NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP (MAP)
RURAL HEALTH WORKGROUP
REVIEW MEETING

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WEDNESDAY
JANUARY 6, 2021

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The Workgroup met via Video Teleconference, at 11:00 a.m. EST, Aaron Garman and Ira Moscovice, Co-Chairs, presiding.

PRESENT:
AARON GARMAN, MD, Coal Country Community Health Center, Chair
IRA MOSCOVICE, PhD, University of Minnesota School of Public Health, Chair
KIMBERLY RASK, MD, PhD, Alliant Health Solutions
JORGE DUCHICELA, MD, American Academy of Family Physicians (AAFP)
DANIEL COLL, MHS, PA-C, American Academy of Physician Assistants
AKIN DEMEHIN, MPH, American Hospital Association
ERIKA THOMAS, MBA, RPH, American Society of Health-System Pharmacists
SARAH MACDERMENT, Geisinger Health
ELIZABETH McKNIGHT, Intermountain Healthcare
JESSE SPENCER, MD, Intermountain Healthcare
CRYSTAL BARTER, Michigan Center for Rural Health Minnesota Community Measurement
COLLETTE COLE, Minnesota Community Measurement
BROCK SLABACH, MPH, National Rural Health Association
CAMERON DEML, National Rural Letter Carriers' Association

KEITH MUELLER, PhD, RUPRI Center for Rural Health Policy Analysis
JANET WAGNER, Rural Wisconsin Health Cooperative
HEATHER BROWN-PALSGROVE, IBM Watson Health Company
MICHAEL FADDEN, MD, Individual Subject Matter Expert
JOHN GALE, MS, Individual Subject Matter Expert
JESSICA SCHUMACHER, PhD, Individual Subject Matter Expert

NON-VOTING MEMBERS PRESENT:
MICHELLE SCHREIBER, MD, CMS
GIRMA ALEMU, HRSA
BRUCE FINKE, MD, Indian Health Service
SOPHIA SUGUMAR, CMS
EMILY MOORE, CMMI
LISA MARIE GOMEZ, CMS
JAMES POYER, CMS
RONIQUE EVANS, MPH, PhD, CMS
JOEL ANDRESS, PhD, CMS
ALAN LEVITT, MD, CMS
JULIA VENANZI, MPH, CMS
JANICE TUFTE, MAP Coordinating Committee
MARIA DURHAM, CMS

NQF STAFF:
CHRISTOPHER QUERAM, Interim Chief Executive Officer
AMY GUO, Analyst, Quality Measurement
MICHAEL HAYNIE, Senior Managing Director
CHELSEA LYNCH, Director, Quality Measurement
NICOLETTE MEHAS, Director, Quality Measurement
UDARA PERERA, Senior Manager, Quality Measurement
SAM STOLPE, Senior Director, Quality Management
SHERI WINSPER, Senior Vice President, Quality Measurement

ALSO PRESENT:
ANDREA BENIN, MD, CDC
DAN BUDNITZ, MD, MPH, CDC
NIRMAL CHORADIA, MD, Acumen
ELIZABETH DRYE, MD, Yale School of Medicine
REBECCA ETZ, PhD, VCU
JOYCE LAM, Acumen
COLLEEN McKIERNAN, MSPH, The Lewin Group
ELLEN RATHFON, AAPA

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P-R-O-C-E-E-D-I-N-G-S

(11:02 a.m.)

MS. LYNCH: Good morning, everyone, and welcome to today's Measure Applications Partnership Rural Health Group Workgroup Review Meeting.

My name is Chelsea Lynch, Director of Quality Measurement at the National Quality Forum. Before we get started I'd like to briefly go to some housekeeping reminders.

For this meeting we'll be using ZOOM for presentations and discussions, and we'll be using Poll Everywhere for voting. Please be sure you have access to both platforms. If you're having any technical issues with either platform, please reach out to the NQF team.

The meeting materials are available at public.qualityforum.org. Additionally, please mute your computer or phone line when you're not speaking.

To ensure your name is displayed

correctly on ZOOM you can right click your picture and select rename to edit.

We encourage you to turn your video on, especially during the measure discussions and when you're speaking.

To switch your display, you can right click View in the upper-right hand corner and select Speaker or Gallery and you'll be able to see more people.

Please use the raised hand feature if you wish to provide a point or raise a question. Priority prioritizes hand raises, so the co-chairs will call on individuals in order.

To raise your hand, click on the participants icon at the bottom of your screen. At the bottom of the list of participants you will see a button that says Raise Hand.

Feel free to use the chat feature to communicate with the NQF Host or IT Support.

Also, we request active participation throughout today's meeting, but if you do need to

step away, please communicate with the private teams so we're able to tally the votes accurately.

Can we have the next slide, please? And the next. And the next.

Okay. So, I'll briefly go over today's agenda.

We'll start with introductions and disclosures of interest.

We'll then move on to overview of the pre-rulemaking approach and the process we'll be following today's -- for today's discussion.

We'll be discussing the measures under consideration for the Clinician Program, Hospital Programs, the PAC/LTC Programs, before moving into a discussion on the COVID-19 measures for all programs.

We'll then open it up to allow an opportunity for public comment before going into the next steps and closing comments.

Next slide.

I would now like to introduce the rest of the MAP Rural Health Workgroup staff.

Nicolette -- I apologize, Nicolette, if I am pronouncing your name incorrectly -- Mehas is another director here.

Katie Berryman is our Project Manager.

Udara Perera is our Senior Manager.

Carolee Lantigua is our Manager.

And Amy Guo is our Analyst.

I'd now like to introduce our co-chairs, Dr. Ira Moscovice and Dr. Aaron Garman. And we'll turn it over to them for some opening remarks.

CHAIR MOSCOVICE: I just wanted to -- this is Ira Moscovice, University of Minnesota. And just wanted to welcome everybody here. We really do appreciate your taking substantial time to provide input to the National Quality Forum as part of the Rural Health Workgroup.

And this is a really important meeting because when you get a chance to provide the rural

lens to suggestions regarding the measures under considerations for hospitals' positions in long-term care or groups in those areas, and it's really important. You know, we've complained in the past that, you know, rurals aren't being considered in these kinds of discussions, and so we really have an opportunity to provide input.

So, I look forward to working with you during the day today. And I will turn it over to Aaron for a few points.

CHAIR GARMAN: Thanks, Ira.

Good morning and Happy New Year to everyone. I want to thank each of you for taking the time out of your schedules to work on this project.

As a practicing rural physician, it's reassuring to know that this group is doing the work to improve my practice and the health of the patients that I serve. Thank you all. And, as Ira said, I look forward to this discussion as well. And let's get to work because we've got a

lot of work in front of us.

So, I turn it back to you, Chelsea.

MS. LYNCH: Thank you both so much.

I'd now like to introduce Dr. Michelle Schreiber, the Deputy Director of Quality and Value at the Center for Clinical Standards and Quality at FEMA, and also invite her to provide some opening remarks.

MEMBER SCHREIBER: So, thank you for that. I appreciate it.

I'd like to wish all of you a Happy New Year as well, and to thank each and every one of you for your participation on this workgroup. It's incredibly important to CMS. And I look forward to hearing everybody's comments today.

Just a couple of remarks.

You're obviously providing recommendations and comment to CMS regarding measures that you believe are appropriate, or perhaps less appropriate, for the value based programs which are very important to the country

in shining a spotlight transparently on quality performance, and on linking that performance to family. And so, the measures that go into that are important, and we do look forward to your feedback.

I would remind everybody that this is a body that makes recommendations and that the final decisions are indeed up to CMS. But, it really is important to hone that process because we change our rule writing very frequently based on the feedback from the MAP process.

I'd also like to really say thank you to those particularly in rural health who have been at the front lines and heroes in fighting the COVID pandemic. We know it's been especially challenging for everybody in health care, but perhaps even more so for those of you in rural health, and to say thank you to everybody for the work that you have done.

And, finally, a thanks to the NQF staff who worked so hard to put the MAP meetings

together. And from CMS, an official welcome to Chris Queram who is now taking over as the interim CMO role.

So, again Happy New Year, and I look forward to a great day. Thank you.

MS. LYNCH: Thank you, Dr. Schreiber.

We're now going to go to who Dr. Schreiber just introduced, our new Interim President and CEO Chris Queram and our Senior VP of Quality Measurement Sheri Winsper.

MR. QUERAM: Hi. Thanks, Chelsea.

And good morning, everybody. I greet you as the Interim President and CEO of the National Quality Forum. I've had the pleasure of working with a number of you over the years in different capacities. And it's my pleasure to join your today for this meeting.

I'd like to make just a couple of comments echoing those that have been made by Michelle, and that's to begin by thanking all of you and the federal liaisons for your commitment

to this process, and most especially to your flexibility in rearranging meeting schedules and using this virtual platform, which we've all become more familiar with during the course of the past year.

A special thank you to the co-chairs. Ira, we've crossed paths over the years. It's been a while. Good to see you again.

And, Aaron, I haven't had the pleasure of meeting you, but thank you both for your leadership of this group.

I'd also like to just make note of the fact that this cycle, this is the 10th year that the National Quality Forum has served as the convener of the Measure Applications Partnership and its various workgroups.

I'd like to offer special thanks to CMS for entrusting to the NQF the stewardship of this critically important process. We appreciate your confidence in us, and look forward to another successful round of MAP activities.

And I would be remiss if I didn't add my thanks to the NQF staff. I've had the pleasure of getting to know a number of them over the last few days and in the weeks prior to assuming this role, and I'm impressed with their dedication, they commitment, and their technical expertise. And I look forward to a good meeting today.

So, thank you for the opportunity to join you and for making these comments.

Sheri, I'll turn it to you.

MS. WINSPER: Thank you, Chris.

Can you all hear me? Okay, thank you.

Welcome, everyone. I'm Sheri Winsper, the Senior Vice President for Quality Measurement at the National Quality Forum. And we are excited to kick off our MAP cycle, despite it being a little delayed this year. But it's going to be a great day, a great meeting, and we are so excited that all of you have decided to join us today.

Although we have made, certainly, some

changes in the timing and the format this year, our purpose definitely remains the same: to really provide CMS feedback from the lens of consumers and provider stakeholder groups to help inform the rulemaking process for CMS quality and performance programs.

We're convening, as we know, in the midst of a national health care crisis. Our nation's resources have been stretched as we face the challenges that COVID has presented us. And now, with two viable vaccinations on the market, we look to a future where we can prospectively overcome the crisis.

MAP will assess the role that measurements and accountability should play related to COVID vaccination, among other very critical measurement issues. We want to thank again our CMS colleagues and partners for your preparation and your partnership with us on the Measure Applications Partnership.

CMS continues to set the right tone

for these meetings and is here today to provide support on the deliberations but, most of all, they are here to listen and hear you feedback.

So, thank you all NQF staff for your work, and CMS as well, for partnering with us. And thank you for all of you for participating here today. We know this takes a lot of time out, but we want to hear your voices related to any challenges that may be unique to the rural health community.

So, thank you so much.

MS. LYNCH: Thank you, both.

I now turn it over to our Senior Managing Director Michael Haynie.

MS. HAYNIE: Good morning, everyone. I'll be leading you through our introduction and disclosures of interest.

First, as a reminder, NQF is a non-partisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments,

innuendoes, or humor relating to, for example, race, gender, politics, or topics that otherwise may be considered inappropriate during the meeting, while we encourage discussions that are open, constructive, and collaborative. Let's all be mindful of how our language in the community be perceived by others.

We'll combine the disclosures with the introduction. And we're dividing the disclosures of interest into two parts because we have two types of members: organizational members and subject matter experts. I'll start with the organizational members.

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

related to the work of this committee.

We'll go around our virtual table here, beginning with organizational members only, please. So, I will call by organization on all of our organizational members. When I call 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 did not identify any conflict of interest after stating your name and title, simply state that you have nothing to disclose. If you have any trouble getting off of mute, you can feel free to use the chat and get in touch with us that way and then we'll circle back to it so we can keep this moving.

All right. So, Alliant Health Solutions.

MEMBER RASK: Hi. This is Kimberly Rask and I'm the Chief Data Officer at Alliant Health Solutions. And I have nothing to disclose.

Thank you.

MS. HAYNIE: American Academy of Family Physicians.

MEMBER DUCHICELA: Hi. This is Dr. Duchicela. I'm sorry, I don't have my video up.

But I represent the American Academy of Family Physicians. I have nothing to disclose.

Thank you.

MS. HAYNIE: Thank you.

American Academy of Physician Assistants.

MEMBER COLL: Hello. My name is Dan Coll. I'm a practicing physician assistant and a member of the AAPA. And I was nominated to this committee as a practicing PA in a rural community. And I have no disclosures.

MS. HAYNIE: Thank you.

American College of Emergency Physicians.

All right. Let's come back to the

American College of Emergency Physicians.

American Hospital Association.

MEMBER DEMEHIN: Good morning. This is Akin Demehin, and I'm Director of Policy at the American Hospital Association. Good to be with all of you again.

Just to let you know, I'm only going to be on this call for a little bit. It will be a bit of a team effort due to some conflicting meetings here at AHA. But really glad to be joined by my colleague Caitlyn Gillooley who after about noon or so will be at the table for us.

I'll kick it over to Caitlyn so she can introduce herself next. I have nothing to disclose.

MS. HAYNIE: Caitlyn?

MEMBER DEMEHIN: Oh, she's not on the line but she will be.

MS. HAYNIE: Okay. All right, excellent.

American Society of Health System Pharmacists.

MEMBER THOMAS: Hi, everybody. My name is Erika Thomas, and I am in the Office of Member Relations and I work with our pharmacists who practice in rural health settings. And I have nothing to disclose.

Thank you.

MS. HAYNIE: Cardinal Innovations.

All right, we'll circle back to Cardinal.

Geisinger Health.

MEMBER MACDERMENT: Hi. I'm Sarah MacDerment. I'm the National Director of Geisinger Health Plan. And I have nothing to disclose.

MS. HAYNIE: Thank you.

Intermountain Healthcare.

MEMBER SPENCER: Yes. Hello.

My name's Jesse Spencer. I'm a family medicine physician in rural Utah. I work with

Intermountain. And I'm the Medical Director of the Family Medicine Group within Intermountain.

Thanks for having me. I have nothing to disclose.

MS. HAYNIE: Thank you.

Michigan Center for Rural Health.

MEMBER BARTER: Good afternoon. This is Crystal Barter with the Michigan Center for Rural Health. I'm the Director of Performance Improvement. We are the Michigan State Office of Rural Health. And I have nothing to disclose.

Thank you.

MS. HAYNIE: Thank you.

Minnesota Community Measurement.

MEMBER COLE: Good morning. My name is Collette Cole. I'm a clinical measure developer with Minnesota Community Measurement. I am new to this workgroup. I'm replacing Julie Sonier who is our president and is now serving on the MAP Coordinating Council. And I am happy to be here.

Thank you.

MS. HAYNIE: Okay. Any disclosure from you?

MEMBER COLE: Sorry. I have nothing to disclose.

MS. HAYNIE: Thank you.

National Association of Rural Health Clinics.

All right. We'll circle back there.

National Rural Health Association.

MEMBER SLABACH: Good morning, everyone. I'm Brock Slabach, Senior Vice President at National Rural Health Association. And I have nothing to disclose.

MS. HAYNIE: Thank you.

National Rural Letter Carriers' Association.

MEMBER DEML: Good morning, everyone. This is Cameron Deml. I'm Director of Insurance Programs for the National Rural Letter Carriers' Association. Happy to be here. And I have

nothing to disclose.

MS. HAYNIE: Thank you.

RUPRI Center for Rural Health Policy Analysis.

MEMBER MUELLER: Good morning, everyone. This is Keith Mueller, the Director of the RUPRI Center. And I have nothing to disclose.

MS. HAYNIE: Thank you.

Rural Wisconsin Health Cooperative.

MEMBER WAGNER: Hello. Janet Wagner here. Tim Size is unable to attend today. I'm the Quality Services Senior Manager. And for disclosure, we do submit chart-abstracted measures and hospital electronic clinical quality measures for small rural hospitals.

MS. HAYNIE: Thank you.

Truven Health Analytics, IBM Watson.

MEMBER BROWN-PALSGROVE: Good morning. This is Heather Brown-Palsgrove. I'm the Senior Director with IBM Watson Health, formerly Truven Health Analytics.

I have nothing to disclose at this time.

I'm also going to take the opportunity to note that I might be stepping away at certain points, so I wanted to make sure to introduce Tom Schenck who is my backup for this committee. And I will pass it over to him.

Thank you.

MEMBER SCHENCK: Thank you, Heather.

This is Tom Schenck. And I also have nothing to disclose.

MS. HAYNIE: Great.

All right. I will do a quick double-back in case we have any issues with getting off of mute to the American College of Emergency Physicians.

All right. Cardinal Innovations.

And the National Association of Rural Health Clinics.

All right. So having this said, thank you all for those disclosures

Now we're going to move on to the disclosures for our subject matter experts. So, because subject matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities.

When you disclose, there is no need to review your resume. Instead, we are interested in your disclosure of activities that are specifically related to the subject matter of the workgroup's work.

We are especially interested in your disclosure of any grants, consulting, or speaking arrangements, but only if relevant to this workgroup's work.

So, just a few reminders I'll say for you. You do sit on this group as an individual, so 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 were paid. You may have legislated as a volunteer on a committee where work is relevant to the measures reviewed by MAP. We are looking for you to disclose those types of activities as well.

And, finally, just because you disclose does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name, what organization you're with, and if you have anything to disclose. I'll go ahead and go through. I'd like to start with our co-chair.

CHAIR GARMAN: This is Aaron Garman, Medical Director of Coal Country Community Health Center, Beulah, North Dakota. And I have nothing to disclose.

MS. HAYNIE: Thank you, Aaron.

Ira Moscovice.

CHAIR MOSCOVICE: Ira Moscovice,

professor at the School of Public Health, University of Minnesota. And I have a couple grants from the Health Resources and Service Administration, and from the Agency for Healthcare Research and Quality related to quality improvement and measure development. But I don't believe there's a conflict with this work.

MS. HAYNIE: All right. Thank you very much.

Michael Fadden.

MEMBER FADDEN: Good morning, everyone. Michael Fadden, a family physician by background and training. Did that for 30 years on the Eastern Shore of Maryland.

I currently work for Cerner Corporation at the --

MS. HAYNIE: Michael, I believe I can hear that you're talking but I -- you're very, very soft. Is it possible for you to move closer to your, your microphone?

MEMBER FADDEN: I've also got a very loud fan going on in the background. I apologize.

Family medicine by background and training. I currently work for Cerner Corporation as a senior clinical executive there. I have nothing to disclose.

MS. HAYNIE: Thank you.

John Gale.

MEMBER GALE: Yes, hi. This is John Gale from the Maine Rural Health Research Center. And, like Ira, we have a few grants from HRSA dealing with rural health issues, but not related to this topic matter. So, I don't believe they're relevant.

MS. HAYNIE: Thank you.

Curtis Lowery.

All right. Let's get back to Curtis.

Jessica Schumacher.

MEMBER SCHUMACHER: Hi. This is Jessica Schumacher. I'm the Associate Director of the Surgical Collaborative, and serve there in

the capacity of the Director of Data Management and Analytics. And I have nothing to disclose.

MS. HAYNIE: Thank you.

Ana Verzone.

Holly Wolff.

All right. We'll just circle back. Again, raise your hand if you're having trouble unmuting.

Curtis Lowery.

Ana Verzone.

Holly Wolff.

Okay. Thank you all very much for that.

At this time I'd like to invite our federal government participants to introduce themselves. They are non-voting liaisons with the workgroup.

Do we have folks from the Federal Office of Rural Health Policy?

Indian Health Services.

MS. GIRMA: Hi. Hi. This is Girma

from HRSA.

MS. HAYNIE: Oh, okay.

MS. GIRMA: I am happy to be here.

MS. HAYNIE: Thank you.

Anyone from Indian Health Services?

MR. FINKE: Hello. This is Bruce Finke. I'm a family physician geriatrician with the Indian Health Service Office of Quality.

Thank you.

MS. HAYNIE: Thank you.

And CMMI and CMS.

MS. SUGUMAR: This is Sophia Sugumar from CCSQ CMS.

MS. MOORE: Hello. Sorry for the delay. This is Emily Moore from CMMI. I had a hard time getting off mute.

MS. GOMEZ: Hi. This is Lisa Marie Gomez with CMS. And I believe there's other folks from CMS. And you have a good representation from CMS.

MS. HAYNIE: Great.

I do see some other CMS names. Would any of you like to introduce yourselves or shall we move on?

MR. POYER: Sure. This is James Poyer. I am a health insurance specialist and the contracting officer representative of the Yale Hospital Measure Development Task at CMS. Thanks.

MS. EVANS: This is Ronique Evans. I am the MIPS measures lead at CMS.

MR. ANDRESS: This is Joel Andress. I am the ESRD measure development lead here at CMS.

MR. LEVITT: This is Alan Levitt. I'm the Medical Officer in the Division of Chronic and Post-Acute Care, CMS. You'll be hearing from Joel and me later on this afternoon.

MS. VENANZI: Hi. This is Julia Venanzi. I am the Hospital IQR for FMLI.

MS. TUFTE: This is Janice Tufte. I'm with the MAP Coordinating Committee. I'm the patient partner subject matter expert.

Thank you.

MS. HAYNIE: All right. Thank you all, very much.

I'd like to remind you that if you do believe you might have a conflict of interest at any time during the meeting, perhaps something comes up that you did not observe before, please go ahead and speak up. You can do so in real-time, you can message your chair who will go to the NQF staff, or you can directly message the NQF staff.

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

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

All right. Well, thank you so much for your cooperation with the roll call

disclosures of interest and introduction. I really appreciate it.

I will pass things over to Udara to continue the meeting.

OVERVIEW OF PRE-RULEMAKING APPROACH

MS. PERERA: Thank you so much, Michael.

We're now going to give a brief overview of the role of national health in the pre-rulemaking process. Then we're also going to go over what to expect during today's review session.

(Audio interference.)

MS. PERERA: So as the Rural Health Workgroup, our charge is to try to provide a rural perspective on the measures that are under consideration to the other MAP workgroups and we'll try to help address priority rural health issues such as the child (audio interference).

Next week we'll be having meetings for each of three setting-specific workgroups. And

these three setting-specific workgroups are MAP Hospital; MAP Clinician; and MAP PAC LTC, which is short for post-acute care and long-term care.

Next slide, please.

The Rural Health Workgroup reviews the measures that are under consideration, which is also known as the MUC list.

I'm going in and out?

MS. HAYNIE: Yes, Udara. We've had several people report that they are having difficulty hearing you. Are you able to switch to a headphone or other --

MS. PERERA: I am.

MS. HAYNIE: You are.

MS. PERERA: Yes.

MS. HAYNIE: Thank you.

MS. PERERA: One second.

(Pause.)

MS. PERERA: Okay. So, the Rural Health Workgroup will review the measures that are under consideration, which is also known as

our MUC list. And we provide input to all three of those setting-specific workgroups.

With the release of the MUC list we sent out the preliminary analyses for the measures for your review. The analyses are developed by our NQF staff and they're intended to try to provide a succinct profile for each measure to try and serve as a starting point for our discussions.

Specifically, we'd like input on the relative priority or utility in terms of access, cost, or quality issues that are encountered by rural residents.

We'd also like to hear about any data collection and/or reporting challenges for rural providers.

Additionally, we would also like to learn about any methodological problems for calculating performance measures for smaller rural facilities.

We'd also like to know about any

potential unintended consequences of inclusion in terms of specific programs, as well as any gap areas of measurements that are rural residents, as well as providers for these specific programs.

Next slide, please.

The Rural Health Workgroup feedback for all three of these setting-specific meetings will be provided to the relevant workgroup for their consideration when they discuss and vote on the measures that are under consideration next week.

A qualitative summary of the discussion that we have for each measure, as well as the quantitative results of our voting, will be included within the measure preliminary analyses that the other MAP workgroup members are provided before their meeting.

Additionally, we'll also have a rural health liaison in each of these setting-specific meetings in order to try and summarize the discussions as well.

Next slide, please.

Next I'd like to talk about the process for today's discussion.

Each of the setting-specific workgroup review meetings will be set up in the same way where we have five steps that we'll go through. The first step is that we'll try and start with the NQF staff describing the program for which the measure is being proposed.

Next, we will then have a lead discussant summarize the measure and give some initial thoughts about whether the measure should be included in the program from the rural perspective.

We'll then open it up to discussion for the entire workgroup. The discussion will include the relative priority utility of the measure in terms of access, cost, or quality issues; any data collection or reporting challenges; and methodological problems when calculating the measures for smaller facilities;

as well as any potential unintended consequences of the measure being included in the program.

Next slide, please.

We'll then vote on the agreement of the measure being suitable for use with rural providers within the program. So, that's in terms of any rural relevance, data collection, and methodological challenges, and potential unintended consequences.

The vote range is one to five, with the higher number reflecting more agreement regarding suitability for the program.

All of the Rural Health Workgroup members should have received an email with the Poll Everywhere instructions yesterday afternoon. So, please let us know if you haven't received that.

And, finally, we will then conclude with a discussion on GAP areas for the specific program as it relates to rural residents and providers.

Before I hand it back over to Chelsea, I do want to take the time to orient folks to our preliminary analyses that we'll be going over today.

So, later on in our meeting today we'll be starting off with Measure 0015 as the first measure for discussion. That's within the Clinician Workgroup. So, if we are talking about the TA specifically, we'll be starting on page 3 for Measure Information and Measure Specifications. That's the blue section of this document.

And that goes on for about 10 pages until we get to page 13 for the Preliminary Analysis. And that's the orange section with NQF staff has filled out in terms of the measure information.

And, specifically, within that orange section you'll find a box for the Rural Workgroup input which will be filled out after this meeting and given to the setting-specific workgroups.

And immediately after that is the green section where any comments are put in.

With that, I'd like to pass it over to Chelsea for questions.

MS. LYNCH: Thank you so much, Udara.

Are there any questions from anyone about this process we'll follow today?

I think a lot of people, I think, participated last year, so hopefully it's pretty familiar to what we've done before.

And just to reiterate what Udara said, so our, a summary of our discussion will go into the TA, including the vote that we'll take that will just be a vote on suitability for the MAP Rural Health Group, their thoughts on it, but it will not go into, like, the final setting-specific workgroup voting. So that, that will happen next year.

And a part of that will -- not next year, next week just to do those final recommendations.

So, we have another 20 seconds or so to have people unmute if they have a question. And with that, we'll get started.

(Pause.)

MS. LYNCH: That was maybe about 20 seconds, so I think we can go ahead and move on to the next section of the meeting.

DISCUSS MEASURES UNDER CONSIDERATION

MS. LYNCH: All right, so, we're going to start today's discussions about the Measures Proposed for Clinician Program. So, there are two programs that we will be discussing: the Merit-based Incentive Payment System, MIPS; or the Medicare Shared Savings Program.

So, we'll first be talking about the MIPS cost measure. So, first we'll start with an overview of MIPS.

This is the Quality Payment Program. It is pay-for-performance. There are four connective performance categories that affect a clinician's payment adjustment. Those categories

are:

Quality;

Promoting interoperability;

Improvement Activities, and;

Cost.

Each performance category is scored independently and has a specific weight.

The goals are:

Improve quality of patient care and outcomes for Medicare FSF -- FFS;

And reward -- and it rewards clinicians for innovative patient care;

And it drives fundamental movement toward value in healthcare.

So the next, so the first measure that we will be discussing is the Asthma-Chronic Obstructive Pulmonary Disease, or COPD, Episode--Based Cost Measures.

This measure evaluated a clinician or clinician group's risk-adjusted cost to Medicare for Patients receiving medical care to manage

asthma or COPD. The measure score is a clinician or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician or clinician group, where each episode is weighted by the number of assigned days during the episode.

This chronic measure includes services that are clinically related and under the reasonable influence of the attributed clinician or clinician group. Services are assigned during an asthma/COPD episode, which is a portion of the overall time period of a clinician or clinician group's responsibility for managing a patient's asthma or COPD. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

The level of analysis is clinician: individual and clinician group/practice.

And Aaron will start our discussion.

CHAIR GARMAN: So, to start us off, our

lead discussants are from Intermountain Healthcare. And Michael Fadden, I will turn it over to you to present the measure.

MEMBER SPENCER: Yeah. So, this is Jesse Spencer again from Intermountain Healthcare.

It seems like, you know, just kind of going through checklists, this is something that certainly we deal with in rural communities. So, it would be something that I think would be appropriate.

I do think there may be some issues with parity in resources. So, for instance, with COPD and asthma a way that you might improve your treatment would be things like pulmonary rehab and access to specialists, which we don't oftentimes have in rural settings. So, that could skew the data somewhat for our rural colleagues in for our patients.

There's also some resources, there's some smoking cessation resources that are not

always available in rural settings, particularly like behavioral-type therapy for that kind of management.

I'm not entirely sure what -- how to define an episode. What that means to me, the way I kind of read that is something like an exacerbation or hospitalization. So, that was a little unclear to me.

And there are some concerns, some unintended consequences would be any time you're looking at cost savings the unintended consequences are how you kind of loop that in with quality metrics. Right? Will there be some -- I hate the rationing-of-care term -- but will there be some, some different care management things when you're considering cost.

And that's always a concern. And that was brought up by the NQF staff and is in the document already. That's something that is being considered.

The last thing when you're considering

this is they did a what looked like a field test. I'm not data specialist or expert analyst, but it looked like the more numbers of episodes that you had or patients with episodes that the reliability of the score goes up. And that's always a concern with rural clinicians or even group practices is basically the number of episodes that you might have is, of course, going to be decreased in numbers actually.

That was my basic one-over. And here's what Michael has to say.

MEMBER WOLFF: Well, thank you. I actually echo a lot of what you said. And having treated a number of patients with COPD over the years, I can tell you it's a complex endeavor. And this measure seems to focus on cost. And that's a pretty big club to wield. I think it's probably not going to really differentiate out outcomes of care, per se.

In fact, I wonder if they go into a lot of detail around how poorly clinicians appear

to adhere to criteria and algorithms of care here. I have to wonder, if we adhered to them very well whether the cost of care wouldn't actually go up.

So, this is attempting to reduce the cost of care, to make care more affordable. I really doubt that it will do that.

Also, I read somewhere -- I didn't have a chance to research this, but there are at least two, maybe three other measures that are more specific to treatment protocol adherence that exist already. So, it seems to me like this is a big, a big stick that is maybe not needed.

And, finally, I wanted to say that while -- or perhaps two more things -- that this, this measure as it applies to rural medicine doesn't really take into account the social determinants of care that are different there than they are typically in other areas.

And then, lastly, I didn't see anything in the documentation here that said it

actually did give an incentive, did it actually reduce costs, did it actually look at quality outcomes as a result of using this tool?

So, I wasn't impressed with it.

CHAIR GARMAN: Thank you, both.

Jesse, do you have any other reflections now that you've heard Mike's take on it? Or does anybody else have any other comments, or concerns, or questions, or a different outlook on this?

MEMBER SPENCER: Yeah, I don't have anything. I'd be open to hearing what the group thought is.

CHAIR GARMAN: Any group thoughts?

MEMBER SCHREIBER: This is Michelle from CMS.

Would it be helpful for us to answer some of the questions that have come up, like, what is an episode? Would it help to define some of that or provide context?

CHAIR GARMAN: Jesse, Mike?

MEMBER SPENCER: I would.

MEMBER WOLFF: I would certainly appreciate it, yes.

MEMBER SCHREIBER: Okay. Thank you. And thank you for the opportunity.

First of all, let me set the context of the cost-based measures in MIPS.

Having cost measures and a cost category in MIPS is mandated, actually, in the MIPS statute. So, we really don't have any choice. And, for the most part we have used broad categories of measures, like Medicare spend per beneficiary, or total per capita cost, which, you know, physicians have found unsatisfactory because they don't feel like that care is attributed to them.

And so, we have embarked upon a series of episode-based cost measures that are much more specific to the treatment of that particular episode of care provided by the physicians who are actually providing that care.

So, I'm going to ask Ronique if you, and maybe the team can just spend a couple of moments defining what exactly is covered in the episode and how a physician might be attributed to that.

Thanks.

MS. EVANS: Hi, Dr. Schreiber. This is Ronique Evans. I am the cost measures lead for the MIPS cost measures with CMS.

I can touch on the definition of, or at least how we define an episode.

So, the episode-based cost measures, the intents for those is to provide a cost, the cost to Medicare for items and services provided to the patient during an episode of care. So, the cost measures here are based on episode group.

And we define an episode group as a unit of comparison that represent a clinical adherent set of medical services for a given condition.

So, the episode group aggregates these items, service and care for a defined patient cohort to assess the total cost of that care.

And I think what I judge as the context, another item that Jesse I believe kind of hit on and Mike alluded to, is that the idea that you've measured will at least be interpreted or take into consideration paired with our quality measures, especially when we kind of get into what is the outcome, or what do we see as risk or result of the cost measures.

So, let me know if that kind of covered what you guys did ask for. I know we can contain this question, especially if you have any other questions you may have.

CHAIR GARMAN: We do have a question that was brought up by Dan Coll.

Dan, do you want to ask the question?

MEMBER COLL: Yeah. I think I just unmuted. Let me know if you can't hear me.

CHAIR GARMAN: Yes. Yes, you're good.

MEMBER COLL: But I'm a physician assistant. And there's a recurring theme under my measure as well, questions about attribution of services to CMS non-physician practitioners; so, PAs, nurse practitioners, and clinical nurse specialists.

And a lot of the discussion we're talking about clinician level and group practice level. And I'm wondering, since CMS is so focused on attributing services to the actual provider of care, does this measure have language, since we know in rural communities PAs, nurse practitioners practice at very similar levels to their physician colleagues, and in rural communities that there is a heavy presence in primary care for PAs, nurse practitioners, and some clinical nurse specialists?

That's my question. Thank you.

MS. EVANS: Yes, this is Ronique Evans. Thanks for the question.

So, with these cost measures the topic

of attribution has been something I think a lot of people have questions for us about.

So, for the asthma/COPD measure specifically, this is one of our first chronic condition episode-based measures. And here the episode's attributed to a group that billed the trigger event for the total attribution window.

So, any episode is attributed to an either individual clinician within the attributed group that either billed 30 percent of primary care E&M codes with the relevant asthma or COPD code, are billed at least one primary care E&M code with the relevant asthma or COPD code; and then, lastly, billed at least two condition-related prescriptions at different time points to two different beneficiaries.

So, let me know if they kind of covered what your question was. But this has been our first chronic condition episode-based cost measures. It's a little different, or not too far different, but it's a little different

than our, our acute care, our procedural-based episode cost measure.

CHAIR GARMAN: There's a couple of questions that have actually come up that people still aren't really clear on what a episode of care is. It says for an acute MI, heart failure, pneumonia, hospital stay and 30 days after.

What is an episode for COPD?

So, you know, as a clinician, I just need to know what that means, if you can clarify that.

MS. EVANS: Okay. Let me think through how I could better address the question.

Yeah, I'm not sure if I'm doing justice to giving you guys a good overview of how developers have established what an episode is. I think it may be, my understanding may be too high level for what Jesse is looking for. So, let me touch based with the developer and I can get at least a better, more in-the-weeds description of episodes for this chronic

condition EBC for you.

CHAIR GARMAN: I think that would be great.

Again, is there a specific time frame for this code or this episode? Or those kind of things would be helpful, I think, to understand.

MS. EVANS: Absolutely.

MEMBER WOLFF: Yeah. I think there's a bit of a paradox built into the whole idea to begin with; right? This is chronic care, it's not an episode.

And so, I would think that any sort of statistical modeling of an episode of care for chronic care could be applicable to other chronic care items as well. Right?

The ambulatory management of heart failure, the ambulatory management of chronic renal disease, and so forth. So, it might be useful to understand that better as we look at other measures.

CHAIR GARMAN: Absolutely. I agree

with you.

So, I'm going to table this to NQF staff and ask you how you want me to handle this. Because I think the next step is to vote.

And as you all know, by our aggressive agenda, we need to be moving on relatively quickly on a lot of these things to get through the measures today, as we have a lot of measures.

So, NQF, what do you want us to do? Do we table this till we get the answers? Do we vote or what?

MS. LYNCH: I will actually ask Sam his opinion since this will all kind of be related to what ends up eventually going into the other workgroups and then, finally, to the Coordinating Committee to see if, do we feel comfortable with just voting now or do we want to try to table it till we get more.

I just don't know if we'll get that answer today, so I don't know if we'll be able to do, like, I don't think we can kind of do that

fast.

MEMBER STOLPE: Thanks, Chelsea.

I think what Dr. Schreiber alluded to here at the beginning of our call, that this conversation that we're seeing will be something of a prelude of what we will see in the other workgroups.

Now, the other workgroups are responsible, when this comes to clinicians, for making an overall recommendation for the suitability of the measures. I think that what this workgroup has done thus far in touching on some of the challenges associated with the measure from a rural lens, such as access to specialty care, or smoking cessation programs, etc., is precisely the sort of feedback that the clinician workgroup will find helpful.

I think once we get into a discussion for overall suitability in a vote, that CMS and the measure developer should plan on being able to explain attribution a little bit more fully

and define the episodes to the satisfaction of the other workgroup.

But, I think for our purposes that we could probably move forward with a vote on suitability for a rural setting.

CHAIR GARMAN: I appreciate that. Thank you, Sam.

MS. LYNCH: Amy, are we ready to vote? Is voting open yet?

MS. GUO: Let me know if you can see the --

MS. LYNCH: Yes.

MS. GUO: Great.

MS. LYNCH: We can.

MS. GUO: All right. So, just before we start with our first vote I did want to give a friendly reminder to the organizational representatives that only one vote should be submitted per organization. So, if there are multiple representatives from your organization, for today we would ask that you coordinate so

that only one vote is submitted for your organization.

So I'm going to go ahead and open the voting for Measure 0015. And could you, please, enter whether you agree that this measure is suitable for use with rural providers within MIPS.

I'll go ahead and activate that.

(Voting.)

MS. GUO: And I see that we have 14 votes so far. I think we have 19 workgroup members in attendance. So we'll wait for the last couple of votes to trickle in.

(Voting.)

CHAIR MOSCOVICE: Yeah, I'm having a problem with the link, also. This is Ira. I'm clicking on one of the categories but nothing's happening.

MS. LYNCH: If it's easier, we can also either have you verbally vote or use chat if you want to just send it to me, if you're concerned,

if you want to remain neutral. Or you can send it to your PA. That's fine.

CHAIR MOSCOVICE: Thank you.

So, who would the chat go to?

MS. LYNCH: You can send it to me.

MEMBER SCHREIBER: This is only for committee members though; is that correct?

MS. LYNCH: Yes, that is.

We have two additional that have come in. I'm not sure how many are on the platform.

MS. GUO: I think we were waiting for 19 total. But should we go ahead and just review the results?

MS. LYNCH: How many do you have right now?

MS. GUO: We have 17 right now out of 19.

MS. LYNCH: Okay. And I have two others. So, we can make sure.

Yeah, we can go ahead and show. I have an additional vote for a 2 and one vote for

a 5.

And then we will keep an eye on the chat as well and then make sure we can map that back to the results that we have from Poll Everywhere and make sure everything works out.

And Ana did send the link again. So, hopefully that might work.

MS. GUO: So, these votes, as well as a summary of the discussion and the average of the votes will be in, inputted into the TA.

MS. LYNCH: I think we can move on to the next measure. Thank you.

The next measure is a Colon and Rectal Resection Episode-based Cost Measure.

This measure evaluates clinician or clinician group's risk-adjusted cost to Medicare for patients who receive colon or rectal resections for either benign or malignant indications.

The measure score is a clinician or clinician group's average risk-adjusted cost for

the episode group across all attributed episodes.

The inpatient procedural measure includes services that are clinically related and under the reasonable influence of the attributed clinician or clinician group during the 15 days prior to the clinical event that opens or triggers the episode through 90 days after.

Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

And this is at the same level.

CHAIR MOSCOVICE: Okay. The lead discussants are from Geisinger Health. And, Jessica Schumacher, your comments are welcome.

MEMBER MACDERMENT: Hi. This is Sarah MacDerment from Geisinger Health Plan. I do not have any experience with this treatment and really don't have any input to provide.

CHAIR MOSCOVICE: Does Jessica Schumacher have any comments?

MEMBER SCHUMACHER: Sure.

So, you know, in terms of the relative priority and utility of the measure, colon and rectal procedures are commonly performed in rural areas. So, in that way, you know, this is a measure that would definitely be relevant to rural providers. And there aren't any specific data collection or reporting challenges. This is a claims-based measure.

My primary concern is the low reliability of the measure with small case volumes. And that, I think, is a particular concern.

As an example, just in the state of Wisconsin we have nearly 40 hospitals here in the state that perform less than five procedures a year, and 35 percent of the rectal cancer procedures are fewer than 10 procedures a year.

And the reliability at that level was .33, so, quite low relative to some of the reliabilities for low volume procedures for some of the other conditions.

I think my other concern was in the combining of the benign and malignant lesions, both in terms of where patients tend to go with malignancies.

But, also, you know, patients diagnosed in rural areas, and patients living in rural areas rather, are more likely to be diagnosed at later stages and have more aggressive treatments as a part of that. And so, it seems as though there could be a high potential to penalize rural providers, particularly in that way.

Both in terms of sort of the procedure itself as well as actually -- you know, it looked as though utilization was going to be looked at 15 days before through the 90 days after the procedure, and that would encompass imaging.

And so, you know, we know that there's actually substandard imaging before rectal cancer surgery in particular, and so, you know, I just, I worry a lot about the incentive for

underutilizing recommended care. There's sort of no quality piece that's built into this measure.

So, those are really my primary concerns.

CHAIR MOSCOVICE: Okay. We have one comment from the group. Talking about the episode of care link, and the thought being that a 30-day trigger might be more reasonable, that the 15-day trigger would be a little bit too short.

So, one comment on that, the length.

Any other comments from the group?

MEMBER COLE: This is Collette Cole. I just had one general comment.

I am new to, I am new to this group. But, like, in evaluating these last two measures I'm keeping -- I'm from Minnesota, and we measure our whole entire state, both rural and metro practices. And I'm thinking in terms of rural applicability.

The previous cost measure, asthma and

COPD patients, have large applicability across all practices. And when I look at this particular measure it struck me as this might be less applicable in the rural.

And I echo Jessica's statements about potential for low volume. But, of course, I would defer to the group if this does have applicability. But some of the conditions I would have a low, a lower volume concern that that might be more of a concern for rural practices.

So, I'm just kind of keeping that kind of a lens, you know, is that an applicability?

And, you know, I would not want a measure to be stalled because of you want to raise everyone up. And if there's an opportunity to increase resources or have more services in the rural area, if you're comparing different types of practices or different costs, you want to have that opportunity available there, too.

So just some thoughts as we're going

forward. Thank you.

CHAIR MUSCOVICE: Thanks a lot for those comments. Other comments from the group?

MEMBER WAGNER: Hi, this is Janet. I don't have a lot of experience with this service, and I'm wondering for rural and malignant services, is there chemo and radiation therapy that those costs are outside of the rural spectrum for those types of cases?

It's a 90-day timeframe, so I'm just wondering after resection there's metastasis if that's an inclusion, and if those additional costs impact. And if so, would the rule have control over that. Thank you.

MS. EVANS: Hi, this is Ronique Evans again. I have been able to get some of the developers on the line, and they should be able to help you guys, are better suited to answer some of these measure-specific questions for you all. So with that, I pass it over to the Acumen Team for you guys to address some of these

lingering questions. Thank you.

MS. LAM: Thanks, Ronique. Hi, my name is Joyce Lam, I'm from Acumen, the cost measure developer. So I think the last question was about the inclusion of chemotherapy services for colon and rectal resection. So this is something that we're just checking in the measure codes list.

In case you haven't seen in the specifications, we do include a detailed list of all those services and the particular rules that apply to them. So we're just double checking this and going through to make sure. And then we can jump in and just provide an answer to that shortly.

Were there other questions that you had about this measure?

CHAIR MUSCOVICE: There was one comment that came up about the 15-day trigger up front, and got a comment that 30 days might be a more appropriate, that 15 days is too short. So

if you had any thoughts about how the 15 days prior to the clinical event came about, that'd be helpful.

DR. CHORADIA: Sure. So this is Nirmal Choradia, I'm a doctor at Acumen. So in discussion with the -- with a group of colon and rectal resection, basically people who are performing this, they actually did discuss in detail 15 versus 30 versus 60 versus none at all. And their thoughts were that in the 15 to 30 days -- or basically the costs within the 15 versus 30 versus 60 days is less important, and they're very focused on just preoperative testing and things of that nature.

That being said, and there was a good bit of discussion on this, of how far that kind of preoperative testing extends. Should the surgeon who is getting this episode be responsible for the -- if they send it over to a cardiologist and that cardiologist, instead of just doing a very basic clear decides to check,

do -- decides to basically do a number of different things, how much should the surgeon who's attributed the cost measure be responsible for? So that was the reason for the 15-day preoperative period.

And then just to go back a little bit and address the question previously. So this episode would not include radiation and things of that nature, with the idea being that this is specifically for the person or for the surgeon that's performing the colon and rectal resection. While the patients may need radiation, they may need chemotherapy, if this is -- if the rectal -- if the colon resection is being done for cancer or some other reason.

That being said, that's not necessarily something that's related specifically to the cost of the colon and rectal resection that the surgeon is performing.

CHAIR MUSCOVICE: Appreciate your comments in terms of clarifying.

DR. CHORADIA: Absolutely.

CHAIR MUSCOVICE: Any other final thoughts on this?

MEMBER SPENCER: This is Jesse from Intermountain. I would just say that any time there's -- it seems like any time there's procedures done in rural communities, and I'm not the expert on this, but oftentimes total cost of care will be a little higher because maybe days of hospitalization are longer and perhaps utilization of a skilled nursing facility or a rehabilitation are little bit higher post-procedure in rural communities because of lack of resources.

So that'd just be something to keep in mind with this particular procedure, because there will be lower numbers done at the smaller facilities, and with that I think there's -- it's hard to get around the trying to decrease days in hospital and utilization of after-care.

CHAIR MUSCOVICE: Okay. I think it's

time to move on for a vote.

MS. LYNCH: Yes, please. Amy, can you open the vote. The vote should be active. I think we're -- I think I saw 17. It looks like we're waiting for one more. Okay, it looks like we have 19.

And we had zero for strongly disagree, six for disagree, five for neutral, eight for agree, and one for strongly agree. So thank you very much.

Before we move on to the next measure, we are running rather behind schedule. Really great questions. We do want to remind the public that there will be time for question and comment at the end of the day. And we really want to focus on the rural perspective for these measures, as they'll go into a lot more of those details that we've been discussing about what an episode means during those longer work group-specific days next week. So we'll try to keep the focus here.

And Amy, if you'd go back to the slides for the next measure. Okay, so the next cost measure is a diabetes cost -- diabetes episode-based cost measure, which evaluates a clinician or clinicians' groups risk-adjusted cost to Medicare for patients receiving medical care to manage Type I or Type II diabetes.

The measure score is a clinician or clinician group's weighted average of risk-adjusted cost for each episode attributed to the clinician group, where each episode is weighted by the number of assigned days during the episode. This product measure includes services that are clinically related and under the reasonable influence of their attributed clinical group. Services are assigned -- actually, my screen just went blank. Thanks.

The services are assigned during a diabetes episode, which is a portion of the overall time period of the clinician or clinician group's responsibility for managing a patient's

diabetes. Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

CHAIR GARMAN: So we have this next measure on diabetes before us, so I would turn it over to the lead discussant from Alliant Health Solutions or the American System --

MEMBER RASK: Hey, this is Kimberly Rask from Alliant, and to sort of focus on your rural questions, this again is a chronic care cost measure. So we know it's part of required under MIPS, the half-cost measures. In terms of relative priority and utility, it is a cost measure for a common condition that would be experienced by rural residents.

They did look at reliability down to 20 episodes per individual clinician or group with reasonable reliability, which seems like low volume is always a problem. But at least with this being a relatively common condition, hopefully most providers would be -- have an --

be at an acceptable reliability level.

In terms of data collection or reporting challenges, this is all done through claims measures, so there's no burden on providers or clinicians to have to report this information. In terms of methodologic problems for calculating performance measures for small facilities, again, it would be the volume issue. But they did do some testing, down to as low as 20 episodes.

And then lastly in terms of potential unintended consequences, I think the unintended consequences are pretty typical for any kind of a cost, similar for this, for any cost measure. Which means that risk adjustment is really important. And so methodologic groups that look at risk adjustment would need to think about some of the risk factors in terms of access and social determinants of health that might disadvantage people in rural communities for this measure.

And those are my comments.

CHAIR GARMAN: Thank you, Kimberly. American Society of Health System Pharmacists, any other comments?

MEMBER THOMAS: Hi, yes, Kimberly, that was really good. You highlighted things that I found interesting. The one thing I did note is in the numerator, there is a calculation, and it uses the national average observed episode costs. And I thought that could be a concern to this group in the rural setting since we know it's typically higher.

And I agree that there's no issue with collecting the data. So I guess that was primarily my other -- the other thing that I noticed.

CHAIR GARMAN: Thank you, Erika. Anyone else, other comments, questions? I see nothing in my chat box. Chelsea, we're trying to gain ground, we're trying to gain time here.

MS. LYNCH: I appreciate that, Aaron. Do want to make sure people, you know, can express

their thoughts.

CHAIR GARMAN: Now's the time. Going once, going twice. Sold, Chelsea.

MS. LYNCH: All right, Amy, let's go ahead and open up the vote, please.

MEMBER COLE: All right, so that should be ready to go.

MS. LYNCH: Okay, we are voting on the diabetes episode-based cost measure for the suitability of previous --- providers within the program of interest, which is MIPS.

And it looks like we're at 18, waiting for one more. Give another ten seconds for one additional person to vote. Okay, we will close voting and share the results. Okay, so we have zero votes for strongly disagree, one vote for disagree, one vote for neutral, 13 for agree, and four for strongly agree.

Thank you, and we can move on to the next cost-based measure, which is Melanoma Resection Episode-based Cost. This measure

evaluates clinician or clinician groups' risk-adjusted cost to Medicare for patients who undergo an excision procedure to remove a cutaneous melanoma. The measure's score is a clinician's average risk-adjusted cost for the episode group across all measures attributed to the clinician or clinician group.

This procedural measure includes services that are clinically related and under reasonable influence of the attributed clinician during the 30 days prior to the clinical event that opens or triggers the episode through 90 days after. Medicare beneficiaries enrolled in Medicare Parts A and B during performance period are eligible for the measure.

CHAIR GARMAN: Our lead discussants are Jessica Schumacher and the representative from the Rural Wisconsin Health Cooperative. So who would like to offer comments?

MEMBER SCHUMACHER: So this measure, this particular measure's been developed and

tested but also now refined rather recently in the summer of 2020. In terms of the relative priority and utility, you know, I think there's a very compelling case, given survival is so high, that there's been observed significant variation complications, post-surgery.

And so this is a very relevant and common procedure that's performed in rural areas. There are key opportunities for improvement, and so there are ways to improve care and reduce costs that are established.

Data collection would be minimal again because of claims. I thought the reliability, even at low volumes, was quite high, it was over, about 0.8 for even providers and provider groups that are performing a minimum of ten procedures. And so I thought that set was good.

You know, I think this measure really has -- the downsides of this measure are sort of consistent with other class measures where, you know, you could sort of reward cost reductions

with no net quality of care gain. And so there are sort of -- there are concerns that I have about that, especially given patients in rural areas are more likely to present with later-stage disease and have more intensive utilization as a consequence.

Those are my comments.

CHAIR MUSCOVICE: Okay, does the representative from the Rural Wisconsin Health Cooperative want to add to that?

MEMBER WAGNER: Hi, this is Janet. The only thing I wanted to add is that for numerator I noticed the sum is like in the prior measure the national average observed episode cost. Other than that, I agree with the prior comments and have nothing to add.

CHAIR MUSCOVICE: Okay, any other comments from the group? Chelsea, I think it's back to you.

MS. LYNCH: All right, Amy, if you could open up the vote.

MS. GUO: The vote for Measure 18 is now open.

MS. LYNCH: I'll give it another ten seconds. Okay you can go ahead and show the results, Amy, please.

We had zero votes for strongly disagree, zero votes for disagree, four votes for neutral, 12 votes for agree, and one vote for strongly agree.

And I am happy to announce that this is our last cost-based measure and we will be turning it over to Nicolette after, so you'll have another person to listen to.

So the episode cost measure evaluates clinician or clinician groups' risk-adjusted cost to Medicare for patients who receive in-patient medical treatment for sepsis. The measure's score is a clinician or clinician group's average risk-adjusted cost for the episode group across all attributed episodes.

This acute in-patient medical

condition measure includes services that are clinically related and under the reasonable influence of the attributed clinician's role in managing care during each episode from the clinical event that opens or triggers the episode through 45 days after.

Medicare beneficiaries enrolled in Medicare Parts A and B during the performance period are eligible for the measure.

CHAIR GARMAN: I can think of nobody better to present this than either John Gale or the American College of Emergency Physicians. Let's talk sepsis. John?

MEMBER GALE: I am just trying to take myself off mute. I think it's -- this is an interesting measure. It works, it is relevant to rural providers and hospitals. The measure itself is primarily targeted to internal medicine.

And it has been tested and the reliability appears to be pretty good, although

it's more reliable for clinician groups than individual clinicians. So the reliability of the minimum ten-episode case is actually better for the clinician groups than the individual clinicians.

Some of the same issues that we always see with rural measures. The question of whether the use of the national average observed cost to generate a dollar figure is appropriate, given the differing costs across urban and rural. And the numerator is the observed cost, expected cost divided by expected cost times the national average. And the denominator is the number of episodes.

So the real question for me is whether or not this -- whether or not, particularly if you get into smaller hospitals there would be sufficient cases. Larger hospitals, yes, but you start getting into critical access and others that may be a pretty small number.

CHAIR GARMAN: Any other comments,

John? Do we have anybody on from the American College of Emergency Physicians? Anybody else have any other comments about this measure, questions, problems?

MEMBER SPENCER: This may be getting into the weeds a little bit, but I wonder about some of those critical access hospitals, if transfer costs play into total cost of care, and that would be a rural concern.

MEMBER GALE: I agree.

MEMBER SPENCER: Not a problem.

CHAIR GARMAN: Anybody else? Chelsea, back to you.

MS. LYNCH: Thank you. Amy, can you open the voting, please.

MS. GUO: The vote should be open now.

MS. LYNCH: Give another ten seconds. Okay, Amy, go ahead and show the results, please.

MS. GUO: We had zero votes for strongly disagree, two votes for disagree, five votes for neutral, 12 votes for agree, and zero

votes for strongly agree.

And I will turn it over to Nicolette to talk about the quality measures under this.

MS. MEHAS: Thank you, Chelsea, hi, everyone, this is Nicolette. So I did want just a quick note that we are supposed to break for lunch at 12:30 Eastern, but we are going to try to spend our allotted time of about five minutes per measure and take a break around 12:45 p.m., and we hope that will be acceptable for everyone so that we can stay on track with our agenda.

And so I'll move into our next measure. We are still talking in context of the MIPS program, and we are moving on to talk about measures under the -- proposed under the quality category. So the first measure being considered is 34. It's Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System.

And this measure is the annual risk

standardized rate of acute unplanned cardiovascular-related admissions among Medicare fee-for-service patients 65 and older with heart failure or cardiomyopathy.

A couple quick notes. This one is specified at the clinician and clinician group levels of analysis. It is an outcome measure that uses claims data and is fully developed and will be submitted to NQF in spring 2021. And another note that it is adapted from a version of this measure that is actually specified for ACOs. But this measure is now specified at the clinician level of analysis.

So with that introduction, I believe, Ira, you're helping facilitate this one, and I'll turn it over to you.

CHAIR MUSCOVICE: Okay, I believe our lead discussants are from the American Academy of the Family Physicians and from the National Rural Health Association. Would someone like to share their comments on this?

MEMBER SLABACH: This is Brock here with NRHA. I'll kick off by saying that obviously heart failure is a significant problem and a significant reason for admission to rural hospitals. And the care as provided to them in this category is really important. I think that the measure is -- so it's measuring something that is relevant in a rural community.

I think that by adding it to MIPS it would extend it from the ACO environment into this clinician role, which I think would make it consistent and appropriate at this point in terms of development of this measure.

CHAIR MUSCOVICE: Okay, any other comments from our colleagues at the American Academy of Family Physicians?

MEMBER DUCHICELA: No comments at this time, thank you.

CHAIR MUSCOVICE: Okey-doke. Any other comments from members of our work group? Okay, I'll turn it back to Nicolette.

MS. MEHAS: Okay, if there are no further comments at this time, we can move to take a vote.

MS. GUO: That should now be open for voting. See that we're up to 18, so maybe ten more seconds for the last vote to come in.

MS. MEHAS: Okay, thank you, everyone, for casting your vote. So this was for the risk-standardized acute unplanned cardiovascular-related admission rates for patients with heart failure for MIPS. And we have zero votes strongly disagree, zero votes disagree, one vote neutral, 18 votes agree, and zero votes strongly agree. Thank you for voting.

Our next measure that is being considered for MIPS is Intervention for Prediabetes. This measure is the percentage of patients that are 18 and older with an identified abnormal lab result in the range of prediabetes during a 12-month measurement period who are provided an intervention.

And I'll note that an intervention must include one of the following, which would be a referral to a CDC-recognized diabetes prevention program, referral to medical nutrition therapy with a registered dietician, or a prescription of metformin. This measure is specified at the clinician or clinician group level of analysis. It is a process measure, and I will note that there are currently no measures addressing prediabetes in the MIPS program.

And Aaron, I'll turn it over to you for facilitation.

CHAIR GARMAN: Thanks, Nicolette. Somebody from the American Society of Health System Pharmacists or the National Rural Letter Carriers Association want to pick it up?

MEMBER THOMAS: Sure, hi, this is Erika, and I just wanted to mention there are a few concerns with this measure related to patients in the rural setting. As Nicolette mentioned, there are very specific interventions.

You have to have a recognized diabetes prevention program, and you have to have referral to a medical nutrition therapy with a registered dietician. That could be an issue in the rural setting.

The other thing is -- well, that's the main thing, is it's so specific. And that was one thing that was noted by the NQF Primary Care and Chronic Illness Standing Committee, who reviewed this in the spring of last year. And the number of limited interventions was an issue.

Those are my only comments.

CHAIR GARMAN: Wonderful, I would totally agree with you on that. I think that's a significant barrier in rural healthcare, having access to those providers. Anybody from the National Rural Letter Carriers Association want to comment on this?

MEMBER DEML: Yeah, hi, this is Cameron. I'd echo what was just said and kind of looking at it. And I'll admit that I'm not a

clinician or a physician, so I guess my bias is I kind of like the measure, that it's aiming at prediabetes as the diabetes or another chronic condition if it's already there.

But I just, my question, and I think is somewhat addressed there, would be, you know, how hard or I guess how wide did this measure aim, and is it able to be accomplished? So I'll keep my comments brief.

CHAIR GARMAN: Thank you. We have a question from Janice Tufte. Is eight the prediabetes number? Did it specify what their guidelines were for prediabetes? Erika, do you see that in the measure?

MEMBER WAGNER: I'm sorry. Yes, it did, and it looks pretty reasonable. Abnormal labs in the range, fasting plasma glucose between 100 milligrams per deciliter to 125, or a two-hour glucose during the 75-gram oral glucose tolerance test between 140 milligrams per deciliter to 199 milligrams per deciliter. Or an

A1C between 5.7 and 6.4.

CHAIR GARMAN: Which is pretty standard for prediabetic.

MEMBER WAGNER: Mm hm.

CHAIR GARMAN: I hope that answered your question, Janice. Anybody else have any comments or questions regarding the prediabetes measure?

MS. LYNCH: Actually, there was a question to me from Janet Wagner. Do you want me to read that out, Janet, or would you like to go ahead and ask?

MEMBER WAGNER: Sorry, yeah, I just had the question, it says a referral is needed, and I was wondering this is claims based. So the patient does need to attend that referral?

MEMBER THOMAS: Hi, it's Erika. This is actually a process measure type.

MEMBER WAGNER: Oh, I'm sorry, that's right. So they just need to refer, and if the patient doesn't attend the appointment, the

referral is the only process or action needed. Thank you.

CHAIR GARMAN: Any other comments, questions?

MEMBER FADDEN: Comment. I wondered to what extent this measure, if it were implemented, might actually influence rural providers to pursue additional resources for patients, both with diabetes and prediabetes. Standing up a prediabetes program is not that difficult, as a matter of fact I've done it in the past. So I just offer that as comment.

CHAIR GARMAN: Thank you. Anybody else? Thank you all for your comments and questions. Nicolette, I'll turn it back to you.

MS. MEHAS: Great, thank you, Aaron, and thanks, everyone, for your comments and the discussion. We will move to voting on measure under consider 40, Intervention for Prediabetes.

So the voting is open and you can cast your votes. And we're voting on the suitability

for potential inclusion of the measure with rural providers within the program of interest, and we're talking about the MIPS program.

MS. GUO: And we're at 18 now, so maybe just a few more seconds for the last response to come in.

MS. MEHAS: Okay, voting is now closed. Results are as follows: one vote for strongly disagree, three votes for disagree, zero votes for neutral, 12 votes for agree, and two votes for strongly agree. Thank you for casting your votes.

And we will move on to our next measure being considered. This is measure under consideration number 42, Person-Centered Primary Care Measure Patient-Reported Outcome Performance Measure.

So this measure is a PRO-PM that uses the patient-centered primary care measure PROM tool, which is a comprehensive and parsimonious set of 11 patient-reported items that assess the

broad scope of primary care and measure the high value aspects of primary care based on a patient's relationship with their provider or practice.

As the other measure that is specified at the clinician or clinician group level, and it is a fully developed measure that has been submitted for NQF endorsement.

And Ira, I'll turn it over to you.

CHAIR MUSCOVICE: Okay, our lead discussants are from the American Academy of Physician Assistants and Minnesota Community Measurement. Your comments are welcome.

MEMBER COLL: Dan Coll, I'm happy to go ahead first for the American Academy of Physician Assistants.

The survey was interesting. There's 11 questions you have to hit. You have to hit eight of the 11 questions to hit viability for the survey result. Patient visit has to be at least one visit in the last year.

My concern with the survey is I notice all the language of the survey questions was for a physician provider. And again, as earlier and kind of a recurring theme is our rural workforces have a mix of providers, not just including physicians.

And so my concern for unintended consequences in a rural area is we may be missing out on a significant portion of the provider population if the language leads patients to believe they're only surveying the physicians and yet their primary care may be a PA or a nurse practitioner. So this could be an unintended consequence and decrease the survey's applicability or confuse participating patients.

CHAIR MUSCOVICE: Okay. Minnesota Community Measurement, any comments?

MEMBER COLE: Yes, thanks, Dan. I'd like to add onto that. I have to put on my measure developer hat at the moment, so. This is coming forward as a PRO-PM, as a performance

measure that uses a patient-reported outcome tool. It looks like a great patient-reported outcome tool that has 11 questions.

But when we're talking about a performance measure, this is more like a CAHPS tool, a patient experience tool. It's not really a performance measure in that it's not seeking a target or a particular outcome. Yes, it is providing rates that are looking more like a patient experience, but it's more like a CAHPS tool.

So I just want to present that caution as it's being evaluated. A performance measure would be like looking at depression rates and expecting a remission of depression over time using a particular patient-reported outcome tool or functional status over time. So there is that particular caution in how this measure is presented.

And but it looks like the tool itself has been vetted and tested. And then I echo Dan's

comments that it is very focused on the physician as the focus of the questions. And I guess the decision point would be would this be duplicative or a replacement for the CAHPS tool that is currently in use in programs.

So that's all that I have to say, thank you.

CHAIR MUSCOVICE: Thanks for your comments. Any other comments from members of our work group?

MEMBER DUCHICELA: Yes, this is Jorge Duchicela from the American Academy of Family Physicians. Can you guys hear me okay?

CHAIR MUSCOVICE: Yeah, we can hear you.

MEMBER DUCHICELA: Yes, sir. It's -- I'm a family physician here in rural central Texas for 30 years, and this is actually the first time that I've seen something like this coming across me. And I love it.

And notwithstanding, you know, the

comments that Mr. Coll has said and Dr. -- Collette has mentioned, I think we need to find something that is applicable to us. And especially in the rural areas with all the limitations on resources that we have vis-a-vis, for example, the previous proposal with us having to refer to a specific type of nutrition type of program for our patients, which in the rural areas is really, really difficult to do.

But talking about this specific primary care measure, patient-reported outcome performance measure, I think it's hitting it right on the head. As far as a rural family physician, this is what matters to me very much on a day-to-day basis. This is something that I have -- I can control.

And it's something that can give me a feedback as to where is it that my access or my ability or my cost or my affability has to with my services that I'm rendering to my patients and the quality that they perceive that they actually

are getting.

I just wanted to mention that this is, for me as a family physician in rural areas, means a lot to me, for quality measures.

CHAIR MUSCOVICE: Appreciate your comments. Any other comments from the work group members? Okay, I think it's back to Nicolette.

MS. MEHAS: Thank you, so --

DR. ETZ: I'm sorry, can we have comments from non-work group members but the developer, who happens to be on the line?

CHAIR MUSCOVICE: Nicolette.

DR. ETZ: Nicolette, you're on mute.

MS. MEHAS: Sorry. If you wanted to. We are behind schedule, but if you wanted to share a very brief comment related to something that was shared, we would allow that. But we'd please encourage you to keep it brief.

DR. ETZ: Sure. So I just wanted to address the two concerns because I of course understand them completely. We received 10,000

patient comments to inform this measure, and not a single one of them used any word other than doctor or clinic. We designed the measure to use the language that patients find most significant to them and most meaningful to them.

And it turns out that they know the difference between doctors and PAs and nurse practitioners, but as a catch-all word, doctor is the word they use no matter who the type of clinician is that they're seeing. Those clinical types are often more meaningful to us academically than they are to the patients.

The second question was about whether or not this was like CAHPS. We actually submitted a table to show that this has one question that overlaps with CAHPS, but it is a completely different measure.

It is not about patient experience or satisfaction, it is actually about patient assessment of all aspects of primary care access, care coordination, comprehensiveness, health

polls, many that are not part of the CAHPS survey, which addressed largely patient satisfaction communication and some coordination.

So I'd like to keep that in mind and to understand in line with your conversation about what is an episode of care in primary care. The most important outcomes are not often disease-specific ones. In fact, 80% of what we do is not related to a specific diagnosis. We need measures that address the work we do. Thanks.

CHAIR MUSCOVICE: Okay, Nicolette, back in your lap.

MS. MEHAS: Thank you. Thank you for sharing those clarifying comments, they're useful.

Okay, so in -- for time, I think we are going to move to a vote on this measure. And so please cast your vote for the person-centered primary care measure and suitability for use with rural providers within the program of interest,

which is the MIPS program.

MS. GUO: So 18, so maybe ten more seconds and then we can share the results.

MS. MEHAS: Okay, voting has closed. We have zero votes for strongly disagree, one vote for disagree, two votes for neutral, eight votes for agree, and seven votes for strongly agree. Thank you for casting your votes.

So I know I said we would stop at 12:45 but we have one measure left in this section, so we're going to try to do this last measure, and then we do promise we will give folks a break. So if we can move on to our next measure that is being considered for the MIPS program, and it number 43, Preventative Care and Wellness Composite.

This measure is the percentage of patients who received age- and sex-appropriate preventative screenings and wellness services. So it is a composite of seven component measures which are process measures, including influenza

vaccination, pneumococcal vaccination, breast cancer screening, colorectal cancer screening, body-mass index screening and follow-up, tobacco use screening and intervention, and screening for high blood pressure and follow-up.

And this one, like others, is specified at the clinician or clinician group levels of analysis. And Aaron, I will turn it over to you.

CHAIR GARMAN: Well, thank you, Nicolette. Our lead discussants for this are Jessie from Intermountain Healthcare and Michael Fadden. Either one of you want to kick this off?

MEMBER FADDEN: Thank you, right. I think one should get us to lunch really quickly. This is pretty straightforward. It says it's in early development, but this actually lumps together those seven pretty well-established preventive services. Very low burden because they're already being reported.

What I like about it is I think it's,

as a clinician looking at this you might say this is better report card of how I'm doing in this realm than just picking one of those seven to focus on. And I think it's going to give an opportunity for clinicians to really judge themselves against others on how well they're performing in this area.

So I think it's a very useful measure. I don't see where it would have any different applicability to rural medicine as opposed to urban medicine. So I think it's pretty straightforward.

Jesse, thoughts?

MEMBER SPENCER: Yeah, I agree that I don't think there's any rural -- well, I don't know if it's my primary care heart or my rural heart that thinks about these metrics that are, you know, composite scores. You still need to pay attention to each individual thing.

And what I worry a little bit with composite scores is, you know, all the data that

goes into a composite score, when you break them down into their individual pieces, it gets complex to make a composite score that means a lot. You almost always have to go into these individual, you know, areas to find where you might -- what you might do to improve your score.

So I worry about them, they're getting a little bit of, with the composite score that doesn't, you know, typically -- I don't know how this composite score's going to look, but it's something like, you know, 60. Like what does 60 mean? I don't know what 60 means. Until you go back and you look at each individual piece and have to look at those metrics.

So I little -- I worry a little bit about that and just the challenges in rural medicine and in family medicine, primary care, about just data aggregation. So if you make a composite score that replaces, you know, seven things, like is something else going to fill in those seven other spots and we're just

continually adding more data aggregation, collection, I guess, so.

Those are my thoughts on composite scores. I mean, I use composite scores in our organization and I like them to a degree, but I do see some issues with a composite score of, you know, 60, what does that mean? And you end up having to dive deeper into the data anyway. Yeah.

CHAIR GARMAN: Yeah, thank you. Anybody else, comments, questions, concerns? I think those are great points. Nicolette, back to you.

MS. MEHAS: Hearing no further comments, we will open the vote for measure under consideration 43, Preventive Care and Wellness Composite. And we're voting on suitability for use with rural providers within MIPS.

MS. GUO: We are up to 18 responses, so maybe ten more seconds.

MS. MEHAS: Okay, thank you, everyone, for casting your vote. We have zero votes for

strongly disagree, two votes for disagree, one vote for neutral, 13 votes for agree, and three votes for strongly agree.

And I believe that brings us through the measures for our first couple agenda sections. So at this time, we would like to take a break. And so we will take about a 15-minute break, and we would kindly ask if everyone can return at 1:10 p.m. Eastern Time.

And Chelsea, is there anything else we should share before we go on break?

MS. LYNCH: No, I think that's it. Thank you, everyone, for all your participation. And we'll try to save up some time on the back end too. So thank you and we'll see you back at 1:10 Eastern Time.

(Whereupon, the above-entitled matter went off the record at 12:56 p.m. and resumed at 1:11 p.m.)

MS. LYNCH: Okay. I think we can go ahead and get started.

So we are continuing on with the clinician-specific measures. The program that we'll talk about next is the Medicare Shared Savings Program which is mandated by Section 3022 of the Affordable Care Act. It is a pay for performance program with -- it's a voluntary program that encourages groups of doctors, hospitals, and other healthcare providers to come together as an accountable care organization to give coordinated high-quality care to their Medicare beneficiaries. The goals are to promote accountability for a patient population as well as coordinate items and services for Medicare FFS beneficiaries and encourage investment in high-quality and efficient services.

So the measure that we'll talk about that is under consideration is Measure 33, which is an ACO-Level Days at Home for Patients with Complex, Chronic Conditions. This is a measure of days at home or in community settings that is not -- unplanned acute or emergent care settings

for patients with complex chronic conditions and shared savings programs accountable care organizations.

This measure includes risk adjustment for differences in patient mix across ACOs with an additional adjustment based on mortality risk at each organization. The level of analysis is at the organization level, and it is an outcome measure.

Ira or Aaron?

CHAIR MOSCOVICE: Yeah, I think this is mine, and our discussants --

(Audio interruption.)

CHAIR MOSCOVICE: I think we have -- someone's got to mute.

MS. LYNCH: If you are not speaking, please ensure you're on mute. Thank you so much.

CHAIR MOSCOVICE: Okay.

MS. LYNCH: Go ahead, Ira.

CHAIR MOSCOVICE: Trivial things. Anyhow, and so our discussants are from Cardinal

Innovations and from Geisinger Health. So if either of you would like to get the conversation going, that would be great.

MS. LYNCH: I don't think our representative from Cardinal Innovations joined, but I believe Geisinger should be on.

MEMBER MACDERMENT: Yes, this is Sarah from Geisinger. I'm on.

MS. LYNCH: Okay.

MEMBER MACDERMENT: Unfortunately I have nothing to add.

CHAIR MOSCOVICE: Okay. Let's hope that some of our workgroup members have a comment or to.

Anybody from the workgroup want to add to this?

MEMBER RASK: This is Kim. I guess I would say this is similar and building on some other measures that are out there that have really tried to focus on keeping people healthy and therefore not being in an institutionalized

setting or any kind of acute care if not truly necessary.

In thinking about it in terms of rural-urban differences, if -- it may actually be if some of the other things that we've said about their being barriers to access services, it might be that rural providers would look particularly good on a measure like this as compared to urban providers. I'm not sure if there's a -- that there would be a detriment to rural providers with this structure, but it would either -- I would think it might even be neutral or it might even be beneficial. Just a thought.

CHAIR MOSCOVICE: Okay.

CHAIR GARMAN: Ira, this is Aaron. As a provider in a rural ACO, we really try hard to keep our patients with complex medical conditions and all of our patients in their homes, and so it's something that we strive for. However, in my home state of North Dakota we have very few rural entities that are in ACOs.

CHAIR MOSCOVICE: Right.

CHAIR GARMAN: And so the challenge would be, one, getting them up to speed is going to be a huge challenge, just with the ACO world in general, and then trying to accomplish this metric.

So I think it would be challenging. I think it's a good idea, don't get me wrong, but I think it would be really challenging in the rural environment.

CHAIR MOSCOVICE: And, yeah, the only thing I would add is that our colleagues at RUPRI, I don't know if Keith Mueller is still on, but they've tracking ACO involvement in rural areas, and it certainly is increasing over time. So although it started out quite modestly, it's starting to grow a little bit.

CHAIR GARMAN: Yeah, I just think you need to have a lot of things in place --

CHAIR MOSCOVICE: Yeah.

CHAIR GARMAN: -- to be able to

provide this home-based care, and a lot of rural entities don't have these things in place. And so it's just a lot of support needed for a rural colleague's education.

CHAIR MOSCOVICE: Yeah.

Any other comments?

MEMBER WAGNER: Hi, this is Janet. I was just wondering about -- we're seeing issues with access for nursing home, and home health also for rural patients can sometimes be difficult. The home health, difficult keeping them at home. And SNF access for those that maybe are no longer appropriate to be at home but aren't able to get into a SNF and the impact that this may have either way on this measure. Thanks.

CHAIR MOSCOVICE: Yeah, I think that complements what Aaron just said.

Any other comments?

Okay. We'll turn it back to you, Chelsea.

MS. LYNCH: All right. Thank you.

Amy, let's go ahead and open the vote for Measure 33, please.

Okay. So as a reminder we are voting on the suitability of Measure 33 for use of rural providers within the Medicare Shared Savings Program.

(Voting.)

MS. LYNCH: It looks like we're at about 15. We'll give another 20 seconds or so.

(Voting.)

MS. LYNCH: Okay. Amy, you can go ahead and show the results.

So we had one vote for strongly disagree, one vote for disagree, five for neutral, and nine for agree, and zero for strongly agree.

Okay. And now I will hand it over to Nicolette, and we'll start talking about measures proposed for hospital programs.

MS. MEHAS: Thank you, Chelsea.

We can move to the next slide. This

is a high-level overview of the four programs that -- in which measures are considered for this section of the agenda. I will note there are a couple other programs that we will discuss in their context when we talk about the COVID measures later this afternoon.

So for this section we will be talking about measures under consideration for the End-Stage Renal Disease Quality Incentive Program, the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals or Critical Access Hospitals, the Hospital Inpatient Quality Reporting Program, and the Hospital Outpatient Quality Reporting Program.

And we will start with a brief introduction to the End-Stage Renal Disease Quality Incentive Program. This is a pay for performance program, and facility scores are also publicly reported. The incentive structure is that as of 2012 payments to dialysis facilities are reduced if facilities do not meet or exceed

their required total performance score. Reductions could amount to a maximum of two percent per year.

And the goal of the program is to promote high-quality services in renal dialysis facilities, improve the quality of dialysis care, produce better outcomes for beneficiaries.

So Measure Under Consideration 39, Standardized Hospitalization Ratio for Dialysis Facilities. And the standardized hospitalization ratio is the number of hospital admissions that occur for Medicare ESRD dialysis patients treated at a particular facility to the number of hospitalizations that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities.

And when used for public reporting there is a note here that the measure calculation will be restricted to facilities with less than five patient-years at risk in the reporting year

to ensure patients can not be identified.

The level of analysis for this measure is facility, so dialysis facilities would be the accountable entity.

A couple brief notes. This measure is an updated version of a measure that is implemented in the ESRD Quality Incentive Program, and it is on the Measures Under Consideration List because of updates to the measure, and these updates are primarily focused on the risk adjustment methods. And I did want to also note that the updated version of this measure has been reviewed and endorsed by NQF. We look forward to hearing your comments from the rural perspective.

And, Aaron, I will turn it over to you to facilitate.

CHAIR GARMAN: Thank you, Nicolette.

So does somebody from Alliant or Michigan Center for Rural Health want to kick us off?

MEMBER RASK: Hey, this is Kimberly from Alliant. In terms of the rural perspective and priority, it does kind of address both the cost and quality domains. And sort of in terms of data collection or reporting burden, it comes from administrative data claims data in CROWNWeb, so it would not be any additional reporting burden for the dialysis facilities.

In terms of methodologic problems calculating performance, it is done at the facility level from what they reported. As you know they're suppressing results for low numbers. They report hospitalization as being very common with the average ESRD patient spending 11 days a year in the hospital, so it seems like there would be enough episodes to have a reasonable reliability to show difference in performance across different facilities.

In terms of unintended consequences, as Nicolette noticed, it has been in current use, and there haven't been any complaints or concerns

about the current measure. And I think there are some -- the improvements that they made to modify it are nice because they are going to be limiting the comorbidities to come from inpatient claims, which means now it can be not just for fee for service Medicare beneficiaries, but also on Medicare Advantage beneficiaries, which under the old version they weren't two equal piles. The measurement was a little bit different.

So I think that it is a revised measure that has been revised in a way that would probably improve its performance and seems reasonable for rural settings. That's all.

CHAIR GARMAN: All right. Somebody from Michigan Center for Rural Health, any comments?

MEMBER BARTER: Yes, thanks. This is Crystal, and I would just echo Kimberly's comments. She covered everything I was planning on. And I agree, I think it's an appropriate measure for rural health.

CHAIR GARMAN: Anybody else with any other comments, questions? Other discussion?

Hearing none, Nicolette, back to you.

MS. MEHAS: Okay. Thank you for sharing your comments. We will move to a vote for this measure. And the voting is now opened, and we are voting on Standardized Hospitalization Ratio for Dialysis Facilities, and we're voting whether it's suitable for use with rural providers within the Program of Interest, which is the End-Stage Renal Disease Quality Improvement Program. Quality Incentive Program, my apologies.

(Voting.)

MS. MEHAS: Okay. We have about 17 votes. We'll leave it open for just a couple more seconds.

(Voting.)

MS. MEHAS: Okay. I think we can go ahead and close the voting. And so for the Standardized Hospitalization Ratio for Dialysis

Facilities Measure we have zero votes strongly disagree, three votes disagree, one vote neutral, 11 votes agree, and two votes strongly agree. Thank you for casting your votes.

Chelsea, back to you.

MS. LYNCH: Thank you, Nicolette.

So the next program that we will talk about is the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals or Critical Access Hospital Measures.

This is a pay for reporting and public reporting program. Eligible hospitals that fail to meet program requirements, including meeting the clinical quality measures requirements receive a three-fourth reduction of applicable percentage increase. The program goals are to promote interoperability between EHRs and CMS data collection.

There is one measure under consideration here. It's Measure 32, and it's the Global Malnutrition Composite Score. The

composite measure consists of four component measures of optimal malnutrition care focused on an adult 65 years and older admitted to inpatient services who receive care appropriate to their level of malnutrition risk and/or a malnutrition diagnosis if identified.

This composite score is looking at screening for malnutrition risk at admission, completion of a nutrition assessment for patients who screen for risk of malnutrition, appropriate documentation of malnutrition diagnoses for patients identified with malnutrition, and development of a nutrition care plan for malnourished patients, appropriate care for inpatients. And this is a facility level of assessment.

CHAIR MOSCOVICE: Okay. Our lead discussants are from the American Academy of Family Physicians and Cardinal Innovations.

I think you mentioned that Cardinal is not on the call. So does our AAFP representative

have some comments for us?

MEMBER DUCHICELA: I don't have any comments except that it appears to me that it's doable in the rural setting with rural hospitals.

CHAIR MOSCOVICE: Okay. How about comments from the workgroup? Any comments from members of the workgroup?

CHAIR GARMAN: This is Aaron again. One concern I guess I would have is volume because it's inpatient, acute inpatient stays. And so for those people that are 65 and older you'd screen them for malnutrition, you'd complete a nutrition assessment and documentation and follow-up and all that stuff, which is very good, very appropriate. I just don't know how many people would qualify in a rural setting in an acute inpatient setting for that, so I guess it would be a low volume question in my opinion.

CHAIR MOSCOVICE: Okay. Yeah, the only thing I would add also is I think it's an important area particularly given what we've been

seeing over the past year with the impact of COVID and food deserts and a whole host of other issues. So I think it is an important issue particularly for rural, but I agree with Aaron, the volume issue is something to be considered.

CHAIR GARMAN: Yeah, I totally agree. I don't want to minimize the importance of it. I just worry about the volume.

CHAIR MOSCOVICE: Mm-hmm. Okay. Back to you, Chelsea.

MS. LYNCH: We can go ahead and open up Measure 32 for voting. Again this is voting to see if Measure 32, the Global Malnutrition Composite Score, is suitable for use with rural providers within the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals or Critical Access Hospitals.

(Voting.)

MS. LYNCH: We are at 16, so we'll give it another 20 seconds or so.

(Voting.)

MS. LYNCH: Okay. Amy, I think we can go ahead and show the results.

Okay. We had zero votes for strongly disagree, zero votes for disagree, two votes for neutral, 14 votes for agree, and zero votes for strongly agree.

And we will be going on to the next program, and Nicolette will take us through that.

MS. MEHAS: Thank you, Chelsea.

So the next program that I will introduce is the Hospital Inpatient Quality Reporting Program. It is a pay for reporting program as well as public reporting program. Hospitals that do not participate or participate in a program but fail to meet requirements receive a one-fourth reduction of the applicable percentage increase in their annual payment update.

And the goal of the Hospital Inpatient Quality Reporting Program is to progress towards paying providers based on quality rather than

quantity of care provided to patients and also to provide consumers information about hospital quality so they can make informed decisions about their healthcare.

And so we will be talking about two measures that are being considered for the Hospital Inpatient Quality Reporting Program. And so this first Measure Under Consideration 32, Global Malnutrition Composite Score. So this is the same measure that Chelsea just introduced and you all weighed in on, but we did want to provide the opportunity for you to provide any rural-relevant context -- comments on this measure in the context of the Inpatient Quality Reporting Program.

And so I won't to go over the description again. I'll just note a couple things that this one is specified at the facility level of analysis. It has been submitted for NQF endorsement. It uses EHR data, and there was a note in the preliminary analysis that this topic

is not something that is currently addressed by measures that are currently used in the Hospital Inpatient Quality Reporting Program.

CHAIR GARMAN: So I guess I would open it up to the group for other comments in this realm of the Hospital Reporting Program. Any other thoughts? Concerns?

MEMBER DUCHICELA: This is from American Academy of Family Physicians. I'm always concerned when -- if I read this correctly, this is tied into how much money or how much payment a hospital will receive for their efforts. Is that correct?

So this is tied in -- I have a question about this whether this -- it sounds to me like this is going to be used to either go up or down in a percentage of amount of reimbursement that the hospital is going to get. Is that correct for what we're looking at for this measure?

CHAIR GARMAN: Nicolette, do you have any background on that?

MS. MEHAS: Oh, it is -- as I mentioned, the Hospital Inpatient Quality Reporting Program is a pay for reporting program. I do want to ask if our colleagues at CMS would like to provide any background or additional information about the program to respond to the workgroup member's question?

MEMBER SCHREIBER: So, hey, this is Michelle, and Julie Venanzi is also on the line and can help comment.

This is basically the same measure, the Global Malnutrition Composite Score. And we usually introduce new measures into IQR before they actually progress further into some of the more payment-oriented programs like Hospital Value-Based Purchasing, or depending on the measure, you know, the Readmissions Reduction, or a raw HAP measure, or a HAP program.

We put it in -- it's listed in Hospital PI because it is an electronic measure, but it actually would be used more in the IQR

Program.

MEMBER DUCHICELA: Thank you for that.

CHAIR GARMAN: Anybody else? I hate to put you on the spot, but, Brock, do you have any comments on this since it impacts hospitals?

Or anyone else?

MEMBER SLABACH: Here we go. I had to un-mute myself. I'm sorry. This is Brock here. I was distracted for a second eating lunch actually. So we're on the Global Malnutrition Composite Score still?

CHAIR GARMAN: Yeah, correct.

MEMBER SLABACH: All right. Well, I thought we just voted on that one, so that's why I was a little bit -- this is continuing the extension of that same measure in those four units?

CHAIR GARMAN: Yeah, this is now under the Interoperability Program. Oh, I'm sorry, for the Inpatient Quality Reporting Program.

MEMBER SLABACH: So this is --

MEMBER SCHREIBER: This is Michelle again. The reason it's in the Promoting Interoperability Program is that we want to keep it in both programs so that we keep the ECQM measure sets aligned.

MEMBER SLABACH: Got it. Well in that sense I think I'm all for as many measures in the electronic format as possible for collection of the data being easier in that context. So if that's the question, I voted in favor of the previous measure, so if -- I think it would be appropriate for this to be updated in that setting as well.

CHAIR GARMAN: All right. Thank you very much for your comment. Sorry to interrupt your lunch.

Anybody else?

MEMBER SLABACH: Oh, no problem.

CHAIR GARMAN: Comments, questions?

Nicolette, back to you.

MS. MEHAS: Okay. Great. Thank you.

So we will move to a vote on this measure. This is Measure Under Consideration 32, Global Malnutrition Composite Score. So this time you're voting for suitability for use with rural providers within the Hospital IQR Program.

(Voting.)

MS. LYNCH: We're at 18, so maybe 10 more seconds.

(Voting.)

MS. MEHAS: Okay. Thanks for casting your votes. We have zero votes for strongly disagree, one vote for disagree, two votes for neutral, 14 votes for agree, and one vote for strongly agree.

We will move on to the next measure that is under consideration for the Hospital IQR Program, and this is Measure No. 3, Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty.

And so this measure will estimate a

hospital-level risk-standardized improvement rate for patient-reported outcomes following elective primary THA or TKA for Medicare fee for service patients 65 and older.

And there is some additional information describing the measure included. It is specified at the facility level of analysis. This is a fully developed measure. It is a new patient-reported outcome-based performance measure.

CHAIR MOSCOVICE: Okay. Our lead discussants are from the American Academy of Physician Assistants and from the National Rural Letter Carriers Association. Who would like to lead off?

MEMBER DEML: Hey, Ira, this is Cameron from National Rural Letter Carriers Association. I guess I'll lead off and again caveat with the other measure that I'm not a physician, nor a clinician. So I kind of -- I guess my -- more than expanding on it really kind

of a question to certainly physicians or clinicians on this one.

I guess one of the questions I have, and I know this is certainly broad, is just are there any limitations just based on the measure being an outcome measure as far as the population that we're focusing on obviously in context to rural health and limitations as in is it low volume? I guess I kind of assume that there's plenty of people 65 and older getting knee and hip replacement. So I'll stop there and kind of pose that question for the group or anyone specifically.

CHAIR MOSCOVICE: Okay. Any comments from the American Academy of PAs?

MS. RATHFON: This is Ellen Rathfon. I'm not sure if Dan's still on.

CHAIR MOSCOVICE: Okay.

MEMBER COLL: I am.

MS. RATHFON: Okay. You go, Dan.

MEMBER COLL: Sorry. I was having a

little trouble un-muting.

MS. RATHFON: Okay. Go ahead.

MEMBER COLL: So my world actually in a rural hospital partly is supporting the surgical services, and specifically orthopedics. So across CMS total joint arthroplasty is top five procedure. Hips and knees are -- they're in their top five for procedures. And many payers are driving patient-reported outcomes, not just CMS, but there have been formations of multiple registries in different states and then nationally as well trying to address more consistent patient-reported outcomes to really better define results. And it's a great project.

As far as this particular measure, I noted there's a threshold of 25 cases, which I think is going to become more and more of an issue. And to put it into perspective the projection is that over 75 percent of joint replacements by 2025 will be in an outpatient setting, and we're actually beating that

projection currently, with the trends to move -- including Medicare moving patients from the inpatient setting to an outpatient status and/or ambulatory surgery centers for joint replacements. So I think the intent of the measure is great.

I do want to express a concern that as we move from the inpatient facility, which from reading the measure this is only going to be for an inpatient facility, we're going to see decreasing inpatient volume. These cases will be done on an outpatient status, if not an outpatient center, and this will mean in -- especially in a rural setting where their volumes will be lower already for a surgical specialty like orthopedics, that this measure is going to become less and less relevant unless it bridges to covering outpatient replacements. Those are my comments. Thank you.

CHAIR MOSCOVICE: Okay. We'll open it up to the floor. Any workgroup members have a

comment on this measure?

MEMBER WAGNER: I'm sorry. I didn't see inpatient in the specifications. Can somebody verify this is inpatient only?

CHAIR MOSCOVICE: Well, it's in the Inpatient Quality Reporting Program, so I assume it's for inpatient only. Is that correct?

MEMBER SCHREIBER: At the moment it's inpatient, but your conversation is interesting to -- for us to consider extending it at some point to the Ambulatory Surgery Program.

CHAIR MOSCOVICE: That's a good comment. Any other comments?

MEMBER COLL: Sorry. This is Dan Coll again. I guess that would be helpful because I don't know if it's just ambulatory -- the ambulatory category because we do know rural facilities may be less likely to have an outpatient surgery center, but they will often, as we are being -- we're being mandated to put these patients into observation/extended

recovery status, and they're not considered inpatients.

So that's why I'm concerned it will have a short life if it focuses only on inpatient because there's such a strong push by both Medicare and commercial payers to move these into outpatient categories and/or outpatient settings. And the only patients that will remain in the hospital will be the sickest patients with the most complications and the most risk factors, comorbidities. So I'm afraid this data will become more and more skewed.

MEMBER SCHREIBER: Yeah, no. Thank you. This is Michelle, and we appreciate your comment.

CHAIR MOSCOVICE: Any other final comments on this measure?

Okay. I think we'll send it back to Nicolette.

MS. MEHAS: Okay, and we will go ahead and open up the vote for this measure. We're

voting on the measure under Consideration 3, Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary THA/TKA. We're voting on whether to vote for use with rural providers within the Hospital IQR Program.

(Voting.)

Okay. The votes came in quickly for this one. So we have 18 responses. So I think we can move to close our voting.

We have zero votes for strongly disagree, four votes for disagree, eight votes for neutral, six votes for agree, and zero votes for strongly agree.

And, Chelsea, I will turn it over to you for the next section.

MS. LYNCH: Thank you so much, Nicolette.

So, we'll move on to the next program, which is the Hospital Outpatient Quality Reporting Program. This is a pay-for-reporting

and public reporting program. The structure is hospitals that do not report data on required measures who receive a 2 percent reduction in annual payment updates.

The goals are to provide consumers with quality-of-care information to make more informed decisions about healthcare options and establish a system for collecting and providing quality data to hospitals providing outpatient services such as emergency department visits, outpatient surgery, and radiology services.

There are two measures that we'll be discussing. The first one is Measure 4, the Appropriate Treatment of ST-Segment Elevation Myocardial Infarction, or STEMI, Patients in the Emergency Department. This is the percentage of the ED patients with a STEMI who received appropriate treatments. The measure will be calculated using EHR data and is intended for use at the facility level.

CHAIR GARMAN: All right. So, we have

to talk about STEMIs. The American College of Emergency Physicians, anybody on from there? Or RUPRI? Either of you want to take this?

MEMBER MUELLER: This is Keith at RUPRI.

I have more questions probably than direct answers. In looking at some of the detail about this, it appears that one of the appropriate treatment criteria is time to the appropriate treatment from the arrival at an ED to getting into the appropriate treatment in either an inpatient environment or a hospital outpatient environment.

And I was a little bit unsure about that and hopeful that somebody else read it more carefully to say, is that really something that would adversely impact in the ability to meet that measurement in rural because of transportation issues in transferring, time and distance?

And the measure is, the data

collection is based on electronic health records, as it says in the summary. And I was uncertain about the reliability of that in rural ED environments.

So, those were questions I had that I was hoping somebody else could answer.

CHAIR GARMAN: Thank you for those.

I was just looking to see if I could tease some of this out. So, it looks like it is based on time, 30 minutes or fewer, to fibrinolysis. So, you could potentially push TNK or TPA at a rural facility or its referral to or transferring somebody for a PCI or an angiogram or cardiac catheterization within 90 minutes of arrival.

So, I think this is pretty standard as far as cardiac care goes. I think it's pretty commonplace as far as what we try to achieve in the rural settings.

Heart is muscle, right, or time is muscle. So, we want to make sure that we do these

things in an effective, timely fashion.

I absolutely agree that a big barrier to that is being rural and having a facility -- my facility that I refer to is about 90 minutes away. And so, for me to get somebody to a PCI-capable hospital within 90 minutes, I've got to be really, really timely in what I do. And so, it does throw up some significant challenges, but I think it's trying to approach a standard of care for our cardiac care patients.

So, I hope somebody from an ER background is on here. That would be great.

Anybody else?

DR. DRYE: This is the developer, Elizabeth Drye from Yale. Do you want me to help clarify that, this time issue, a little bit further?

CHAIR GARMAN: Sure. Absolutely.

DR. DRYE: Okay. Yes, I mean, it's a more complex process measure than usual, in that it's all STEMI patients, and as you all know,

there's three treatment modalities for reperfusion. If it's an onsite facility that can do PCI onsite, it's PCI. Otherwise, providers can use fibronolytics to dissolve a clot or they can transfer a patient if they are not a hospital -- just commenting, obviously, in the rural setting -- that provides PCI to a PCI hospital.

And it's that third category I wanted to clarify. The clock starts ticking for this measure at the facility. So, if you're at a rural facility, it's not holding you to that 90-minute time to PCI deadline, if you're not a PCI hospital. The criterion it measures is do you transfer within 45 minutes. So, you start the transfer process out. So, it's a little less prescriptive or the target's a little more flexible in that way.

But if it's an onsite PCI hospital that's citation-consistent, you know, I think we've had as a field consistent plea for a long

time is the time to PCI would be within 90 minutes.

So, trying to treat those three scenarios fairly across all providers.

CHAIR GARMAN: Great. Thank you. Thanks for that clarification.

Anything else, Keith, on this?

MEMBER MUELLER: No, that clarification was very helpful. Thank you.

CHAIR GARMAN: Anybody else, comments, questions?

Hearing none, Chelsea, back to you.

MS. LYNCH: Okay. I think we are ready to open up the vote for Measure 4, please.

Okay. So, again, we are voting for the suitability of this measure for use within the hospital OQR program.

(Voting.)

It looks like we have almost everyone, but we'll give another about 10 seconds or so.

Thank you.

Okay. We had zero votes for strongly disagree, zero votes for disagree, four votes for neutral, ten votes for agree, and three votes for strongly agree.

So we will move on to the next measure for this same program, which is Breast Screening Recall Rates. This is Measure No. 5.

This measure calculates the percentage of beneficiaries receiving a mammogram or a digital breast tomosynthesis, or DBT, screening studies that are followed by a diagnostic mammogram, DBT, ultrasound, or MRI of the breast in an outpatient or office setting within 45 days. And this is also a level of analysis at the facility level.

And I'm not sure if Ana is still with us. I know Curtis is not. So, I'm not sure we had a lead discussant, but we can at least basically see if Ana was able to join us.

CHAIR MOSCOVICE: Ana, are you here?

MS. LYNCH: I think she may have had

a conflict.

CHAIR MOSCOVICE: Okay. Well, I can offer some initial comments, and then, hopefully, my colleagues on the Workgroup can add some comments.

This is, in my opinion, an interesting measure. It's claims-based. So, that's good. The data is there. And it's an important issue that really hasn't been looked at before.

The challenge, the major challenge, is, well, is there a benchmark for this? And the American College of Radiology suggests anywhere between 5 and 12 percent is a reasonable recall rate. But, if one were to use this measure, it would seem to me, for the population that you're looking at, it would be good to identify what you believe is a clear target recall rate.

And the interesting part of this is that you don't want this rate to be too low or too high. You don't want to be doing it when it's not necessary, but you don't also want to be

missing people who really you need to have them recalled and looked at.

And at least from the description of this, the concern is, for low outliers, they tend to be more rural, small, non-teaching, and for high outliers, it's urban, larger, and non-teaching. So, it has potentially some real impact in terms of low reporting on this in rural facilities.

That's all based on the fact that this is not based on a specific clinical guideline there. The developers looked at getting consensus across clinicians and what the literature suggests, but there isn't a specific guideline, which, if we had that, we could probably have some benchmarks identified.

But, as I said before, there aren't any CMS measures that address the recall rates for breast screening. And so, I think it's a relevant measure and I don't think the volume issue is going to be as big an issue here in terms

of the initial group of folks who are being screened.

So, I'll leave it at that and just open the floor for conversation. If our physician colleagues have some thoughts, that would be great to hear those.

MEMBER SPENCER: Yes, this is Jesse.

CHAIR MOSCOVICE: Go ahead, Jesse.

MEMBER SPENCER: I was just going to -- a point of clarification: this, then, looks at the amount that were medically necessary that actually happened or they're actually, like you were suggesting --

CHAIR GARMAN: This for radiologists.

MEMBER SPENCER: Yes, okay. Okay. Perfect. Great.

CHAIR GARMAN: This measure, actually, is looking at the radiologists --

MEMBER SPENCER: Right.

CHAIR GARMAN: -- more so than primary care.

MEMBER SPENCER: That makes sense.

CHAIR GARMAN: If I refer somebody for a mammogram, a screening mammogram, how much recall do they have, based on their ability to read that image?

MEMBER SPENCER: Right.

CHAIR GARMAN: And maybe it has to do with our equipment. Maybe it has to do with the radiologists themselves.

But, in my opinion, at first blush, this looks really reasonable, but, from a rural standpoint, when you start getting into the weeds, I would have a hard time supporting this because it looks more at radiology than it does at primary care. That being said, there are some rural facilities who have radiology. So, is it reasonable to look at for them?

We, for instance, refer our patients to another radiology group who is 90 miles away, and I don't have any impact on that. So, whether they do a recall or not is up to them; it's not

really up to me, as a rural provider. So, I'll leave it at that.

CHAIR MOSCOVICE: Other comments from committee members?

MEMBER SCHREIBER: This is Michelle, and I have a comment on the last comment.

If you refer out -- let's say you use a service that's 90 miles away or, frankly, some use one that's 900 miles away -- wouldn't you, though, as the referring provider, perhaps want to know that, so you would adjust your referral patterns accordingly, if somebody were really an outlier? So, could you --

CHAIR GARMAN: Yes, if I have another option.

MEMBER SCHREIBER: Yes.

CHAIR GARMAN: I might, you know, if I have to go 900 miles, I might struggle finding another option. Even at 90 miles, I struggle at that. I've got two groups.

MEMBER SCHREIBER: I just know some

people use Nighthawk nighttime services and things like that.

CHAIR GARMAN: Absolutely.

MEMBER SPENCER: Yes, I mean, if they're able to separate the rural from the urban cohort in that group, though, right? So, if it's a radiologist, and they're looking at the radiologist's numbers, you might not -- I guess it would still pertain. Sorry. Yes, it would still pertain.

CHAIR MOSCOVICE: Yes, I appreciate Aaron's comments. I would just say that in many ways this is more a population-based measure from my perspective. It's really looking at what is happening to women in terms of appropriate follow-up breast screening.

As you said, I think the focus here is not going to be pointing your finger at the primary care physicians. It really is more on the decisions of the radiologists. But I think that's an important issue.

And if there aren't other options, then there need to be other options created if the rate is really extraordinarily high or extraordinarily low. It sounds like on the rural side it's the low part that's the challenge.

Any other comments?

MS. McKNIGHT: This is Liz McKnight. I had a clarifying question.

So, it looks to me like this measure is proposed for the hospital outpatient quality reporting subset. And I understand that it's very similar to a measure that was retired several years ago, the OP9, Imaging Efficiency. I was curious to know, and if this group understood, why it was retired in that form in the past.

And then, a second question would be, since it's going to be potentially added to the hospital outpatient quality reporting, is this a measure that, if you were a consumer, would really give you insights into where you might

choose your care? It seemed to me that it might be difficult to interpret in terms of how I, as a patient, might seek care.

MS. McKIERNAN: Elizabeth, this is Colleen McKiernan from The Lewin Group. We're a part of the development team for this measure. I can go ahead and answer your question.

So, OP9 was a measure that we also developed and that CMS retired most recently a few years ago. And it was retired because OP9 did not align with current clinical practice. So, it did not include digital breast tomosynthesis in a screening or diagnostic modality for the denominator and numerator, respectively.

In presenting the updated measure, we have added DBT to the denominator and the numerator. And then, another change that we made is we did define the range for the recall rates. So, in OP9 we had a ceiling of 14 percent, not 12, and we did not have a lower threshold because

there wasn't one in the evidence that we could locate. So, we just said that values near zero could represent cases of missed cancer. And so, here we're presenting the range as high as to 12 and we're also presenting the DBT in the denominator and numerator. So, those are the changes.

And then, for use by consumers, I agree that this measure provides probably more value to administration, clinicians, et cetera, but I do think it's important to know if the values are inside the range or outside the range. I think that that's more important than the recall rates necessarily.

So, a facility for which the value is inside the range means that they're probably recalling the right number of women to get the follow-up screening. And then, if outside the range, then they may need to implement some quality improvement processes, and some of which were discussed earlier about maybe changing the

way that they read or finding a different radiologist, if they're available, to make their referral. But we're hopeful that the within range and outside of the range is a little bit more interpretable than the exact number that a facility receives for this measure.

CHAIR MOSCOVICE: Okay. Any other final comments?

Okay. I'll turn it back to you, Chelsea.

MS. LYNCH: Okay. Wonderful. We'll go ahead and open up the voting for Measure 5, Breast Screening Recall Rates, for the suitability with rural providers within the hospital OQR program.

(Voting.)

We'll give it another 10 seconds or so.

Okay. I think we can go ahead and show the responses.

So we had one vote for strongly

disagree, two votes for disagree, six votes for neutral, nine votes for agree, and one vote for strongly agree.

And I will be handing it over to Nicolette to talk about our next program.

MS. MEHAS: Great. Thank you, Chelsea.

Next, we'll be talking about measures proposed for postacute care at long-term care programs. The two programs that we will be talking about are the Hospice Quality Reporting Program and the Skilled Nursing Facility Quality Reporting Program. And each of these has one measure in this section that we will be discussing.

I will give a very high-level introduction to the Hospice Quality Reporting Program. It is pay-for-reporting and public reporting program. Hospices that fail to submit quality data will have their annual payment update reduced by 2 percent through fiscal year

2023, and then, by 4 percent beginning in 2024.

And the goal of the program is to address pain and symptom management for hospice patients and to help patients meet patient-centered goals while remaining primarily in the home environment.

So, next, I will introduce Measure Under Consideration 30, Hospice Care Index, which is being proposed for the Hospice Quality Reporting Program.

The Hospice Care Index monitors a broad set of leading claims-based indicators of hospice care processes. There's 10 indicators and they reflect care throughout the hospice stay and by the care team within the domains of higher levels of care, visits by nursing staff, patterns of live discharge, and per-beneficiary spending.

Index scores are calculated as the total instances a hospice meets a point criterion for each of the 10 indicators. The Index, thereby, seeks to identify hospices that are

outliers across an array of multifaceted indicators simultaneously.

This is a new composite measure. And most of these indicators are providing new information for areas that are not currently assessed in the Hospice Quality Reporting Program.

CHAIR GARMAN: Thank you, Nicolette.

So, our lead discussants for this are Holly Wolff and someone from IBM Watson Health Company.

Do either of you want to start us out?

MEMBER BROWN-PALSGROVE: This is Heather Brown-Palsgrove. I can speak from IBM Watson Health, but if Holly is ready to start, I can also jump in.

I'll go ahead and start. Holly, please jump in.

I wanted to paste into the chat some of the 10 indicators that are part of this composite. I'm having limited success. So, I'm

going to paste the first part, and then, hopefully, the second part can be a second chat.

But I will note that this is an index and a new measure, as Nicolette had mentioned. This really came in response to feedback from public comments and stakeholder associations for a need for a measure that reflected the multifaceted approach for hospice. Hence, the index approach and the indicators that were selected.

I hope you can read that, if folks are interested in taking a look at the 10 different indicators.

They conducted a stability analysis with two years' worth of data that suggested that this would be a sound approach. It sounds like, in developing this, it was a very thoughtful approach mentioning the stakeholders, as I said before, and then, also, leveraging a technical tech from CMS and the HQRP who weighed in as well.

This is using claims data from

Medicare Part A in rural beneficiaries. And I took notes because there's no many screens that I have up.

I think the question here -- and this is a really interesting measure and it's new, and again, it was wanted -- I think the question here is whether or not this is appropriate for the purposes of these recommendations and for a rural setting.

I did look around a little bit, you know, because the stakeholders mentioned -- MACPAC was among them, OIG. MACPAC did do a study looking at hospice services. And it sounds like the use of hospice services has increased since 2000. And so, it has increased in the rural areas, but there, obviously, is more limited access to hospice services.

There is an exemption clause in this measure that hospitals with fewer than 20 discharges will not be counted.

And I'm really looking forward to

folks weighing in with some of their perspectives on hospitals in rural settings, given this important measure.

CHAIR GARMAN: Thank you, Heather.

Is Holly available to give us her comments?

If not, anybody else have any other thoughts on the Hospice Care Index measure?

MEMBER COLE: This is Collette.

I just have a question, just briefly. Looking at the specs, I'm wondering about the feasibility in the testing. It seems like a really, really complex measure. If it can be accomplished by evaluating claims without human intervention or submission of data or more burdensome, then I would be for it. But I'm just curious about the testing and the results of that, if anybody has any feedback about that.

MR. LEVITT: Yes. Hi. This is Alan Levitt from CMS. I'm not sure if you can hear me.

CHAIR GARMAN: Yes.

MR. LEVITT: Again, as you mentioned -- and thank you all for your thoughtful comments -- the measure is claims-based and it's based on those 10 indicators. And the way it's set up, it's really the outliers for those 10 indicators. So, in other words, those hospices that may fall, let's say, within either the top or bottom 10 percentile within those indicators would be the ones that would perhaps not receive a score for that indicator. And so, essentially, it's a measure that would look at those that really are the outliers.

And regarding the testing of the measure, particularly one of the things that we're concerned about and do care very much about is the rural setting, and particularly in home health and hospice we are. And so, one of the things we look at for measures that are developed in hospice, for example, is really how our rural hospices are performing on this measure. And

when we look at that, for example, the scores are just as good as urban hospices. And so, that was very reassuring in regard to that.

In terms of another issue that may come up from the standpoint of the rural setting and rural hospices is reportability. And when we look at that, again, the reportability appears to be anywhere from, depending on which quarters you start using, anywhere from 85 to 87 percent of the hospices would be able to report on this measure using the '20 claims as well.

I'm not sure if that helps to answer some of the questions.

CHAIR GARMAN: That was great. Thank you.

Collette, did you have some comments? I saw you --

MEMBER COLE: Oh, I was just going to say, so it's pretty much algorithm-driven then, the calculation?

MR. LEVITT: Hold on a second. Well,

the answer would be yes. I mean, essentially, it's based on the data is coming from claims, and again, it would be based on how they are performing within that particular indicator.

MEMBER COLE: Okay. Great. That answers my question. Thank you.

CHAIR GARMAN: Thank you for those comments.

Anyone else with questions or comments?

Great discussion.

Hearing none, we'll turn it back to you, Nicolette, I believe.

MS. MEHAS: Great. Thank you, Aaron, and thank you to our discussants and the committee members as well, and the clarification. I think it was helpful for this measure.

So, we will go ahead and open up the voting. We are voting on the measure Hospice Care Index, whether it is suitable for use with rural providers within the program of interest,

which is the Hospice Quality Reporting Program.

(Voting.)

I think we have 18 votes that have come in. So we'll go ahead and close voting.

And the results for the Hospice Care Index measure are as follows: zero votes strongly disagree, one vote disagree, five votes neutral, twelve votes agree, and zero votes strongly agree.

Chelsea, I'll turn it back over to you.

MS. LYNCH: Great. Thank you, Nicolette.

So, the next measure is for the Skilled Nursing Facility Quality Reporting Program. This is another pay-for-reporting and public reporting program.

Skilled nursing facilities that do not submit the required quality data will have their annual payment update reduced by 2 percent.

The goal is to increase transparency,

so that all patients are able to make informed choices.

The measure under consideration here is Measure No. 2, which is the Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization.

This is an outcome measure that will estimate the risk-adjusted rate of HAIs that are acquired during skilled nursing facility care and result in hospitalization. This measure is risk-adjusted to level the playing field and to allow comparison of measure performance based on residents with similar characteristics between SNFs.

It's important to recognize that HAIs and SNFs are not considered never-events. The goal of the risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs that are required during SNF care and result in hospitalization when compared to their peers.

This is a general HAI, not infection-

specific, and the level of analysis is at the facility and state level.

CHAIR MOSCOVICE: Okay. I think the lead discussants -- well, Ana Verzone is not on. So, it would be RUPRI Center.

Comments?

MEMBER MUELLER: Yes. The description that's on your screens is pretty thorough. I would just add a note here that it does require a 25-case threshold for an annual report, but that something like 86 percent of all skilled nursing facilities meet that threshold. There was not an urban-rural breakdown on that.

It seems reasonable. I mean, the use in the program is reporting. You're not assessed based on that report. And the intent, as I read it, is to get a better understanding, as it implies in the short description, of the distribution of rates across skilled nursing facilities, so that, then, we can take further action.

CHAIR MOSCOVICE: Thanks, Keith.

Any other comments from our Workgroup members?

Okay. I would just add, before I turn it back, that I think HAIs are an important issue for SNFs, and it's not just rural, but urban also. And so, I think it's an important measure.

I'll turn it back to Chelsea.

MS. LYNCH: All right. Amy, if you could open up the voting for the Skilled Nursing Facility HAIs Requiring Hospitalization.

Did we lose Amy and her shared screen?

Carolee or someone from the team, are you able to cover for Amy, so we can get our last vote before our break?

Oh, it looks like Amy is back on. Perfect. Wonderful. Thanks, Amy. Okay. Great.

So the voting is open.

(Voting.)

We're at 17. We'll give another minute or two, or not minute or two, but second

or two.

Okay. Let's go ahead and show the results.

So we had one vote for strongly disagree, zero votes for disagree, zero votes for neutral, 15 votes for agree, and two for strongly agree.

That wraps it up. We got right back on track. So, thank you, everyone, for that.

Since we are a little ahead of schedule, we will make our next break 15 minutes, but still come back a little bit early, which will allow for a little bit more time for any questions and answers related to the COVID presentation that we will receive after the break. So, we ask everyone to come back at 2:35.

(Whereupon, the above-entitled matter went off the record at 2:21 p.m. and resumed at 2:38 p.m.)

MS. MEHAS: Okay. I think hopefully folks have had the chance to join us again. I

wanted to welcome everyone back this afternoon, thank everyone for your participation so far.

So next we will be discussing the timely and important topic of measures for COVID-19. We'll have the opportunity to hear from colleagues at CMS before the workgroup discusses each of these measures, but before that I would like to turn it over to NQF Senior Vice President Sheri Winsper for some introductory remarks.

MS. WINSPER: Thank you, Nicolette. I wanted to just provide a couple of introductory remarks regarding the COVID-19 vaccine measures and give a little bit of perspective related to how NQF did the preliminary analysis and followed our selection criteria and just wanted to clarify one or two things.

So you'll see in the preliminary analysis that for the COVID vaccine administration for healthcare workers and then patients that it resulted in a do not support with mitigation recommendation, initial

preliminary recommendation. I wanted to clarify that NQF does fully support appropriate vaccination for all kinds of illnesses, of course those that have been tested and are safe and appropriate, whether that's the flu, other illnesses or in this case COVID-19.

We wanted to just clarify that the support of vaccines and giving them is different than evaluating a measure that would specify how we should be able to measure the administration of those vaccines. So just wanted to be sure that that was clear.

What we did is with our selection criteria, we wanted to be sure we were maintaining the integrity of our process and also the MAP process for evaluating measures. And as you know there are several selection criteria that were looked at. So when we looked at the selection criteria we followed that algorithm and it resulted in the initial preliminary recommendation.

What really we're being tasked with, or you all are being tasked with today is to really look at providing feedback to CMS on whether is this the best way to measure COVID-19 vaccine administration for healthcare workers, and then I believe there's one for patients as well.

So evaluating a measure and whether it's a good specification and way to measure quality or a clinical intervention is different than in our minds whether we support just the particular clinical intervention in general. So just wanted to clarify that and that it does not mean that NQF does not support vaccination, and in particular for COVID.

So I'll turn it over to Dr. Michelle Schreiber to also provide some introductory remarks, or presentation.

MEMBER SCHREIBER: Yes, thank you, Sheri. We just wanted to frame the conversation because this is very new, frankly for all of us,

us at CMS, you as providers and NQF.

By the way, Sheri, we completely understand why and the rationale for why NQF came to the recommendation that it did and recognize that you are not anti-vaccine. It is the way that we evaluate measures that we cannot bring to you, to NQF nor to any of you any validity or reliability data on a COVID vaccination measure because that doesn't exist. The data doesn't exist.

And so in that sense this is very different how we are bringing a quote, unquote measure forward to you with as much information as we have, but without the same validity and reliability and testing that you would normally come to expect from us in a measure. And so we certainly understand what your rationale was at NQF, and maybe the rationale of the Committee, but let us frame it a little bit.

And the reason for us wanting to even bring this forward in such an initial stage is

that we couldn't introduce measures into our programs without going through the MAP process. The MAP process if you all recall is statutorily required that we get comment on measures before putting them into programs, and for us not to bring this forward would have meant an entire year's delay in even any consideration for being able to bring measures forward.

And so we are providing you with the best and most recent information that we have in an ever-evolving situation, quite honestly, because we would like to include vaccination in any quality program for transparency, public reporting and eventually potentially payment programs because of how important this is to everybody, to public health.

So with that being said, can we advance to -- let's see, the next slide. Keep going.

Okay. So we have several measures that we're bringing forward for you here today.

The first is going to be around COVID vaccination among healthcare personnel across a wide array of settings, okay, including us -- so this is for staff. Okay? This is going to apply to hospitals, to inpatient rehab, to long-term care hospitals, inpatient psych, ESRD. You can read the list yourself. It is a wide range of settings. It doesn't include home health. And sometimes what happens is that there are rules around what data CMS can and can't collect, quite honestly, and so that's why you may see things that may not make complete sense sometimes, but we are introducing a measure on vaccination for staff.

Then we'll be introducing a measure for vaccination of patients -- I'm going to turn this over to Alan in a moment to go through some of the rest of the slides -- for patients in end-stage renal disease facilities, dialysis facilities.

We do not have one, you may note, for

patients in skilled nursing facilities despite all of the press and the publicity in the prioritization of residents in nursing homes getting the COVID vaccine because we couldn't answer some key questions of data collection before this meeting occurred. And so that's why you don't see that, although we certainly recognize that as a high priority area for residents to be vaccinated.

We do not have a proposal for vaccination for patients in hospitals for the reason that the current data is suggesting that maybe it's non-indicated to vaccinate patients in hospitals because of an immune reaction. So there are specific reasons why some things are included and some things aren't.

And finally we do have vaccination of patients at a clinician level in the MIPS program.

We are developing these measures in cooperation with the CDC just as we have

developed measures for influenza vaccination, for example. And the one for staff will be very similar to the influenza staff vaccination again that we have across many sites. And the CDC is the measure steward and we're working very closely and collaboratively with them.

So I'm going to turn the rest of the slide presentation over to Alan Levitt, and Joel Andress will also comment on vaccination by clinicians in the MIPS program.

I know, Andrea, I saw you on the phone from the CDC, and Dan Budnitz may have been on earlier. So the CDC may comment as well, but we did want to set this framework for all of you on the Committee. Thank you. Alan?

MR. LEVITT: Okay. Thank you. Thank you, Michelle.

And for the next few minutes I'm going to give you an overview of the quality measures that we've developed really in collaboration with our NHSN colleagues regarding COVID-19

vaccination.

And as Michelle mentioned, Dr. Budnitz and Patel and their team from the CDC are on the call, both to listen to the discussion and also to help to answer questions, but also please note that at the Joint Hospital and PAC/LTC Workgroup meeting next Monday they will be presenting these measures in a slide presentation in much greater detail.

As we meet the -- continue to meet the challenges of the COVID-19 pandemic, there are important lessons we've learned so far including the importance of our public/private partnership. And as Michelle emphasized before, that's really why we're here today, to present and discuss measures under consideration that under normal circumstances we would likely not be proposing at this level of uncertainty right now. But this past year has been far from normal circumstances, and so I wanted to thank the NQF staff for their understanding and allowing us to present these

measures today.

I mean, we understand the algorithms. We understand how categories are decided and such, but conventional pre-rulemaking and the entire rulemaking process was really not made for times of a public health emergency that we're in now and in terms of the timing and the timelines that are necessary to try to operationalize all of the important data and information that we want to be able to have available to report upon and to have it done in such a timely manner.

And that's why we're here today, understanding all the challenges that we are bringing forward in terms of proposing the measure today, but yet to be able to give you that understanding, to be able to let you ask questions, to continue to be part of this public and private partnership that we value so much.

The first measure I'm going to describe is the one that's listed here, which is MUC20-0044, which is the SARS-CoV-2 vaccination

coverage amongst healthcare personnel, which is going to be under consideration for multiple settings and CMS programs.

When we first started considering the approaches to publicly reporting COVID-19 vaccination data back in the spring we recognized that there would likely be an evolving recommendation regarding vaccine administration such as things as exclusions, contraindications for vaccination, frequency or timing of initial vaccination, and ultimately the frequency of re-vaccination to maintain a COVID-19-free future.

First and foremost I think we should all be enormously thankful for the ingenuity of our vaccination developers to be able to produce a remarkably safe and efficacious vaccine in record time. The data that has been presented either -- if you've read in the literature or in reviewing the review done by vaccines -- by regulators is beyond what I think even the most optimistic of vaccine proponents could have ever

expected, however, recommendations regarding vaccine administration may continue to evolve.

And so in collaboration with CDC colleagues, we developed a healthcare personnel vaccination measure which would allow for these flexibilities in vaccine administration, and the result is this measure of healthcare personnel vaccination coverage that we're going to be talking about today.

Go to the next slide. Okay. The NHSN is the measure steward because they have successfully done these healthcare personnel vaccination measures before. And in this case it's NQF 0431, which is influenza vaccination coverage among healthcare personnel. We built on that success as our CDC colleagues were able to develop data collection forms similar to those used in this measure, NQF 0431, but would also be able to account for any necessary flexibilities based on changes in vaccination requirements and administration over time.

Go to the next slide. Next slide just shows how the healthcare personnel flu vaccination measures get publicly reported on our Care Compare websites currently. This example just kind of shows you within inpatient rehab facilities you can see how -- you can see a comparison of influenza staff vaccination rates for three different facilities.

Go to the next slide. The next slides lists the federal programs that will be considering this measure under consideration for their upcoming rulemaking session. Again they will be presented at the workgroup discussions on Monday in the Hospital Workgroup and in the Post-Acute Care/Long-term Care Workgroup as well, and they will take the discussions that -- and the voting that's done here today -- they'll be taking that in terms of their own deliberations on Monday.

Go to the next slide. The next slides describes the numerator and the denominator for

these measures. Drs. Budnitz and Dr. Patel and their entire team will be discussing the modules that were developed to collect the data for these measures on Monday, but as you can see on the slide the numerator allows for flexibilities as we continue to learn more about how to successfully and safely vaccinate healthcare personnel.

But in summary we will be reporting the percent of eligible healthcare personnel working in a particular setting who are up to date with the current COVID-19 vaccination requirements, whatever up to date might mean in the future.

Go to the next slide. The measure will exclude those healthcare personnel with contraindications to vaccination which will hopefully remain few and far between. And if adopted into our programs the measure would be initially calculated on a quarterly basis by the NHSN for publicly reporting on our Care Compare

website for whatever the applicable healthcare setting would be.

Go to the next slide. The next slide is this next measure under consideration, which is MUC20-0048, and this is the SARS-CoV-2 vaccination coverage for patients in end-stage renal disease, or ESRD facilities. This measure is being considered for the ESRD QIP, and once again would be stewarded by and collected through the NHSN. As noted in the measure description this measure would track once again up to date COVID-19 vaccination coverage of ESRD patients.

Go to the next slide. Similar to the healthcare personnel COVID-19 vaccination measure, the numerator of this measure allows for flexibilities as we continue to learn more how to successfully and safely vaccinate ESRD patients.

And if you go to the next slide, exclusions for this measure would be similar to the healthcare personnel vaccination measure and will hopefully remain minimal. If adopted in the

ESRD QIP the measure would be calculated again on a quarterly basis.

I'll now turn it over to Dr. Joel Andress so Joel can now briefly discuss the CoV-2 vaccination by clinicians measure to be considered by the MIPS Program. Joel?

MEMBER SCHREIBER: Joel, are you muted?

Can you guys tell, is Joel on the line?

MS. DURHAM: Michelle, I IMed him and I have -- oh, he's on the line and unmuted.

PARTICIPANT: Joel, it's Joe from Merck. You might have to hit *6 on your phone.

(Pause.)

MEMBER SCHREIBER: We can go to the next slide until we can hear from Joel. Alan and I will do this.

MR. LEVITT: Yes, is there somebody from -- maybe from Mathematica who's on who could go through --

MEMBER SCHREIBER: Yes, Joel's texting and saying that his unmuting is not working. Alan, I think you and I can do this.

So this is for consideration in the MIPS Program, and it is for patients who are seen by a provider in their clinic, whether or not those patients have had a COVID vaccination and it applies to all patients aged 18 and older seen for a visit during the measurement period. The exceptions here are if a patient receives hospice services, a patient contraindication, in this case patient refusal, although we are continuing to rethink that, and if the vaccine is unavailable.

So the numerator is patients who have never received or who are -- have reported as having received a COVID vaccination dose or if they have completed their course. So it allows for flexibility with that.

On the next slide you can see that again it was the same issue for the measure

development process that we identify this as a priority. In response to the current public health crisis, we do have an expert workgroup who is informing development of the measures. It's not being brought forward for NQF endorsement prior to submitting this for consideration because again the information and the reliability and validity data just aren't available at this point.

Next slide? The implementation then on the next slide, if you guys want to advance it? Thanks.

The implementation then would be potentially proposing this in the MIPS Program in performance year 2022. We realize by that time that we will have much more information to bring forward and frankly recommendations around COVID vaccination. And we're still discussing the best way to incorporate this into MIPS, but we want a measure in the MIPS Program that reflects patient vaccination.

I believe that is our last slide. The pathway for implementation I think that you can certainly all understand.

So that is the last slide. We wanted to make sure that we had just set this background for the group to consider in your deliberations of whether or not you would recommend this and certainly know it might apply to a rural setting. We do understand that this is different than how we have brought measures to this group in the past. I think everybody understands the unusual exceptional circumstances behind that, but CMS is trying to be very proactive with developing measures around COVID vaccination.

And I will pass this back then to NQF. Actually before I do that, if I may, let me ask Alan or the CDC if they would like to have any closing comments first.

MR. LEVITT: Nothing directly from me. Just a note, again I think Joel had mentioned that the slide is correct. Apparently I think

what may be within the specs, that may be on the MUC forms may be different than what is on the slide, but what was just presented on the slides is correct.

MEMBER SCHREIBER: Did CDC want to make any comments?

DR. BENIN: Hi, Michelle. Thank you. It's Andrea. Are you able to hear me?

MEMBER SCHREIBER: Yes, thank you.

DR. BENIN: Thank you. We don't have any specific comments. I can see if Dan Budnitz or Dan Pollack have any additional comments that they would like to make.

I will mention that we are currently having -- data is starting to accrue in the data collection modules for these -- for the ability to calculate these metrics, and so we will very soon hopefully be in a position to be calculating the metrics and using them for the facilities and other stakeholders. So if that's helpful to the conversation. We don't have any data to share

right now, but it's all very new. As Alan alluded to it's really over the past few weeks that we've been starting to collect data. So thanks.

MEMBER SCHREIBER: Thanks, Andrea. Okay. With that we will turn it back to NQF for voting and comments from the Rural Group. Thank you.

MS. LYNCH: Thank you so much. And I will just share that these updates happened after the PAs were sent, and we will send the updated versions after the rural health and public comments have been incorporated.

And before we move on to the rural health discussion I just want to at leave space to see if there are any questions from anybody in the audience before we get into like -- we'll certainly talk about all the measures, but if there are any general questions.

MR. ANDRESS: I'm sorry. This is Joel. Can you all hear me?

MS. LYNCH: Ah, we sure can. Hi.

MR. ANDRESS: Okay. I'm sorry. I just ended up calling back in. I'm sorry. I just -- one clarification to make. Alan did -- and Michelle did a fine job of covering the particular pieces. There's just a point of clarification I need to make.

What Alan was referring to with regard to the specifications -- if we can go back to slide 65 briefly? Thank you so much.

So the main point of -- the point of divergence is really more a matter of clarification. In the original MUC list that we'd provided we noted that the numerator included any patients who had ever received or reported having ever received at least one dose of a vaccination.

We changed that here; and unfortunately that language did not get in the documentation that made its way to you all, to reflect that the patients -- that we'd want to be able to distinguish between those patients who

received at least one dose or who had received a whole course of the vaccination.

The rationale for that is not that -- it's not that it would make a difference with regard to the score on the measure. Either case would be valuable. We would give credit for the -- to the provider for having accomplished either one, but we consider that to be valuable policy making information from our perspective in order to identify the saturation of vaccinations within the population. And a big part of what we view as the role of these measures going forward at least initially in that they'll provide us the kind of information we need to drive policy making decisions around vaccination policies in the future.

And so that's a distinction we think was -- we thought -- believed was important to make, and we want to try to make sure that any feedback we're getting from the MAP, including this group here, is taking that issue into

consideration. And I appreciate the extra time and apologize for the snafus.

MS. LYNCH: No problem. And I think we have another version of the description, so when -- I'll see if there are any other questions first, but then I'll just make sure that we are -- because this is the first measure that we'll talk about. So I just want to make sure we're all on the same page. But any other general questions before we get started?

Okay. So I think we can go ahead and advance like I mentioned.

So the first COVID measure under consideration will be for the MIPS Program, which we discussed earlier, but as a reminder it's a quality payment program that's pay for performance with four connected performance categories, each scored independently and has a specific rate and really looking to reward clinicians for innovative patient care and improving quality of patient care and outcomes

and drive a fundamental movement forward towards value in healthcare.

So that measure again, which you just kind of touched on, was again that -- the COVID vaccination by clinicians. And correct me, Joel, if this is incorrect or where the nuance is here.

But the percentage of the patients aged 18 or older seen for a visit during the measure period who have ever received or reported having received a single dose or the full vaccination course.

MR. ANDRESS: Yes, I think that is the -- let me see.

MS. LYNCH: This is the updated -- okay.

MR. ANDRESS: Yes.

MS. LYNCH: I just want to make sure. Okay.

MR. ANDRESS: Yes, thank you very much.

MS. LYNCH: I thought that sounded

familiar, but I just wanted to make sure I was understanding correctly.

Okay. And as we mentioned the specifications are incomplete, but we will lead off the discussion here. And this is again rural perspective on having this measure about COVID vaccination by clinician in the NIMS Program. And I forget if we left off with Ira or Aaron. Okay. Aaron?

CHAIR GARMAN: Yes, it's me. So our lead discussants are the Minnesota Community Measurement and National Association of Rural Health Clinics. Anybody want to tee this up?

MEMBER COLE: I'd be happy to start. This is Collette Cole from Minnesota Community Measurement. Kudos to CMS for getting a measure, a much needed measure together and ready for use and thank you for the presentation to kick this off. As indicated the specifications are incomplete and not tested. I think they're very fitting in accordance with previous vaccination

measures just like this. And as we're all aware of we are smack in the middle of a pandemic with a new vaccine and mass distribution and vaccination efforts currently underway. And I just have a couple comments.

I know traditionally in the federal program and MIPS and all the measure programs we have fairly strict measurement periods and some date confines that go around that, and I'm hoping as these much-needed measures roll forward that there is continued flexibility. So in particular with some of the exceptions about the vaccines not being available and in terms of a measurement period that perhaps there is some flexibility around those dates as we get further along into this upcoming measurement period or measurement year determining what those date parameters will be when we're talking about measurement.

But otherwise I think it's a great much-needed measure for the rural applicability, and all of us actually.

CHAIR GARMAN: Thank you, Collette. Anyone else, comments? Concerns? Discussion?

I'm not seeing much, Chelsea.

MEMBER SLABACH: Aaron?

CHAIR GARMAN: Yes?

MEMBER SLABACH: This is Brock here. And thank you, Collette, for that discussion.

I guess after the presentation and now looking at what we're going to be voting on I'm not really sure -- I mean I guess I'm conflicted as an -- I mean it's obviously appropriate for rural context, but are we approving the actual measure or just saying that it is appropriate for a rural application? Maybe I'm thinking through this too much, but I'm just not really clear on what we're voting on.

MS. LYNCH: Right now -- so this workgroup votes on the applicability of it to a rural provider. And then that information gets put into the preliminary analysis which is then discussed by the site-specific workgroup. So

clinician, hospital and PAC/LTC, which will discuss it, and kind of vote more towards that approval next week and then as well as the Coordinating Committee later on in the month. So this -- for our discussion it is just about how it affects rural providers and a rural population.

MEMBER SLABACH: And that's despite the fact that it's not -- it's only emergency use authorization and not -- healthcare institutions can't require employees or anybody really to get these vaccines at this point, so I mean this is really an interesting conversation. I'm really conflicted in terms of now setting up a vote.

MEMBER COLE: Oh, I'm just going to -- an additional comment. I might have muddied it by going into the realm of is the measure ready in terms of all those things about incompleteness, but being that this is an unusual circumstance and an unusual kind of set of measures and unusual situation that we find

ourselves in, I guess -- and the presentation that we had just following it that kind of explained all of those issues, I think it's good for us to consider all that, but then again our purpose here is: is it appropriate for the rural setting?

So I think given all of those considerations we can vote. Do we think this is appropriate for the rural setting? It would be easier if it was a standard thing. And I just wanted to share just from my measurement perspective, we've had to put some caveats on measures that we've been traditionally doing for many years, so as we go forward we made decisions that, yes, we're going to proceed forward with reporting our diabetes measure, but we are going to put caveats all over that by saying this is really some unusual circumstances that providers, patients and everyone have found themselves in, so please don't compare these rates to prior year rates. So just kind of understanding that

context.

CHAIR MOSCOVICE: Yes, this is Ira. I guess following up on that can we put caveats on this rather than having just a straight vote? I think that's what Brock sort of --

MS. LYNCH: Yes, and --

CHAIR MOSCOVICE: And I would like to -- I think others would also like to put some caveats on this.

MS. LYNCH: So the discussion that we have as well as the voting results both get -- a summary of the discussion and the votes get rolled into the preliminary analysis. So it's not just a Rural voted an average of 4.5. There is a little bit more detail there, if that helps.

CHAIR MOSCOVICE: Yes, so we should elaborate on --

MS. LYNCH: Speak your caveats, yes.

CHAIR MOSCOVICE: Okay. So it's the speaker, not --

MS. LYNCH: Share your caveats now,

yes.

CHAIR MOSCOVICE: Well from my perspective I mean there are a couple of things to think about, one of which is do we say once it gets approved or endorsed by NQF, then we so forth, so forth or do -- or there could potentially be -- I don't think we're talking necessarily about caveats on the measure itself in terms of how it's being measured as compared to the process it needs to go through for us to say yes, let's use this on the rural population. That's just my thoughts.

MS. LYNCH: I'm happy to open it up to Sam or Matt or Amy who've spent a little bit more time on these COVID measures if you want to discuss it a little bit further on that point.

MEMBER SLABACH: And I would like to caveat too, and maybe this isn't appropriate, so somebody correct if I'm not here, is it -- there's a -- once it gets past emergency use authorization, and it has full approval from FDA

for application in the -- then I would feel like that these measures could be really valid, like we do with the flu vaccine in institutions and within populations.

CHAIR GARMAN: I think that's a really good point. I mean it's still not approved, so the challenge lies there. Anybody else, thoughts, questions?

MEMBER RASK: This is Kimberly. I guess I think taking it from the lens of all of the concerns that we have about specification and role and details are going to be concerns that are addressed by the broader measures community is going to be addressed about whether or not it is endorsed.

And we've certainly seen on some of the other measures that we looked at earlier today that had not been endorsed it said pending endorsement of the measure, but I think where we could be the most helpful is to the standing committee for -- in this case the Clinician

Committee, is there anything that we want them to take under consideration from the rural perspective as they look at this? Do we think that this measure in some way disadvantages people who live in rural communities?

I'm having a hard time seeing that it would. To my mind there's -- this is as important or as useful in a rural setting as an urban setting, so my comment to their deliberations would be I don't see an objection from a rural perspective for this metric, if that makes sense. I think that measuring this would disadvantage our rural providers or measuring this would disadvantage our rural folks.

I mean I'm looking at also -- everything that we've heard is that there are some issues with distribution and getting it to rural folks, so having a metric out there whether you're -- where you're actually measuring this vaccine may be our best way of ensuring that our rural communities in fact get that vaccine. So

that's kind of how I'm looking at it.

MEMBER BARTER: This is Crystal with the Michigan Center for Rural Health, and access was going to be the one issue I brought up, but I believe that they mentioned that this wasn't going to go in effect until 2022, so hopefully our supply and distribution issues are a thing of the past by that point.

CHAIR MOSCOVICE: Yes, that's a good point.

CHAIR GARMAN: Yes, great points. Anybody else?

MEMBER WAGNER: This is Janet. The only thing I might comment is we do see a high degree of pushback on COVID as well as the vaccine in our rural communities. I don't have numbers on rural versus non-rural, but just wonder the impact there.

CHAIR GARMAN: Yes, we see that every day, the anti-vax movement or the vaccine-resistant movement, and it's really challenging

in a rural setting, absolutely.

MR. ANDRESS: Excuse me. This is Joel. I can speak to that momentarily. I mean one of the things that we took into consideration is that, one, we were going to want information on people -- patients who didn't want vaccination, but we were also not in a position where we wanted to hold clinicians accountable for that.

So one of the things that we included in the specifications is a series of exceptions. One of those is for contraindication. Another one is for patient refusal. So we would get the information about that had -- a refusal had occurred, but we wouldn't be penalizing the provider as a consequence of that.

CHAIR GARMAN: Yes, that would be helpful. Any other comments? Great discussion.

CHAIR MOSCOVICE: Yes, this is helpful before we enter into the voting on all these --

CHAIR GARMAN: Anything else?

I think it's Chelsea that I need to turn this back over to.

MS. LYNCH: So Amy, I think we're ready to vote on this measure, which again it is just is it suitable for use with rural providers within the program of interest, which right now we're talking about NIMS. MIPS not NIMS. My apologies.

(Voting.)

MS. LYNCH: So sixteen. We'll give a few more seconds.

(Voting.)

MS. LYNCH: Okay. Amy, I think we can go ahead and show the results. So we had zero votes for strongly disagree; one vote for disagree; one vote for neutral; 11 votes for agree; and three votes for strongly agree. So now we will move to the next measure which will come from Nicolette.

MS. MEHAS: Thank you, Chelsea. So next we will talk about Measure Under

Consideration 48, which is the COVID Vaccination Coverage for Patients in ESRD Facilities. So this one is being proposed for potential inclusion in ESRD QIP.

We talked about this program earlier today, but as a reminder it is the Pay for Performance and Public Reporting Program. Payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Reductions are on a sliding scale which could amount to a maximum of 2 percent per year. And the goal of the program is to improve the quality of dialysis care and produce better outcomes for beneficiaries.

And the measure that is being proposed for potential inclusion in the program is COVID Vaccination Coverage for Patients. So this one is in particular for patients in end-stage renal disease facilities, so it looks at vaccination coverage among patients in facilities and receiving maintenance dialysis and those with

acute kidney injury including in-center hemodialysis, home hemodialysis or peritoneal dialysis is at the facility level of analysis. And we heard a very nice introduction of this measure already by Dr. Levitt.

And so we're interested in hearing your comments on this measure. I'll just give a kind reminder, we're really interested in comments on particular unique considerations about these measures, specifically for rural providers and patients that would be included in these programs. And so going back to our categories, thinking about relative priority, any data collection or reporting challenges, if you can foresee that there would be any problem calculating the measure or potential unintended consequences.

So Ira, I will turn it over to you to facilitate our discussion.

CHAIR MOSCOVICE: Okay. Our lead discussants are representatives from the National

Association of Rural Health Clinics and from the Rural Wisconsin Health Cooperative. The floor is open for your comments.

MEMBER WAGNER: This is Janet. I can go if you'd like. I feel that it's appropriate for the rural community. I don't see the unintended consequences. Would be a good measure for the quality and impacts of class. So being that patient refusal is excluded in this I feel it would be appropriate.

CHAIR MOSCOVICE: Okay. Other comments from our discussants, lead discussants?

Okay. Why don't we open it up to the broader workgroup? Comments from our workgroup members?

MEMBER RASK: This is Kimberly. I'll just say this is a really high-risk group that has a high risk of morbidity from any kind of an infection, high risk of hospitalization. So in terms of a patient population that is -- spends a lot of time in group facilities or receiving

home dialysis they're in and out of care settings it would be I think one of the higher priority groups to ensure that they are being fully vaccinated.

CHAIR MOSCOVICE: Okay. Other --

MEMBER RASK: And I don't -- yes.

CHAIR GARMAN: Oh, sorry.

MEMBER RASK: I'm sorry. No, and then given that I don't see a disadvantage, I don't see it being less of an issue for a rural end-stage renal disease patient than for an urban.

CHAIR MOSCOVICE: Thanks. Other comments from our workgroup?

So I just had one clarifying comment. Are we talking about rural patients in end-stage renal disease facilities located in rural areas, or are we talking about any rural patients who are in any end-stage renal disease? Are we talking about any patients who are just in rural -- what's the rural part of it? Is it the patients, the location of the ESRD facility, or

some other combo?

MEMBER RASK: I would say just from my perspective when I've seen this, I do some work with ESRD networks and they -- we often use rural for both of those. It's their rural patients who are getting dialysis or getting dialysis support in non-rural facilities, and there are also a lot of rural facilities that are providing dialysis to rural patients. I do not -- I often -- I do not see that often broken up separately, but I'm not sure if others have seen it differently.

CHAIR MOSCOVICE: Okay. Other comments from the workgroup members?

I'll turn it back to Nicolette.

MS. MEHAS: Great. Thank you, Ira. Thanks everyone for discussion. We will move to a vote on this measure, Measure 48, COVID Vaccination Coverage for Patients in ESRD Facilities. Voting on suitability for use with rural providers within ESRD QIP.

(Voting.)

MS. MEHAS: We'll give people a couple more seconds.

(Voting.)

MS. MEHAS: Okay. We have 16 total results. I think we can go ahead and close voting. The voting results are as follows. We have zero votes for strongly disagree or disagree, one vote for neutral, 11 votes for agree, and four votes for strongly agree.

Thanks for casting your votes, and I will turn it back over to Chelsea to talk about the COVID Vaccination Coverage Among Healthcare Personnel Measure.

MS. LYNCH: Thank you, Nicolette. So the next measure we're going to be talking about -- we'll be talking about the same measure across various programs. So the voting will be per program and it all relates back to this measure, which is Vaccination Coverage Among Healthcare Personnel. So tracking the vaccination coverage among healthcare personnel

and throughout the various facilities.

Aaron and I will be going through this. Again, we'll do it by -- you want to go to the next slide? Oh, sorry. Go back. Our first one will actually be a continuation of the ESRD -- for -- yes, for ESRD QIP will be the first -- this measure for that program, the one that Nicolette just went over.

CHAIR GARMAN: The ESRD Program. And our lead discussants for this are Michigan Center for Rural Health and the National Rural Health Association.

I wonder if -- I mean the conversation is about the same for all of these groups, right, with maybe little caveats based on location, but I'm not sure that -- I guess I don't know if location really matters if we're really talking about COVID vaccination. So I don't know how you want to handle this other than -- we could vote on each individual thing, but the conversation really is the same conversation.

MS. LYNCH: Yes, I think we do need to vote on every single one, but certainly if the conversation is the same, we can -- we could just make note of that if there's anything additional. But as we are talking we have now switched it over to the healthcare personnel versus to the patients to see if there's any new indications there that people would want to consider.

And we can go a little bit over the programs, too, but it will be the -- so the ESRD QIP, the Ambulatory Surgical Center Quality Reporting Program, the Hospital Outpatient Quality Reporting Program, the Hospital Inpatient Quality Reporting Program, Inpatient Psychiatric Facility Quality Reporting Program, the PPS-Exempt Cancer Hospital Quality Reporting Program, Inpatient Rehab Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, and the Skilled Nursing Facility Quality Reporting Program.

So we do have a little bit of

information about all of those programs through the slides if it's helpful, if people need a little bit more information about the programs themselves, but you can kind see the settings that are coming up.

CHAIR GARMAN: Thank you for that. So --

MR. STOLPE: Just one other thing to note, Aaron, and --

CHAIR GARMAN: Yes.

MR. STOLPE: -- sorry to jump in.

CHAIR GARMAN: No, that's --

MS. LYNCH: Go ahead, Sam.

MR. STOLPE: Some of these are remarkably similar. You do have the option, if the Co-Chairs feel that it's appropriate, to motion to carry the vote from a previous measure. So if in the course of discussion it's looking like the settings really make a big difference as for whether or not the measure makes sense from a rural lens, then it of course would be

appropriate to go ahead and vote.

By NQF's own procedural requirements there has to be a unanimous decision to carry the vote, so if there is no objection you can elect to move forward with having the previous vote from the same measure essentially applied to the -- a different setting. Carry over the results for that measure.

CHAIR GARMAN: Excellent. Thank you for that. Ira, I might need you on this then if we need to do this together. So first I'd ask --

(Simultaneous speaking.)

CHAIR GARMAN: -- Michigan Center for Rural Health or somebody from the National Rural Health Association to weigh in on vaccination coverage among healthcare personnel. And then we can address specific sites and perhaps make a motion to carry this forward, correct? Incorrect?

CHAIR MOSCOVICE: Yes, Aaron, I think it might just be helpful as we go through each

program -- the question is: is there anything different?

CHAIR GARMAN: Yes.

CHAIR MOSCOVICE: And we could see which ones people say that there's no difference, in which case we can carry the vote over if we all agree to that, and talk about -- only discuss in detail the ones where we don't think it's the same.

CHAIR GARMAN: Perfect. So from my understanding at this time we're talking about the End-Stage Renal Disease Quality Incentive Program vaccination coverage among the healthcare personnel in that program.

CHAIR MOSCOVICE: Right.

CHAIR GARMAN: Does anybody want to talk about that? Concerns about that? Issues?

I think vaccination coverage for our healthcare workers is a great idea. Anybody else?

MEMBER RASK: This is Kimberly. I

also agree vaccination coverage for our healthcare workers is a good thing.

One question is I'm wondering in a lot of ESRD facilities as well as long-term care facilities, if I remember from reading the specification it's an employee who spent at least one day during the time period in that facility. We have facilities that share a lot of workers, that workers go across different places. So we probably want to be sure there's a mechanism -- or I'm not sure, something to the effect that if someone -- that worker may have gotten their vaccination someplace else other than the place that's reporting on them. And I assume there's a mechanism for sharing that information, but I just wanted to raise that.

CHAIR GARMAN: That's a great point because people do work in multiple facilities. Any other concerns, statements, comments?

I think then we could move forward with a vote, Chelsea.

CHAIR MOSCOVICE: Well are we voting on this measure, or are we voting on just continuing --

CHAIR GARMAN: I think we have to vote on this measure, and then we can talk -- then we go to the next facility and we can vote on carrying it over or if there's any differences. That's my understanding. Is that correct?

CHAIR MOSCOVICE: Oh, okay.

MS. LYNCH: That's my understanding, too. Is that right, Sam?

DR. BUDNITZ: This is Dr. Budnitz from the CDC. Just wanted to make one point of clarification, and that is to Dr. Rask's question. The measure does include vaccination at this facility or elsewhere.

CHAIR GARMAN: Perfect. Thank you for that clarification. All right. Any other points of clarity or concerns?

If not, let's open up the vote. Again this is for ESRD.

MS. LYNCH: For the vaccination of healthcare personnel suitable for rural providers within the program of interest, which right now we are talking about the ESRD QIP.

(Voting.)

MS. LYNCH: We're at 15, so we'll give it another few seconds.

(Voting.)

MS. LYNCH: Okay. Amy, I think we can go ahead and show the results. We had zero votes for strongly disagree or disagree, two votes for neutral, 11 votes for agree, and three votes for strongly agree.

So the next program for this measure is the Ambulatory Surgical Center Quality Reporting Program, which is a pay for reporting and public reporting program structure. The centers that do not participate or fail to meet program requirements will receive a 2 percent reduction in the annual payment update.

CHAIR MOSCOVICE: So I'll take this

one. And I guess it's the same lead, Michigan Center for Rural Health and the National Rural Health Association. Any comments from those discussants?

MEMBER BARTER: I don't believe I have any in light that it's pay for reporting versus pay for performance currently. That would be only comment at this time.

CHAIR MOSCOVICE: Okay.

CHAIR GARMAN: Yes, nothing further to add.

CHAIR MOSCOVICE: Okay. So can I make a motion that we have the vote for the previous measure be used for this measure also, and then we vote on that motion? Is that how we do this?

MR. STOLPE: No need to vote. It's just if there is anyone who objects.

CHAIR MOSCOVICE: Ah.

MR. STOLPE: So if there's -- if someone says I would actually vote differently on this one, then we would open up the voting.

CHAIR MOSCOVICE: Okay.

MR. STOLPE: Otherwise we'll just move on.

CHAIR MOSCOVICE: Okay. As suggested, if anyone objects to using the same voting, we'd like to hear your comments.

MS. LYNCH: And we will give some time, and if anybody is uncomfortable putting in the chat or speaking up, you can chat me directly and we can do it that way as well.

CHAIR GARMAN: Good.

MS. LYNCH: So we'll give about 15 seconds I guess to make that decision. It's a little harder to do it virtually.

(Pause.)

MS. LYNCH: Okay. No objections from what I can see, so I think we can move onto the next program, which is the Hospital Outpatient Quality Reporting Program. Another pay for reporting and public reporting program where hospitals that do not report data on required

measures receive a 2 percent reduction in annual payment updates.

CHAIR GARMAN: So again I would reach out to the Michigan Center for Rural Health and National Rural Health Association for their comments.

MEMBER BARTER: No additional comments particular to this study or program.

CHAIR GARMAN: Thank you.

MEMBER SLABACH: Same here.

CHAIR GARMAN: Thank you. Anybody else?

Then I would ask if there is any opposition to using the prior, prior vote for the measure?

Again if you're uncomfortable with that, please send something to Chelsea or - nothing.

MS. LYNCH: Okay. I'll give another five seconds just in case someone is a little shy.

All right. I think we can move onto the next program as well, which is the Hospital Inpatient Quality Reporting Program, another pay for reporting and public reporting program where hospitals that do not participate or participate but fail to meet program requirements receive a 1 percent reduction on the applicable percentage increase in their annual payment update.

CHAIR MOSCOVICE: Okay. I'm not sure why the Michigan Center and NRHA has --

MS. LYNCH: We did it by measure, and it's the same measure.

CHAIR MOSCOVICE: Any comments from colleagues at the Michigan Center for Rural Health or the NRHA?

MEMBER BARTER: No additional comments for this program. Thank you.

CHAIR MOSCOVICE: Okay.

MEMBER SLABACH: Nothing here either.

CHAIR MOSCOVICE: Okay.

MEMBER SLABACH: I mean I could

talk --

(Simultaneous speaking.)

CHAIR MOSCOVICE: I think we're in the same situation, so if anybody has an objection to carrying over the previous vote, they can either use the chat or declare it virtually, either way.

MS. LYNCH: Okay. We'll give another five seconds or so.

All right. So I think we can go ahead and move onto the next program, which is Inpatient Psychiatric Facility Quality Reporting Program, which is another pay for reporting and public reporting program where these facilities that do not submit data on all required measures receive a 2 percent reduction in the annual payment updates. So inpatient psychiatric facility.

CHAIR GARMAN: And Brock and Crystal, we're looking to you two again.

MEMBER BARTER: No additional comments.

MEMBER SLABACH: Recurring theme, no comment.

CHAIR GARMAN: Anybody else with comments, concerns?

Hearing none, anybody in objection to using the prior vote?

Turn it back to you, Chelsea.

MS. LYNCH: The next program, please? So PPS-Exempt Cancer Hospital Quality Reporting Program, which is a quality reporting program that is voluntary and data are published on Hospital Compare.

CHAIR MOSCOVICE: Okay. So any comment from our reps from Michigan Center or NRHA?

MEMBER BARTER: I do not. Thank you.

MEMBER SLABACH: Nothing here. Thank you.

CHAIR MOSCOVICE: Okay. Anyone objects to using the prior vote, now is the chance to chat with Chelsea or declare virtually.

MS. LYNCH: We'll give another five seconds.

All right. We will carry those votes forward again.

And now the next program is Inpatient Rehab Facility Quality Reporting Program, which is a pay for reporting and public reporting program. Inpatient rehab facilities that fail to submit data will have their applicable IRF perspective payment system payment update reduced by 2 percent.

CHAIR MOSCOVICE: Brook and Crystal?

MEMBER BARTER: No comment.

CHAIR MOSCOVICE: Okay. Anybody in objection to using the prior vote?

Hearing none, we'll turn it over to Chelsea.

MS. LYNCH: We can give a few more seconds just in case, but yes, I think we are good to carry the votes over again.

And our next program will be the Long-

Term Care Hospital Quality Reporting Program, another pay for reporting and public reporting program where long-term care hospitals that fail to submit data will have their applicable annual payment plan reduced by 2 percent.

CHAIR MOSCOVICE: Okay. Any comments from Crystal or Brock?

MEMBER BARTER: I do not.

MEMBER SLABACH: None here.

CHAIR GARMAN: Okay. Anyone has an objection, now is your chance to use the chat to Chelsea or virtual.

MS. LYNCH: I saw a comment through somewhere else. I'm not sure which question or program it was for. Apologies to Collette out for it, but just want to make sure, it sounded like you were wondering about does a rural setting apply for which -- I apologize for that.

MEMBER COLE: Yes, that was me. That's okay. It was the inpatient psychiatric hospital.

MS. LYNCH: Okay.

MEMBER COLE: And it's okay. We're already beyond that, so it's all right.

MS. LYNCH: But, yes. So all of this would be the rural considerations for any of these things. So if you're -- the rural setting for these locations.

Okay. And my apologies. Did we ask about the -- moving the vote forward already for this one?

CHAIR MOSCOVICE: Yes.

MS. LYNCH: All right. Okay. And no objections, so okay. We will carry the vote forward for this program as well.

Okay. And I do believe this is our last program. So Skilled Nursing Facility Quality Reporting Program, another pay for reporting and public reporting. Skilled nursing facilities that do not submit the required quality data will have their annual payment update reduced by 2 percent.

CHAIR GARMAN: Got to go back to the well. Brock or Crystal, any comments?

MEMBER BARTER: No comment. Thank you.

MEMBER SLABACH: No.

CHAIR GARMAN: Thank you both. Any objection to using prior vote?

And back to you, Chelsea.

MS. LYNCH: All right. Thank you. We will move that vote forward as well. Okay. And then Ira and Aaron, if you would like to open it up to public and member comments.

CHAIR MOSCOVICE: Okay. We're open for public comments, and I guess you can raise your hand on the platform. Has anybody do that?

MS. LYNCH: I don't know if they have yet. Carolee or Amy or Udara?

PARTICIPANT: Janice Tufte has her hand raised.

CHAIR MOSCOVICE: Okay. Janice, why don't --

MS. TUFTE: Hi.

CHAIR MOSCOVICE: -- you share your thoughts?

MS. TUFTE: Thank you.

MS. LYNCH: Oh, I think you just muted again, Janice.

MS. TUFTE: I don't know why it did that. I'm sorry. I'll still learning all the processes, and I appreciate your patience as I go along in the MAP process. I've generally just served on the workgroup, so the MAP Coordinating Committee is a little bit more advanced, learning all these different domains, right?

So I learned a lot on the rural today and I really appreciate everything that was mentioned. And I did write in the chat, I wasn't supposed to, but I found out later -- is I was concerned about the resection and the colon resection, the MUC20-0016, because I've actually had a colon resection and the 15-day prior is a trigger. I don't know, I think it's too short of

a time possibly in rural; maybe it isn't. But even -- I live in Seattle and it was with a 30-day for sure with the multiple tests and meeting with the surgeon before, whatever before the actual resection. So I just think 15 days might be a little short. I think it's something they should look at.

And I just had a question about the diabetes, but you guys answered it. And I wanted to thank you for the patient reported outcomes, and I hope that in the future there might be a rural patient that's involved and very involved with recruiting patients to be involved with NQF. And so right now I think there's one rural individual that's somewhat interested, so perhaps in a year or two we'll have individuals that will be able to serve actually on the workgroup. So thank you for all your work.

CHAIR MOSCOVICE: Okay. Thanks for that comment. Any other comments from the public?

Well I think I'll turn it back to Chelsea or Nicolette. It's one of the two of you.

MS. LYNCH: We'll give just a few more seconds. I know sometimes it's difficult to be done -- get people off of mute, so make sure that we're getting close there.

(Pause.)

MS. LYNCH: Okay. And since we did end up a little bit ahead of schedule and we kind of rushed through some of those programs at the beginning, I think we should take a few minutes and just talk about any gaps that meet the -- from a rural perspective in any of the programs that we've discussed or for any of the measures that we've discussed before we head into the next steps, just since we're a little bit ahead of schedule and we didn't really have time for that during our earlier discussions.

(Pause.)

MEMBER SPENCER: This is Jesse from

Intermountain. I think that it may be worth just reiterating the idea that there were gaps in the -- I guess the prediabetic education services and such as nutrition and also in pulmonary rehab, some of those specialist things. There are gaps there in rural communities that I guess we did address, but I think it's worth readdressing those.

They're not huge hurdles, as we've learned with COVID. Actually a silver lining has been the use of video visits for those types of things, so they're not -- the hurdle is not as big as it has been, but it's still there.

MR. STOLPE: Jesse, this is Sam. Did you have any specific programs that you thought would be a specially good fit for those types of measures?

MEMBER SPENCER: OMAVA is one for prediabetes that I know has been used. And I don't know -- honestly this is just purely based on my own area, kind of what we've used for

prediabetes, but that might be a program that's available to rural communities --

MR. STOLPE: Oh, sorry, Jesse.

MEMBER SPENCER: -- that would be easily --

MR. STOLPE: I meant was there a quality program specifically --

MEMBER SPENCER: Oh, no.

MR. STOLPE: -- that would be important for this?

MEMBER SPENCER: No. No, no, no. Thank you.

MR. STOLPE: Okay. Thanks.

MS. LYNCH: Other thoughts on rural health quality measure gaps?

Are there any other questions or concerns that anyone would like to address with this wonderful rural workgroup that we have here? I know it's been a while since we've all gotten together, so I just want to make sure there's any space for any concerns that people would like to

bring forward related to the Measure Applications Partnership and any measures that we've talked about that maybe we needed to readdress because maybe we rushed through it, especially the cost base measures.

MEMBER SLABACH: This is Brock here. I'll just make a quick comment that first of all thanks to CMS and NQF for the measures that we had under consideration today. I was pleasantly surprised about the unanimity around agreeing that they were more rural-relevant today than they have been in the past. So many of the measures in the past have been totally irrelevant for rural providers, so I want to thank them -- thank you all for that.

And I think that as we go forward obviously there's a lot of things that have gaps, but I don't know that we're going to be able to solve all those this afternoon. But I think we've hit a lot of important topics today.

CHAIR MOSCOVICE: Chelsea, I'm just

wondering, so what do you see for next steps for this workgroup?

MS. LYNCH: What a wonderful transition. I will transition that to Amy.

MS. GUO: It's almost like it was planned.

(Laughter.)

MS. GUO: So I can run us through the next steps for the MAP work, at least for this cycle. So at this point the full MAP Rural Health Workgroup has finished its meetings for this cycle. In the next couple of days NQF staff will be integrating the feedback from today into the preliminary analysis documents and then we'll be circulating those with the Clinician, Hospital, and PAC/LTC Workgroups.

So those workgroups are meeting early next week on January 11th and 12th. I also want to note that at those meetings there will also be liaisons from the Rural Health Workgroup. They'll be present at each of those meetings so

that our discussion from today can be represented. And after those meetings the workgroups' combined recommendations will be shared publicly, and those will be available for public comment from January 15th through January 20th.

After the public commenting period, the Coordinating Committee is slated to meet on the 25th. They will discuss and finalize recommendations, and we are planning on sending final recommendations from all of the workgroups combined to CMS by the end of the month.

We also have a timeline here. Most of that is the same information, but we did want to note that after the recommendations go to CMS, we'll also plan to release a report in March summarizing this year's pre-rulemaking recommendations, but that is what's going -- what's coming up in the next couple of weeks. And I think that's all that we had planned to share for today.

We wanted to thank everyone again for their participation in MAP. And since we have the contact information up here, just wanted to remind the group that if you have any questions or if you wanted to follow up with anything we discussed today, you can always email us at maprural@qualityforum.org.

And I think at this point I would ask Ira and Aaron if there's anything else that you want to share, or do you want to provide any closing remarks?

CHAIR MOSCOVICE: Yes, I would just start by saying obviously thanks to everybody for really putting in almost a full day's work. We were a little bit behind up front, and Chelsea was getting real nervous. Lo and behold, we got done early, so that's great.

And this has been -- from my perspective this has been a really interesting day, and I really do agree with Brock that it was nice to see measures that are very much relevant

out in rural America.

I guess the only other thing I would ask, I hope that we can continue to do work on some new activities as they come forward, and I'm sure Chelsea and Nicolette will make us aware of that if that is to occur down the road. But it's been a pleasure working with the group, and hopefully we'll get a chance to interact in the coming year. So I'll turn it over to you, Aaron.

CHAIR GARMAN: Thanks, Ira.

Yes, I echo those sentiments. I learn something new every time I work with this workgroup. I think it's a great group and highly-educated, well-meaning people, which is really appreciated from a rural doc out in the sticks. So thank you all again. I appreciate it.

And thank the NQF staff for all the hard work that you guys do. And I look forward to working with you all in the future if so desired. Thanks.

MS. LYNCH: Thank you all so much. We

really appreciate all of your hard work and all your attention and hanging and bearing with us as we were trying to get through, making sure -- we didn't know the COVID measures would go quite as quickly as they did, but really great news. But again, thank you all so much for all of your hard work. We truly appreciate it. And please do not hesitate to reach out if you have any questions.

MEMBER SCHREIBER: Chelsea, if I may, on behalf of CMS --

MS. LYNCH: Oh, sure.

MEMBER SCHREIBER: -- I'd like to -- thank you -- I would like to thank the group for first of all spending so much time and thinking through very carefully these measures. We value your opinions. There are many things that came through that we will take back for further consideration. But just wanted to say again thank you to everybody for participating, and thank you again to the NQF staff for organizing this.

MS. LYNCH: Do you want to say anything, Sheri, or are we good?

MS. WINSPER: I was just -- I apologize. I hit the wrong unmute button. I was just going to say thank you everyone for your time today, and we appreciate CMS' partnership as well.

MS. LYNCH: Thanks everyone. Have a great day.

(Whereupon, the above-entitled matter went off the record at 4:00 p.m.)