionable ways to improve.

And I also looked at the exclusions as an issue potentially with, you know, having caregiver re -- or a guardian as a respondent.

I know that can cause complications in terms of who is speaking for whom. But, that is something in the question.

Also dementia, as being an exclusion. And how that affects, you know, what affects that might have in terms of disparities, right, because of the ways that those questionnaires can be, and can have -- maybe they can have some bias. I know that's a case with Alzheimer's sometimes.

So, those are the main points. I'd like to see what other people have to say that I sort of identified with this, with this measure.

Co-Chair Zephyrin: Great. Thank you David. Thank you Sarita. You definitely highlighted some of the areas that I -- I had thought.

These questions about the exclusion criteria and the stratification piece and the response bias. So,

definitely the sort of overarching issues to raise.

Any -- any other thoughts from others in the group as well? Around aspects of health equity, you see this measure advancing, or social determinants of health that should be considered, for example, related to this measure.

I think we've -- David and Sarita alluded to some of that. The one other exclusion criteria which, which you didn't mention, was around patients that were discharged to another facility or to another hospital.

Sometimes there are reasons for that because a payer says, or income, or et cetera. And so, definitely something else, I think, to think about as well, in terms of who's being excluded.

And also, the time, the response period can also be a challenge too. Yes Beth, there's some comments being -- that are coming up regarding -- yeah exactly.

Great. And so, I think we've had some robust conversations in the first quarter of this meeting. And a lot of those apply.

And thanks Leonor, satisfied as a term is very culturally dependent. So, I agree with David's point.

Did anyone comment on, if this one is risk-adjusted? I see David and Sarita shaking their heads.

Member Mohanty: No. It's not been.

Co-Chair Zephyrin: Okay. Thank you. It's not. Okay. Lightning speed everyone. Or is it the post-lunch? I don't know, post-lunch sleep.

I say we go to a vote. I don't see any raised hands. I think some of the other measures coming up are going to have some additional robust discussion.

So, I'll turn it over to Ivory unless anyone wants to

chime in on the phone or raise their hand one last time.

Great. Ivory is on it. Okay, let's vote. Ivory, back to you. I don't know if you're on.

Ms. Harding: The poll is now open for MUC2021-095: CoreQ Short Stay Discharge Measure to be Included Within the Skilled Nursing Facility Value-Based Purchasing Program.

Please submit your response to share the potential impact on health disparity if this measure is included in the proposed program.

A few more seconds. Okay, the poll is now closed for MUC2021-095. And the responses are as follows:

Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

Seven members responded that this measure has potential to have a negative impact by increasing health disparity.

Nine members responded that this measure will have no impact on health disparities.

Eight members responded that this measure has the potential to have a positive impact by decreasing health disparity.

And zero members responded that this measure has a high potential to have a positive impact by decreasing health disparities. Thank you.

Co-Chair Zephyrin: Thank you.

MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities

Ms. Lynch: Okay. We will move onto the next measure under consideration, which is MUC2021-

130: Discharge to Community - Post Acute Care Measure for Skilled Nursing Facilities.

This is a fully developed outcome measure that estimates the risk-adjusted rate of successful discharge to community from an SNF with successful discharge to community including no unplanned re-hospitalizations and no death in the 31 days following SNF discharge.

The measure is that both the facility and stay level of analysis, is endorsed by NQF, and is risk-adjusted.

The measure developers provided some updates to this, their submission about the spit sample reliability testing that was included. So, going to turn it over to Acumen for some brief updates about this.

Ms. Mattivi: Hi, thank you, Chelsea. This is Kris Mattivi from Acumen. And we appreciate the opportunity to provide a couple of brief clarifications to the materials that were provided to the committee for review.

The empirical analyses that you have in your materials are the ones that were used when the measure was endorsed by NQF in 2019. Acumen has since updated those analyses using more recent claims data.

But, these latest results are still very similar to those NQF endorsed results that you have in your material.

The interpretations regarding validity and reliability, remain unchanged. In addition, for this round of testing, Acumen applied several different approaches to the split sample reliability testing to account for the reduction in sample replies that occurs as a result of that testing.

Regardless of the approach that was used, the

reliability ranged from 0.78 to 0.88, which again, is consistent with the level observed during NQF endorsement.

So again, thank you for the opportunity to provide those clarifications. We have some other members of the Acumen team on the line that can help provide clarifications if necessary.

Co-Chair Zephyrin: Thank you. And I'll turn it over to Melony Sorbero, our first subject matter expert.

No, Melony are you on? Maybe you're muted if you're trying to talk. Or Beth Godsey at Vizient? Maybe you can get us started just in case.

Member Godsey: Sure. I can certainly get started.

Co-Chair Zephyrin: Yes, thank you.

Member Godsey: Yeah, I think, you know, this has been a well-established measure. I think in the sense of looking at it from an equity lens, you know, particularly for patients who are having challenges in their community, being discharged to their community, might -- might be somewhat problematic for certain -- for certain facilities who are located in areas where social determinants to heath are more of a concern than other parts of the country.

So, I think that that is, you know, reporting performance could be skewed in some ways, based on where that particular facility may be, and the patient populations that they may serve. As well as the patient, when they are discharged, what kinds of access to resources are they going to have.

So, particularly around social determinants to health, not only for the community, but where that patient may end up having to choose to go, could be certainly some of the challenges that I think that this measure could provide some, skewness, if you will, related to overall performance.

And the other piece is, I think that we, you know, some common things have come up related to just capture of social determinants, capture of data elements, the real data, SOGI data, those types of things.

You know, I know that that is challenging for even our most sophisticated health systems across the country.

I know that skilled nursing facilities, with some of the lack, some lack resources that that may have to capture that information clearly, it might increase some burden to be able to capture that accurately and consistently.

And so, from -- from an equity perspective, I think it's got some challenges that might need to be addressed. And I just want to bring that up to the group.

Co-Chair Zephyrin: Thank you. Thanks Beth. And Melony, she maybe having some trouble getting on.

But, you know, I'd love to open it to the group. I mean, and this measure, I think this was the -- this was the one where there was some, you know, initial concerns about nursing home residents, people who were nursing home residents at base line, and therefore much less likely to be discharged to the community.

And you know, just wondering in terms of, what's the skew to that, to that population in terms of real or SOGI data?

And Beth, I think your point around some of the SDOH implications are -- are really important.

We'd love to open it up to the group around any other health equity concerns. Or how do you -- what aspects of health equity do you see this measure examining?

Oh, Sri from Acumen, sure. And then any other

social determinants of health, or drivers of health that should be considered.

But Sri, did you want a chance to talk?

Member Sorbero: Hi, this is Melony. Can you hear me now?

Co-Chair Zephyrin: Yes, thank you. Oh, Melony. Okay.

Member Sorbero: Can you hear me, this is Melony. Can you hear me?

Co-Chair Zephyrin: Yes. We can hear you. Thank you.

Member Sorbero: Sorry, I've been having some technical difficulties --

Co-Chair Zephyrin: No, that's fine.

Member Sorbero: Apparently with you being able to hear me.

Co-Chair Zephyrin: We can hear you now, that's great.

Member Sorbero: So, I just wanted to reinforce what Beth said about how important the resources in the community are going to be for this measure.

Particularly, around the availability of home health care. And even more social services available in the community around like food delivery services, and things like that.

Because I think consistent with just readmission measures broadly, I think this is going to be sensitive to characteristics like food insecurity, housing instability, and other characteristics that typically put beneficiaries at risk for any kind of readmission to the hospital after they've been discharged to the community, regardless of what type of facility they're being discharged from.

The other thing I wanted to note is that in the materials, it says that the developer stratified the measure by dual status. And did not find differences in outcomes.

But, there really wasn't much information provided on whether they did this at a population level, or whether they looked at stratification within the nursing home.

And what that variability would be across, you know, nursing homes. And whether there was difference, you know, a within nursing home difference by dual status.

So again, I just wanted to stress that I do think this one is very susceptible to patient characteristics.

Co-Chair Zephyrin: Thank you. Thanks Melony.

Mr. Nagavarapu: This is Sri from Acumen. Thanks for the opportunity to respond and the discussion.

On the nursing home point, this was actually a point that CMS looked into closely after those initial concerns were raised many years ago, and actually adjusted the measure to account for this.

So, the way that this is accounted for now is that those who are baseline nursing home residents, are excluded from the denominator for the measure. For exactly the reason that you're alluding to in the comments, the fact that those residents are likely to have discharges back to the nursing home.

And I think that interacts with the second comment that came up regarding dual eligible status. Before making that change, there as you could expect, was quite a large difference between dual eligibles and non-dual eligibles, because of the high percentage of dual eligible beneficiaries in nursing homes.

And that one change has helped address that issue in a substantiative way. So, once the -- looking at earlier testing results here, once nursing facility

baseline residents are excluded from the denominator, about 81 percent of skilled nursing facilities had a score difference within just two percentage points in a version of the measure that risk adjusts for dual status versus a version that does not.

And only about one and a half percent had a score difference that exceeded four percentage points.

And so this is something that we'll continue to keep an eye on. But are happy to report that the nursing home exclusion helped address some of the concerns that CMS had as well on this front.

And the last thing that I wanted to note was, for some of the other factors that people have noted so far, there are denominator exclusions to try and help with very particular situations that you might expect to come up among particular vulnerable subpopulations.

For instance, discharges to psychiatric hospitals, discharges to disaster alternative care sites or federal hospitals, discharge to hospices. Any planned discharges to an acute hospital around tech setting, those are all excluded from the denominator.

Again, with the hope of trying to get at what some of the comments so far have gotten at. And take account of those sorts of situations.

So, I'll leave it at that. But, I'm happy to answer other questions about the measure.

Co-Chair Zephyrin: Thank you. Thanks for sharing that level of detail.

So, that's really helpful in terms of -- and I guess this goes back to the prior question, in terms of the exclusions and who's potentially left out. And then also again, I echo what Melony stated around this potentially, you know, just the impact of the drivers

of health on this particular -- the particular measure as well.

Mahil, can you -- I see your hand raised.

Member Senathirajah: Yes. Yeah, it's sort of a follow up to what Sri was saying. Can you remind me, was ARC socioeconomic status tested as part of the model for this measure?

And a couple of other measures? Or was there a testing of any social risk indicator?

Mr. Nagavarapu: Yes.

Member Senathirajah: Beyond the dual eligible?

Mr. Nagavarapu: Yes, thanks for the question. There was early socioeconomic factor testing for the measure.

Interestingly for the race and ethnicity covariates in the testing of the risk adjustment model, it appears that non-white beneficiaries actually have slightly higher rates of expected discharge to community once the other covariates in the model are controlled for.

That could lead right into the fact that the risk adjustment model is very comprehensive in terms of the covariates that are included.

So, beyond the basic demographics of age it interacted with sex, there are clinical covariates based on ACCs and principal diagnosis of the prior hospitalization, as well as indicators of the stays, acute stays in history. So, the number of acute stays and the length.

So, an explanation for why the early testing results are showing that result could be there. And so, what that suggests is that risk adjusting for race/ethnicity would actually, in some sense, work against non-white beneficiaries in the measure.

We do also have testing for, early testing results at the same time for ARC SES index. There the pattern is sort of nonmonotonic across quartiles of the SES index.

There is some indication of lower discharge to community rates among lower SES index quartiles. But, that's like a nonmonotonic relationship.

Given, you know, the facts that I just went through, the choice was made to not risk-adjust for social risk factors in the final NQF endorsed version of the measure.

Co-Chair Zephyrin: Okay. Thank you. I see Susannah, you have your hand raised, and also a comment in the chat.

Do you want to speak to that?

Member Bernheim: Just briefly comment. But this is not -- not the comment that I have in the chat.

But, I think this is a case where it's important and valuable from the perspective of this committee that there's not risk adjustment for things like social determinants of health. Because what you want is not to have the expected rates be changed for those patients.

Ideally, if this measure acts as we would hope, and it does not have that risk adjustment, it will incentivize, -- and I'm late, so I couldn't check this, but specifically about the risk adjustment, it will incentivize that in order to ensure discharge to the community that is successful, you have to address the patient's needs.

Now that will have a different burden on different providers, which is really important to attend to. But, it should incentivize that we're trying to make sure that when folks go home, we're paying attention to all of the things in their lives that may make that challenging to be successfully staying at

home.

And I think that that's what this measure is meant to do. Which is different than stratification, which I totally agree would be a useful add.

Co-Chair Zephyrin: Um-hum. Thanks Susannah. David?

Member Machledt: Thank you. Yeah, I want to -- and you know, part of me, I'm just trying to also understand the measures as I go.

That there's so many exclusions for this measure, my concern and question is, at what level are the care experiences of all those people who are excluded, being, you know, people who are discharged to law enforcement or court, you know, discharged to a psychiatric institution, you know, are they not being included in terms of the quality picture?

So, it's a bigger question of not necessarily the effectiveness of this particular measure.

But then how -- you know, what are bracket -- who are we bracketing out of the pic -- of the quality picture here?

And I don't have an answer to that question. But, it's just one I think that's important to recognize.

Co-Chair Zephyrin: And I think that's a really important point. Especially although are there -- does this incentivize addressing sort of those other -- other opportunities to now remove them from the denominator?

Who knows. But, just something to think about.

I see Melody, you have your hand up?

Member Sorbero: Sorry, it was muted. But, that's another concern that I have with this one, is that you know, I agree not wanting to risk-adjust away

any differences.

But, if stratification is going to be critical, and also -- and I also just want discharged, period.

Because my concern would be that if there are concerns about someone potentially leading to the SNF not performing well on this measure, maybe they'd never get discharged when they're really prefer to be home.

Co-Chair Zephyrin: Thank you. Some great discussion. I see some additional comments in the chat that I think we'll definitely take into account. Particularly around Mahil, thanks for your comments, and Lenore and Susannah.

Any others before we move onto voting for this measure? Definitely some robust conversation.

All right. Let's move on to vote just for the interest of -- of time.

Ms. Harding: The poll is now open for MUC2021-130: Discharge to Community - Post Acute Care Measure for Skilled Nursing Facility to be Included in the Skilled Nursing Facilities Value-Based Program.

Please make your response to share the potential impacts on health disparities if this measure is included within the proposed program.

A few more seconds. The poll is now closed for MUC2021-130. And the responses are as follows:

Zero members responded that his measure will have high potential to have a negative impact by increasing health disparities.

Eleven members responded that this measure has the potential to have a negative impact by increasing health disparity.

Five members responded that this measure will have no impact on health disparity.

Eight members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities. Thank you.

Co-Chair Zephyrin: Thank you. Chelsea, are you going to go over this? Or --

Ms. Lynch: I was double muted. That is something I didn't know I was muted on. So, I apologize.

Co-Chair Zephyrin: No problem.

Ms. Lynch: I was like, it doesn't show I'm muted. But, indeed I was. Sorry about that.

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

So, the next measure under consideration is MUC2021-124: Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization.

This is a fully developed outcome measure that estimates the risk-adjusted rate of healthcare associated infections that are acquired during a skilled nursing facility care, and results in hospitalization.

The measure is at both the facility and stay level of analysis is not endorsed by NQF, and is risk-adjusted.

Co-Chair Zephyrin: Okay, thank you. Let's turn to Joy. Joy Bland, are you on? Can you --

Member Bland: Yes, hi.

Co-Chair Zephyrin: Hi.

Member Bland: Excuse me.

Co-Chair Zephyrin: Thank you.

Member Bland: In looking at this measure, I -- and the evaluation appears to be, you know, infections that were acquired during stay.

I looked at some of the information that there were other measures similar to it. There are, but there's not a lot of overlap.

They do have some exclusions of what they consider the types of infections. Chronic infections, infections that typically require long period of time to present themselves. Infections that were prior to a hospital stay, as was stated, are risk-adjusted.

As I looked at it from a health equity perspective, and we're looking at, you know, skilled nursing facilities and the rates, I felt there could be some benefit to disparities as you look demographically to see where the trends are, and having more acquired in one area than another.

So, there appeared to be some benefit that you could tie that into different demographics, geographically, and break it down by different disparities, ethnic backgrounds, and give consumers the ability to evaluate that as they're looking at where their family members are going, or themselves.

So, I want to turn it over to Alicia, if Alicia is on the call, to add to some of my observations on this measure.

Co-Chair Zephyrin: Thanks Joy.

Member Cole: Hi. Yeah, you know, here's the thing, as a HAI survivor twice, healthcare associated infections, whenever I see risk adjustment, my red flags go up when it comes to HAI.

Because I sat for nine years on the State of California, Department of Public Health HAI Prevention Advisory Committee. And with a lot of the data, once we risk-adjusted, some of our poor

performing facilities looked pretty good.

And you know, a third of our hospitals, 113 to be exact, had higher than average infection rates for several years in a row. But, because the risk-adjustment made them look like they were going pretty well.

Once the data was up on the website, it was hard for patients to really get a good idea when they're trying to make selections about their hospitals and all that.

So, we really have to be careful. And as an African-American woman who was in the hospital for two months with an HAI, and my HAI was not discussed once in the infection prevention department meeting.

So, I think we have to be really cautious when we're talking about risk-adjusting out. When we're taking about -- I'm going to leave it at that.

I'm going to leave it at that for now.

Co-Chair Zephyrin: Thank you. Thank you, Alicia. Others, any additional thoughts around the aspects of health equity?

Do you see this measure advancing or not advancing? And around what social determinants of health should be considered?

I think that the theme around risk-adjusting and who that potentially ex -- what population that potentially excludes, is a -- is an important one, and an overarching theme that I think that we definitely have to, we can acknowledge.

And any additional thoughts?

Member Bland: And I didn't see in the literature, and maybe Alicia, you picked up on, I did not see in this question in the chat if they would be risk-adjusting by SCOH or race, in what was provided.

So, Alicia you picked up on that?

Member Cole: I didn't see it. But, I just --

Member Bland: Um-hum.

Member Cole: In general, I know how these go. And you know, there's so many different aspects.

Once you allow risk-adjusting, then you start going, is it deep space incisional infection? Is it a UTI that should have been caught earlier?

Because if you're dealing with an older population, you already know the signs that okay, they're not thinking clearly. They're agitated.

And that was allowed to be missed. And so, now we're dealing with a UTI that is more serious than it would have been had there been better training.

But, if you've risk-adjusted it out because of the age, that negates the fact of poor training.

Member Bland: Um-hum.

Member Cole: You know, so there are issues that affect HAIs that have other things to do with than the infection itself.

Member Bland: Okay.

Member Cole: And part of that is early detection. And if you're risk-adjusting everything away because that patient, you know, was older, or something like that, you have to look at the population.

If you're servicing a group that if you're a skilled nursing facility, and you have a high rate of urinary tract infections, then you should be more skilled at dealing with that.

And you should be better able to recognize that this might be a urinary tract infection. There are other factors involved.

My dad was in treatment for cancer and he ended up dying not of cancer, but of a urinary tract infection and sepsis, which two days prior to that I said, if you're not coming in here timely to empty out his nephrostomy bag, he's going to end up with a UTI and sepsis.

So, we need to get onboard that I can't be the only one coming in here every 45 minutes if I'm in a -- and not at the hospital. You know the time period that it takes for his bag to fill up.

And invariably every single time I came in that room, my dad's bag looked like a balloon. And he was in writhing pain.

So, there are other factors. It's not just, oh, you're a cancer patient, so we're going to risk-adjust you out.

Member Bland: Right. Right.

Member Cole: And these HAIs are multi -- multifaceted.

Co-Chair Zephyrin: Absolutely. And the measure, and maybe others can chime in, the measure said there's risk-adjustment for resident characteristics.

And as well as then, so they have sort of the HAI number, and then they -- then they sort of adjust.

And to your point, you know, if it's a preexisting infection they sort of are, you know, excluded. Or infections that, you know, maybe community acquired.

So, there are a number of exclusions as well.

Mr. Nagavarapu: If it would be helpful, I'd be happy from the measure developer, to speak to the risk-adjustment point.

Co-Chair Zephyrin: Yeah. Maybe we can talk about just the risk-adjustment. And then -- and then we

can see if there are any additional questions and then move to the voting.

Mr. Nagavarapu: Absolutely.

Co-Chair Zephyrin: That's great.

Mr. Nagavarapu: So, there's a question in the chat about whether the risk-adjustment includes social determinants about their race.

Co-Chair Zephyrin: Right.

Mr. Nagavarapu: It -- the risk-adjustment model includes age and sex categories as well as original reason for Medicare entitlement, which could include disability.

It does not include other social or risk factors, or race. And that -- that is an intentional choice for reasons that are related to the comments that Dr. Cole just made, as well as the comments that Dr. Bernheim made earlier in the interest of not setting a lower standard of infections for patients with high social risk factors.

In terms of the other covariates that are included in the risk-adjustment model, the development process and the technical expert panel that was involved in it, was definitely sensitive to the points that Dr. Cole made.

I think this is a really tricky case where you want to ensure that you're not penalizing the skilled nursing facility for items outside of their control.

But, you also don't want to over-adjust away the types of factors that Dr. Cole was talking about.

And I think the measure strikes that balance in terms of the types of covariates it includes.

So, in addition to the ones it noted, it includes covariates on whether beneficiaries have previously been on dialysis, certain clinical categories, like

surgical categories associated with inpatient stays, and prior diagnosis of an inpatient stay, as well as items having to do with, let's say, ICU use prior and number of prior IP stays.

So, the idea there is to ensure that we're trying to create a level playing field for skilled nursing facilities, while still focusing on infections that are resulting from their care rather than the hospitals care, given that there are separate infection measures for hospitals.

And so the hope is to have that balance. And one promising set of results that I think suggest strongly that we've been able to strike that balance, is we've done analysis relating a fiscal year 2019 measure scores on this measure to later incidents of COVID cases at nursing facilities and COVID mortality at nursing facilities.

And what you see is a very clear relationship between the quintiles of SNF HAI measure performance and both number of COVID cases and mortality.

So, just to give you an example, if you look at the lowest quintile of HAI performance, the average number of COVID-19 cases per thousand residents there was 141.

If you look at the highest quintile of HAI performance, it was 222. About 80 cases per thousand residents more, which is just a dramatic effect.

And it's similar in, you know, the types of effects as you can imagine, also translate into COVID mortality in a very direct way.

And so, for that reason, I think that the measure is a hugely important one for the program. And critical in the sense of reducing disparities.

I mean, if a measure like this was in existence

during the pandemic, I think that would have had an important story to tell about disparities that -- that going forward with what we saw.

Co-Chair Zephyrin: Thank you. Great, thank you Sri for that -- for that additional level of detail. Very helpful.

There's some excellent comments in the chat. Any additional thoughts or questions before we vote? Or perspectives?

Member Machledt: I had a -- this is Dave. I had one other quick question. And this has to do with how -- how the program -- or what are the expectations?

You know, this is -- we've talked, this is a risk-adjusted measure. And you know, as Dr. Cole noted, there's a danger of setting a really low bar, or simply sort of erasing some important differences.

But, of course, we want -- we don't want to restrict access and reward those skilled nursing facilities that would have a different case mix that would lead to better results.

The other point there is like, you know, is this being used as a kind of -- to track sort of improvement over time?

Like how is it tied to this quality withhold that's the basis of this program? And you know, that's one way, I think, that gets around that might help address some of those issues about that contrast.

And I don't understand like exactly how the measure would be used in the context of this program.

You know, and that, I think, has an influence about, you know, -- I mean, I know we're not making reference, but I think it has an influence on the way that it impacts directly.

Co-Chair Zephyrin: Absolutely. And that's an excellent point.

Member Schreiber: But what --

Co-Chair Zephyrin: Okay.

Member Schreiber: This is Michelle from CMS. Would you like me to answer the program question?

Co-Chair Zephyrin: Yes, thank you.

Member Schreiber: So, under the Consolidated Appropriations Act, about a year ago, Congress authorized the expansion of the SNF Value-Based Purchasing Program. Which up until now has had only one measure, readmissions.

So, it allowed to expand that to ten more measures. The desire would be that this measure, SNF HAI would be part of the expanded SNF Value-Based Purchasing Program.

And let's say there's ten measures, and let's say they're equally weighted, although that's not necessarily, you know, a decision that's already been made.

This would then be 10 percent of the overall determination of the score for what a SNF's performance would be.

The measure does include a 2 percent withhold from skilled nursing facility. And then there's a potential payback of 60 percent, but it varies depending on how the skilled nursing facility performs.

So, if they performed really well, they will get that back. If they don't perform well, they won't.

Does that answer your question?

Member Machledt: It does. It helps give some more context to it. But, what it -- my question is sort of around what does scoring well mean?

So, is the measure something that's scoring well compared to all the other SNFs after risk-adjustment?

Member Schreiber: Yes.

Member Machledt: Or is there also a self-compare meth -- method of, you know, what the SNF was doing last year versus how it -- how it you know, would perform this year.

Member Schreiber: Yeah. Alan, I may have to defer to you on that one. If there's an improvement part of the scoring, of if it's just in comparison to all other SNFs.

Member Cole: So, this is Alicia. This made me think of an issue that also came up on our HAI Advisory Council when it came to risk-adjusting.

So, when we began to acquire data over a period of years, once we got five years in, and we were about to put it on the website, a comparison for each of the years, suddenly the SIR changed. The standard infection ratio changed.

And the way they define some of the risk-adjustments. And so, while we had data for five years, when it came to the point, let's compare the data and let's see the progression or not, all of that changed, and the data was useless, because you couldn't compare year to year.

So, I have an issue with that potential as well.

Co-Chair Zephyrin: Thank you. And Alan -- is Alan from CMS, can you respond to that question?

Member Levitt: Yeah, I --

Co-Chair Zephyrin: Great. Oh, thanks Alan.

Member Levitt: Hi, yes, this is Alan. I think that it was pointed out on a slide from before in terms of the incentive structure for the program, the way it

was set up.

Is that there are improvements for, and there is a performance score. And so, it's kind of achievement and improvement scores that are included together as part of the SNF's performance score in the program.

And just one other thing to note, in this, that this measure was reviewed by the MAP last year. And actually it's been finalized, the rulemaking for the SNF Quality Reporting Program.

So, this is a measure that's going to be publically reported as part of the Quality Reporting Program. And now this is for the -- this new expanded program that's going on for the Value-Based Purchasing Program.

Co-Chair Zephyrin: Thank you.

Member Machledt: I'd just like -- I think I'd like to -- and I don't know again, if I'm missing something, I apologize.

But, if it's risk-adjusted, is it worth, or is it valuable in a publically reported measure to include both the risk-adjusted and the not risk-adjusted results?

So that people can have that context and understand it. Or does that make it too confusing?

Member Schreiber: No. I guess the question is, we risk-adjust measures for clinical indications all the time.

And we don't post risk-adjusted versus not risk-adjusted for clinical indications, because what the -- what we're really trying to do is compare apples to apples.

So, for that case, I just -- I guess I'm struggling, because that would have implications too really every measure to not risk-adjust.

And most of this is clinical risk-adjustment.

Co-Chair Zephyrin: Um-hum. And so, I think just for time, we should move onto voting.

I think those are excellent points. And Mark, your comment in the chat in terms of risk-adjustment methods, you mentioned that you'd like to see an update with more detail that includes their gender identities and the data. But not sure whether current data completeness allows this broadly.

I think those are really excellent points. And we can definitely add to sort of overarching themes, because this applies to so many of the measures that we are talking about.

So, thank you for the robust conversation. Why don't we -- discussion. Why don't we move to voting?

Ms. Harding: The poll is now open for MUC2021-124: Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization to be Included in the SNF Value-Based Purchasing Program.

Please submit your response to share the potential impacts on health disparities if this measure is included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-124, and the responses are as follows:

Two members responded that this measure has high potential to have a negative impact by increasing health disparities.

Six members responded that this measure has the potential to have a negative impact by increasing health disparities.

Seven members responded that this measure will have no impact on health disparities.

Five members responded that this measure has the

potential to have a positive impact by decreasing health disparities

And one member responded that this measure has high potential to have a positive impact by decreasing health disparities. Thank you.

MUC2021-137: Total Nursing Hours Per Resident Day

Ms. Lynch: Thank you. So the next measure under consideration is MUC2021-137: Total Nursing Hours Per Resident Day. This is a fully-developed structure measure that makes up the total nursing hours, so RN, LPN, plus nurse aide hours per resident day. It is case-mix adjusted based on distribution of minimum data set assessments by Resource Utilization Groups. It is not endorsed by NQF, and it is risk adjusted.

I don't think we can hear you, Laurie.

Co-Chair Zephyrin: I did the same thing you did last time. I'm turning it over to Roberta Waithe, the American Nurses Association, or Leonor Fernandez.

Member Boston-Leary: Yes, hello. This is Katie Boston-Leery. I'm here for Roberta. She's not able to attend today, and I didn't get a hand-off from her. Sorry.

Co-Chair Zephyrin: Wait. So do you want to provide, do you want to discuss the measure? Should Leonor, we can have Leonor Fernandez go first. That's fine.

Member Boston-Leary: Yes, I'll let Leonor go ahead because I'd like to hear her thoughts first.

Co-Chair Zephyrin: Fantastic. Leonor, can you start with the discussion? Thank you.

Member Fernandez: Sure. I think that, you know, from what I read, this measure really measures something that is highly linked to quality. The total

nursing hours per resident day is a high predictor of all quality measures, so I think it's highly relevant.

I think, in terms of what we learned during COVID and the experiences in skilled nursing facilities, interesting articles that I read, it didn't seem like this was the major predictor. So the major predictor actually had to do more with the percent of, the size and the percent of the facility and the percent of marginalized populations within that facility, which also tracked together.

So I think, basically, it's an important one for quality. It says here it's risk adjusted, but I don't know in what ways. If someone could jump in and explain in what ways it will be risk adjusted. And then most of the literature was around RN nursing hours and did not include the RN, LPN, and nurse's aide.

Co-Chair Zephyrin: Okay. Thank you. So it sounds like some of the potential equity implications are around the types of facilities that this may be implemented in, depending on the distribution of the population of those facilities.

Katie, anything you wanted to add before we open it to group?

Member Boston-Leary: Yes. This is Katie. I'll just weigh in to say the one concern that I have, though, is that a lot of these facilities are not set up for RNs to be the typical workforce that's in those environments. It's mostly LPNs. So I know that there's more to come from the CMS side to possibly change that, and it does help with addressing a lot of the issues with quality because staffing in long-term care is a major issue. It's been decimated since the pandemic, and it continues to be an issue because there's not much of a pipeline, not to mention a lot of LPNs are now being hired into hospitals, which is further impacting long-term care staffing.

So, you know, I definitely think that this is something that needs more thought because for all the reasons that I just mentioned, in addition to what Leonor said.

Co-Chair Zephyrin: Right. And it looked like for the measure description it included total nursing hours, RN, plus LPN, plus nurse's aide. But as you mentioned, not all hospitals may count them, count LPN or nurses eight hours.

Any other comments from the group? Okay. So any insights on stratification of nursing hours spent by patient demographics? I think that's an important overarching point that we can raise, Beth, and definitely add that to the overarching comments around stratification. Thank you.

Should we move to voting for this one, Chelsea?

Mr. Shulman: Hi. This is Evan Shulman from CMS who works on this measure. Did you want us to maybe provide anymore or any comments in response to some of the comments raised?

Co-Chair Zephyrin: Sure. Did you want, are there any insights on the stratification aspect or --

Mr. Shulman: Well, so, first off, I do want to say there is one comment about staffing being decimated, and I would just encourage all of us to be careful about the anecdotes that you respond to and focus on the data. Census has also been down throughout the pandemic with maybe limited exception recently. The actually average ratio of hours present per day throughout the pandemic did not vary very much because the number of actual residents went down, which may be another problem, but the actual ratios did not change that much.

Nursing homes are required to have an RN at least eight hours a day, and they're also required to have 24 hours of licensed nurses. These categories and

all the hours reported directly from nursing homes 2:20:38 system for our LPN or CNA or nurse aide.

So I just wanted to provide that clarification on the information. I'm certainly happy to answer any questions. The risk adjustment, basically, is on the clinical needs of the person. It is not adjusted based on socioeconomic status or any, you know, race or ethnicity. So we believe that it incentivizes the need to provide the right level of care based on the person's unique needs, regardless of their background. Thank you.

Member Boston-Leary: This is Katie. I just want to add in one more thing. What I stated is not anecdotal. We definitely have data that indicates that staffing is a concern across the country at RN and LPN level. And I'm not suggesting that this is not a measure that should not be in place because nurses will welcome it because there has not necessarily been enough attention, well, enough focus on adjusting to understanding how staffing needs to be adjusted based on volume.

So I do agree that that is important, but I'm just also mindful, I feel responsible to provide the backdrop, as well, of the current state. Thank you.

Mr. Shulman: Let me agree with you. I was merely responding to the term decimated. You know, staffing has been an issue for a very long time before the pandemic. And, yes, the pandemic has had a negative effect on it, as well. I was merely just wanting to make sure everyone was aware of what the data shows. But thank you. It's a great clarification.

Ms. Lynch: And, Laurie, are you still on? We see a little, maybe a low bandwidth. We just wanted to check. Laurie, are you there? Okay.

So while she gets reconnected, if there is no additional comments or anything, we can go ahead and move to the polling question.

Co-Chair Angove: And I can jump in, if need be. This is Rebekah, the other co-chair.

Ms. Lynch: Okay. Thanks, Rebekah. It looks like she's trying to sign back in, so thank you.

Member Fernandez: Could I add one last thing?

Co-Chair Zephyrin: Great. Thank you.

Member Fernandez: I just wanted to add that I meant to raise that, you know, communities of color are more concentrated into for-profit SNFs, and for-profit SNFs have, on average, lower nursing hours. So I think I didn't mention that that's an important equity quality consideration.

Co-Chair Zephyrin: Thank you. Thanks, Leonor. Sorry I dropped off. I have two devices.

Any additional comments before we move to voting? Thank you for that important additional point. Great.

Ivory.

Ms. Harding: The poll is now open for MUC2021-137: Total Nursing Hours Per Resident Day is to be included within the SNF Value-Based Purchasing Program. Please submit your response to share the potential impact on health disparities if this measure is to be included within the proposed program. Three more seconds.

The poll is now closed for MUC2021-137, and the responses are as follows:

Zero members responded that this measure has a high potential to have a negative impact by increasing health disparities.

Four members responded that this measure has potential to have a negative impact by increasing health disparities.

Six members responded that this measure will have no impact on health disparities.

Ten members responded that this measure has the potential to have a positive impact by decreasing health disparities.

And two members responded that this measure has a high potential to have a positive impact by decreasing health disparities. Thank you.

Co-Chair Zephyrin: Thanks, Ivory.

Ms. Lynch: Thank you, everyone. So we will be transitioning now to discussing some measures that are being considered for multiple programs. The structure for this section will include an overview of the measure and then an overview and discussion for each program the measure is being considered for.

But as we're discussing it, I know we've had some similar discussion already for some of our measures. But particularly because these measures are being considered for multiple programs, if we feel like the discussion and polling results will be similar for the measure or cost to different programs, we are able to motion to carry those polling results from one program over to the other program for the same measure under consideration.

So this will need to be unanimous decision. And so if, at any point, there's a motion and you disagree, please feel free to share that verbally; or if you want to maintain being anonymous, which is completely understandable, you can also message that to me, as well, and then we will just vote separately for each program.

MUC2021-136: Screening for Social Drivers of Health

So the first measure that we will be discussing, looking forward to this one, I think, MUC2021-136.

This is Screening for Social Drivers of Health. This is a process measure that is currently under development and assesses the percentage of beneficiaries 18 years of age or older that are screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. The measure will be used for the clinician group facility and beneficiary population level of analyses and will be stratified. This measure is being considered for two programs, MIPS and the Hospital Inpatient Quality Reporting Program.

Co-Chair Zephyrin: Thank you, Chelsea. Why don't we turn it over first to Nneka Sederstrom.

Member Olayiwola: Actually, I'm going to take the lead on the conversation right now. This is Nwando.

Co-Chair Zephyrin: Okay, great. Thanks, Nwando.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

Member Olayiwola: Thank you so much for the opportunity to chat with everyone today, and I'm really excited about this measure and the accompanying measure, 134, that we're all going to be discussing, I believe, next.

Essentially, what we're looking at here is the opportunity for the first time in any of the federal programs to actually have a social drivers of health measure that would allow percent or division across different programs, and that, you know, really does bring alignment to some of the division that the administration has laid out around adjusting health equity and understanding social determinants of health.

What this particular measure is looking at, it's looking at your whole population and screening the population for the composite of measures that's part of the accountable community, Accountable Health Communities Model, which has those different

measures of screening for social drivers of health and building those measures into these different programs.

The accompanying measure will be not just a percent screened but percent reported. So this will also be stratified, and so we think it's important because, if anything, we've seen the impact of health-related social needs on diverse communities and communities of color over the last year and a half, and so I think it's important that that's called out as a particular component of this particular measure.

So I can stop there, but I think that it's great that we've got in this group, I don't know, 30-plus measures that we're looking at. We have two here that are explicitly tackling social drivers of health and health inequity.

I don't think of Nneka is able to chime in. I know she's got a few things going on today, but this --

Co-Chair Zephyrin: Yes, she sent in a text. She's listening in.

Member Olayiwola: Okay. Yes, so we had a chance to connect and discuss this in detail earlier, and we are in alignment. So I think I feel comfortable speaking on her behalf, and I see she documented that, too, as well.

Co-Chair Zephyrin: Great, fantastic. Why don't we open it up to the group? I think these next two measures are definitely first of their kind for MUC.

Others want to weigh in? I mean, we talked a lot about --

Member Godsey: Hi, this is Beth.

Co-Chair Zephyrin: the drivers of health throughout this. Okay, great. Is that Alicia?

Member Godsey: Beth.

Co-Chair Zephyrin: Beth. Okay, great. How are you?

Member Godsey: Yes. This is Beth. Thanks for this. I guess a couple of questions related to the screening part of this measure. Can you speak a little bit more about the standardization that you recommend putting in place so that screening is uniform across the country? The reason why I ask is I know that there have been other attempts of organizations to collect screening types of information, and what has come back from those results has been, you know, we screen everybody, you know, like, everything gets captured; and we know that that's not true.

So I guess I just want to ask for some clarification on how the screening process would be standardized, if you could highlight any of that, and create the consistencies across the country.

Member Olayiwola: Yes. No, thank you. That's a great question, and, again, I didn't mention that I agree that we definitely need to have some alignment but absolutely don't want to miss the opportunity to have something like this included.

So I think that the measure stewards, a couple of them are on the line. I'd love to have them weigh in on that particular question.

Mr. Perla: Great. Thanks. I can jump in. I'm Rocco Perla with the Health Initiative with the technical advisor to the measure developer, The Physicians Foundation. And, Beth, it's a fantastic question.

In this situation, the measure is the standard and the tool would have to tie to the standard. So if the measure is a standard that any tool used for reporting must be aligned with the measure, otherwise you can't report on it, and so the data that would be collected would be standard relative to the five driver of health domains that was mentioned earlier. And at this moment, CMS has the opportunity to really kind of define that standard from the perspective of the measure.

And then, you know, ahead of the sector beginning to kind of identify multiple competing standard measures, we believe and the measure developer believes that, once this measure is introduced, it's going to create a conversation around what are the most effective tools to be able to do this.

The other observation is that many health systems, clinics, providers, practices around the country are already beginning to screen using a number of highly-used and reliable methods. But at this point, the focus is on collecting the data, not necessarily on telling practices which tool to use. That would be something that would have to be addressed moving forward in terms of thinking about ongoing improvement relative to data collection and standards.

Member Cole: Hi. So this is Alicia. Piggybacking on what you just said, yesterday I had a doctor's appointment and it was my Medicare wellness checkup. And two of the pieces of paper that I was given to fill out, one of them was centered on this very thing. It asked me questions like have you had in the last two months any trouble purchasing food or groceries for yourself before you ran out of money. This is never true for me, this has been sometimes true for me, this is always true for me, this is frequently true for me. It asked questions about did I have trouble getting transportation to my appointment.

So all of these things that we are talking about right now were on the questionnaire that I had to take yesterday at my doctor's office. And so one of the questions that I have is, so, say, for example, I had put down, yes, I'm running out of money and I don't have food, I'm running out of money and I don't have money for my prescriptions, what then? What are we doing in terms of solutions once these individuals are identified, other than collecting the data?

Co-Chair Zephyrin: That's a great question, and this measure is actually about whether people are screening or not and that question also applies to the next measure which we're going to talk about in terms of whether people screen positive or not. So we can either address that now or wait until we get to the next question because I do think that's a really important question.

Co-Chair Angove: And, Laurie, I want to add to that. So I work for an organization that provides direct services and social need navigation, and one of the things that we find is you need the data to be able to show that there's a need for services. So it's a little bit of a chicken or the egg.

So just think about that. I know doctors don't want to ask questions they don't have a solution to, but, on the other side, from a social service perspective, whether that's nonprofit or governmental services, you have to demonstrate a need before money and resources are going to be allocated to meet that need.

Co-Chair Zephyrin: Great. Thank you. Oh, I'm sorry. We have some hands -- oh, go ahead, Nwando. Sorry.

Member Olayiwola: I would double-down on what Rebekah said. I think it's really important that we are actually asking. I think the consequences of not asking are probably more severe than the consequences of asking.

And I agree entirely with what was said by Alicia that we want to make sure that this is also -- I think some of the guidance would involve making sure that, as you're asking, you're also building the systems to be able to provide resources and interventions, but you don't even know what you have and what you need to be providing.

Co-Chair Zephyrin: Thank you, Dr. Olayiwola. We have four hands raised. Oh, five. So I'm going to

start with Karthik, then Kirsten, then Chris, then Jeff, then David. I will remind you. But let's start with Karthik.

Member Sivashanker: Okay. Thank you. Appreciating the discussion. So just kind of building on some of those points, you know, I do think there is a harm with asking and then not having any resources to offer, both to the provider and to the patient. So there's an expectation when you ask and you screen about this that there's going to be some help offered. And not having this tied to a clear set of resources, tools, that they're also providing to clinicians and practices is a real setup for frustration for the providers who are then screening all these patients and may not feel it's actually doing anything about it and frustration or disappointment for patients who are getting screened and the not actually getting any help as a result.

So I absolutely agree we need to be doing screening. I think this is absolutely necessary. But I'd love to see more around how is this going to be complemented by actually providing resources and tools and support to make sure that this happens.

And then in terms of, like, having a standardized tool, I get, you know, waiting on, I understand some of the points that were made in terms of a quality improvement perspective, but I think if we're talking about accountability, then we need to have, I think it makes sense to have a tool identified a priori.

So maybe I'll pause there, but I guess where I want to conclude is I think this is absolutely critical. I don't want to, like, disagree with screening for social drivers of health. I think we need that. I'm just a little bit worried about the lack of a standardized approach here and the lack of, like, how we're going to operationalize this to actually do something with it.

Co-Chair Zephyrin: Okay. Thanks, Karthik. Kirsten.

Member Bibbins-Domingo: Thanks. I think, from safety-net hospitals' perspectives, this is something that our facilities have been doing a lot of. I think the question is -- and we think it's important.

I think the two things that I would flag have to do with just the intensity of the resources required to do this, especially dealing with the variability in the measures being used, doing this with our varying IT systems. And I think understanding whether we have a measure that can be implemented across various IT systems that are now randomly trying to do this in a very patchwork type of way I think is going to be important.

And then I do think the issue, I don't think that we -- I do think that we have to be able to ask even when we don't always have all of the resources available because I do think collecting the data drives allocation of resources. But I think in many of our facilities are going to be sitting in settings where the lack of community resources will also be an issue, as well as the ability to link to community resources. And I think that need will be great, and I think that's also a flag that just needs to be raised.

Co-Chair Zephyrin: Thank you, Kirsten. Chris, why don't we -- Oh, Nwando, did you want to respond to that, Dr. Olayiwola?

Member Olayiwola: Yes, I think that's great and appreciate Dr. Bibbins-Domingo's comments and the one previously, as well, just regarding, you know, the tools used.

And maybe, Rebecca, if you're on, you could respond to that one. I know you had a lot of input in this particular part of the measure.

Ms. Onie: Yes, absolutely. So I'm Rebecca Onie with the Health Initiative, along with Rocco, technical advisor to the measure developer, The Physicians Foundation. Deeply appreciate the vigorous discussion on this one. These are all the right

questions.

Just a few thoughts and comments here. A very important point, Alicia, that you raised and others raised around, okay, great, so we ask these questions, what do we do about it. Nwando, to your point, the next measure that's for consideration does require reporting on the screen positive rate, which is crucial.

You know, just a couple of thoughts on this because this, of course, is something we've thought about significantly, along with many of the various colleagues who have, likewise, helped shape the measure. A few things. One is just, you know, in practice, as was mentioned, you know, thousands of clinical sites across the country are already screening their patients to address drivers of health and acting on those needs. In the Comprehensive Primary Care Plus model, through CMMI alone, there's 2,440 primary care practices that are doing screening and navigation.

So, in part, this measure is really important to say, for clinical sites that are doing this, how do we for the first time actually recognize and incentivize those practices to do what they're doing and continue, candidly, to get deeper into this work, including understanding the technology and workforce requirements to get folks what they need. So that's one piece.

You know, the other thing we would just say, and this was mentioned, too, is, you know, given the variability and the prevalence of drivers of health across geographies, patient populations, and also just the realities of clinical sites' capacity to provide navigation, you know, this staging of introducing the first ever drivers of health measures into the federal quality frameworks is quite important. And so, you know, we, by design, with our colleagues at The Physicians Foundation, did structure this as a pay-for-reporting at this early stage, but the firm

belief is that the data collected and learning from these foundational measures should, in an expeditious way, inform, you know, both future revisions to the measures, setting appropriate performance targets, and, most importantly to what was just shared, the design of a next set of navigation and needs resolution measures.

I think, to Nwando's point, it's important that we actually do understand what is the prevalence of these issues in our patient population to be able to make sure that those subsequent measures are designed appropriately. Thank you.

Co-Chair Zephyrin: Thank you, Rebecca. Chris, Chris Grasso.

Member Grasso: Sure, yes. Thank you so much. I just, you know, sort of echo a lot of what's already been said and really want to just, you know, emphasize how critical this measure is. I understand there's imperfections in it, but it's so important to be able to start to begin to collect these data. These data, for example, I'm part of a Federally Qualified Health Center, and they've started asking these health centers who care for about 30 million people, you know, across the country, urban and rural areas, you know, and are some of the most underserved populations. And it's been so critical to collect these data, and I think it's really important to demonstrate, as some people said, the problems or the needs because there's no way to get resources unless we're able to sort of really demonstrate that.

But what I really wanted to sort of suggest around this is think about the denominator and the way that you've defined practice because I think that's going to leave a lot of openness and interpretation, and I sort of suggest maybe even thinking about being more specific, a person who's had an appointment in the last year or last three years and how you might really look at that because I think to

leave some room for organizations to kind of pick and choose and make themselves look good in that way.

And, you know, we also want to understand, like, who's not coming back, right? And so I think that's an important piece there because the people who are most impacted by social determinants of health or any social drivers are the people who may not be coming back to the facility.

So just maybe think about ways that we can sort of maybe capture that in that denominator. Thank you so much.

Co-Chair Zephyrin: Thank you, thank you. Very important points. Jeff Huebnerl.

Member Huebnerl: Yes, thanks. I mean, this has been a great discussion. I'm really enjoying hearing all the perspectives, and I'm very excited about this measure and I'm more excited about the next one. I'm going to be thrilled if this has been partnered with closed-loop screening referrals being completed, but I understand that's a far way off for a lot of us.

You know, it's just interesting because, in my own health system, and I work in an academic health system that's an advanced payment model, it's a next-generation ACO, we've been pretty deliberate about this and we're not as far along as a lot of the rest of the country, and that's been challenging for a lot of us. But by the same token, you know, we've been in an engaged partnership with a lot of community members and trying to make sure this is done correctly in our EMR and that we have authentic partnership and resources with community health workers and social work in our own system and in the community to do this well.

So I'm learning a lot about the appreciation for the fact that we may need the data to press this more routinely across the country, so good to hear that

perspective. But I also am, I have some of the same concerns that were raised previously.

Co-Chair Zephyrin: And David Machledt.

Member Machledt: Yes, thanks. Just a short comment that I was, you know, as I'm listening to this, I was thinking about who is this stratified for, you know. Besides what beneficiaries are screened, knowing what the results were, I was thinking about the issues for access to these different needs and how acute they are for disability populations, disability community, and, in particular, we haven't talked really that much about disability today and I wanted to flag that here in particular as something that I see these screenings connecting to those resources as particularly relevant and important for the disability community.

Co-Chair Zephyrin: Absolutely. Susannah Bernheim.

Member Bernheim: Yes, this has been really helpful and I share lots of the things that other folks have said about the importance of getting this information and the resources it takes to do well and the importance of having something you can do with it.

But the one thing that I'm struck by, especially what Jeff said about just how much his group has invested and how to do this, my only concern is that if we really drive incentives to collect the data without driving to some standardization, we're going to find ourselves in a place where there's been a lot of resources invested and, ultimately, we're going to need some baseline standardization so that we can do some comparability.

And so I didn't start this discussion thinking this, but I've come to feel like it would be better if there was some standardization right out the door if we're going to roll this out nationally because I worry that we're going to actually have to create situations where everybody is backtracking to now have

something that's standard. And it may be useful to put some guidance around what these fundamental drivers, how they're defined, as this rolls out to avoid being in a world that's a little chaotic and not being able to use the information the way we want to.

Co-Chair Zephyrin: Right. Well, this has been a great discussion. I know we have more to discuss. We also have the next measure to talk about.

Yes, Dr. Cole, go ahead.

Member Cole: Just a short thing. I completely agree with what was just said about standardization because we don't want to have an unintended consequence of people being asked these questions and feeling bad about themselves and also not telling the truth about whether or not they can afford their medication or they can afford their groceries or whether they can afford to get there. You don't want people to then feel bad. You don't want them to be labeled because these are kind of very personal and intrusive questions.

And I can tell you to have a solution also is a great thing, and I'll just give you a personal example. I was on blood thinners for two and a half years, so I went from Lovenox to Coumadin, and then I had to go on Eliquis. And Eliquis, it's not covered by Medicare and it was $400 a month. So then after a year and a half of $400 a month, I went into the doctor and I was like, look, dude, I can't afford $400 a month for another year and a half, two years, or however long I have to be on this, I need some help. And my doctor, God bless him, he got on the phone with the manufacturer trying to get me samples. Other patients who had finished their Eliquis began to, you know, we all started donating to one another our leftover Eliquis and that kind of thing. So it's so important to have a solution.

Co-Chair Zephyrin: Yes. That's an excellent point. And, Leonor, you also raised a good point around

there's the balance between whether, strategically, if this is a good step for health equity versus are we pulling the health equity value of the measure itself. And so I guess part of just for -- all of these points are really important, and I guess the question that we also want to answer is what aspects, you know, do we see this potential measure as advancing health equity? Obviously, this is about drivers of health. So in terms of our questions around what social terms of health should be considered related to this measure, that applies, as well.

But I think, you know, I think just reframing in terms of the questions that we want to answer, in terms of what aspects of health equity do we see this measure advancing, and I think we talked about that a bunch. And also in what ways could the measure exacerbate disparities or provide unintended consequences, and we've talked about not linking it to resources. But this is about, you know, a yes/no in terms of is there screening for social drivers of health and then we can transition to the next MUC around screening positive.

Any other thoughts or questions? This has been a great discussion, lots of great comments in the chat. And do you think we're ready to vote on this in terms of the equity impacts?

Member Olayiwola: Dr. Zephyrin, I just want to make sure that we address the question about the validation of this measure because I think it came up a few times and it probably would be helpful before for us to do that. So, Rocco, if you want to just chime in on that.

Mr. Perla: Absolutely. I saw that question come in. It's a great question. And just so folks know, the measures were actually based on the Accountable Health Community's pilot, so this is a CMS pilot that has been running for five years, screened over a million beneficiaries across 600 clinical sites, and so the five core domains that have been identified here

are actually the same ones that have been field tested for five years and have undergone independent validation.

And just to speak quickly on that, those five domains have actually been validated both at the item level, so individually looking at food, housing, transportation, and at the tool level, and have demonstrated both fairly high reliability when compared to other instruments, typically, Cohen's kappa statistics above 0.6, which is really good, in addition to demonstrating findings that suggest strong concurrent and predictive validity.

So there has been a number of testing that's been done. A lot of the individual items and the questions were actually part of a National Academy of Medicine panel that did an incredibly intense review of every one of those questions that were asked. So there's a bit of science both sitting behind it pragmatically, as well as scientifically.

Co-Chair Zephyrin: Right. Thank you. Thanks, Rocco. Why don't we move on to voting on the equity impacts, Olivia. And then we'll have part two of this conversation.

Ms. Lynch: And just a reminder that this measure is being considered for two programs, so there's a potential for two votes. The first one is for MIPS and then it's also the Hospital IQR. But if we don't think there's much difference between at the clinical program versus the hospital program, we can motion to move the polling results forward.

Co-Chair Zephyrin: Chelsea, how do you want people to indicate that? Do you want them to indicate in the chat or --

Ms. Lynch: So, first, we can vote for the MIPS, and then we can just do kind of a verbal agreement. And if anybody disagrees with moving it forward, they can just choose the chat or vocalize it, as well.

Co-Chair Zephyrin: Okay, great. Thank you.

Ms. Harding: The poll is now open for MUC2021-136: Screening for Social Drivers of Health to be included within the MIPS program. Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

A few more seconds. Okay. The poll is now closed for MUC2021-136, and the responses are as follows:

Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

One member responded that this measure has potential to have a negative impact by increasing health disparities.

One member responded that this measure will have no impact on health disparities.

Twelve members responded that this measure has a potential to have a positive impact by decreasing health disparities.

And ten members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: Okay. Thank you, everyone. And as I mentioned, this measure is also being considered for the Hospital Inpatient Quality Reporting Program. This is a paper reporting and public reporting program that hospitals that don't participate in the program or participate and failed to meet the program requirements receive a one-quarter reduction of the actual percentage increase in their annual payment update. The goal of the program is to progress towards paying providers and based on the quality, rather than the quantity, of care they give patients and provide consumers information about hospital quality so that they can

make informed choices about their care.

So if there's any additional discussion related to the measure for this program, and then there's also the consideration, if we think the discussion and the votes will be the same, we can motion to move those votes forward, as well.

Member Olayiwola: Is it my cue to come in? I just want to be sure that you're --

Ms. Lynch: Oh, it's just, yes, are there any additional things about this, still the screening, not the screened positive. So same measure, and it looks like there's a request to vote again, so we will have, we will vote.

So any additional discussion around this same measure for the Hospital IQR Program, and then we'll do a different vote, as there's a request to do that. So we will still hold a different vote.

Co-Chair Zephyrin: So do we want to vote now or later?

Ms. Lynch: If there's any other additional discussion first and then if --

Co-Chair Zephyrin: Okay, great. So any additional discussion from the group in terms of the consideration of the same measure for the Hospital Inpatient Quality Reporting Program?

Yes, Susannah, I see your question. It is an interesting question. Did you want to add anything from that discussion?

Member Bernheim: No. I mean, I'm of two minds. I'll just say them. One is hospitals, you know, it's probably a less burden for hospitals to add this in. Hospitals tend to be better resource entities, so that's an argument. But not everybody visits the hospital, and there are a lot of ways it makes much more sense to have this conversation in the context of your clinician practice. And we don't want people

to be asked the same questions, you know, many times in a row, although these things, social drivers of health, can change, so you can't ask it just once.

So I guess I don't really have a strong opinion, which is why I was just doing it in the chat.

Co-Chair Zephyrin: Okay. Any other thoughts before we vote again?

Member Cole: I'm just wondering if these same types of intimate questions will work the same from an equity and a patient standpoint in a hospital because if you are a patient, you know, with your primary care physician, you're going to have a different kind of relationship than you would with a plethora of doctors coming in and out of your room in the hospital. And as a patient answering those, they may be worried that if I say I can't afford food or I can't afford transportation, I may not be able to afford the bill once I get out of here, my co-pay, and that kind of thing. Is that going to affect the types of treatment that I'm being offered or whether I'm getting a CT scan versus an MRI or am I going to get, you know, is that going to affect my care options if I'm admitting that, you know, I'm food insecure or that kind of thing, you know.

And I'll just tell you from a personal experience, because I got a whole lot of them because I've had over a decade of weekly doctor appointments and I've been in the hospital more times than you can count, I literally had a nurse ask me, so what do your parents do? Like, how can they afford to sit here at your bedside every day for two months? Like, don't they work? How can you afford to be here? And I just, I told her, well, you know, my last name is Cole, and you've heard of Nat King Cole. My dad is a trust fund baby. And she's like, really, really? And I just looked at her like, I didn't say no. I just wanted her to go back and just think about that. Like, really?

Co-Chair Zephyrin: I think your point on the

unintended consequences is a really important one, really important one. I see Karthik has his hands up, and then I don't know who else was just talking. Karthik, did you want to say something?

Member Sivashanker: Yes. I just want to highlight maybe through a story what I'm concerned about here because I think -- so my patients are up in the North Shore area. I work at Justice Resource Institute for my clinical work, and all my patients are very, very poor. They are not doing well. And I'm their psychiatrist, but I spend most of my time, and I'm going to tell you honestly, trying to help them figure out their housing and trying to get them a smartphone so they can get a job. And I spend hours, literally, a week doing that.

So it's not just about asking the questions. If you're like most providers, when you ask the questions you feel an accountability to do something about it. And if you're not resourced, that is a time and that is an investment on your part as an individual practitioner or as a system. And when we think about the fact that our systems are not taking care of the same populations, that we have segregation across our healthcare system, we have safety-net hospitals taking care of the vast majority of our historically-marginalized patients and then we have affluent AMCs taking care of a minority of them, and the same thing is true across individual providers, the burden of this could fall very differently and the impact could fall differently. And I'm just worried that we're not thinking through the potential downstream consequences enough because we're so excited about the need for screening, which we all agree on. But there's some real risks with rolling out a measure like this before it's fully vetted and has, you know, is part of a broader bundle that we can offer.

Co-Chair Zephyrin: Thank you. Jason, I see your hands up.

Member Suh: Yes. Thanks for letting me talk. So as a hospitalist, I see value in this, but I also see a lot of negatives, which is these are the social determinants that drive readmissions for the hospital, so I think it's a quality thing. But when they present to the hospital, they're under such duress, such stress, they're so sick. I don't know if it's a great place for it.

And to the previous speaker, it just seems the wrong time and the place. I think they need to be somebody they trust, a PCP, an outpatient screen, much more than the technician at the emergency room or a social worker that they don't know at 3:00 in the morning. That's my worries. Does that make sense?

Co-Chair Zephyrin: Yes, no, those are great points. So I think, can we move on to the voting for this one? Nwando, do you want to make one quick point, and then we'll move on to the voting for the screening for social drivers hospital measure.

Member Olayiwola: Yes, I do. I do want to just caution us. My whole career as a primary care physician, even until now, has been as a safety net, and I definitely understand, Karthik, your thoughts here and the experiences that are relevant when you're taking care of people in real time and having to address these needs.

But I'm worried that, I don't want us to be in a position where we wait for perfect and we don't at least get the good. And I think it was a question, a very specific question that should probably be answered before we vote because people were asking about, you know, what do we know about the hospital versus the primary care environment. So I don't know if Rebecca or Rocco can answer that quickly because there is data that the measure developers kind of looked at to understand that particular nuance.

Ms. Onie: Yes, this is a fantastic question. And just

to echo the fact that we all would certainly want everyone to have a trusted relationship with a primary care physician, and I think it's been noted in the chat and the discussion that's not always possible. And we certainly, from an equity perspective, wouldn't want folks who don't have the benefit of that to not have the opportunity to be able to have a conversation around what their unmet social needs are.

Just super quickly on the testing point, which is important. The measure has been tested extensively in a variety of settings. We've talked about the fact that it's been tested through the accountable health communities model in over 600 clinical settings. Forty percent of which are the drivers of health screenings that have occurred through the model are in hospital settings, 54 percent are in primary care practices. So I think we can have a degree of confidence that the measure has been tested in both of those settings with efficacy.

Co-Chair Zephyrin: Great. Thank you. And so why don't we move to voting. And, Karthik, I guess, to your question, again, we're voting on the equity impact of this measure. You know, we're not specifically, we're not voting, we're polling, answering the poll question on the equity impacts of the measure, not necessarily voting or endorsing the measure. That's our role as a group but definitely important questions and considerations, and we all need to understand what the measure is about to be able to vote, to poll. Sorry. I'm not supposed to use the word vote.

Olivia, I'll turn to you for the poll. Okay, great. Thank you. Ivory. Sorry, I said Olivia.

Ms. Harding: The poll is now open for MUC2021-136: Screening for Social Drivers of Health to be included within the Hospital Inpatient Quality Reporting Program. Please submit your response to share the potential impact on health disparities if

this measure is to be included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-136, and the responses are as follows:

Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

Two members responded that this measure has potential to have a negative impact by increasing health disparities.

Three members responded that this measure will have no impact on health disparities.

Nine members responded that this measure has a potential to have a positive impact by decreasing health disparities.

And ten members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Thank you.

Co-Chair Zephyrin: Thank you so much, Ivory.

Co-Chair Zephyrin: So we'll move on to the next measure, MUC2021-134: Screen Positive Rate for Social Drivers of Health. This is a process measure that is currently under development and assesses the percentage of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation, utility help needs, or interpersonal safety using a standardized validated screening tool.

The measure will be through the clinician, group, facility, other, and beneficiary population level of analyses and will be stratified.

This measure is being considered for the same two programs, so the clinician MIPS and the hospital

IQR.

Co-Chair Zephyrin: Excellent. Thank you.

Dr. Olayiwola, are you doing this as well?

Member Olayiwola: Yes. Not a whole lot to add here, because I think we've had a really robust discussion on the last one. I just want to make sure that we think about these almost as a pair. It would almost be, in my mind regarding screen, but not report. And I think that might be -- you know, set us up for working potential and operability without having that accountability there. So this one is really more about reporting the positive rates as opposed to just doing the screening, so I think there's more conversation I'd want to have around this one, but yes, let's talk.

Co-Chair Zephyrin: Thank you. So we've had a robust discussion and I think a lot of the points probably apply to those, but any additional thoughts around -- you know, two questions around equity impacts, what aspects of health equity be seen as measure advancing or not? What potential ways the measure could exacerbate disparities or have unintended consequences?

Susannah, I see your hand up.

Member Bernheim: I apologize. I actually don't understand what this measure -- So if you have a positive screen, so if I screen 100 people and 50 of my patients have food insecurity, is that better than if 30 do? The way it reads it's like you get credit for having -- I don't understand this measure completely.

Co-Chair Zephyrin: Sure, absolutely. Rebecca, Nwando, or Rocco?

Mr. Perla: Yes, I can jump into this to your question. So basically, the first measure was just around the act of screening. So are you screening and what

percent of your patient population are being screened? And the measure developers separated that out from the actual results, recognizing that those are -- those are two different tasks, but interrelated. So you need to screen and then you need to report. And so wanted to be really clear around those two functions relative to the measure approaching the information that will be moved forward.

Member Bernheim: So what's a good result on this measure that's good performance?

Mr. Perla: The initial approach to performance, the measure developers recommended a pay for reporting, so there are no benchmarks or standards relative to what's good or bad. It's really just about collecting the data.

Standards can be developed moving forward, but that was part of the approach to saying now let's understand what the screening is like, what the results are like, and then think about that conversation without doing that without having that baseline in play.

Member Bernheim: All right, so I just want to echo -- in the MIPS program I don't recall -- would that be publicly reported, right, so then would my -- because I've heard in other contexts concerns from providers about public reporting, the rate of patients that they care for from various demographic backgrounds because it can play out in lots of different ways, right?

I mean as a patient you may well want to know that as who does this provider take care of, but as a -- anyway. We've heard providers say this might have unintended consequences, but they may be like well, they're not taking care of patients with -- I mean it can play out a lot of different ways.

Again, I'm trying to understand would you then publish a report, my positive screening rate as a

commission group?

Mr. Perla: I would defer to CMS on that, Susannah, but I would say just before that is if a provider or practice had a higher rate of food security or a higher rate of a driver called positive screen rate that may begin to explain some of the challenges in the community and may explain some of the challenges of quality scores and so the need for investing in communities to support practices.

So the measure can be interpreted in a number of different ways, but right now, if you're an ACO, for example, and you're in a food desert or a low-food access area, no one knows. That's not accounted for. And so this kind of measure would create some visibility to that. So I think it's a really interesting question around what the public perception might be around the reporting. But to be sure, there's multiple ways to sort of view that. But I would defer to the folks at CMS in terms of the degree of visibility the measure would have.

Co-Chair Zephyrin: I see Kirsten has her hand up and then Sarita.

Member Bibbins-Domingo: I think we've already talked about the variability of the measures. This seems one where the variability of the measures makes this one really challenging. I totally see that if you screen, it would be good to know the results of that screen, but the variability means that it makes it difficult to compare across systems, across practices, across whatever. Just small unintended consequences is that we -- some of our facilities use screens that have unmet behavioral health needs in addition to social health needs. And depending on how you're recorded or how the screens are aggregated over time or whatever, you'll get results you can't compare over time.

Let me say that the other that I would mention and I see this as a really very positive and general, of course, about this -- both of these measures and

what they will do over time. I do think that the way we are talking about this percent reported has to do with the idea that healthcare, both clinical practices, and hospitals can intervene on the population level, not just on the individual health needs of a patient or social driver and social determinant needs of a patient, social needs of a patient. And that's where, I think, this does have the potential for positive impact to see that a population level, but even there it would be helpful to have more standardized processes for this measure. It seems not quite fully baked yet for the intent we think it will have.

Co-Chair Zephyrin: Okay. Thank you, Kirsten.

Why don't we go to Sarita, and then we're going to go to the voting right after that.

Sarita?

Member Mohanty: I think I echo what Kirsten said and I just think, you know, for this kind of measure, I think having a little bit more clarity about what the intent or purpose of it is, it's hard, but I think a lot of folks are going to have a lot of these ongoing questions about the -- what's the impact, the purpose of this particular measure because I have a lot of questions and a lot of lack of clarity about what we're hoping to achieve with this.

Co-Chair Zephyrin: Thank you. Any other comments on equity impact of this measure before we can move to the voting -- the polling? All right.

Ivory?

Ms. Harding: The poll is now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health to be included within the MIPS program.

Please submit your response to share the potential impact on health disparities, if this measure were to be included within the proposed program.

A few more seconds. The poll is now closed for

MUC2021-134 and the responses are as follows: 0 members responded that this measure has high potential to have a negative impact by increasing health disparities; four members responded that this measure has the potential to having negative impact by increasing health disparities; three members responded that this measure will have no impact on health disparities; en members responded that this measure has potential to have a positive impact by decreasing health disparities; and four members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Co-Chair Zephyrin: Thank you. Chelsea.

Ms. Lynch: The next program would be Hospital IQR. So same measure, hospital IQR instead.

And I know there is a question about the MIPS program for our CMS colleague. I'm not sure Alan or anyone else from CMS can provide some clarity to Koryn's question.

Ms. Gomez: So this is Lisa Marie. Can you all hear me?

Co-Chair Zephyrin: Yes.

Ms. Gomez: So is this question about -- is it Koryn's question?

Co-Chair Zephyrin: Yes.

Ms. Gomez: Okay. So under the program, each measure that is reported must have the score. There are circumstances in which we can suppress an order, but under the law like we are required to score a measure, so it cannot be necessarily not scored. So I want to make sure I'm answering the question, so is that the question?

Co-Chair Zephyrin: It seems to clarify the structure of the MIPS program. My understanding the law prohibits CMS from pay-for-performance measures.

Member Schreiber: This is Michelle. I'm sorry, I'm trying to understand the question, too.

Co-Chair Zephyrin: Okay.

Member Schreiber: In MIPS, all MIPS questions are scored and they are used in pay-for-performance because MIPS is a pay-for-performance program. In the IQR, it is a pay-for-reporting program. The measure will be scored. The only payment is whether or not you have reported. If you're in compliance with having reported, then you're considered in compliance with IQR.

Co-Chair Zephyrin: Thank you. Any other -- so this is the same measure, but focus on the IQR, the Hospital IQR program.

Mr. Perla: Can I just jump in real quick just to clarify one point, if that's okay?

Co-Chair Zephyrin: Sure.

Mr. Perla: In terms of validity. So I just wanted to make a point that the extensive testing that's been done on the measures actually requires that not only is the screening done, but the results are known. You can't validate an instrument without actually knowing the result. So when we are doing multiple testing that's been done that's a standard. So I just wanted to make that point clear.

Co-Chair Zephyrin: Great. Thank you. Can we move on -- I think we can move to voting around the hospital inpatient quality reporting program for the same measure, unless there's additional discussion. Great. Thank you.

Ivory?

Ms. Harding: Now open for MUC2021-134, Screen Positive Rate for Social Drivers of Health to be included in the Hospital IQR Program.

Please submit your response to share the potential

impact on health disparities if this measure was to be included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-134 and the responses are as follows: zero members responded that this measure has high potential to have a negative impact by increasing health disparities; three members responded that this measure has potential to have a negative impact by increasing health disparities; five members responded that this measure will have no impact on health disparities; nine members responded that this measure has potential to have a positive impact by decreasing health disparities; and four members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Co-Chair Zephyrin: Thanks, everyone. So we will power through -- I know this has been a really long discussion question, but this is our last measure before we take a short break. Unfortunately, it will be a short break since we are pretty far behind.

MUC2021-084: Hospital Harm – Opioid-Related Adverse Events

But the next measure is MUC2021-084: Hospital Harm, Opioid-Related Adverse Events. This is a fully developed outcome measure that assesses the proportion of inpatient hospital encounters where patients aged 18 years of age or older have been administered an opioid medication, subsequently suffered the harm of an opioid-related adverse event and were administered an opioid antagonist within 12 hours. This measure does exclude opioid antagonist use in the operating room.

The measure at the facility level of analysis is endorsed by NQF and is not risk adjusted or stratified. This measure is being considered for two hospital programs, the Hospital IQR and the Medicare Promoting Inoperability program for hospitals.

Co-Chair Zephyrin: Thank you. Damien Cabezas, can you start us out with discussion? Or Sarah Shih.

I see Damien, you're on mute if you're trying to talk.

Member Shih: This is Sarah.

Co-Chair Zephyrin: Okay.

Member Shih: I had to hop off. I just came back on, just in time to discuss --

Co-Chair Zephyrin: Perfect, great.

Member Shih: All right, so I think this is lower is a better measure with an intent for safety. This is I think when inpatient -- people that have been admitted for inpatient care that have been given essentially too high of a dose of the opioid medication that could cause them harm and overdose, or essentially low respirate breathing and potential death.

And so naloxone can be administered to reverse those effects. And then the idea is to be able to assess whether systems are using naloxone to reverse these effects.

I think I had a really hard time understanding how the intersection, again, because I think throughout this conversation we've been talking about whether it's a measure that has potential to increase disparities or inequities in care versus all the precursors that come up to these events.

And I think the one thing I would rely on is maybe the group who are hospitalists to explain whether -- what are the factors that go into administration of the opioid medication and why is that potentially overdone or not done cautiously enough? Because when I think about it like when you compare hospitals, lower resource hospitals may somehow be disadvantaged, but I'm not sure how.

So that was my one concern as I read through this, is like I was trying too hard to tease apart where is the inequity maybe from a system perspective and not necessarily at the person who is receiving the care perspective because I think it's an important measure if you're trying to measure safety and I think there's other hospitals here that maybe can speak to that more, but that was my initial understanding. I don't know if others wanted to comment. Damien?

Co-Chair Zephyrin: Thank you, Sarah. Why we don't we open it up to the group around -- Jason, I see your hand is up or is it up from before?

Member Suh: No, it's new. So I'm a hospitalist and so sometimes the stuff that we're being presented with here are great quality measures. I don't know how it applies to equity sometimes though, you know?

This specific is a huge mess across the country. Opioid epidemic is pandemic, much worse than COVID. That's one point.

Point two, with changes in the last five to ten years around what's in scope and out of scope for nurse practice, the way we scale pain medications and treat patients' pain which is on a subject of scale on an object of finding is very difficult to do without a doctor present at the bedside 24/7.

And so a lot of systems have in which you can give a med and if there's no reaction to the pain you give another med. The surgeon operated three hours ago and the patient is still in a lot of pain. And sometimes we're doing quality things to try to help this patient's pain and we overshoot.

So measuring NARCAN use in the inpatient setting is a quality measure. I don't see how it applies to equity at all. But there's also this huge epidemic of chronic users who -- it's not I don't trust my patients, but I sometimes don't trust my patients.

I've had patients in the inpatient setting who take their own narcotic, who shoot up heroin on top of pain meds we give them and we have to somehow exclude that variability, because those patients get NARCAN in the ED and on the floor and multiple times in the hospital, depending on what happens.

So I think this is a great quality measure. I don't see the equity bit here, but it's very, very complex.

Co-Chair Zephyrin: Thank you. Thanks, Jason.

One more comment and then I think we can open it up to voting.

Dr. Cardi Smith.

Member Smith: Thank you. Yes, I think what I was thinking about with this one in particular is that we know that there tends to be bias overall around opioids. And there's literature to suggest that when patients are receiving opioids or are perceived to be receiving opioids, that the clinician's reflex is to do NARCAN if someone is showing a sign of what may be considered, you know, opioid-induced somnolence. And that's sort of an anchoring bias, right, because that person may be having some other medical condition that, in fact, is not an opioid overuse issue or related to harm. So I do wonder how using this measure might actually be skewed towards being more minorities who might be encountering this issue just because clinical teams aren't thinking of other medical conditions that might be contributing.

Co-Chair Zephyrin: Thank you. And so in terms of -- I think just for time reasons why don't we shift over to doing the poll and really the considerations around just equity impact. I think we've heard some really excellent points from Sarah, Cardi, and Jason, and others in the chat.

Ms. Harding: The poll is now open for MUC2021-084, Hospital Harm, Opioid-Related Adverse Events

to be included in the Hospital IQR program.

Please submit your response to share the potential impact on health disparities if this measure would be included in this proposed program.

A few more seconds. The poll is now closed from MUC2021-084 and the responses are as follows: zero members responded that this measure had high potential for having negative impacts by increasing health disparities; 3 members responded that this measure has potential have a negative impact by increasing health disparities; 12 members responded that this measure would have no impact on health disparities; 5 members responded that this measure has the potential to have a positive impact by decreasing health disparities; and 1 member responded that this measure has high potential to having positive impacts by decreasing health disparities.

Ms. Lynch: Thanks, Ivory. And the next program, because we haven't covered it before, I'll give a brief summary. It's the Medicare Promoting Interoperability Program for Hospitals. This is another pay-for-reporting and public-reporting program where eligible hospitals and critical access hospitals that fail to meet program requirements including using the clinical quality measure requirements receive a three quarter reduction of applicable percentage increase and the goal is to promote inter-operability using the certified electronic health record technology to improve patient and provider access to patient data.

So really if there's any additional questions, or it's also possible if it's the same, and we think the voting will be the same, we can motion to pull those votes forward as well.

Co-Chair Zephyrin: Are there other comments or should we move to voting in terms of equity impact?

I think we can transition to the voting. Great. Thank

you.

Ms. Harding: The poll is now open for MUC2021-084, Hospital Harm Opioid Related Adverse Events to be included within the Medicare Promoting Inoperability Program for Hospitals.

Please submit your response to share the potential impact on health disparities if this measure would be included in this program.

One more second.

The poll is now closed for MUC2021-084 and those responses are as follows: zero members responded that this measure has high potential to have a negative impact by increasing health disparities; 1 member responded that this measure has potential to have a negative impact by increasing health disparities; 16 members responded that this measure will have no impact on health disparities; 5 members responded that this measure has potential to have a positive impact by decreasing health disparities; and 1 member responded that this measure has high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: Thank you, everyone. I know that was quite a marathon and we're only halfway through. So let's take a seven-minute break and come back at 3:58 p.m. Eastern Time and we will go back to just taking one measure at a time by program as we will try to see if we are able to kind of move forward a little bit quickly. We really want to have conversations so certainly appreciate everyone's engagement so far, but let's take a break.

Co-Chair Angove: Did you say 3:58?

Ms. Lynch: Yes, my brain is done. Yes, 3:38.

Co-Chair Angove: Great. Thank you.

Co-Chair Zephyrin: Thank you.

(Whereupon, the above-entitled matter went off the record at 3:32 p.m. and resumed at 3:38 p.m.)

Ms. Lynch: Okay, and I have that it is 3:38, so we will start recording again. Wonderful, thank you.

And welcome back, everyone. I know that was a very, very quick seven minutes, but let's go ahead. We will be transitioning back to considering measures that are being proposed for clinician programs. So just one measure at a time, one -- for all of this program, so I think that'll be helpful too.

Medicare Parts C & D Star Ratings

So we will be covering measures that are under consideration for the Medicare Part C and D Star Ratings.

So this is a quality payment program and used for public reporting for Medicare Advantage incentive structure. It is public reporting with the quality bonus payments. And for standalone prescription drug plans, the incentive structure is public reporting.

The goals of this program are to provide information about the plan quality and performance indicators to beneficiaries to help them make informed plan choices and to incentivize high-performing plans.

MUC2021-053: Concurrent Use of Opioids and Benzodiazepines

The first measure under consideration is MUC2021-053, Concurrent Use of Opioids and Benzodiazepines. This is a fully developed process measure that assesses the percentage of Medicare Part D beneficiaries, 18 years and older with concurrent use of prescription opioids and benzos during the measurement period.

This measure is at the health plan level of analysis, is endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: I want to thank everybody before we get started on this one for just the level of thoughtfulness and discussion that we have had this entire day. Thanks for hanging in here with us. We are about an hour behind, and so I just want to refocus everybody on really honing in on the equity and disparity implications.

I know there's been some rich conversation about the wider measure itself. And while some of those details are very important to make assessments around equity, there's also going to be a larger group that is going to review and probably have some of the same conversations we have had.

What we don't want to do is miss the equity pieces, and that's what we're being tasked to pull into their conversation and advise them on. So if we could try to keep it focused, and I'm going to try to make time, but we'll see what we can do.

Damien, you're our lead discussant on this one, I'm going to hand it over to you.

Member Cabezas: Hi, good afternoon, and I apologize. I had to step away on the opioid-related, although I got my vote in. But I'm, sadly I missed that discussion, and apologize for that.

In terms of this measure, I think that this is a really important measure in my opinion, just in term -- to measure the use of opioids and benzodiazepines as it relates to minorities and underserved populations. So I do think this is an important measure.

I, similar to the previous measure that we talked about, I do -- from a treatment point of view I think it's an important measure. I struggle, similar to the last measure, in terms of the tie-in to equity and health disparities. But I do think it's a good measure for treatment purposes.

Co-Chair Angove: Yeah, and that's okay if we don't find the tie to equity. Not all of these will have an

explicit one. We'll talk about it and see what other people have to say.

Roberta, our second lead discussant, I'm going to hand it over to you. Roberta, if you're talking, you may be on mute. I'm trying to scroll through participants and see if you are still with us.

Co-Chair Zephyrin: I think she couldn't make the call, Rebecca.

Co-Chair Angove: Okay, thank you. Well, in that case, I'm going to open it up to the group. Again, comments and thoughts on what aspects of health equity do you see this measure advancing, and what social determinants of health should be considered related to this message.

Feel like I used my professor voice and I've scared everybody. Leonor, I see your comment. Absolutely, stratification. And so we're going to move that to the end of the -- end of the meeting and talk about that, because that's a consideration for a lot of these measures.

What about any way that you see that this measure could exacerbate disparities or have unintended consequences?

Member Huebner: Yeah, this is Jeff. I can go ahead and just say, I mean, I'm grappling with this one. I'm trying to re-review the specs on it a little bit. Clearly this is best practice to avoid concurrent prescriptions. But there are times when it is appropriate, and especially with appropriate screening evaluation and consideration and education and working with the patient.

And we know that people from non-White backgrounds are sometimes undertreated for pain and anxiety, so that could be an unintended consequence.

Co-Chair Angove: Great, thanks for -- thanks for

that insight. Anybody else want to add anything? Anyone on the phone? All right, Damien, did you have something to add?

Member Cabezas: No, nothing to add.

Co-Chair Angove: Your box lit up, so I'm just making sure.

Member Cabezas: Okay.

Co-Chair Angove: All right, let's move this to polling, and I appreciate the solidarity in trying to keep us on time.

Ms. Harding: For MUC2021-053, Concurrent Use of Opioids and Benzodiazepines to be included within the Medicare Parts C and D Star Ratings. Please submit your response to share the potential impact on health disparities if this measure were to be included in this proposed program.

A few more seconds. The poll is now closed and for MUC2021-053, and the responses are as follows. Zero members responded that this measure has high potential to have a negative impact by increasing health disparities.

Six members responded that this measure has a potential to have a negative impact by increasing health disparities. Ten members responded that this measure will have no impact on health disparities.

Four members responded that this measure has a potential to have a positive impact by decreasing health disparities. And zero members responded that this measure has high potential to have a high potential to have a positive impact by decreasing health disparities.

MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

Ms. Lynch: Thank you, everyone. The next measure is MUC2021-056: Polypharmacy: Use of

Anticholinergic Medications in Older Adults. This is a fully developed process measure that assesses the percentage of Medicare Part D beneficiaries age 65 years or age or older with a current use of two or more unique anticholinergic medications during the measurement period.

This measure is at the health plan level of analysis, is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: All right, Lanita White, can you start us off? If you're talking, you may be on mute. All right, she may be having technical issues or maybe had to step away. Sarita Mohanty, can I -- can I hand it off to you?

Member Mohanty: Sure, I can -- I can start, and you know, yeah, I look forward to comments.

So I, yeah, I think in terms of health equity, in terms of disparities, I think, you know, one of the things we recognize is that, you know, there's high burden of like anticholinergic, you know, has a lot of -- and I think this was stated in the specs, about negative association with cognitive performance in older adults.

You know, we don't actually have a lot of knowledge from my understanding, but people can correct me if I'm wrong, about the knowledge of the side effect outcomes as it relates, you know, and the impacts of things like health literacy and language on that.

So I think, you know, this is actually a measure I think is important because it's polypharmacy as it relates to safety. But it would be important to do some level of stratification of this measure as well to see which subpopulations, you know, are being impacted by, you know, kind of overuse or overprescribing of anticholinergics.

And so, I mean that's kind of -- I'll just stop there. That's kind of my general of this -- of this -- you

know, I mean, it is not a patient-reported measure. It's captured by data. So I, you know, those were kind of my, some of my initial thoughts.

Co-Chair Angove: And Lanita, are you able to join us? I want to give you space to comment if you're there. All right, well maybe she'll be back on in a few minutes. Let's open up the floor to others with thoughts or comments around the health equity implications of this measure.

And Sarita, I did note that you did mention stratifications, so we'll absolutely have a larger discussion, because that's come up in multiple measures. But if there's no other thoughts or concerns around either equity or the unintended consequences on exacerbating disparities, we can move it to the poll.

All right, yeah, let's take the poll.

Ms. Harding: The poll is now open for MUC2021-056, Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults to be included within the Medicare Part C&D Star Ratings Program. Please submit your response to share the potential impact on health disparities if this measure were to be included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-056, and the responses are as follows. Zero members responded that this measure has high potential to have a negative impact by increasing health disparities. Two members responded that this measure has potential have a negative impact by increasing health disparities.

Fourteen members responded that this measure has no impact on health disparities. Four members responded that this measure has potential have a positive impact by decreasing health disparities. And one member responded that this measure has high potential to have a positive impact by decreasing health disparities.

MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System-Active Medications in Older Adults

Ms. Lynch: Great, thank you, everyone.

The next measure under consideration is MUC2021-066, Polypharmacy: Use of Multiple Central Nervous System Active Medications in Older Adults. This is a fully developed process measure that assesses the percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of three or more unique central nervous system-active medications during the measurement period.

The measure is at the health plan level of analysis, is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: All right, you had me confused until you changed the slide. Perfect.

Ms. Lynch: It's very similar.

Co-Chair Angove: Sarita, I'm passing it back to you as lead discussant on this one as well.

Member Mohanty: Okay, sounds good. Yeah, again, I'll be brief. So I think, you know, when we think about these CNS-active medications, things like benzodiazepines, I think even opioids fall into this, tricyclics, etc.

And I think when we look at -- it's kind of similar, somewhat similar to the last measure in that, you know, it's not patient-reported outcome measure.

But I think we -- this also will benefit from a stratification because you know, particularly those with mental health diagnoses, you know, they're going to -- use tends to be higher in this subgroup. We would want to understand that.

Nursing home resident increase of course had been -- you know, we see this a lot. So being able to

understand and stratify by where this is being, you know, where the prescriptions are -- or the medication use is happening.

I think we also recognize that it has impacts on those with disability and some higher risk. So I would say, you know, similar to the last one, stratifying both measures. And just you know, just a note that this did exclude, you know, the exclusion -- I think it excluded patients who were in hospice care and those diagnosed with a seizure disorder.

So just to, you know, avoid any kind of what they call unintended consequences. So don't think I have much more else to add to this. And obviously look forward to hearing what others think.

Co-Chair Angove: And Lanita, would you like to jump in and comment on this one?

Member White: I don't have anything to add to this one. I don't. I was looking at it, and I was thinking what was I supposed to say on this. But I didn't have any notes on this one, not added to it. So I'm sorry, I didn't have anything.

Co-Chair Angove: That is fine, let's --

Member White: My audio is working, by the way, thank you for that. I'm sorry about that earlier.

Co-Chair Angove: No problem. Technology is great when it works. Let's open it up to the group. You know, and specifically I think because it's related to the polling question, any brief comments or thoughts around why this may exacerbate disparities, have a positive or negative, and/or any considerations related to equity.

And David, I see your hand up.

Member Machledt: Yeah, thanks. I haven't had as much time as I'd like to like digest this one and the last one as well, but it seems, as related to the risk of falls, that it could have an important impact on

institutionalization, which is a really key, that's a key issue for people with disabilities.

And I think also a setting-specific stratification on this one in particular, knowing that, you know, some medications, sometimes people get over-medicated in certain settings. And I don't know if this would help shed some light on that potentially.

So I wish I had a little more time to deal with it, but, or to dig into it. But it seems like it would be an important measure, you know, to stratify to see how -- what impact it might have on helping access to care for, or care, for people with disabilities.

Co-Chair Angove: Any other thoughts to share on this one? Couple things coming into the chat, I appreciate that. And absolutely we'll asterisk this one for stratification as well. I think that's a common thread we've seen a lot today.

All right, let's move to the poll for this one. Thank you, Ivory.

Ms. Harding: The poll is now open for MUC2021-066, Polypharmacy: Use of Multiple Central Nervous System-Active Medications in Older Adults to be included in the Medicare Part C & D Star Ratings Program. Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-066, and the responses are as follows. Zero members responded that this measure has high potential to have a negative impact by increasing health disparities. Two members responded that this measure has potential to have a negative impact by increasing health disparities.

Thirteen members responded that this measure will have no impact on health disparities. Seven members responded that this measure has potential to have a positive impact by decreasing health

disparities. And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: Great, thank you, everyone. So quick transition back into hospital programs. So just to get your mindset on hospital, not clinician anymore.

So in this section, we will be focusing on three programs, End-Stage Renal Disease Quality Incentive Program, Hospital In-Patient Quality Program, and the PPP-Exempt Cancer Hospital Quality Reporting Program. And note we did talk about some of these programs already.

End-Stage Renal Disease Quality Incentive Program

So we will start with the End-Stage Renal Disease Quality Incentive Program. This is a pay-for-performance and public reporting program. As of 2012, the incentive structure is that to reduce payments to dialysis facility if the facilities do not meet or exceed the required total performance score.

These payment reductions are on a sliding scale and could amount to a maximum of a two percent reduction per year. The goal of this program is to improve the quality of dialysis care and produce better outcomes for beneficiary.

MUC2021-101: Standardized Readmission Ratio for Dialysis Facilities

So the measure for this program is MUC2021-101, Standardized Readmission Ratio for Dialysis Facilities. This is a fully developed outcome measure that provides the standardized readmission ratio for dialysis facilities.

This ratio represents the number of observed index discharges from acute care hospitals to that dialysis facility that resulted in an unplanned readmission to an acute care hospital within 4-30 days of discharge

to the expected number of readmissions given the discharging hospital and the characteristics of the patient and based on the national -- on a national norm.

The measure is based on Medicare-covered dialysis patients, is at the facility level of analysis. It is -- not endorsed by NQF, and it is risk-adjusted.

Co-Chair Angove: All right, Stephanie, can I have you start us off with thoughts on this one?

Member Clouser: Yeah, just two thoughts on this one, both of which I think we've talked about in other measures today.

The first, we know there's a gap in equity in kidney care, kidney -- kidney disease prevalence care and outcomes, so that topic in general is very important. And I do have, again, questions on the risk adjustment that I think we talked about in one of the other readmissions one -- readmissions measures earlier.

Co-Chair Angove: Great, and Leonor.

Member Fernandez: Hi, yeah, it sounds like this had been sort of a contentious kind of measure that has a long trail, you know, before it. And my understanding is that it hasn't met the criteria for sort of reliability in some way by one of the groups in NQF.

It is intended to do something that is incredibly important, and it tried to exclude, I believe, admissions within three days and other exclusions to try and make it more valid.

So I think the details that matter are in what is the risk adjustment that is done. And I don't know if someone here could comment more on why the reliability was felt to be not acceptable.

Ms. Lynch: A point of clarification, at least for the NQF endorsement that failed on validity. And I may

call out my colleague Matt Pickering, if you're on, if you have any contacts for this measure.

Dr. Pickering: Yes, hi, this is Matt. Just to add, so our Scientific Methods Panel did not pass the measure on validity due to some correlation concerns. So looking at the measure score and correlating it to other outcomes.

The Scientific Methods Panel did not find the correlations to be adequate for this measure, and our standing committee upheld the Scientific Methods Panel decision, agreeing that validity was not satisfied. So the measure did not pass on validity for those -- for those reasons.

Co-Chair Angove: So did that -- did that answer the question? I know there's a question in the chat from Jason. Jason, do you want to share, are you able to ask your question?

Member Suh: I just don't get this one very well, which is dialysis patients are chronically ill. And I started off my medical career as a dialysis tech, and those patients are in and out of the hospital all the time. And sometimes it's not related to their dialysis or their -- or kidney disease.

And so if they come from an acute care hospital, yes, they're going to dialyze them, but that's their chronic state. And so -- so to have a correlation between the two, I just don't get it. And so maybe that's why the Scientific Method didn't pass muster on this one, I don't know.

Member Fernandez: I don't know, maybe the person who just commented before can add to that, but my understanding is that there are issues about this being, the access being on the dialysis center rather than on the hospital, and how much it is within the aegis of control of the dialysis center to prevent readmission.

The spirit of it is to create much greater

collaboration between the dialysis center and communication with the hospital. It was adjusted for several things, including acuity and illnesses, you know, chronic illnesses. So maybe I'll stop and someone can comment.

Co-Chair Angove: And if we don't have clarity on that point, maybe think around the potential for exacerbating health disparities, or it there are health equity implications within this measure.

So I'm not seeing a whole lot of activity.

Member Fernandez: Can I just add to that, then?

Co-Chair Angove: Please, yeah, please.

Member Fernandez: I think an example would be this: I have a lot of patients who speak Spanish and go to a dialysis facility, but no one speaks Spanish at the dialysis facility. And therefore there is not great communication about what should happen between the hospital and the dialysis center.

So it could be that it's creating forces to improve that and hire more Spanish speakers or use an interpreter, blah blah. So it can have health equity implications.

Co-Chair Angove: Leonor, I really appreciate that example, I think that helped us all. Jeff, I see your hand up.

Member Huebner: Yeah, just to add to that briefly. You know, in the past our system's been involved with some work around, and I think a lot of other high-performing systems in this area are expanding case management and social work and the language resources that were just referred to to help improve quality of care for what Jason said is a very chronically ill population.

But these patient populations often are in need of additional assistance with that sort of approach, and that does have the potential to reduce

readmissions.

Co-Chair Angove: Great, so I think we're ready to do the poll. I don't see any hands going up, chatting, to try to give you time if you're looking for the button. The chat's pretty quiet. Leonor added something, thank you for that.

So let's go to the poll, I think we're ready for this one.

Ms. Harding: The poll is now open for MUC2021-0101, Standardized Readmission Ratio for Dialysis Facilities to be included within the End-Stage Renal Disease Quality Incentive Program. Please submit your response to share the potential impact on health disparities if this measures is included within the proposed program.

A few more seconds. The poll is closed for MUC2021-101, and the responses are as follows. Zero members responded that this measure has high potential to have a negative impact by increasing health disparities. Two members responded that this measure has potential to have a negative impact by increasing health disparities.

Nine members responded that this measure will have no impact on health disparities. Ten members responded that this measure has potential to have a positive impact by decreasing health disparities. And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Hospital Inpatient Quality Reporting Program

Ms. Lynch: Thank you, everyone. So we will be transitioning to our next hospital program. It is the Hospital Inpatient Quality Reporting Program, or Hospital IQR, which we talked about previously.

So again, this is hospitals that, it's a pay-for-reporting and public reporting program where

hospitals that don't participate in the program or participate and fail to meet the program requirements receive a one-fourth reduction in the applicable percentage increase in their annual payment update.

MUC2021-106: Hospital Commitment to Health Equity

So this first measure, if we go to the next slide. The first measure under consideration is MUC2021-106, Hospital Commitment to Health Equity.

This is a structural measure that is still under development, and it assesses the hospital's commitment to health equity using a suite of equity-focused, organizational competencies aimed at achieving health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

The measure will include five attestation-based questions, each representing a separate domain of commitment. The hospital will receive a point for each domain where they attest to the corresponding statement for a total of five points.

It will be at the facility level of analysis since it is still under development and has not been submitted for endorsement by NQF, and risk adjustments or stratifications have been identified.

Co-Chair Angove: All right, let's jump right in. Leonor -- am I pronouncing your name right?

Member Fernandez: Oh, thanks, Rebecca, it's Leonor.

Co-Chair Angove: Leonor, apologies.

Member Fernandez: No, no problem, it's a hard one. So yeah, this is a happy one, I hope, in that it is a structural measure, but it's bringing in important elements. And it includes data collection, data

analysis and by race, ethnicity, SOGI, etc. And I don't think disability is included.

And it also brings in organizational features that hospitals will attest to in terms of having structures and someone identified who is in charge of these issues of health equity.

So I think the only thing I would add is, and we're not here to modify the measure, is that there are certain things not present in it regarding data transparency, regarding other aspects. But, and community engagement is in there too as well. So, I'll stop there. So I think it's very relevant.

Co-Chair Angove: Thank you, and Emily, thoughts on this one? Let's see, is she --

Ms. Lynch: I don't think Emily's been able to join.

Co-Chair Angove: And I keep doing that, don't I. I'm sorry. I did not commit to memory --

Ms. Lynch: You never know, you never know, she might have been able to join. I think it's appropriate to ask.

Co-Chair Angove: All right, well, I am sure that even without Emily's expert input we will have some robust conversation and comments on this one. So opening the floor. Any thoughts, comments, ideas around how this could potentially exacerbate health disparities, how it could improve health equity? I'm excited this one has health equity in the title.

Let's go with Mahil, and then Beth, I'll go to you next, Beth Godsey.

Member Senathirajah: Yeah, thanks. I'm excited there's health equity in the title as well. This is more a question.

So in developing the structural measure, as part of the development, will there be sort of analysis of whether, how well-connected it is to disparities, or

reducing disparities? I know that's more of a question about the measure itself, but obviously it's got a strong promise to address that.

Co-Chair Angove: Yeah, it's a great point and very relevant, right, is it lip service to the problem or is it connected to outcomes. Do we have the details on that if it's going to be connected to quality of care?

Member Schreiber: This is Michelle, we do have our contractors on the phone who can address this. But I'll start by making some opening comments on this one.

This is really an initial attempt to see if hospitals are doing what is largely considered best practices around health equity. In other words, do they have a commitment to obtaining -- do they have a plan.

Do they have an equity plan, do they -- are they collecting the data? Are they stratifying their own measures based on their data? Do they have a leader commitment to equity?

Over time, obviously, there are other components that could be added, educational components. Are they doing training? So there are many components that could be added to this, and over time we will also be able to correlate this with outcomes.

But that won't happen with the initial measure, that will happen over time. And I would ask our contractors if they want to comment at all.

Co-Chair Angove: Yeah, thanks, Michelle. Are there contractors on the phone that want to offer brief comments around Mahil's question?

Ms. Wallace: I'm Lori Wallace. One point that I just want to make is the fact that I know there was a question about transparency, so I'm trying to remember the exact question that was just asked.

Member Fernandez: I think in my comments I had mentioned that it didn't specify that -- it talks about

data and data stratification, which was excellent. It didn't, I think, go as far as to say that that data, those data must be shared with the public.

Ms. Wallace: And I don't think that -- I think that the idea is for this measure to be a first step, as Michelle, as Dr. Schreiber mentioned. And it's really about signaling to hospitals the importance of doing these things, as well as the idea of their providing resources to reduce health disparities.

I don't think at this point -- and I also just want to say that the measure is totally specified. But the initial point of the measure is to signal, and then additional components or aspects can be implemented down the line.

Member Senathirajah: Thank you.

Co-Chair Angove: Beth, I know you've had your hand up for a while.

Member Godsey: Yeah, thanks. I guess some questions on -- my conversations with hospitals across the country have been that, yes, they would affirm that they are working on equity and that they have programs in place. And yet we're still not solving the problem.

And so I want to make sure that even though that we're putting forth a recommendation that hospitals, you know, state their commitment, that it actually -- that it actually is measuring or attempting to measure what's really going on. And my concern with this is that it may not be.

You know, when we've -- when we've taken a look at hospitals across the country and evaluated their commitment, I think they all have raised their hands high. What the challenge has been is being able to really identify the root cause of what's going on.

So you know, it could be more rose-colored glasses

of a view for this particular measure and say, yes, we're all going to say yes to this measure. And just want to make sure that that doesn't lead us down a path of, you know, that we've addressed an issued or that we're addressed concern when we really haven't.

Member Schreiber: So it's Michelle. I think your point is well taken, and I recognize that many hospitals will raise their hands and say yes. But I think that there are specific elements in this that will give then pause to say are they really doing it.

Do they actually have a plan, are they actually stratifying their own performance metric, you know, their, the internal quality dashboards of hospitals. Are they stratifying their data for race and ethnicity, for example, or least the data that they might have.

So I think that there are specific action steps that are included here that hospitals I think actually will have to think about whether or not they're doing those.

Member Cole: Yeah, I'm sorry.

Co-Chair Angove: Alicia, go ahead, and then David, I see your hand, I'll get you next.

Member Cole: I want to piggyback that, because my thing is, you know, there has to be some action behind this. You can't measure intent, you can't measure culture in terms of someone's belief and we really want to be the.

I mean, I look at this when I see the word health equity in the title, and it makes me think about the way patient-centered was the buzzword for years, you know. Patient-centered, our care is patient-centered and this and that.

And so I'm always cautious when something that has to do with patient safety or health equity or it's in the headlines. Because what I'm looking for is

what's in paragraph 5, in the small print. And so how are we going to have action steps that actually show that health equity is a priority. Are we measuring it, are we utilizing the data.

You know, what are your hiring statistics, what does your board room look like. What do your patient and family advisory councils look like. Is your facility accessible to the handicapped. Do you have ramps.

There's so many things that, you know, do you have translators that are able to address the needs of your demographic and your population of the people who come.

So there are so many -- this can be broken down into so many areas that I think just an overall, you know, vision board kind of statement doesn't really do it for me.

Co-Chair Angove: Yeah, Alicia, I appreciate your comments. And I think what I heard Michelle saying was that this could be or the vision was that this was going to be the first step in probably a very incremental push towards all of those things you're talking about. But I work in that field, I totally appreciate those concerns.

Member Cole: Well, the first step, by the time you take the first step, everybody's brochures, commercials, literature, they're going to plaster we have signed on for health equity all over everywhere long before they actually have the plans and actually do the things.

So it's like the horse will already be out of the gate once they sign onto this. We agree to, we implement. And --

Co-Chair Angove: David, I want to make sure I get to you.

Member Cole: Yeah, thank you, sorry.

Member Machledt: Yeah --

Co-Chair Angove: No, thanks, Alicia.

Member Machledt: Thank you, I agree, you know, and I'm probably going to -- I'm sort of following on. My concern with this measure is that it sets too low a bar in way, even though -- or you could say it's a first step. But then, you know, and I recognize how important that is.

Co-Chair Angove: We lost -- David, can you just repeat what you just said, we lost you for a minute. At least I did.

Member Machledt: Oh, sorry. So I think it -- there's a danger that it sets too low a bar. That like when is the next step going to come.

And I'm also, I had some concerns, you know, if you're asking a hospital if they're collecting demographic information. Of course, you know, in many cases if you have a Medicare, a person who -- there's issues with, you know, if the hospital is collecting demographic information, it may be different than what the Medicare program has for that person, which is different from the what the Medicaid program might have for that person.

So in some ways, the demographic data collection is not specific to the hospital level. So I just, you know, my concern is that it's very -- it doesn't seem necessarily actionable or I can see how it, if the hospitals never thought of this, that it says there has to be something in place.

But that's my concerns, is it's just -- it may be more better to start off with a specific subcomponent instead of trying to get the whole picture and watering everything down.

Co-Chair Angove: So Leonor did, in the chat, copied and pasted some of the specifics which I think get into some of the questions that you and Alicia are raising, so I just want to --

Member Machledt: I see this, and also saw that, you know, the concern that CMS expressed about these kind of structural measures not connecting to clinical outcomes. And that's sort of ultimately where my concern is.

Member Cole: And you -- can I piggy back and say these are not even always even issues of race and age. I was in a facility one time navigating a patient, and the woman in the bed next to her was Armenian and only spoke Armenian.

And this was in Glendale, CA, which the population is so heavily Armenian that Kim Kardashian was considering running for mayor. That's how many Armenians live in Glendale. And yet the hospital there had no one on staff who could speak to this woman in Armenian, in her native language.

So you know, when we talk about health equity and being really true to the demographic and the population in our market share, you know, we have to pay more than lip service than that.

Co-Chair Angove: So anybody want to add anything that we haven't heard or any other points related to advancing health equity or unintended consequences of this measure?

This was a really great conversation, I appreciated. Let's move to polling on this one.

Ms. Harding: The poll is now open for MUC2021-0106, Hospital Commitment to Health Equity to be included within the hospital IQR program. Please submit your response to share the potential impact on health disparities if their measure is included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-106, and the responses are as follows. One member responded that this measure has high potential to have a negative impact by increasing health disparities, two members responded that this

measure has potential to have a negative effect by increasing health disparities.

Three members responded that this measure will have no impact on health disparities. Nine members responded that this measure has potential to have a positive impact by decreasing health disparities. And four members responded that this measure has high potential to have a positive impact by decreasing health disparities.

MUC2021-122: Excess Days in Acute Care After Hospitalization For Acute Myocardial Infarction

Ms. Lynch: Thank you, everyone. The next measure under consideration is MUC2021-122, Excess Days in Acute Care After Hospitalization for an Acute Myocardial Infarction. This is a fully developed outcome measure that estimates days spent in acute care within 30 days of discharge from an inpatient hospital for an acute myocardial infarction.

This measure is intended to capture the quality of care transitions provided to discharged patients hospitalized with an acute MI by collectively measuring a set of adverse acute care outcomes that can occur post-discharge, including emergency department visits, observation stays, and unplanned readmissions at any time during the 30 days post -- the 30 days post discharge.

The measure is at the facility level of analysis, is endorsed by NQF, and is risk-adjusted.

Co-Chair Angove: Thank you. Kirsten, Kirsten, tell me how to pronounce your name. Can you start us off?

Member Bibbins-Domingo: Sure, it's Kirsten.

So I think the things to flag for this is that this is a risk-adjusted measure but is not risk-adjusted for other social factors, social drivers of health in the performance between hospitals differed based on

the facility's proportion of low -- patients of low socioeconomic status, at least by the performance data submitted to NQF.

So I think there's a question of at least stratifying for this measure to identify disparities and gaps, but also to consider the risk adjustment or to understand this measure better.

Co-Chair Angove: Thanks, and Mark.

Member Friedberg: I don't have much to add. I mean, it's the same issue we've encountered in other measures where we're worried about the incentive running one direction and the wealth effect running a different direction. So, that's a persistent challenge.

Co-Chair Angove: Any additional thoughts or comments around unintended consequences or the relationship of this measure to health equity and reducing disparities?

All right, I'm going to move us right along, then. Let's put the poll up for this one.

Ms. Harding: The poll is now open for MUC2021-122, Excess Days in Acute Care After Hospitalization for Acute Myocardial Infarction to be included within the hospital IQR program. Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

A few more seconds. The poll is now closed for MUC2021-122, and the results are as follows. Zero members responded that this measure has high potential to have a negative impact by increasing health disparities. Two members responded that this measure the potential to have a negative impact by increasing health disparities.

Nine members responded that this measure will have no impact on health disparities. Seven

members responded that this measure has the potential to have a positive impact by decreasing health disparities, and zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty

Ms. Lynch: Thank you all. We will transition to the next measure under consideration for this program, which is MUC2021-120, Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty.

This is a fully developed cost resource use measure that estimates hospital-level risk-standardized payments for an elective primary total hip or total knee arthoplasty episode of care starting with an (telephonic interference) admission to a short-term acute care facility and extending 90 days post-admission for Medicare fee-for-service patients who are 65 years of age or older.

This measure has a facility level of analysis and is risk-adjusted. This measure is endorsed by NQF, although this version of the measure includes 26 new ICD-10 codes which were not part of the specifications when the measure was admitted for NQF endorsement.

Co-Chair Angove: David, can you start us off as lead discussant?

Member Machledt: Sure. So this is an existing measure that's being modified, and from what understood, like she said, they've just added some new ICD codes to it. And it's not a measure of quality per se, it's a measure of the cost of care for an episode for a total hip or knee replacement.

So my main understanding of this in terms of it is that it should be paired with other quality measures. So you know, because if you're just looking at payment, you're not really sure if that's due to having higher levels of complications or if it's due to charging, you know, to having higher, just higher number of procedures that are done.

So that is, I think it's hard to evaluate this in terms of equity without seeing what it's tied with. And I understand there are other measures that it is expected to be tied with, so that's the main thing I understood about this.

There are some exclusions as well, but I don't have a whole lot to add about that, whether those exclusions would increase or decrease disparities.

Co-Chair Angove: Thanks, David. Kirsten.

Member Bibbins-Domingo: This is another one where the issue of whether variation in payment indicates disparities in care or are influenced by other social factors. And the question of whether this would also benefit from risk adjustment for social -- social drivers of health.

And then the last thing just to mention is that the -- and not quite related to equity but one we should monitor for equity is that this is a pretty dynamic area where much is moving from inpatient settings to outpatient settings, and it is likely that the people who will be cared for in outpatient settings will be younger, healthier people.

And to the extent in that context this would influence who's going to be left getting these types of procedures in the inpatient setting that we should monitor the impact of equity over time.

Co-Chair Angove: All right, Beth, I'm going to go right to you, I see your hand up.

Member Godsey: Sure, and I just want to reiterate

the comments that were made earlier today about this being a primarily elective procedure that already in some situations may predispose this measure to patients that are more affluent and have more access to resources than others.

So this goes back to the access question. I don't have anything more to add, other than just to reiterate that that was brought up earlier and wanted to make sure that that gets tagged with this one as well.

I think overall this measure is complex and complicated and stratifying it by social determinants of health would add very little value in evaluating disparities.

Co-Chair Angove: And Mahil.

Member Senathirajah: This is Mahil. You know, so this is a cost measure, and this measure has always been in use in programs of lower is better.

But I'm just concerned that, you know, stinting of care related to race or other socio -- social needs status may be a factor here. So that in fact scores may be lower or appear to better as a result of less care being provided.

And the pairing with the quality measures doesn't really happen on a regular basis. This measure alone may not be a good reflection of the care received by the groups with known underutilization.

Co-Chair Angove: Thanks, Mahil. Anybody else want to speak to the equity or disparity implications of this measure? Melony.

Member Sorbero: Yeah, I am a little concerned that any payment or cost measure can be influenced by resources available in the community. So that underresourced -- providers in underresourced communities may be challenged by these measures if they don't -- if the patients don't have adequate

access to, I don't know if they would need home care or if they would need other services that they aren't able to get access to that might increase like to the readmission that would subsequently increase their -- the episode payment or episode costs.

You know, I'm a little less familiar with this clinical area to know the extent to which this would be a factor, especially considering these are elective procedures.

Co-Chair Angove: I think it's a global concern, though, that we should put on that list of kind of bigger things to think about. But it's a really good point.

All right, let's move this to polling.

Ms. Harding: The poll is now open for MUC2021-120, Hospital-Level Risk-Standardized Payment Associated With an Episode of Care for Primary Elective THA and/or TKA to be included within the hospital IQR program. Please submit your response to share the potential impact on health disparities if this measure is included within the proposed program.

A few more seconds. The poll is now closed for MUC2021-120, and the responses are as follows. Zero members responded that the measure will have a high potential to have a negative impact by increasing health disparities. Eleven members responded that the measure has the potential to have a negative impact by increasing health disparities.

Seven members responded that the measure has no impact on health disparities. One member responded that the measure has the potential to have a positive impact by decreasing health disparities. And zero members responded that the measure has high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: Wonderful, thank you, Ivory. And we do seem to be picking up some speed, which is great. But just wanted to kind of let everyone know the plan.

If for some reason some of our upcoming measure require a little bit more discussion and we're not able to get to all the measures under consideration, we'll poll to see if people are able to stay on longer or ask for written feedback after the meeting.

And then if we're also not able to get to the overarching discussion, we'll set up a voluntary other discussion outside of this, just to make sure we have time to cover all of these important issues. So just kind of wanted to let you know where we are there.

PPS-Exempt Cancer Hospital Quality Reporting

So the next program that we'll talk about we have one measure for. So this is the PPS-Exempt Cancel Hospital Quality Reporting Program. This is a voluntary quality reporting program where the data are published on Hospital Compare.

The goal of the program is to provide information about the quality of care in cancer hospitals, particularly the 11 cancer hospitals that are exempt from the inpatient perspective payment system and the inpatient quality reporting program.

And also 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.

MUC2021-091: Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer

So the measure under consideration here is MUC2021-091, Appropriate Treatment for Patients with Stage I through III HER2 Positive Breast

Cancer. This is a fully developed process measure that assesses the percentage of female patients aged 18-70 years old with Stage I through Stage III HER2 positive breast cancer for whom appropriate treatment is initiated.

This measure has a clinician group level of analysis, is not endorsed by NQF, and is not risk-adjusted or stratified.

Co-Chair Angove: Chris, I'm going to have you kick it off as our first lead discussant.

Member Grasso: Sure. So thank you. I think we can all agree that ensuring that people who have breast cancer are getting treated is a critical issue and worth measuring. But I'll just kind of jump to the chase in terms of my concerns with this measure.

Any time that we restrict a measure to only certain (telephonic interference), we're immediately eliminating others who could also have that anatomy as well. So for example, anybody who's transgender, gender diverse, non-binary would basically be excluded from this measure, which is a significant concern, because this is a group that is frequently invisible and left out of the healthcare system. So that's a major concern that I have with this measure.

Another concern I have is that just the definition around appropriate treatment in that it's not necessarily directly linked to some sort of a treatment recommendation I think just leaves some openness to interpretation and bias in how people might decide which treatment somebody could get.

And you know, as we've talked about throughout this day, I think you know, it's so important when we think about how this type of care is delivered and the costs associated with and social determinants of health and race and how these decisions might be made based on cost or beneficiaries for that matter.

So I'll just pause there to keep us on track.

Co-Chair Angove: Great comments, thank you, Chris. And Tala, and tell me if I'm pronouncing your name wrong, please.

Member Mansi: You're pronouncing it correctly, thank you.

Yeah, I just want to echo Chris's sentiments. I think that this measure certainly the denominator is exclusionary. There's research that shows that trans women are at a higher risk of breast cancer than cisgender men, and this group is not included in this measure.

We also know that racial disparities exist within breast cancer screening and diagnosis. Regular screening is an important part of diagnosis breast cancer early on, and we know that Black Americans have higher death rates due to cancer, more than any other racial and ethnic group.

Specifically, Black women are 40% more likely to die from this disease than White women. And the reason for this gap is delayed diagnosis and inequitable access. So the fact that this measure is not stratified by race, ethnicity, insurance status, federal poverty level represents those gaps, but that has come up with all, you know, pretty much all the measures that we've discussed.

We know that this poverty, race, uninsured status, lower level of education are all significantly associated with higher breast cancer mortality rates. So the determinants of health that can be considered include housing, economic opportunity, environment, and transportation.

While this measure is imperfect, collecting this data will be important. And that's all from me. I'll open it up for discussion.

Co-Chair Angove: Yeah, thanks, Tala, and great

comments. Alicia, we have to teach you how to raise your hand.

Member Cole: I know, I got to figure it out. So yes --

Co-Chair Angove: I'm always looking up here, but thanks for being persistent, Alicia. Jump in.

Member Cole: So yeah, I agree with all the comments that have gone before. The only other comment I had to add to that is I think in the slide before, it turned before I got to it and I'm on a different page on the other screen. But I think it was voluntary reporting.

And so in light of all the other comments, yes, let's see, yes, is a voluntary quality reporting program. So just having worked on the HAI Advisory Committee for so long, anything that is voluntarily reported tends to leave the door wide open for cherry picking, and there's nothing that you can do about that data.

You know, the facilities are only going to want to put themselves in their best light. And so if they're going to publish data and make it public and report it, they're going to publish things that make them look good. And anything that doesn't or is borderline, you're going to find that no data available or not enough numbers to, you know, post.

So I think that was the first red flag that I saw, in addition to all the other comments. Thank you.

Co-Chair Angove: So Tala, I noticed you added a little bit in the chat about this impacted a limited population that receives the diagnosis. That's great. Any other comments or thoughts that anyone wants to share on this one?

All right, I think our lead discussants did an incredible job of comprehensively covering this, and

I think we are ready to go to the polling.

Ms. Harding: The poll is now open for MUC2021-091, Appropriate Treatment for Patients With Stage I through III HER2 Positive Breast Cancer, to be included within the PPS-Exempt Cancer Hospital Quality Reporting program. Please submit your response to share the potential impact on health disparities if this measure is included in the proposed program.

A few more seconds. The poll is closed for MUC2021-091, with the responses as follows. Four members responded that this measure has high potential to have a negative impact by increasing health disparities. Five members responded that this measure has a potential to have a negative impact by increasing health disparities.

Three members responded that this measure will have no impact on health disparities. Five members responded that this measure has potential to have a positive impact by decreasing health disparities. And zero members responded that this measure has high potential to have a positive impact by decreasing health disparities.

Ms. Lynch: And with that, making sure I was not on mute, let's -- we can do a quick five-minute break, or we'll just round it up to seven again. And come back at, I'll do my math better, at 4:55 p.m., and then we'll move on to the next section.

(Whereupon, the above-entitled matter went off the record at 4:47 p.m. and resumed at 4:55 p.m.)

Discussion of MAP Health Equity Advisory Group Review Process

Ms. Lynch: Welcome back, everyone. It is 4:55, so we will go ahead and get started.

Now that we have everybody back, we do have a proposal for consideration. I think there's a lot of

interest to discuss these overarching issues that keep popping up.

So, we are able to do some offline voting. I do think that covering the MUC2021-104: Severe Obstetric Complications eCQM, might be really helpful for the entire group to discuss.

But then the other four measures, we would follow up with a survey. Like a Surveymonkey where you could give your vote, as well as like, give some comments just to kind of add some reasoning and rationale behind to like why you're voting for, and what you think the concerns are.

But then after we discuss that one measure, we would then transition to that overarching discussion until about 5:45, which is when we would then open for public comment.

(Pause.)

Ms. Lynch: So, is anybody opposed to that?

Member Machledt: I'm not opposed, I just have a question. How long will we have to do the written comments?

Ms. Lynch: We are figuring that out on the back end right now.

Ideally, it would be a pretty quick turnaround just because ideally, we would like to have it available for the workgroup meetings next week.

But I think we might be able to share those verbally, so we'll do some on our back end but we'll, we also, it doesn't exist yet so we also need to create it.

Member Machledt: Okay.

Ms. Lynch: So, but yes, we'll try to, we'll make that clear.

Member Machledt: Great, thank you.

(Pause.)

Ms. Lynch: All right, any dissension from that plan? Seems like we're good.

(No audible response.)

MUC2021-104: Severe Obstetric Complications eCQM

Ms. Lynch: Okay. So, we will let me pull my notes together.

Okay, so let's go ahead and skip to excuse me, the Severe Obstetric Complications eCQM slide.

(Pause.)

Ms. Lynch: Okay, perfect.

So, this is a fully developed outcome measure, that assesses the proportion of patients with severe obstetric complications, which occur during the inpatient delivery hospitalization.

The measures at the facility level of analysis is not endorsed by NQF, and is risk adjusted and stratified.

The measure is under consideration for two programs, as a Hospital IQR and the Medicare Promoting Interoperability Program for Hospitals. Which you've covered both of those for context, and they're both hospital level.

Co-Chair Zephyrin: Great, thank you. And, let's turn to Tala Mansi. Please let me know if pronounce your name correctly.

Member Mansi: You did, thank you.

Co-Chair Zephyrin: Okay, great, thanks.

Turning it over to you.

Member Mansi: Thanks.

Co-Chair Zephyrin: For the discussion. Thank you.

Member Mansi: Thank you.

So, this is a critical measure to advance health equity in the United States. This measure is an outcome measure, assessing the proportion of patients with severe complications during inpatient delivery hospitalization.

And, this measure has potential to advance health outcomes and disparities that exist between white populations, and people of color.

The measure is risk adjusted and stratified.

It's common knowledge that although the U.S. is one of the most developed countries, there continues to be a staggering increase in the number of pregnant, women who suffer from complications associated with severe maternal morbidity.

It's been found that rates of severe maternal morbidity are steadily increasing, and approximately 144 out of 10,000 women are hospitalized for the delivery, have experienced severe maternal morbidity, including hemorrhage, embolism, stroke, and other serious complications.

We know that there's racial disparities in severe maternal morbidity. Two hundred twenty-five point 7 versus 104.7 per 10,000 deliveries in non-Hispanic Black individuals versus non-Hispanic white individuals.

It's critical that this measure is stratified by federal poverty level, race/ethnicity, and insurance status.

One important determinant of severe maternal morbidity may be the neighborhood that the patient lives in. We know that structural racism and oppression shape neighborhoods and institutions, which result in differential access to opportunities

and resources.

And, to that point, nearly one-third of the higher rates of severe maternal morbidity in cases are in low income, or predominantly (telephonic interference) neighborhoods that can be explained by hospital quality.

In other words, living closer to a hospital, which sees a higher population of low income or minority patients meant it was, it's more likely that a woman would deliver there.

Yes, so all in all, this measure is pretty essential for the effort, the sexual and reproductive justice movement, and essential for reducing disparities.

I'll pass it over to Chris.

Co-Chair Zephyrin: Great, thank you.

Member Grasso: Great, thanks so much, and Tala, you did a great job.

In an effort not to be redundant and keep us moving along, I just really want to echo all that you said, and how this is really a critical measure in thinking about ways in which, you know, we could really stratify and identify, you know, those disparities that we're seeing in different populations.

And, even so much how this relates back to prenatal care as well. And, thinking about this as a outcome measure.

One thing I do want to say about this too, that I found that I was positive, was that they talk about patients who were pregnant. And actually again, going back to that, not restricting that to only females.

So, I was actually glad to see that.

So, in the interest of time, I'll just turn it over to others, because I know there's a lot of people that

might have a lot of thoughts on that.

Co-Chair Zephyrin: Thank you, thank you, Chris. Thanks, Tala.

I'd like to open it up to the group just in terms of equity considerations, which we've heard from both Tala and Chris, but any other implications around potential ability to exacerbate disparities, or unintended consequences.

I don't see any hands raised.

And, also this is a measure for two different programs, and so we can as you're when we get to the vote, just to think about if you wanted to carry the votes forward from the hospital program.

From hospital measure to the Medicare measure, to the Hospital IQP, IQR measure. And, the Medicare Promoting Interoperability measure.

Any comments or thoughts?

I mean I think this measure clearly, we've heard about the equity implications around maternal health, and this would allow to be able to address maternal morbidity, and mortality.

Well, maternal morbidity within the hospital setting. Chris, as you've mentioned, also prenatal and postpartum implications, too.

(No audible response.)

Co-Chair Zephyrin: I think everyone's just excited to get to the discussion.

Okay, Beth.

Member Godsey: Yes, I'll just make a quick comment.

I think that you know, this again goes to the discussion but just to put it on the record, I think that it's what you have access to care.

And, certainly there's complications that are associated, that are already mentioned, but I think having the appropriate access to care to mitigate, or to reduce these complications, is an important piece.

So, whether this measure helps provide that insight or not I'm not sure, but we get to, want to make sure that we highlight that point.

Co-Chair Zephyrin: Thank you.

Any responses to that point, or any questions about that?

Member Cole: Wait, hold on. Hold on, let me, wait. Oh, there we go.

Co-Chair Zephyrin: Okay, Alicia, I see a hand up, yes.

Member Cole: Okay, and I just want to say in addition to access to care, you know, we have to also look at communication when it comes to minority women as well.

I mean, Serena Williams almost died in childbirth and she has, it wasn't about access to care.

There was a young lady, god, I can't think of her last name, they did a whole episode of the, of The Resident, about her. And, her husband has now become an amazing patient safety advocate.

Top of the line healthcare, both of them. Insurance, top of the insurance at a well-established hospital.

And, so it's not always about access to care when you're dealing with people of color. You're also dealing with biases, and communication breakdowns, and those kinds of things I think we need to be aware of as well.

It's not just you don't have good prenatal care, you don't have access to care. You can have all of those

things and still have issues.

Thank you.

Co-Chair Zephyrin: Absolutely. Excellent point, thank you Alicia.

Any other thoughts before we move to voting on the equity implications of this?

(No audible response.)

Co-Chair Zephyrin: I think we can move to voting unless there are any additional comments.

And, if there's no objection, then we can vote for both Hospital Inpatient Quality Reporting Program, and move the votes to the Medicare Promoting Interoperability Program for Hospitals.

I can't say interoperability today.

Ms. Harding: The poll is now open for MUC2021-104: Severe Obstetric Complications eCQM, to be included within the Hospital IQR Program.

Please submit your response to share the potential impact on health disparities, if this measure is included within the proposed program.

(Pause.)

Ms. Harding: A few more seconds.

(Pause.)

Ms. Harding: The poll is now closed for MUC2021-104, and the responses are as follows.

Zero members responded that this measure has a high potential to have a negative impact, by increasing health disparities.

Zero members responded that this measure has potential to have a negative impact, by increasing health disparities.

Zero members responded that this measure will have no impact on health disparities.

Twelve members responded that this measure has potential to have a positive impact, by decreasing health disparities; and seven members responded that this measure has high potential to have a positive impact, by decreasing health disparities.

Co-Chair Zephyrin: Thank you.

And, any objections to carrying this over to the Medicare measures?

Ms. Lynch: If there are there any concerns that you, so I guess, so if you have a concern, let us know, and then we will read those.

And you can share that verbally, in the chat, or if you want to remain anonymous you can just send it to me.

Member Schreiber: This is Dr. Michelle Schreiber. Just for clarification of the committee, it's included in promoting interoperability because this is an electronic clinical quality measure, and therefore, has to be part of promoting interoperability, as well as the other program.

Co-Chair Zephyrin: Thank you, Dr. Schreiber.

Ms. Lynch: Okay, seeing no concerns with polling those votes forward, we will poll the votes forward and to the Promoting Interoperability and Transition, to the fun part of our day. What a great way to end it.

So, I forget one of our colleagues, we were able to quickly pull together a slide, so we'll work on getting that pulled up for the overarching discussion.

Co-Chair Zephyrin: Great. And, Susannah in the chat put some three global topic suggestions, as well.

Ms. Lynch: Yes, that's perfect. And, I think as we are trying to, okay. We're slowly getting there.

Member Schreiber: Chelsea and the Co-Chair, this is Michelle again.

Would it help for me to spend maybe a couple of minutes talking about some of the strategic directions CMS is considering around equity?

Because I think it might help with some of the questions that we have, like stratification, and things like that. Because actually we would love the committee's feedback on that as well.

Co-Chair Zephyrin: Michelle, I think that would help, absolutely.

Member Schreiber: Okay. Let me know when you want to start.

Co-Chair Angove: Jump in.

Member Schreiber: Go for it? Okay.

First of all, I want to thank everybody for an incredible discussion today. A very robust discussion, and we appreciate the feedback.

I will say there is a question of how is this used. It will be presented at the MAP meeting, so that the MAP who is considering whether or not to recommend measures to be used in the program, have your recommendations about how this might affect equity.

And, if for example, a measure were really found to have a very significant adverse effect on equity, it may change the vote of the MAP committee.

And, it may very well change the opinion of CMS about how we use these measures. Because we take this consideration back significantly.

There are many, many initiatives that are being

discussed not only across CMS, but really across the entire federal government, of how to promote equity.

Things like you've seen for broadband, for example, expansion. Things like that you've seen with hopefully some of you saw the Vice-President's announcement around maternal safety, and some of the initiatives that are happening there, including the Medicaid expansion of paying for postpartum care up to 12 months, at least to allow for the state waiver versus (telephonic interference) encouraging that.

So there are many things that are ongoing.

Within CMS in terms of the measurement, there are several things. First, you saw although you found it a little low bar, a structural measure that at least introduces to hospitals, and then it would be expanded to really, any facility, is do you have a commitment to equity?

Because we think the leadership commitment to equity, and ensuring that they have plans and are looking at their data, is a fundamental first step.

Although recognizes there are many other things that you would all like to add, in many ways of actually ensuring that people are doing what it is that they're going to raise their hand for.

The second is stratification. And, we've certainly heard on many of these measures, a desire to basically stratify every measure.

So, the question for this group is, stratify by what? Because that could be a very long list. Race, ethnicity, and in which case, which ones do you want to stratify for?

Is it by sexual orientation and gender identity? Is it by disability? Is it by social determinants?

So, there's a very long list and you can imagine,

that actually it would get very complicated for any one given measure to be stratified in 25 different ways. Although maybe that is what it takes to actually get at the underlying issues.

So, we would like your feedback.

But we are looking at starting next year, with providing stratified reports back to facilities, about their performance in select measures.

We will be stratifying largely by race and ethnicity, but there are other conversations that are ongoing for stratifying on other topics, such as dual eligibility, or just using geocoding. Or area deprivation indices.

And, so there will though start being stratified measures likely next year. But it won't be all of them. Not yet. Because I think we also need a lot of experience.

As we've been doing the modeling for this, the differences at least among the different facilities aren't huge. They're really in some cases, only around one percent.

But those one percents add up when you look at a whole country.

So, how we communicate those data back to facilities so that it is a serious issue even though the numbers may seem small, I think is another challenge that we're going to face.

Nonetheless, I think the long-term goal is stratification of all applicable measures, but it will take time.

Another question that we heard today is around patient reported outcomes. We would very much like to increase the percentage of patient reported outcomes, because we think the voice of the patient is essential.

And, I heard today a lot of conversation about language and cultural sensitivity, and agree with that.

So, I would look forward to your comments about so, what are some of the things that we should be doing to ensure that we can reflect cultural and language sensitivity?

A question for you that we are sort of processing through, and that's how do we best measure access to care?

It's easier, easy, uh huh, when the patient already is in the system getting care, but it's a little harder to know about those patients who don't get into the system of care.

And, to be able to track that and know that perhaps they didn't have access to care, or they weren't getting the appropriate referrals.

There's particular interest among the administration, for looking at things like how do we ensure that diabetic patients are getting access to appropriate care, for the prevention of amputation.

In other words, are patients getting referrals for re-vascularization, rather than waiting until things have progressed to the point where amputation is needed.

So, that's one specific topic that has come up as an area of interest.

In terms of stratifying the measures and looking at other initiatives, I think you probably can tell that some of the high priority items include maternal health, mental health, kidney care, sickle cell, I think is going to actually rise to the top as well.

But introducing topics and measures around specific focus areas that perhaps haven't been focused on as much in the past, or certainly look at, looked at in an equity lens.

So that all of the measures we will be looking at with an equity lens (telephonic interference) committee meetings (telephonic interference) involving actual measures around equity.

Such as the Medicare C&D Program, the Medicare Stars Program, has been piloting the use of a HESS score, the health equity system score, which is kind of a summary of how the plan is doing in terms of their performance in equity.

So, that's another direction that we're looking at.

So, hopefully you can see that there's a multi-pronged approach. And, with that I'll pause. Happy to take questions, but really would like people's feedback, especially around the stratification issue.

So, thank you. And, to the Co-Chairs, you guys have done a wonderful job with this committee today. Thank you so much.

Co-Chair Angove: Thanks, Michelle.

Co-Chair Zephyrin: Thank you.

Co-Chair Angove: And, maybe could go to that next slide, and Laurie, you and I can just see how well we improvise.

Co-Chair Zephyrin: Right, no, that sounds great.

Co-Chair Angove: I think what would be great today, if we could kind of pick up that charge that Michelle just asked, but then also on this list, see if there's anything that this group would add.

Because I think the first place to start is what are these overarching equity themes that are going to be important for maybe not all, but the majority of the, the majority of the measures that we've encountered today, and in the future.

So, try to get that comprehensive list. And, then absolutely focus in on the question on the table

around stratification.

Co-Chair Zephyrin: I think one thing to add to this overarching equity theme, there was, there were several comments about around who's being excluded, and like the exclusion criteria.

That's kind of (telephonic interference) dovetail -- I don't know why that's happening. Kind of dovetails into the point around what patient populations are used for testing.

Co-Chair Angove: The other one I saw that, where I heard that isn't, I don't think is on this list, are the equity implications of measures that take away funding from facilities. That came up on a few today.

David, why don't you jump in here. I see your hand up.

Member Machledt: Yes, that also, that could sort of subsumed, a lot often in the risk adjusted discussion as well.

I wanted to, oops, sorry. I wanted to add the, this is sort of a bigger process question, but about that we haven't really had any time or opportunity, to discuss the gaps that have an impact on equity.

In other words, there's anytime you know, you're choosing an unstratified measure, you're also not choosing something. There's an opportunity cost associated with that.

And, we don't have, or I don't have a really clear picture of the broader, you know, it's sort of like looking at individual measures in this process, we can miss the forest for the trees.

It's not just it has to be, you have to have the individualized analysis, but also sort of a picture of what is the whole program doing.

I know that's not what we're doing, but it really has

an important aspect of equity of like, if We're going to choose to say this measure would be a good one, there may be a better one that is not, not being, not that we don't have access to or something like that.

Or that it may be that you have you know, one patient population, or a community that is really being not covered in the whole picture with, with the quality measurement.

And, we just don't have that, within this process, we don't have a way of really addressing that.

Co-Chair Angove: Beth, do you want to add something?

Member Godsey: Yes, thank you.

I think one key overarching piece that may not, that was stated today that may not be captured in this slide, is we have to come out with a standardized way that we want to collect what we want to stratify.

Whether that's through CMS providing guidelines for meaningful use on how to be able to capture these elements that are critical around SOGI, and REAL, and those aspects that we want to stratify or capture around social determinants of health.

I think we need some, hospitals are needing clarification, specifically, and support around how to capture this in an (telephonic interference) meaningful way.

Not only for the docs to helping the patient, and how the patient can benefit from them sharing this information about what challenges that they might be going through, how that's going to actually help their care.

So, I think it's an important piece that maybe even be bullet one before we get to stratifications and conditions, and patient populations. Help us understand how we, what we need to measure and

collect in a standardized way.

Member Schreiber: And, Beth, this is Michelle. Thank you so much for the comment. I can't believe I didn't mention that because it is number one. I spend my day talking about data collection.

There are many initiatives again across CMS, really across the federal government, of where is the best place to collect the data, and what is the data that we should be collecting?

Because we don't want to be asking patients every single time they turn around. We want to make sure that the data is interoperable so that we can be sharing it, and so that it can be standardized.

We want to standardize the definitions of what is being collected. And, so there is a great deal of effort going on here.

I think some advances have been made for those of you who follow ONC and the USCDI in version 2.

And, in version 3 they actually ratified a number of the Gravity Project initiatives for developing this standardized data elements around some of these.

And, I think that will become the definitions, but you're absolutely right. We have to have a clear understanding of who's collecting the data, how are we collecting it, what are we collecting. Making a sure that it's standardized, and frankly, making sure that it's interoperable, and can be used.

The other thing that I would add to that, is that we need to be talking to the communities and the patients about why we're collecting this data.

There's a tremendous amount of distrust and frankly, rightly so, amongst the community and patients about why we're collecting this data. And, some fear actually, that this data will be used against people.

And, I think a greater educational awareness for really, the country, but certainly for all patients as we're asking them for this data, is what are we going to do with it, and being honest about we're using this to improve the equity.

Member Godsey: Thank you for that comment. I think that that is spot on, and I appreciate the follow up.

I 100 percent agree that patients are wanting to know what this information will be used for. Why do you need to know this about me? Will this be used against me in the future? I don't know, and it has in the past for some patients.

And, so any clarity that CMS could offer and provide in that space that would give comfort not only to the providers in asking to help support them, but the patients in knowing that it would be used in a trusted way, I think would be, would advance considerably this process.

So, thank you for that comment.

Member Schreiber: We are working on that. There isn't a complete consensus yet.

Co-Chair Angove: Mark, I'm going to pass it over to you. I'm trying, I'll go down the list of hand raised.

Member Friedberg: Sure, thanks.

Yes, one thing and I really struggled with this in the exercise today, is separating the properties of the measure itself from the uses of the measures.

Measures are tools, and they, almost any measure could be used in a way that exacerbates or improves inequities.

I think it's actually really unusual to have a measure that somehow is going, you know, you can predict how can it drive absent a specific application in a specific program, where you know absolutely every

aspect of the program.

I think we see that when we get into discussing about risk adjustment, or social determinants, racial, ethnicity, or whatever it is in like the Hospital Readmission Productions Program, for example.

That people argue past each other because they're talking the measure, as if the only thing you can do is risk adjusted, instead of change other aspects of the program to mitigate any adverse wealth effects on institutions that serve the proportionate shares patients of color.

So, I'd like to sort of see that in here, and there's probably some kind of battery of different programs that this group could sort of say look, this measure is going to have the following concerns and programs of the following types. And, just be aware of these as you implement it.

We're not going to be able to probably go too much beyond that is my guess, and without getting into the specifics of programs that don't exist.

Co-Chair Angove: That was a great point, thank you.

Member Senathirajah: This is Mahil. I'm just going to echo the sentiment about being thoughtful about what we collect, because it will in fact, sort of determine what we can stratify on.

But also, as another thought, you know, I was thinking that we might have more empirical data on which to identify measures for reporting.

So, in my mind those measures where there are disparities along different dimensions, might be those that are most important.

So, I think in a next iteration when we have data, it might be useful to look at that and let some of the data drive the reporting decisions.

Co-Chair Zephyrin: And, just to add to that, it also would be hopeful as we move forward, to have the equity considerations be incorporated across the entire process. I guess this is similar to what you were talking about, Michelle.

But when the measures are being submitted in the application, you know, it includes some of the data on the various groups, and the potential equity considerations.

So by the time it gets to this point, this isn't the first time it's being considered and hopefully, some of the questions that Mark just raised, can be addressed early on as the measures are going through this process of approval.

Member Schreiber: Yes, I think we need to be including a large section of this in the Measures Blueprint, which is what measures developers actually use, you know, the way that they develop measures.

The asking those questions. Even from the time of conceptualization of a measure before it's built.

Co-Chair Zephyrin: Right, exactly.

Co-Chair Angove: Yes, it would have been great if we got a lot of the clarity that we got on the phone on the call today, in that background paperwork. Having them think about it upstream is a great, great solution to that.

Chris, oh, go ahead Mahil.

Member Senathirajah: No, I was going to say I know measure developers are sort of at the beginning of needing to incorporate, or at least test out some social determinants of health risk adjustment.

So, it would be good to know sort of how that turned out, why it was or wasn't adopted.

Co-Chair Angove: All right, Chris?

Member Grasso: Yes, no, thanks so much.

I think this just has been such a rich discussion today and I really, what I wanted to say that so much of this is going to be a iterative process. And, it's really a step in the right direction.

And so I just sort of also view this as not letting perfect be the enemy of good, and sort of see us being able to sort of work on this and fine tune it as we go along.

But the other piece I wanted to kind of specifically call out here to, around when we're thinking about demographics. And, while it's important to look at race and gender identity, you know, the intersection of these identities we oftentimes see the greatest disparities in equities.

And, so I think it will be important for us to move to that point where we're looking at it by intersectionality.

So, for example, we know that BIPOC transgender women have some of the greatest disparities in equities. So, I think the only way that we'll really sort of identify that is by looking at these demographics together.

Thanks so much.

Member Schreiber: Thank you.

Co-Chair Angove: And, do we want to talk through what that stratification, or some of those things should be? Or what we'd like to see on that list?

I know Michelle had asked for us to brainstorm around it.

Member Schreiber: Please, yes.

Co-Chair Angove: I wish we could --

(Simultaneous speaking.)

Co-Chair Zephyrin: I would love everyone's, yes.

Co-Chair Angove: Yes, I wish we could whiteboard. This is where we need a whiteboard--

Co-Chair Zephyrin: Yes.

Co-Chair Angove: -- and just make a running list.

Co-Chair Zephyrin: We would love everyone's thought.

I mean I think, I mean one of my thoughts is around definitely incorporating race and ethnicity, and gender, as a baseline.

But with an arc towards you know, getting to broader and, you know, the broader SOGI and REAL categories.

And, it doesn't necessarily mean Michelle, that everything needs to be considered at the same time. But there should be an opportunity to address SOGI, REAL, disability, and where there's opportunity for the intersections, where you have the appropriate ends, then that's fine.

But definitely starting with race and ethnicity.

Oh great, in the chat, thanks Tala and Gerald. Yes, definitely the disability aspect is critical.

Co-Chair Angove: And, from my experience, and the group I work with currently, I think economic disparities --

(Simultaneous speaking.)

Co-Chair Zephyrin: Right.

Co-Chair Angove: -- have to be included when you think about the implication for not only payment for care, but all of the things that wrap around, you know, transportation, work disruption. Just

everything.

So, I would include economic disparities and if it isn't on the list, also rurality, right?

So, I know we have a rural advisor here, which is interesting because it's actually you know, one of these categories.

I don't know that we need to break out every category, but I just found it really interesting that, you know, there is a group committed to one aspect of health equity, which is the rural populations.

(Pause.)

Member Schreiber: Oh, I see from Tala actually, a nice list of things to stratify for.

Let me ask you specifically. There are area deprivation indices, for example. Census tract. What do people think of using those for stratification?

(No audible response.)

Member Schreiber: Because when you 're talking about big data sets, you know, and Medicare, CMS basically stratifying big data sets.

Some of these that are on the list demand that we actually have that data, and much of that would have to be self-collected.

I mean there's some imputed models for some of this, but a lot of this would have to be self-collected.

So, what are some of the other mechanisms that may be in place now, like census, or zip code, that we have on virtually everybody?

Dual status, is that adequate for example, that we could be using now before we have all of this information?

Co-Chair Angove: We use ADI at PAF. The only limitation is that you're not going to get individual

level data from that.

Member Schreiber: Right.

Member Senathirajah: This is Mahil. We did a little bit of work with the ADI and SVI for a hospital project in California. And, so I think there's some methodological issues to unpack.

How homogeneous are zip code level data? And, just how the composites are actually made and weighted.

But I think it's you know, in the absence of actually, or until we have a complete patient data, I think it may be worth looking at.

Member Bibbins-Domingo: Yes, I would say that there, I think just we've used them a lot during the pandemic where arguably, like a place based variable has implications because of the nature of what you're trying to measure.

And, they both have some value just because you can analyze, and they have limitations.

There's lots of different measures, so right away you come up which one you're going to choose, and they do perform actually quite differently.

And, they're not a replacement for doing other individual level characteristics, by the factors that we are talking about for.

And, so I think that they can be useful adjuncts, but they are not a replacement. And, I think where they've come into a problem is thinking of them as replacements.

Member Senathirajah: Yes, I agree.

Member Godsey: Yes, I would agree with that. I think that there's, this is Beth. I think that there's, we've done quite a bit of research on our end to assess all the different indices that are out there.

Some have challenges on collecting or assessing, rather, a more holistic view of the community than others. And, I think that's something that CMS should be aware of, and maybe even have some discussion around which indices best assess the community.

But the comments are made around you don't quite have specifics on the individual person, is really well said, and it is certainly a concern.

But I do think having a clear view that holistically understands what's going on in the community, would be a huge first step.

And, that there are indices that are better at assessing or addressing that than others, and CMS should explore that.

(Pause.)

Ms. Lynch: Susannah has her hand raised.

Co-Chair Zephyrin: Susannah?

Co-Chair Angove: Yes, go ahead, Susannah.

Co-Chair Zephyrin: Did you want to comment?

Member Bernheim: Thank you, sorry. I was double muted again.

Just a couple words about what I put in the chat, right.

So, in these conversations, many times we said this should be stratified, this should be stratified.

And, I think that the intent there, not to put words in other committee members' mouths, is we should know what this looks like when it's stratified.

We should understand our population better levels where there are disparities in this quality, and we should understand what in different institutions or providers, whether there are gaps in care, where

they exist, measure.

But I don't think, I don't personally believe that we necessarily want to stratify all measures, right?

Because our concern measures are in the world. There's a concern that the stratification of measures where there aren't significant gaps, will take resources away from folks among where there are gaps.

And, there's a lot of things to be figured out about how we use stratified results in payment programs, because of sample size issues, for one.

There's a few others. If you stratify and then pay based on gaps, providers who don't care for Black patients, or don't care for disadvantaged patients, are simply off the hook even if they're providing low overall quality.

So I love measure stratification, but I just, I think it, both of the NQF committees I've been in it's come up, and then we've sort of never gotten back to like, what do we really want to do.

And, I think it would be amazing for this committee to spend some time thinking about when we ask if we stratify results, when and in what circumstances, do we really want to build an into payments program, because it's going to be an important tool if it's used strategically.

And, I think this group is probably better positioned to help CMS think a little bit about how to do that strategically, so we're really getting the results we want from the use of stratified measures in these programs.

(Pause.)

Co-Chair Zephyrin: I see Beth's hand. Beth had some comments.

Member Godsey: I just wanted to echo that

comment that when we're from a committee perspective, you know, we're asking for stratification to give insight into the measures, so that we can provide you with a much more informed recommendation, or poll result, really.

Because I think what we're asking for in the context of this committee, I wouldn't say that agreeing with the other earlier comment that Susannah made, is that I don't necessarily think that we are saying that we think that these should be in a program.

I think what we're saying is that we would like to see these stratified, so that we would have more information to help inform the poll results that you are asking for us to provide you.

(Pause.)

Member Machledt: I really, I understand I think the points that Susannah was making are really important.

They also feel a little bit, I think that there's a lot of, there's a huge amount of expertise in this group, and because you know, the information that we got to provide feedback often didn't even include anything about whether there's stratification or how it's done, or what the, whether the measure stewards thought about that while they were developing this.

It makes it very hard to provide that expertise because we don't even have that information.

So, I feel like those, that problem would be in a way a good problem to have, that we have to discuss about what to do and what not to do. And, how to avoid some of the potential unintended affects.

But it feels like what really needs to happen is this prioritization from the beginning of pushing, and I'm not saying it's not happening, I know it's happening, but that it gets built into the process as an

expectation.

And, I think that that will help to get a lot of refinement on what is actually meant by that stratification, and where is it feasible and where is it not.

Because there are huge problems with how that data is collected, where it's coming from, whether it's from the Medicaid program, and also what level you're looking at.

Are you looking at a health plan when you know, we haven't really talked about, a lot about managed care plans, quality versus, you know, this is mostly fee for service stuff.

So I think there's like those things are all really important to keep in mind, but just like to see this built in a little bit earlier.

Member Schreiber: And, I think you're absolutely right. The challenge is that this is frankly, new in that we don't have the data that we can bring you right now for stratification for most of these, most of these indicators.

It doesn't in fact, actually currently exist.

Ms. Lynch: Okay, I wonder in our last five minutes, I certainly don't want to cut the overarching discussion too short, but also if there is any feedback for the process that we use today as certainly open to receiving that.

If we don't have time to cover it today, you can certainly send it by email. This was our first time doing this discussion with all of you and like certainly now, you've seen the type of information that is currently available.

And, so are we asking the right polling question? We do like to have a qualitative and quantitative analysis that we can, a summary that we can provide to the workgroups. But certainly you know,

open to any of that feedback as well.

But again, if there's other overarching issues to discuss, I don't want to take away from that.

Member Senathirajah: This is just more of a process scope issue. Is it within the purview of this committee to consider whether measures should be adjusted, adjusted for social risk, or is that really a separate, as opposed to just stratify? Or is that a separate through NQF CMS discussion?

Ms. Lynch: I think the way at least, we're currently set up is to review the measures under consideration for the federal programs, as they are provided.

Member Senathirajah: Okay, great.

Ms. Lynch: But I think a lot of these overarching topics are things that we can take and kind of share back and hopefully, see differences going forward.

David?

Member Machledt: My biggest concern, and I know that some of this is outside of your control, because I think this has been an excellent discussion. I've learned so much today.

But it's just a question of time also. We got this on the 3rd and it's the 9th, and there was a weekend there.

It's a huge amount of data to process, and there's just not, there's not enough time to really give everything the amount of attention that it deserves.

And, also knowing how things fit into the larger programs. I don't know if that could have happened at the orientation, or something like that, to get a better picture of what you know, what the different programs are, and where they're at.

Just because I think that Mark's point about the use

of measures as opposed to the measure itself, is a really critical one. And, it's hard to see what our role is right now.

I wish that we could have a bigger role in that discussion as well.

Member Schreiber: David, let me just address a couple of things.

By statute, the measures under consideration must get published on December 1. We've tried to do it earlier, but the clearance process is sometimes very long.

We actually closed the MUC list back in May, and so there's lots of review and review before it gets published on December 1. So, that's kind of the time line.

And, then we want to have these meetings before January as much as possible, but really inform rule writing, which starts in January, quite honestly. The first of the payment rules go out like around April. At least the rule proposals.

We are open to considering other time frames. But we are also open to whether or not this should be like an iterative process, with multiple meetings throughout the year so that we can be doing things like, educating some of the background of the measures.

And, educating about the programs in advance so that when we get to this point, you know, people will have a lot more background.

So really, any considerations or feedback that people have regarding that, I think both NQF and CMS would really like to hear about it.

But the time crunch really comes from the MUC list goes out December 1, and rule writing starts in January.

Member Machledt: Yes, I understand.

Member Schreiber: And no one (telephonic interference) obviously.

Ms. Lynch: Okay, any other final thoughts, certainly feel free to leave them in the chat as well.

But any closing thoughts from the advisory group before we open it up for public comments?

(No audible response.)

Opportunity for Public Comment

Ms. Lynch: Okay, so I think we will go ahead and transition to the other slide deck, and open it up for members of the, and yes, you can stay on for public comments everyone, and then we'll close with next steps, especially since we have some additional things to do.

But if there are any members of the public who would like to share your comments, we are open for them.

If you are on the platform, you can raise your hand, or you can also just unmute and we can navigate it that way.

Mr. Thomason: Can I speak?

Ms. Lynch: Yes, please state your name.

Mr. Thomason: Sure. I'm Richard Thomason, Policy Director for Blue Shield of California Foundation, which supports lasting and equitable solutions to make California the healthiest state, and end domestic violence.

So, the foundation strongly supports the two measures you've been considering around screening for social drivers of health, and the screening positive rate 134 and 136.

We think these are especially important given HHS's

stated commitment to health equity, and CMS's identification that a key measurement gap exists for measures that reflect social and economic determinants.

There's so much momentum for these measures across the health sector, so we think it's imperative that we begin to implement the social driver of health measures into federal payment programs, especially in the wake of the deep health inequities revealed by our national response to COVID.

We note that there's no other patient level SDOH measures, or equity measures, that are under consideration for this measurement cycle.

Thousands of clinical practices across the country are already conducting SDOH screening to identify patients' unmet social needs, including via half a dozen CMMI models.

But without the benefit of any formal quality measures, guidance, or tools from CMS. So we think it's essential that both of these SDOH measures move forward this cycle.

Given the disproportionate impact of SDOH on people of color, it's crucial from an equity perspective, to recognize providers for reporting the screen positive rate for their patients, so we can better understand racial and ethnic disparities and drivers of health, that in turn fuel the disparities in health outcomes.

To reward screening but not reporting of the screen positive rate, would continue to mask these disparities.

Finally, given the variability and the prevalence of drivers of health across geographies and populations, as well as variability and clinical capacity, it makes sense to us that the staging of introducing SDOH measures is done in a thoughtful way.

These would be foundational SDOH measures that will enable CMS to set appropriate performance targets, and then design measures, further measures focused on navigation and successful resource connections for patients.

So, we urge the advisory group to recommend both these measures and act on CMS's commitment to tackling equity, to closing its social and economic determinants gap, and to enacting measures that are meaningful to both patients and providers.

Thank you.

Ms. Lynch: Thank you, Richard.

Veronica Gunn?

Dr. Gunn: (No audible response.)

Ms. Lynch: Veronica, you may be double mute, okay.

Dr. Gunn: Yes, thank you it took me a second to get off of mute. I appreciate that.

I am going to probably echo many of Richard's comments.

I'm Veronica Gunn, I'm a pediatrician, and a public health professional with more than 20 years of experience in clinical care, health care administration, and public health leadership. Having included a term as a state health officer.

I so appreciate the inclusion of patient level measures of social drivers that help for the very first time.

And although equitability is one domain of quality, this is the first time that I'm aware of, that equity is being recognized in the CMS measure set.

Providers in all settings are exhausted with seeing these issues arise with our patients. Especially given

COVID's devastating impact.

Food insecurity, housing instability, utility needs, you name it, all make extremely difficult for our patients to achieve optimal health.

And, we know that our patients of color disproportionately experience these social infrastructural drivers of health.

And, as in my work, when that patient is a child, the burden is experienced by both the patient and the caregiver.

Having these measures validates the importance of screening for these needs, and allows providers recognition for the reporting of the results of screening.

As a physician, I would not adopt a screening practice without seeking the results of the screen. In the same manner, it's important that this committee recognize the importance of including both MUC136 and MUC134, in the measure sect.

Finally, from a practice standpoint, I want to be able to establish a baseline prevalence of positive screens for my patient population before being required to report on those referred to navigation.

Having that phased approach as Richard mentioned, to measure development allows for adequate data collection, to inform subsequent measures, and also enables clinicians time for planning.

For example, will I need to bring on additional staff, or train additional staff members to ensure adequate navigation support?

Again, I appreciate the inclusion of this, as well as the opportunity for offering public comment.

Thank you.

Ms. Lynch: Thank you, Veronica.

Kellie G?

Ms. g: Hi, yes, my comments are sort of more general.

I've really enjoyed the conversation today, and am hopeful in what the advisory group is pointing out.

And, one of the things I want to agree upon is when we look at data stratified or disaggregated, it's one step in the process. And, I want to add that hospitals and health systems are not practiced in this area.

I talk with many hospital and health system quality leaders, and they are not stratifying, or disaggregating their data. And, I think if we take this step with these measures, then the hospitals and health systems will follow.

So, that's very positive but there's also the issue around gaps in outcomes. So, it's not just stratifying to get the stratified for stratifying sake, but it's looking at the gaps, meaning what percentage of the patient population is in the denominator, and what is their portion of the outcome like we've seen with COVID.

So, I just want to encourage us to look at not only disaggregation, but examining the gaps that we find that lead to these health inequities.

Ms. Lynch: Thank you, Kellie.

Are there any other public comments?

(Pause.)

Ms. Lynch: If you're dialed in to unmute --

Dr. Chen: Hi --

Ms. Lynch: Oh, go ahead. Perfect.

Dr. Chen: Is it permissible to speak?

Ms. Lynch: Yes.

Dr. Chen: My name is Dr. Alice Chen. I'm calling from Covered California, I'm the Chief Medical Officer.

I apologize, I'm calling from the airport and have not heard the entirety of the discussion. I have been following these members very closely.

I would just like to highlight the fact that I think we, as a nation, and I say this as part of what we call the 3 M's, Medicaid, Medicare, and marketplaces, are really honing in on equity, and we don't have a lot of tools at our disposal.

And, I do think no measure is perfect, but that we need to start by having some standardized measures.

From where I sit, we have 11 health plans in the marketplace here in California. They're all doing their own thing. They're all using different measures.

We need to, if we are committed to this, would really exhort us to choose some standard measures, evolve them as we go, but and I think I heard the end of Veronica's comments which is we need to screen.

And, that's really important for point of care intervention. But we also need the result at a systems level, so that we know where to invest and where to prioritize our resources.

So, I'd really want to just say that Coverage California fully supports adoption of toward the screening, and the reporting of the positivity of the measures.

Thank you.

Ms. Lynch: Thank you, Alice.

Any other comments from the public?

(No audible response.)

Ms. Lynch: Give it about another 30 seconds, just in case there's anybody trying to unmute.

(Pause.)

Ms. Lynch: I see no hands raised or comments in the chat. We will go ahead and go on to the steps.

I'll transmit it over to you, Victoria.

Next Steps and Closing Comments

Ms. Freire: Thank you, Chelsea.

I will now go over the time line of upcoming activities.

So, the public commenting period that has been open ends today. And, then feedback, the polling results, feedback discussion, like has been mentioned multiple times today, will be incorporated and distributed to the workgroups before the review meetings happening next week.

This includes the clinician, hospital, post-acute long-term care workgroup, and then the coordinating committee workgroup, which will happen in January.

We will then have a second public commenting period that will go on from December 30 through January 13, and then the final recommendations will go to CMS by February 1 of next year.

Just for a visual on the time line, we are currently in December, so the advisory group meetings end today with health equity, and then next week we will start with our workgroup review meetings.

January the MAP Coordinating Committee will review, will have their review meeting to finalize recommendations, and then again February 1, the

final report will go to CMS HHS.

Here is some contact information, as well as resources. There is the project page for the Health Equity Advisory group, our share point site, and email for any questions or comments, or feedback.

And, I will turn it back over to Chelsea.

Thank you.

Ms. Lynch: Wonderful. Thank you, Victoria.

So, we will follow up with the offline survey to obtain the polling results, and any comments regarding the four measures we weren't able to discuss today.

I will warn you they are still for multiple programs, so you will see probably quite a bit of questions on that survey because we will do a polling for each of the different programs.

But we will try to denote if they're a hospital program or clinician program or a PAC/LTC just in case that helps in.

And, we'll share some additional information so you have some background on what those programs are.

But we will share that and the time line as quickly as we're able to.

But really appreciate everyone's participation today. It was really incredible, really appreciate you staying on some of you have, and certainly appreciate our co-chairs.

And, I will turn it over to Rebecca and Laurie for any of their final closing remarks as well.

Co-Chair Angove: Chelsea, you summed it up great. I'm just very appreciative to be part of today, and thankful for this amazing group, and all of the

insights that I think made this a very successful first Health Equity Advisory Group meeting.

And, I'm excited to see all of the good work that comes out of this meeting, and future meetings.

So, thanks for hanging in there with us all day, and I will pass it over to Laurie to bring us home.

Co-Chair Zephyrin: I echo that as well. Thank you all for your comments, and the conversation. Really very meaningful, impactful. Learned a lot from them today.

And, also just for our first Health Equity Advisory meeting. I'm looking forward to what to come next. It's just really a great time that we're in, moment in time, and I'm looking forward to seeing these measures have significant impact.

So, thank you for all you do, thanks for your time, thanks for sticking it out with us until 6 p.m.

Take care, everyone. That's 6 p.m., Eastern.

Adjourn

Ms. Lynch: Yes, take care. For people on the West Coast, you still have three more hours before the end of your day.

Our heart goes out to you, but thanks everyone. Have a great evening.

(Whereupon, the above-entitled matter went off the record at 5:59 p.m.)