National Quality Forum
Measure Applications Partnership
Rural Health Advisory Group
Wednesday, December 8, 2021

The Advisory Group met via Videoconference, at 10:00 a.m. EST, Keith Mueller and Kimberly Rask, Co-Chairs, presiding.

Present:

Keith Mueller, PhD, RUPRI Center for Rural Health Policy Analysis; Co-Chair
Kimberly Rask, MD, PhD, Alliant Health Solutions; Co-Chair
Crystal Barter, MS, Michigan Center for Rural Health
Collette Cole, Minnesota Community Measurement
Cameron Deml, National Rural Letter Carriers' Association
Jorge Duchicela, MD, American Academy of FamilyPhysicians (AAFP)
Bill Finerfrock, MD, National Association of Rural Health Clinics
Sandi Hyde, MSPS, LifePoint Health
Perry Payne, JD, MD, MPP, Truven Health Analytics/IBM Watson Health
Rhonda Robinson Beale, MD, UnitedHealth Group
Rena Sackett, PharmD, American Society of Health-System Pharmacists
Stacy Scroggins, PA-C, DMSc., American Academy of Physician Assistants
Brock Slabach, MPH, National Rural HealthAssociation

NQF Staff:

Dana Gelb Safran, ScD, President & CEO
Tricia Elliott
Victoria Freire
Amy Guo
Chelsea Lynch
Susanne Young

Individual Subject Matter Experts (Voting):

Michael Fadden, MD
Karen James, PhD

Cody Mullen, PhD
Jessica Schumacher, PhD
Ana Verzone, MS, APRN, FNP, CNM

Federal Government Liaisons (Non-Voting):

Nidhi Singh Shah, Centers for Medicare & Medicare Services (CMS)
Susy Postal, DNP, Indian Health Service

Also Present:

Kathleen Balestracci, PhD, MSW, Center for Outcomes Research & Evaluation (CORE) Yale University School of Medicine
Susannah Bernheim, MD, Yale CORE
Diana Cardona, MD, American College of Pathologists
Raymund Dantes, MD, MPH, Centers for Disease Control and Prevention (CDC)
Caitlin Drumheller, American Society of Clinical Oncology
Taemi Cho, PharmD, CMS
Stephanie Carter, American Academy of Dermatology
Tamyra Garcia, MPH, Deputy Director, Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards and Quality, CMS
Miriam Godwin, MPP, National Kidney Foundation
Timothy Jackson, Center for Clinical Standards & Quality, CMS
Kris Mattivi, Acumen, LLC
Joseph Messana, MD, Kidney Epidemiology and Cost Center, University of Michigan
Vinitha Meyyur, PhD, Center for Clinical Standards & Quality, CMS
Sri Nagavarapu, Acumen, LLC
Rebecca Onie, JD, The Health Initiative

Sara Pai, PhD, MD, Society for Immunotherapy of Cancer (SITC)
Rocco Perla, EdD, The Health Initiative
Gary Price, MD, The Physicians Foundation
Ronen Rozenblum, PhD, MD, Brigham & Women's Hospital
Ben Shirley, Pharmacy Quality Alliance
Grace Snyder, Center for Clinical Standards & Quality, CMS

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(10:02 a.m.)

Welcome and Introductions

Ms. Lynch: Good morning, my name is Chelsea Lynch, and I'm a Director in the Emerging Initiatives at the National Quality Forum.

I'd like to welcome all of you to our web meeting for the Measure Applications Partnership Rural Health Advisory Group review meeting for the 2021-2022 pre-rulemaking cycle.

We truly appreciate that all of you joined us today and that you're prioritizing this work within your busy schedule. Before we begin, I'd like to share a couple of housekeeping items with the group.

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

Please choose the chat box to communicate with NQF Staff and with each other. During our discussion, we will be using the raised-hand feature and we will put instructions in the chat box on how to do that throughout the meeting.

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

Please note we are recording this meeting and the recording transcript and meeting summary will be posted to the project website when available.

Finally, for Members of the Rural Health Advisory Group, please send an email with a link to Poll Everywhere yesterday, which we will be using to answer the polling questions for each measure under consideration.

Please let us know if you have any problems accessing the link and we will do a test run question before our discussion on the measures under consideration.

I'll briefly go over our very full agenda for today. We'll start with welcoming marks, introductions, and disclosures of interest followed by some opening remarks from the Center for Medicare and Medicaid Services.

We'll provide an overview of the pre-rulemaking approach and the structure for today's discussion. We'll then transition into our discussions on all the measures under consideration.

As a reminder, we will be discussing measures under consideration for clinicians, hospital, and post-acute care and long-term care programs, as well as measures that are being considered for multiple programs.

After discussion of the measures under consideration, we'll transition to an overview and discussion on the Rural Health Emergency Hospital Program.

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

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

I would now like to introduce Dana Gelb Safran, NQF's president and CEO and invite her to share some welcoming remarks. Dana?

Dr. Gelb Safran: Thanks, Chelsea, and let me add my warm welcome to all of you for the December review meeting of Measures Application Partnership Rural Health Advisory Group.

It's really a pleasure to be in front of this group and

NQF is really delighted to continue our partnership with the Centers for Medicare and Medicaid Services in convening the map to provide input for performance measures being considered for use in CMS programs.

The MAP Rural Health Advisory Group is charged with helping to address priority rural health issues, and has been doing this for more than five years now.

Your work has never been more timely or important.

You are not only addressing issues related to low case volumes and other important measurement issues, but the important issues around access and quality for populations residing in rural areas really has been heightened by the COVID-19 pandemic.

I'd like to really thank the Advisory Group members and federal liaisons for taking time and energy from your busy schedules to provide this important input as part of the pre-rulemaking process.

Discussions from previous convenings of the MAP Rural Health Advisory Group have provided important feedback on the measures under consideration by CMS and we look forward to your contribution on this year's measures under consideration.

Finally, I want to offer a special thanks to our Co-Chairs Kimberley Rask and Keith Mueller for their ongoing leadership of the MAP Rural Health Advisory Group.

We look forward to working with all of you over the course of this day and to the discussion ahead. With that, let me hand it back to you, Chelsea, to provide introductions of the Co-Chairs.

Ms. Lynch: Thank you so much, Dana. I would now like to invite our Co-Chairs, Dr. Kimberley Rask and

Dr. Keith Mueller to share some welcoming remarks.

Let's start with you, Kimberley.

Co-Chair Rask: Good morning, all, again.

I'd just echo, as Dana said, we really appreciate you all taking out your time to be able to provide this really important input from the rural perspective to the other Standing Committees.

I know it can look like a daunting agenda, I will admit I feel daunted by it too. But what I would remind you is that the other standing groups are the groups that have the responsibility for accepting measures.

Our role here is to let them know what we as advocates for the rural community would like them to know about those measures, if there are things that we think are particularly pertinent to the rural community, either barriers they may need to consider or else reasons that we would really support this kind of measure being included.

So, if that helps a little bit, I think it's really valuable input. I have been one of the presenters that have presented this information to a Standing Committee and they really do listen.

So, they will very much appreciate our input and I look forward to the rest of today. Thank you.

Co-Chair Mueller: I want to echo Kimberley and welcome everybody to what will be a long day and a very productive one. I'm really looking forward to the discussions around the measures and the input from the Committee.

As Kimberley said, we know this is important to the overall process and will be well received if people pay attention to what we have to say. So, thank you and I look forward to the day.

Ms. Lynch: Thank you both. As a reminder, NQF is a

nonpartisan organization.

Out of mutual respect for each other, we kindly encourage that you make every effort to refrain from making comments related to, for example, race, gender, politics, or topics that otherwise may be considered during the meeting.

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

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

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

Organizational members represent the interest of a particular organization. We expect you to come to the table representing those interests.

Because of your status as an organizational representative, we ask you only one question specific to you as an individual. We ask you to disclose if you have an interest of $10,000 or more in an entity that is related to the Work Committee.

Let's go around the table beginning with organizational members only, please. Victoria will call on anyone in the meeting who is an organizational member.

When she calls her organization's name, please unmute your line, state your name, your role and organization, and anything you wish to disclose.

If you did not identify any conflict of interests after

stating your name and title, you may add I have nothing to disclose. Victoria?

Ms. Freire: Thank you, Chelsea. Like Chelsea mentioned, I will now begin with the organizational members. If you are on the line, please unmute yourself and let us know you are here.

I'll begin with the American Academy of Family Physicians.

Member Duchicela: Good morning, this is Jorge Duchicela, family physician from rural central Texas. I've been practicing for 35 years and I'm a member of the AFP. I have nothing to disclose.

Thank you.

Ms. Freire: Next the American Academy of Physicians Assistants.

Member Scroggins: Hello, my name is Stacy Scroggins, and I am a physician assistant.

I have been a physician assistant practicing in rural Oklahoma, actually southeast Oklahoma in a little town named McAlester for the past 20 years. And I have nothing to disclose.

Ms. Freire: Thank you. Next the American College of Emergency Physicians.

Okay, the American Hospital Association?

Okay, the American Society of Health Systems Pharmacists?

Member Sackett: Hello, everyone, my name is Rena Sackett, it's a pleasure to be here today.

I am a pharmacist by training and I work at the American Society of Health Systems Pharmacist as a Director of Member Relations and I have nothing to disclose. Thank you.

Ms. Freire: I'll go next. LifePoint Health.

Member Hyde: Good morning, I'm Sandi Hyde, I'm the Assistant Vice President of Quality Data for LifePoint Health.

We are a health organization with hospitals in many states, 64 percent of whom are rural and I have nothing to disclose.

Ms. Freire: Thank you, next the Michigan Center for Rural Health? Okay, I will go to the Minnesota Community Measurement.

Member Cole: Good morning, this is Collette Cole.

I'm a clinical measure developer with Minnesota Community Measurement and I wish to disclose we are the measure developer and steward of many pro-PM-based measures in the areas of depression, asthma, orthopedics, and oncology.

Thank you.

Ms. Freire: Thank you, Collette. I will go now next to the National Association of Rural Health Clinics. I will go next to the National Rural Health Association.

Member Slabach: Good morning, everyone, this is Brock Slabach, Chief Operating Officer for the National Rural Health Association. Formally, a rural hospital administrator for over 20 years and I look forward to our discussions today.

Just an organizational note, I do have to step away at 11:00 a.m. Eastern for a prior commitment. It shouldn't be long and I'll be back.

Ms. Freire: Thank you. I will now go to the National Rural Letter Carriers Association.

Member Deml: Good morning, all, this is Cameron Deml, I'm the Director of Insurance Programs for the National Rural Letter Carriers Association.

So really to lead up the rural carrier benefit plan which is the plan that's part of the federal employee

health benefit pro for rural letter carriers of the Postal Service.

So, nationwide plan and nothing to disclose.

Ms. Freire: Next, Truven Health Analytics, LLC, and IBM Watson Health Company.

Member Payne: Good morning, everyone, I'm Perry Payne, the Healthcare Transformation Leader at IBM Watson Health, where I focus on a number of equity issues on quality-related issues and I have nothing to disclose.

Thank you.

Ms. Freire: Lastly, the United Health Group.

Member Robinson Beale: I'm Dr. Rhonda Robinson Beale, senior Vice President in Chief Medical Officer for United Health Group focusing on medical policy.

At United within our company, Optum, there's a lot of focus on rural because of many contracts with Medicaid.

And so there's extreme interest in how rural health networks work but more importantly, how to measure the adequacy and the effectiveness of the rural health. Thank you.

Nothing to disclose.

Ms. Freire: Have any organizational reps joined the call since I started the attendance? Hearing none and seeing nothing in the chat, we can move on to our subject-matter experts.

Ms. Lynch: Thank you for those disclosures. We'll now move on to the disclosures for our subject-matter experts. Because subject-matter experts are individuals, we ask you to complete a much more detailed form regarding your professional activities.

When you disclose, please do not review your

resume. Instead, we are interested in your disclosures and activities that are related to the subject matter of the Advisory Group's work.

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

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

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

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

Please give your name, what organization you're with, and if you have anything to disclosure. Victoria will now go through the roll and call your name so you can disclose.

We'll start with the Co-Chairs.

Ms. Freire: Thank you, Chelsea, I will begin with our Co-Chairs, starting with Kimberley Rask.

Co-Chair Rask: Good morning, I wish to disclose that my employer, Alliant Health, is a QIN-QIO contractor for CMS and an ESRD network contract with CMS. Thank you.

Ms. Freire: Thank you, Kimberley. I will move to Keith Mueller?

Co-Chair Mueller: I'm Keith Mueller again with the Rural Policy Research Institute in the University of

Iowa.

No direct engagement in any of the activities but indirect because our research center does occasionally evaluate programs and there may be a little crossover there.

Ms. Freire: Thank you. Michael Fadden?

Member Fadden: Good morning, Michael Fadden here. (Audio interference) Chief Medical Officer of at Community Health Center (audio interference) 10 years I worked for Cerner Corporation as a medical (audio interference). I have nothing to disclose.

Ms. Freire: Thank you, Mike. Next, Reverend Bruce Hanson. Karen James?

Member James: Yes, I am a Medicare patient and caregiver. I was nominated by Alliant Quality Health, where I'm a member of the Beneficiary Family Advisory Commission.

I'm a medical technologist, I was a hospital lab director. I was born and raised in Iowa, I now live in rural North Carolina and I have no other disclosures.

Ms. Freire: Thank you, Karen. Next, Cody Mullen?

Member Mullen: Good morning, my name is Cody Mullen.

I'm a clinical associate professor at Purdue University and a senior advisor with the Indiana Rural Health Association, where I previously served as the policy research and development officer for the previous seven years.

IRHA has several HRSA grants, though I'm not a PI of any of those.

I also need to disclose that I'm a member of the CMS Quality Measure Development Plan and Quality Measure Index, Technical Expert Panel as well.

Thank you, and like Brock, I have a conflict so I will be off for about a half hour at that time.

Ms. Freire: Next, Jessica Schumacher.

Member Schumacher: Jessica Schumacher on the surgical collaborative of Wisconsin at the University of Wisconsin, Madison.

I'm an associate professor and I'm primarily involved in the performance platform for the surgical collaborative and focus on rural measures specifically and I have nothing to disclose.

Ms. Freire: Next Ana Verzone.

Member Verzone: Hi, I'm not sure if my video is working.

But I'm Ana Verzone, I'm a family nurse practitioner and a nurse midwife and a site nurse practitioner who works in rural areas of Alaska with the Rural Anchorage service unit and other organizations.

The only thing I have to disclose is occasionally I'll receive a small stipend for giving a talk about rural healthcare at different organizations.

Ms. Freire: Thank you. Next Holly Wolff. Have any of our other subject-matter experts joined the call since I started taking attendance?

Thank you, I will now invite our federal government liaisons to let us know if they're on the call. Center for Medicare and Medicaid Services, CMS?

Ms. Shah: Hi, this is Nidhi Singh Shah from CMS.

Ms. Freire: The Health Resources and Services Administration, HRSHA? The Indian Health Service, IHS?

Dr. Pai: Hi, you have Dr. Susy Postal with IHS, thank you.

Ms. Freire: Thank you, everyone. I'd like to remind

you that if you believe you have a conflict of interests at any time during the meeting, please speak up.

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

If you believe that a fellow advisory members may have a conflict of interest or is behaving in a bias manner, you may point this out during the meeting, approach the chair, or go directly to the NQF Staff.

Does anybody have any questions or anything you'd like to discuss based upon the disclosures made today?

Thank you all for your cooperation, I know that was quite a list to get us started. If you have any questions, please reach out to us but we'll go ahead and move on.

I'm very fortunate to be joined by a great team here working on the Rural Health Advisory Group and I'd like to thank Katy, Susanne, Amy, Victoria, and Gus for all of their hard work.

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

I'd now like to hand it over to Tamyra Garcia, the quality measurement and value-based incentives group Deputy at CMS for some welcoming remarks for the Advisory Group.

Ms. Garcia: Hello, everyone, can you hear me clearly?

Ms. Freire: Yes, we can.

CMS Opening Remarks

Ms. Garcia: So, we could go ahead and move to the next slide, please.

Good morning, everyone, as Chelsea shared, my name is Tamyra Garcia. I'm the Deputy Director of the Quality Measurement and Value-Based Incentives Group.

I'm here today on behalf of CMS. Our COMMIT team, which is made up of 120 public servants who work tirelessly to move the needle of quality forward, and Dr. Michelle Scheiber, our fearless leader who I'm sure many of you have engaged with in previous discussions.

So, we'd like to welcome those of you who are new to this group as well as those who have served in this capacity for maybe a few cycles. For those of you who are new, this slide here really describes your call to action.

So, CMS is charged with considering measures under consideration to ensure we are aware of how these measures could potentially impact rural health and rural health outcomes.

I really appreciate the advocacy approach that Dr. Kimberley Rask noted a few moments ago. I thought that was really insightful.

Because your collective expertise and recommendations really well inform what CMS proposes in our value-based programs. So, this activity is statutorily required but with that being said, they are strongly considered for future inclusion.

We aren't just checking a box here, we are really listening to what folks have to say today.

In addition to providing recommendations on what measures should be considered for inclusion in our programs, there's a new activity that's emerging within the last year that the last bullet speaks to here.

This activity, although it's not statutorily required, it

is helpful in terms of providing recommendations on what CMS might consider to be measures that are prime for consideration for removal from our programs.

And this work was noted in the 2021 Consolidated Appropriations Act, so we did want to signal that is a new activity the MAP is engaged in this year.

Next slide.

Okay, so what's really the scope of your work? It was described a few times here but just to reiterate, you're being asked to consider all measures across CMS' value-based programs through the lens of rural health.

As you all know, there are important considerations, common themes in this area, locations, values, in-tax to small facilities, access of course, and unintended consequences, things that we may not be able to take into consideration or understand due to the breadth of expertise that we have on our team that you all are offering to us.

Next slide.

So, in addition to the warm welcome, we wanted to do a few things. We wanted to note at a high-level what we're focused on in the Agency. This slide really describes that and breaks it down a bit.

So, we're currently tracking to several priorities and rural health is included here absolutely, but it was special enough to have its own slide. So, as you all know, COVID-19 is something that has just ravaged the healthcare system.

But folks have been extremely resilient through the challenges and we're interested in continuing to work on our ability to respond to the pandemic so that is absolutely of noted importance and a priority from a CMS perspective.

Next, the promotion of health equity, improving

access, improving outcomes, ensuring timely and appropriate referrals, ensuring that folks have an equitable experience of care across the board.

Whatever sociodemographic, race, ethnic group, whatever their orientation is, it shouldn't be of importance in terms of the type of access to care they have and the quality of care they receive.

Additionally, maternal health and safety. I'm not sure if you all are aware but yesterday was the first maternal health day of action and the White House noted several different activities that were happening across the country.

But terminal health and safety is absolutely a priority in CMS and across the department currently.

So, we wanted to note that here. Mental health and behavioral health as well, resiliency in emergency preparedness, which is also connected to the COVID-19 work we do.

Safety absolutely continues to be a priority, and again, not just patient safety but workforce safety. We saw a lot during the pandemic but there are challenges with workforce safety as well as and resiliency.

Digital transformation is absolutely important to us. We'll talk a bit more about that in the next few slides. The climate change is also something we note of importance.

There's actually a newly established office on climate change and health equity that really takes a deep dive into how climate change impacts both across the country and how at-risk populations are unduly impacted by climate change.

So, natural disasters, different events that result from it, and so there's an office that's focused on engaging a network in really trying to ensure that

we are not experiencing poor health outcomes as a result of climate change.

And then, of course, last but not least, value, that is a common theme that we've seen through many, many years throughout our quality work. Next slide.

So, this slide here of course is a deeper dive into our including initiatives in rural health, which has absolutely been a priority of ours.

In the context of rural health, there are specific priorities that we're tracking to and it's not by any means limited to these things but we thought important to note today.

So, the first is really around the evolution of digital healthcare, digitalizing healthcare and measurements is really truly the next step or the next best step to usher us into the 21st century and our quality work into the 21st century.

So, what we're really looking to do is just harness the power of data by ensuring seamless communication through things like interoperability, digital measures, and that will really allow us to engage in predictive quality data analytics.

We also believe that will really truly allow us to promote health equity better as well due to access to data and the types of data we can have access to.

And then it empowers the patient in a way that they could ensure that data are accurate and included in systems as opposed to interactions that may make them uncomfortable with their providers.

In addition to that digital healthcare work, we are focused on standing up the recently mandated work around emergency hospitals and the quality measures associated with that.

That work was mandated statutorily through the 2021 Consolidated Appropriations Act. So, we're

hard at work on that, as well as a ton of work in the clinician setting.

So, we're tracking to automatic, extreme, and uncontrollable circumstances policies for MIPS and 2021, as well as the MIPS transformation to MIPS value pathways, or MVPs that we refer to affectionately as MVPs.

So, those things are really front and center in terms of initiatives in rural health that we're focused on for the near future. Next slide.

So, in summary, I just wanted to say thank you again for your efforts, your dedication to those of you who have done this for several years and those of you who are new to this work.

Thank you for all that you do. We truly look forward to the feedback that you all will provide today. We want you all to have a peaceful holiday season and are excited to really get to work.

I'm going to turn it back over to you, Chelsea.

Ms. Lynch: Thank you so much. I'm actually going to hand it over to Amy to provide an overview of the approach we'll use during today's discussion.

Overview of Pre-Rulemaking Approach

Ms. Guo: Thank you, Chelsea. So, we'll start off with a brief refresher on the role of the MAP Rural Health Advisory Group in the pre-rulemaking process.

I know we have many returning to Members in this group and we also had great attendance during our orientation meeting in October and we've also mentioned a couple of times already this morning.

So, I think this content will look very familiar to many of you.

But just a one final reminder, the charge of this particular group is to provide input on rural specific

measurement issues, share rural perspectives that are relevant to the selection of quality measures for MAP, and provide input on priority rural health issues such as low case volume challenges.

During our discussion today, the Rural Health Advisory Group will review each of the measures that are in the 2021 Measures under Consideration or MUC list.

And for each measure that we discuss today we're hoping to cover the following points. First, we'd like to hear members' thoughts related to relative priority and utility in terms of access, cost for quality issues that are encountered by rural residents.

We also like to hear your thoughts on any data collection or reporting challenges that a measure may pose for rural providers.

We'd like to hear about methodological problems for calculating performance measures, any potential unintended consequences if a measure is included in specific programs, and finally, any gap areas in measurement that are relevant to rural residents or providers for specific programs.

Our discussion from this week will be shared with the setting-specific groups prior to their meeting and discussions next week.

And those setting-specific groups include the MAP clinician, MAP hospital, and MAP Post-acute Care and Long-term Care Workgroups. The input from the Rural Health Advisory Group is provided to the setting-specific workgroups in a couple of ways.

First, your feedback is incorporated into the preliminary analyses, or PAs, that describe each measure. You'll recall that after the release of the MUC list last week, our team circulated a list of preliminary analyses or PAs for the Advisory Group's review.

These were the documents that included specifications submitted by each measure developer as well as short, written analyses of each measure that were developed by NQF Staff.

Those PA documents will be updated with summary of our discussion from today, as well as the results of polling questions from today.

Those updated versions will then be shared with each setting-specific workgroup so that Members are able to reference them before their review meetings next week.

In addition to the PAs, we will also have NQF Staff attending those workgroup meetings. They will be present to summarize the Advisory Group's discussion for each measure under consideration during those meetings.

If these raise the Advisory Group's input, we'll help lay some of the groundwork for the detailed measure-by-measure discussion next week and they'll help inform the overall recommendations that come out of the setting-specific workgroup meetings.

Now that we've reviewed how the Rural Health Advisory Group fits into the larger MAP structure, I do want to take a moment and talk through the process for today's discussion.

We'll use the same five-step process when discussing each of the measures under consideration today.

First, NQF Staff will start off the discussion by describing the federal program where each measure is being proposed.

Next, we'll have the lead discussant summarize the measure and share their first thoughts on whether the measure should be included in the proposed program, if it's suitable for rural providers, or if

there are any additional questions or concerns they have about the measure.

After the lead discussants share their first thoughts, we will then open up discussion to the full Advisory Group.

Again, the main topics that we want to cover here include relative priority and utility data collection or reporting challenges, methodological problems, or potential unintended consequences that might result from including these measures in programs.

Once we've made it through the discussion we will then ask that group to participate in an online poll.

The polling helps us get a quantitative idea of the Advisory Group's perception of the measure and whether or not the group feels the measure is suitable for use with rural providers.

The polling will use a five-point scale and that will range from strongly disagreeing to strongly agreeing that a measure is suitable for use with rural providers.

After the polling is complete, we will then conclude with a discussion on gap areas for the specific programs that are relevant to rural residents and providers.

And before we continue and start jumping into discussion, we did want to pause here and run through that test question that Chelsea had mentioned at the beginning of the meeting.

We want to make sure that all the Advisory Group Members are able to access and utilize the polling platform. Again, Advisory Group Members should have received an email yesterday evening with instructions for accessing the platform.

If you haven't received that, please reach out to our team and we can send you the link again. We do ask that if you have it handy, please don't put it in

the public WebEx chat.

We only want that to be available for Advisory Group members. So, Susanna, I will hand it over to you to walk us through the testing question.

Ms. Young: Thank you, Amy. So, at this point, we want to do a test question. I do see some are already responding.

So, this question is open and unlocked so you should be able to view and answer this question, what region of the U.S. do you call home?

Let us know if you're having any issues reaching the platform or using the platform. I see we have some responses but not everyone, so we'll give it a few more seconds.

Please reach out if you're having trouble.

Member Verzone: This is Ana Verzone, I'm on a mobile device. Is there something different about that?

Because I went to the polling section and it said there's no poll that's opened, but it seems like this is a poll.

Ms. Young: Are you following the link? Do you have web access on your mobile device?

Member Verzone: I do, I just think the format may be a little different if anybody else can see where that link is. I see the options, tapping on things. Let me see if it will open.

Member Slabach: This is Brock here. I selected my choice and it didn't clear the screen but it said response recorded. Does that mean it was successful?

Ms. Young: Correct, yes. If the question is still open and unlocked, it's not going to clear yet. We only have the first test question open and activated.

Member Verzone: Is this considered a poll?

Ms. Young: Yes.

Member Verzone: Because I go under polling and it says the presenter has not opened a poll, so I'm not sure why it's saying that because I can see the question.

Co-Chair Rask: Are you going to the separate link for the poll or are you just seeing the test question which is in the slide of the WebEx, I'm wondering?

Maybe because of the device I'm on, there's options for sharing content, chatting, Q&A, and polling. And so when I click on polling it takes me to a new page and it says the presenter has not opened the poll.

I don't know if this is because it's the test question.

Ms. Young: If it's a different link, then it's not part of the WebEx platform.

Member Verzone: Okay, so where is everybody else seeing the link? Because I'm on a different device so that might be what the problem is.

Ms. Lynch: The link was sent via email but if it's easier --

(Simultaneous speaking.)

Member Verzone: I've done this before, it's just been a while so I didn't really --

Ms. Lynch: Totally understand.

Member Verzone: When you kept asking me am I using the link, I was looking for it on WebEx but, yes, if it was sent to me I'll find it, thanks.

Ms. Lynch: We can also send you a private message in WebEx if that's easier too, if you can see the chat through WebEx on your phone.

Member Verzone: And then you can have the direct

link. Thank you.

Ms. Lynch: Are you still having a problem too? Looks like you figured it out too.

Member Verzone: Could you send me the link in the private chat? That way I don't have to try to search my email, that would be helpful. Thanks.

Ms. Young: Sure, thank you, everyone. We'll turn it back over to you.

Ms. Guo: Thank you, Susanne. Sorry, I had to take a moment to refind the unmute button.

All right, so with the voting test being completed and hopefully folks figuring out the link, I will go ahead and actually hand it back to Chelsea for any final questions before we begin our discussion on specific measures.

Discuss Measures Under Consideration

Ms. Lynch: Thank you, Amy. Are there any questions about the approach that we're using for today's discussion? You can work through any Poll Everywhere issues for the first poll for the first MUC as called.

I just want to pause to see if there are any questions before we get started. Okay, I think we can go ahead and get started. We're going to start our review with the measures under consideration for the 2021-2022 pre-rulemaking cycle.

Merit-Based Incentive Payment System (MIPS) Program Measures

We'll start with the measures under consideration for clinician programs. For this section, we'll focus on two programs, merit-based incentive payment systems and Medicare Part C and D star ratings.

First, we'll review measures under consideration for the merit-based incentive payment system or MIPS.

This is the quality payment program with a pay-for-performance incentive structure.

There are four connected performance categories, quality, promoting interoperability, improving activities, and cost. Each of these categories is scored independently and has a specific weight.

The final score out of 100 percent will be used to adjust payment for eligible clinicians. This is intended to improve patient outcomes for fee-for-service Medicare and reward innovative high-value patient care.

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

Our first measure under consideration is MUC 2021-125, psoriasis improvement in patient-recorded severity.

This is a fully developed patient reporting outcome measure that assesses the percentage of patients aged 18 years and older who were diagnosed with psoriasis who at the initial visit has a patient-reported age severity assessment performed with a score greater than or equal to 4, and who achieve a score reduction of two or more points at a follow-up visit.

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

Co-Chair Rask: Now we will turn to our discussants. Brock, would you like share your thoughts?

Co-Chair Mueller: It looks like he stepped out for just a minute, looking at the screen here. He'll be right back, I assume.

Co-Chair Rask: Jorge, do you have some thoughts to share?

Member Duchicela: This is Jorge, and I would let

Brock intervene whenever he would like to but from the rural point of view as a family physician in Central Texas, this is good, this is something we can use.

So, I don't have any problems with it.

Member Slabach: Brock here, I don't have any problem with this one either.

I do want to note, and I think we'll see a couple of things on this, and perhaps I'm wrong in interpreting the data that was presented in the sheets on each measure, but this is not NQF-endorsed.

I pause really heavily on that because I'm not sure the intention of the measure is going to be exactly represented in the results. So, I am concerned about that and I'll just express that as part of my comments on this measure.

Co-Chair Rask: Thank you both. Does anyone else in the Advisory Group have a comment they would like to share on this measure?

I see one comment in the chat, how do you account for low population numbers and the lack of statistical equity?

What I would say is this, since this is part of the MIPS program, this is one that is reported by clinicians. So, a clinician would choose to report this, this is not something that is calculated at population level.

Brock, do you concur with that?

Member Slabach: Yes, I would. It would apply mostly to clinics that have maybe dermatology and other clinics that have more presentation of these types of cases.

Member Robinson Beale: This is Rhonda, I'm the one that asked that question. Do you post what

would be a minimum-size population so that a physician would know whether or not they would really qualify for equitable display of performance on this?

Co-Chair Rask: That is a good question, I'm not sure I can answer that. I believe under the MIPS program there is a certain number of patients that a physician is required to report on for each measure and again, it is voluntary.

So, a clinician would choose to report this measure, they would not be required to report this measure. Any other thoughts or comments on the psoriasis measure?

I would add I think it's nice that we really are looking for more patient-reported outcome measures so this is a nice addition to the argumentarium.

Member Slabach: Does anyone know, Kimberley, if the measure is being presented to NQF for endorsement?

Co-Chair Rask: I do not know that answer to that. Is any of the Staff aware of the answer?

(Simultaneous speaking.)

Ms. Lynch: Go ahead.

Ms. Garcia: I figured we could try to see it on both ends, checking with the CMS team and then you can check on the NQF side to see if there's any feedback on whether or not this is being included for endorsement.

Ms. Lynch: Tricia, Matt, or Taroon, do you know the plans for this measure and it being submitted to NQF for endorsement consideration or evaluation?

Ms. Elliott: We're doing a quick check, Chelsea. I don't see it in a current cycle but we'll double-check though.

Co-Chair Rask: Certainly, that also could be added to our comments, that the Advisory Group prefers NQF-endorsed measures and have the Workgroup take that under consideration as they consider it.

Member Slabach: This may be a CMS-generated measure, I don't know if there's an outside measure steward that is going to be submitting this for endorsement. So, that could be the answer, I'm not entirely sure.

Ms. Carter: Hi, my name is Stephanie Carter, I'm with the AAD and we are the stewards of this measure. I just wanted to announce that I'm on the line if there are any questions that I could help answer.

In regards to the NQF endorsement, we have not recently submitted this measure for NQF endorsement but it's not out of the question. It's just it has not been submitted for endorsement recently.

So, yes, I did want to say that and in regard to the previous question, CMS does have case minimums if a clinician would like to report the measure.

Co-Chair Rask: Thank you. Any other discussion from the Advisory Group before we move to polling on our overall recommendation?

Member Robinson Beale: I don't know if you can see, I raised my hand.

Ms. Lynch: I just saw that, sorry, Rhonda.

Member Robinson Beale: I just wanted to make sure it's working. Thank you, it's so great to have the organization putting forth the measurement. Just a quick question, why 18 years and older since psoriasis is seen in children also?

And again, I'm looking at it from the volume in rural areas in terms of having enough patients that could be counted into this measure. So, I'm just

wondering why 18 years and older?

Ms. Carter: We did consider that. Primarily, we selected 18 years and older because the tools that are included in the measure, at least one of them was validated for inpatients that were 18 and older.

So, that's primarily why the measure was specified in that way, but that can be something that we can take back and further discuss. When it was originally developed, that was why, because of the validation of the tool.

Member Robinson Beale: Thank you, I appreciate your answer.

Co-Chair Rask: Other comments or questions?

Member Slabach: Before we vote, this is just a question. I'm inclined to vote for the measure but I'm really concerned about its lack of NQF-endorsement.

So, do I vote no because of the lack of NQF endorsement or do we have a provision that strongly suggests the Advisory Group strongly suggests it be NQF endorsed.

Co-Chair Rask: All right, I'm going to turn to the Staff. I think I remember us having done similar things before?

Ms. Lynch: Yes, just to clarify, the polling is about the suitability from a rural perspective, and so firmly suitable to most suitable, it's not a recommendation for the measure to go into the programs.

They're really just the perspective from a rural perspective. So, I think you can take that into consideration with NQF endorsement, maybe it's seen as being suitable.

So, it's really more is the psoriasis measure suitable from a rural perspective? And then from the

quantitative side can leave the comments about NQF endorsement on that side.

It's a cross between the two so there's no direct way to really impact that but that's how we do the qualitative and the quantitative summaries for the workgroups.

Co-Chair Rask: Thank you, Chelsea, for that clarification.

With that in mind, the idea of the polling is taking this measure, how relevant or useful would it be in a rural setting, with a one being not very relevant or useful and a five being very relevant or useful in a rural setting.

And then the other comment will be included and shared with the Workgroup. Are we ready to move to the polling?

Ms. Lynch: I think Rhonda has her hand raised again.

Co-Chair Rask: I'm sorry, thank you.

Ms. Lynch: That's okay, I just saw it.

Member Robinson Beale: I apologize for being so inquisitive but my question on this, do we have any sense of the prevalence of psoriasis in rural communities?

The reason I bring that up is that in looking at rural communities there's certain conditions that have a higher prevalence than others.

That would certainly speak to the relevance of this particular measure or the importance of this measure, those that are practicing?

I just wonder if we have that information?

Ms. Carter: I was trying to look up overall prevalence. I don't have information specifically on

rural prevalence data on psoriasis. But again, that can be something that I can look further into.

Member Slabach: This is Brock here. I just had a question or maybe a comment. I don't look at this as having a rural interface necessarily because I believe this is a problem that would impact urban and rural populations equally.

I don't know that but that's my sense. So, the question for me is, is there something inherently problematic for rural application within this measure itself?

And I don't find this to have any problem in terms of its rural application outside of lacking its NQF endorsement.

Co-Chair Rask: Any other comments or hands raised that I'm not seeing?

Ms. Lynch: I don't see any hands raised.

Co-Chair Rask: Are we ready for the polling question then?

Ms. Lynch: I think so. While Susanne pulls that up, again, just a reminder that this measure's suitability from a rural perspective is not a recommendation for it to go into the program.

That comes from the Workgroup.

Ms. Young: Thank you, Chelsea. The poll is now open for MUC 2021-125, psoriasis, improvement in patient-reported itch severity within the Merit-based Incentive Payment System.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program. I'll give it a few more seconds.

The poll is now closed for MUC 2021-125 for the Merit-based Incentive Payment System. Zero

members strongly disagreed, zero members disagreed, one member was neutral, 11 members agreed, and three members strongly agreed.

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

Ms. Lynch: Thank you, everyone, back to our first measure so that's wonderful and we'll move on to the next. The next measure is MUC 2021-135, if you could advance the slide?

So, this is very similar to the measure we just reviewed about psoriasis but it's about dermatitis.

So, this is a fully developed patient-reported outcome measure that assesses the percentage of patients aged 18 and older with the diagnosis of dermatitis where an initial visit has a patient-reported itch severity assessment performed with a score greater or equal to 4 and who receive a score reduction of 2 or more points on a follow-up visit.

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

Co-Chair Rask: I see Brock had to jump off. A quick comment before you jump?

Member Slabach: Perfect timing and I apologize but, yes, this is I think ditto from the last conversation on psoriasis. So, again, no NQF endorsement, I'll just make that note.

It applies just like it did before, so that's my quick comment on this.

Co-Chair Rask: Jorge, your thoughts on this measure?

Member Duchicela: Yes, I agree with the conversation from the previous diagnosis of psoriasis and the methods. And I look at it from a work-flow-type issue and how we as clinicians

decide which MIPS to take and how is that going to interfere with the work flow.

It seems to me it's a relatively easy thing to do and it's something that we have not looked at.

At least, we've spent a lot of our time with obesity and diabetes and hypertension and all those things, which are hugely important, but from the continuity care and also the access of care, itching is a big deal.

If someone itches and they cannot stop that, someone needs to take care of that and it gives the clinician the opportunity to take care of other things because the patient will come in.

So, for us to pay attention to this and not be in such an intrusive type of tool to test and to follow up I think is good. I don't see anything wrong with it.

Co-Chair Rask: Thank you, I appreciate your comments also. Any other comments or discussion from any Advisory Group Members? Any questions for our discussants?

I do not see hands being raised but please double-check me.

Ms. Lynch: I don't see any either.

Co-Chair Rask: All right, not hearing anyone opposed to moving to polling on this metric? Sounds like we're ready to go.

Ms. Young: Okay, the poll is now open for MUC 2021-135, dermatitis, improvement in patient-reported itch severity within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed measure. I'll give it a few more seconds.

The poll is now closed and locked for MUC 2021-135

in the MIPS. Zero members strongly disagreed, zero members disagreed, zero members were neutral, ten members agreed, and four members strongly agreed.

MUC2021-063: Care Goal Achievement Following Total Hip Arthroplasty

Ms. Lynch: Thank you, everyone.

I'll now move on to the next measure under consideration. We will be discussing MUC 2021-063: Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA).

This is a fully developed patient-reported outcome measure that assesses the percentage of patients aged 18 years and older who have had a Total Hip Arthroplasty or Total Knee Arthroplasty during the performance period and who completed both a pre and post-surgical care goal achievement survey, demonstrated that 75 percent or more of the patient's expectations from surgery were met or exceeded.

This measure is at the clinician level of analysis, is not endorsed by NQF, and the measure will be reported as is two risk-adjusted dates stratified by a procedure, so a THA or TKA.

Co-Chair Rask: Thank you, Chelsea. Rhonda, would you like share your thoughts on this measure?

Member Robinson Beale: In terms of looking at this, it certainly is an area where there is a lot of activity.

I would question, and I question from a clinician's perspective, this is not my area of expertise, how comfortable is one with meeting a patient's expectations as it relates to a procedure like this?

And would that in some way limit the use of this particular tool if patients have high expectations of total pain reduction or lack of pain in terms of

actually wanting to use this?

Because you'll never score well on this. So, I just raise it from that perspective.

Dr. Rozenblum: This is Ronen Rozenblum, I don't know if you see me and hear me.

Member Robinson Beale: We barely hear you.

Dr. Rozenblum: This is Ronen Rozenblum, I'm the measure developer lead for the Brigham & Women's Hospital, also the steward. And we developed this measure just mainly because of this question.

So, this is one of the PROMS and PRO-PM that really focuses on the patient goals and expectations, which is a high priority of CMS now in BOW, and we believe, strongly believe, this measure will promote patient engagement.

And the idea here is not so much to meet the patient expectation as much as to really engage patients in the decision-making and to encourage providers, clinicians, and surgeons to have conversations with patients about their expectation and goals, and basically, making a decision according to that.

This is the main idea. Our belief is based on a very comprehensive work, qualitative, with patients, providers, and payers.

That's a lot of value to promote patients and their care, but as well as to have a benchmark so payers and providers really thought it was as good idea to create a benchmark which doesn't exist.

There's not currently any measure in PRO-PM that really addresses care goal achievement, which is at the heart of patient-centered care.

Co-Chair Rask: Thank you. I see some questions in the chat but first I'd like to give Karen an opportunity to share your thoughts on this measure,

and then we'll open it up for broader conversation.

Member James: I think both Rhonda and the latest speakers' comments are appropriate. My concern is that I think patient expectations, like Rhonda, are not measurable.

So, can there be something added to this with some kind of a review with their physical therapist?

Because all of these patients go through physical therapy and the physical therapists are going to know whether it was a successful procedure or not, maybe more than the patients will.

Co-Chair Rask: Yes, I was going to say this may relate to one of the questions in the chat.

Is there a standardized tool to collect these expectations and goals, how are they administered, and are the questions asked by the provider or does it require another separate survey administration?

Dr. Rozenblum: So, I would be happy to address this. This project took us three years, it was sponsored by CMS.

We developed this measure in a comprehensive way doing environmental governmental system mixed-method approach of quantitative and qualitative, where we develop two surveys, pre and post total hip and total knee replacement surveys, which were based on, as I mentioned, focused on patients, providers, and payers.

We did the cognitive testing, the validated test, there's no additional burden, not for rural and not for other populations in 223 minutes.

Then we tested the two surveys that assess expectations and focusing on three main domains in total hip and total knee, which is pain, which is physical function and wellbeing. So, it's capturing the main domain, it's completely in line with the other measures in orthopedics, in PROMS and not

PROMS.

Then after we validate the measure in cross-sectional setting, we actually did it prospectively for two years where we took a cohort of patients that took the measure before and after.

And basically, we looked at any other PRO-PM per data sets.

So, to the question, we have developed measures that we believe are valid and are asking basically a patient about their goals and expectations, which is very subjective and there's a lot of value in that.

To the question of how these surveys are administered, we tested and that's what we recommend, to use these surveys in different modes. So, these surveys can be completed by patients in HR.

So, we actually incorporate that into Epic and patients were be able to fill out these surveys in the clinic using iPad or via the patient portal, as well as on paper.

So, basically, we found that these simple surveys can be completed by paper base or EHR similar to any other measure, and that's why we don't think there's any issues with rural clinics that don't use EHR.

So, it's very flexible.

Member James: I have a concern from a rural perspective because I think the patients in the rural areas are probably going to have many more patients that are obese, overweight, and will have different sets of expectations based on their physical size when they get these procedures done.

If there's something that can involve that or something that can be added to that to clarify this?

Dr. Rozenblum: Yes, so I really respect that.

So, based on measure experts, other measures in the field that we did the environmentals in and all the input that we received, we did, as you see in the slide, we suggested our measure for age, gender, and BMI.

So, this basically exactly your concern, we addressed that so we are, basically, managing that by risk adjusting for BMI. So, it's to the point.

So, we don't have any concerns about that because it's already risk-adjusted. Thank you for this question.

Ms. Lynch: Sandi Hyde has her hand raised.

Member Hyde: Thank you. I do believe that patient expectations are important.

I do wonder, however, has any consideration been given to a mode adjustment study, like they did for HCAT, to evaluate whether or not individuals with EHR access versus paper access would answer differently?

Especially since most other rural communities will probably be on paper and urban areas may be more likely to be through the EHR portals.

Dr. Rozenblum: Thank you for this question, I think it's a good question. So, as part of the measure development, we also did some testing, as I mentioned, in different modalities.

But we also did test-RETEST when patients took it via REDCap in papers. There's a step and we personally didn't see any differences.

I'm not saying there couldn't be differences but we didn't see and we don't anticipate that they will have any differences. It's a very simple, straightforward measure which is also important to say in the context of rural, that doesn't require any other measure, as well as doesn't require the limitations basically to go to the clinic to be relying

on something, another requirement.

It's a very simple question about their expectation and how else before and after.

Member James: Will doctors be rated based on the patients get them 75 percent of them have the expectation met?

Will doctors be decided whether they get paid or how they get paid based on that?

Dr. Rozenblum: Yes and no. Basically, there is a specification that 90 days before the surgery, the patient has to take the pre-survey. And just for the sake of the conversation, there is only eight questions we are talking which take two minutes.

We tested that before. Then as part of the mental specification of 90 days to 1, the 90 days post-surgery, the patient will take another thing about basically their physical function, their pain level, or wellbeing questions.

And then using the simple, and I will get into your question as I answer your question, to then basically using a simple method that does not require any specific mechanism for rural places.

We'll see the benchmark, basically, between the questions item before and after. Now, the threshold that we decided, as you suggested, is 75 percent based on qualitative and quantitative.

So, that's what providers, patients, as well as payers suggest to us to have a threshold, a threshold that based on what we found is little room for improvement, basically, patient-centered care.

And once they hit the 75 percent with the core of the 25 population, then they will be reimbursed for that. So, to your question, he decided to be part of the program.

To meet the patient expectation doesn't mean to

exceed the expectation of the patients. So, if I have a moderate expectation and that's what I got, it's completely fine.

Member James: Will it take into consideration at all whether the surgeons who are performing these surgeries are in a large group of orthopedics or whether they are just a one or two-person business who maybe don't have the same degree of expertise and experience?

Dr. Rozenblum: Here is the beauty in terms of the expertise. In terms of the content, this layer of expertise patient-centered case. So, in terms of expertise, the provider doesn't really need a lot of expertise to discuss with the patient about their expectations.

We are expecting them to do that.

In terms of your question in terms of it's a small clinic, a big clinic with a lot of patients, I think this is basically going back to the guidelines of the program, not so much about our manager.

We don't think it's going to affect -- there is a requirement of the program for there to apply to the program, which is not related to our own measures specifically.

Co-Chair Rask: Thank you for this discussion, this is very helpful.

I do want to remind everyone that our purview, what we're really focusing on, this group, are there issues around this measure that we think impact rural providers or people in rural communities that we want to bring attention to?

I think one of the points that Karen just brought up is a great example of that, thinking about a small group, a solo practitioner perhaps in a rural community versus a practitioner in a city with a group of 20 providers who have maybe seen a very

different mix of patients.

And so that is one of the important points that we can bring to the other NQF workgroups and also that issue, as you mentioned, the importance of the risk adjustment for BMI if we think that's a particular focus in rural communities.

I see that Mike has his hand raised.

Member Fadden: I just wanted to comment that I think we got a little sideways in our discussion. This is really about the patients' goals, not the surgeon's goals or anybody else's.

And I think it's an extraordinarily important measure. And it's going to be ugly and dirty at some times because if the patient's expectations aren't set properly pre-operatively then they won't be met post-operatively.

So, it seems to me this is really going to measure how well the communication happened before the surgery by the individual provider and by perhaps the group that person is in.

But mostly, it's going to be about that person who helped set those expectations to begin with. And if those are set properly, then the surgeon and the group will have no problem with meeting this particular measure.

So, again, let's talk about this as a focus on the patient outcomes and their perception of this. And by the way, they can have an awful outcome and still have met or exceeded the expectations that were set.

So, I think it's just really important to see this as really about the patient outcome. I apologize for the background noise.

Dr. Rozenblum: Thank you so much, I really appreciate your point.

Just one last thing to say about the rural, which is very important, because I was listening to the other measure, we have data based on report that in terms of incidence and prevalence of total hip and total knee and rural, it's the same like rural in other places.

Member Fadden: That does not surprise me a bit because Round 1 of the patient setting those expectations and then doing the surgery and seeing them do Round 1, it doesn't matter whether you're in a zip code that's got 100 people in it or 50,000.

Co-Chair Rask: I see a chat from Keith, what are the unintended consequence in terms of patient selection at orthopedic clinics and how clinicians manage expectations, which are great thoughts.

I'd say in some ways that relates to Mike's point, that it is about that conversation, having a measure like this really encourages and rewards those who have the conversation.

Other thoughts on this measure?

Member Fadden: Not just have the conversation but are skilled at having the conversation, right?

Co-Chair Rask: Yes.

Dr. Rozenblum: The measure developer based on all the qualitative input that we received from so many people, we are not anticipating any unintended consequence, seriously nothing, just a positive outcome from that.

Co-Chair Rask: Other thoughts from the Advisory Group? Let me know if there are hands raised I'm not seeing. So, no hands raised, no comments, are we ready to move to the polling?

Not hearing any objection I'd say yes.

Ms. Lynch: Take it away, Susanne.

Ms. Young: The poll is now open for MUC 2021-063 Care Goal Achievement following a THA or a TKA within MIPS.

Please share your response to whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

I'll give it a few more seconds.

The poll is now closed and locked for MUC 2021-063 within MIPS. Zero members strongly disagreed, two members disagreed, three members were neutral, six members agreed, and two strongly agreed.

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

Ms. Lynch: Thank you, we'll go ahead and move on to the next measure under consideration, which is MUC 2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM).

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

Substantial clinical benefit improvement would be measured by the change in score on the joint, specific patient-reported outcome measures instruments measuring hip or knee pain and functioning from a pre-operative assessment to a post-operative assessment.

This measure has not been endorsed by NQF but it's slated to be evaluated for endorsement in the fall

2021 cycle.

Co-Chair Rask: Thank you. Anisha Turner, did you join the call? Collette, would you like share your thoughts on this measure?

Member Cole: This is a highly desirable patient-reported outcome measure that is assessing outcomes for patients with total hip and total knee replacement.

It is indicated for Medicare fee-for-service patients only aged 65 and older.

I have to share that our organization is steward and developer for a very similar measure in the MIPS program, a lot of similarities looking at a target-based outcome and looking at some of the detail of the measure. Based on our past experience, I have a few concerns about the calculation of an average or a change between the pre-operative and post-operative. And I'm curious if the way of handling non-response is going to be sufficient.

We had an experience of eight years of not having post-operative function testing as we had anticipated, and this prompted us to change the construct of our measure, which is looking for a specific target that occurs post-operatively.

In terms of rural applicability, as previous measures, even though one may assume that the specialty providers are gravitating towards a more urban setting, these types of measures and these conditions are across urban and rural conditions.

In Minnesota, we have segments of rural providers and specialists that are also providing these procedures. So, I think the rural applicability is there, thank you.

Co-Chair Rask: Now we'll open it up to the rest of the Advisory Group. Any other thoughts or questions, concerns, in terms of rural applicability

for this measure?

So, Collette, what I'm hearing from you, I'm interpreting a general positive feeling towards this being an appropriate and good measure for rural providers.

Does it raise questions about the specification of the measure but in terms of the rural applicability, generally positive?

Member Cole: Yes, Kimberley, and I can't remember if I mentioned the difference between this and the existing measure is this is inclusive of patients undergoing a total hip arthroplasty as well.

What I couldn't tell from the specification was if the actual outcome rates are combined for those two populations.

So, although the goals are the same for total hip and total knee, I don't know if I would put those two population together.

I might recommend stratifying the results by if you have a hip replacement or a knee replacement due to different patient characteristics, however, that may come through in risk adjustment.

So, yes, overall, applicability for rural application is absolutely there. Thank you.

Dr. Balestracci: My name is Katie Balestracci, I am one of the measure developers. Would it be appropriate to make a comment or two here?

Co-Chair Rask: Certainly.

Dr. Balestracci: So, yes, this measure was submitted for initial endorsement to NQF this fall, it was passed by the Scientific Methods Panel for validity and reliability. So, I did want to note that.

This is a measure that does require the post-operative window because we do want to assess

improvement. And we're working very closely with CMS on implementation in order to make sure that can happen.

It is a combined measure, the follow-up period is intended to make sure that full recovery from both hip and knee are addressed in that way.

And because of the risk adjustment, we believe we are sufficiently addressing each procedure.

It also seems a measure because a number of physicians do both procedures in order to make sure that we are giving clinicians sufficient volume that it made sense to combine the two measures.

Lastly, there is response bias statistical approach applied to this measure because I think we all know in this field that PRO-PMs are a little harder to collect and we do think it's very important to include that.

The non-response bias approach takes into account race and dual eligibility as well as the AHRQ SRS index.

So, we think that we have really appropriately identified both clinical and social risk factors that could be really important in response bias.

Thanks for the opportunity.

Co-Chair Rask: Thank you, and I'd like to share some other chats. Karen in the chat says I think measuring functioning is a better application than patient expectations.

And then she raises a question, TKAs have a much lower level of improvement than do THAs, so should they be separated?

And I think if I heard from Katie's discussion, your thoughts were that putting them together helped with having a sufficient sample size. Was that the rationale behind it?

Dr. Balestracci: It is one of the rationales. It is also the rationale again that many physicians are doing both, that the care team that works with patients are often doing both.

And that because we have risk adjusted with both and essentially each procedure in mind, we are able to with the risk adjustment address some of those differences that may exist.

Co-Chair Rask: Thank you, I understand Rhonda has her hand raised?

Member Robinson Beale: Thank you, partly my question may have already been answered. But regarding functionality, is there anything within the measure that takes into account the occupation of the individual?

The reason I bring that up, in a rural area you have far more individuals who are engaged in bearing manual type of work, working on farms and other types of things where their recovery as it relates to any joint procedure might be lessened or might be an issue that might impact the outcome.

Dr. Balestracci: This is a measure that risk-adjusts for things like pain in another joint, lower back pain, other things that could certainly impact individuals who are involved in quite physical occupations.

We do not risk-adjust for one occupation specifically but do take into account chronic pain.

The other thing I'll just mention quite briefly, which may address some of your comment, is that this is an improvement threshold that allows for physicians to consider patients even with great severity baseline, because patients with great severity still have an opportunity, a very high opportunity to show improvement on this measure.

It was very important to us to make sure we did not disincentivize the treatment of patients with greater

severity at baseline.

Co-Chair Rask: Any other thoughts or comments from the Advisory Group in terms of the rural suitability of this measure?

Member Finerfrock: I have a question.

Co-Chair Rask: Go ahead.

Member Finerfrock: Given that this is obviously a rural perspective, in terms of risk adjustment, rural individuals typically have more challenging access to services that would be appropriate post-operatively.

That might be physical therapy, it might be also just the ability to individually engage in some form of post-operative care.

Is there any consideration to doing risk adjustment based on the geography of the patient, recognizing there may be factors that affect the ultimate outcome that are beyond the control of the hospital or the surgeon but are more reflective of the social determinants of health, if you will, that exist for the rural patient.

Dr. Balestracci: Yes, hi, again, it's Tracie here. There are a number of risk factors again that are addressing social determinants of health. Health literacy is part of the risk-adjusted model.

We think that may reflect that. I do understand your concern and one of the hopes of a measure like this is to bring attention to the importance of that as well.

But we are, through our risk adjustment model, attempting to address a number of factors that will impact the ability for improvement.

Member Finerfrock: You mentioned health literacy but what about this issue of availability, or services that would be appropriate in the context of post-surgical care?

Dr. Balestracci: Our hope is that a measure like this would really incentivize the work and practice of a physician and a physician group to create those important connections to post-operative care.

It is very hard to assess at this time and we recognize that surgeons themselves have limitations in that area.

We still believe, however, that this measure will have a really positive impact on the delivery of care to patients with these procedures and certainly support the very large issue across healthcare of post-operative care for patients in rural areas and access issues.

Co-Chair Rask: Thank you, and I think this really is a theme that we hear a fair amount through a lot of these measures, that access barriers to be able to get services that would promote good function.

It may mean that in a cross-sectional view, rural providers might be disadvantaged to non-rural providers.

At the same time, if we don't collect this information, how do we help make the case to improve care for rural residents?

So, I think that's an important part of the qualitative comments. Chelsea, I think you go to the Workgroup to understand that members of the group raised concerns about not disadvantaging rural providers.

Member Finerfrock: Also rural patients.

If I'm the patient and I go two hours to get an orthopedic surgeon who is going to do my knee and then I go home and I'm two hours away, that surgeon in the urban area has no ability to influence the accessibility I might have to services in that community.

Yet if I have a poor outcome, the concern I would

have is it's going to lead to cherry-picking and lemon-dropping of patients where they say, you know what, I'm not going to recommend you for a total knee because it's going to result in a poorer quality score, because I know you don't have access to post-operative services.

So, it's going to be at a patient level as well, not just the rural provider.

Co-Chair Rask: Collette, you have your hand raised?

Member Cole: Sorry if I'm backtracking a little bit in the conversation but in terms of supporting different occupations, I pulled up a copy of the KOOS JR. tool and it is very rooted in function and pain related to that function. So, some specific questions are twisting or pivoting your knee, do you have pain related to that and on a Likert scale, straightening your knee fully, going up or down stairs or standing upright?

So, it's looking specifically at are you having pain but it's looking at pain within the context of function.

Co-Chair Rask: Thank you. Are there any other comments or questions related to the rural suitability of this measure? Hearing none, Chelsea, I think we're ready for the polling.

Ms. Lynch: I'll have Susanne pull that up but, Bill, since you were just able to join us and missed our initial introductions and disclosures, while Susanne is pulling that would you mind introducing yourself with your organization and any disclosures, please?

Member Finerfrock: Sure, I'm Bill Finerfrock, with the National Association of Rural Health Clinics. I don't believe I have anything to disclose.

Co-Chair Rask: Welcome.

Member Finerfrock: Sorry I was late.

Ms. Young: The poll is now open for MUC 2021-107, clinician level and clinician group level THA or TKA, patient-reported outcome-based performance measure within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-107 within MIPS. Zero members disagreed, three members disagreed, five members were neutral, seven members agreed, and zero members strongly agreed.

MUC2021-090: Kidney Health Evaluation

Ms. Lynch: Wonderful, thank you, we'll go ahead and move on to the next measure under consideration, which is MUC 2021-090: Kidney Health Evaluation.

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

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

Co-Chair Rask: Thank you, Chelsea. I believe Mike is not on the call but is that incorrect?

Member Fadden: I'm here.

Co-Chair Rask: Mike, thank you, we'd love to hear your thoughts.

Member Fadden: I appreciate you getting this one up here. This is a difficult one for me to review. The goal of this is very, very important.

This should be done, so to just go through this, an Estimated Glomerular Filtration Rate is an index of how well kidneys are functioning.

And of course, kidney disease and diabetes is an enormous problem outlined exhaustively in this description.

A second indication or a second way of measuring that is with the Albumin-Creatinine Ratio. These things should be done at least once a year in folks with the diabetes.

Where I have a problem with this, though, is on the rural side.

In fact, there are some things that were said in here, let me just see if I can find it, much of the testing is completed through smaller laboratories and is also often scanned into VHR with availability of the data in discreet fields laboratory.

This does not highlight an issue with the data flow from VHR to the main but the data transfer from the laboratory to VHR where the level of granularity is less specific, thereby more challenging to capture.

So, I really think there could be big issues here in the rural setting for being able to meet this measure based upon what they've shared here.

Again, I want to make sure that from a clinic standpoint, this is an extraordinarily important thing to do but I just really worry that it's going to look bad in rural because they can't get the data of their system.

Co-Chair Rask: Okay, thank you. Cody, your thoughts on this measure?

Member Mullen: I would agree with Michael and some of his thoughts. Clinically, this is a vitally important measure, if anything it's maybe more important in rural with the high prevalence of diabetes that we have there.

I have a lower ratio of referrals to nephrology potentially in rural to ensure that we have this quantifiable measure for our permanent care team to really know when will that referral be made and how to support that.

But I do agree on the faxing and EMR entry, I'm just concerned that while this may be a good measure and may be captured, it may never make it back to the clinician to interact with the measure to be able to give recommendations back to that patient.

And also, I'm also concerned about the lack of lab capacity to do all these different tests. It's a little bit outside of my scope but I know these are not standard lab tests.

So, communities that may not have a hospital-style lab but more of a clinic-based lab are now having to ship these measures out, again creating other issues in care in measures brought back into the main system for information.

But overall, a clinically necessary measure.

Member Fadden: I find it disturbing a little bit -- disturbing isn't the right word.

But just to quote, finally, there is an aspirational aspect to the new measure that the UACR test necessary for the numerator requires the use of a quantitative albumin test, which was recommended.

But it's actually not done by very many clinicians. So, in fact, the data they're acknowledging isn't that data.

Co-Chair Rask: Thank you.

So, if I'm hearing both of the discussants are strongly in favor of clinically of the need for this measure but are concerned with the data the measure is being based on may substantially disadvantage rural providers.

Member Fadden: I think that's true. I guess what would be really reassuring is if they took a look at rural providers and really did an analysis of the capability and shared that with us.

Co-Chair Rask: Thank you. Are there other thoughts from the Advisory Group on this measure?

Member James: One consideration is that the Urine Albumin-Creatinine Ratio requires a 24-hour urinalysis urine collection in order to be done accurately.

To be able to do that in a rural environment is probably more difficult than in another type of environment.

The GFR is at least a serum test and can be done with the blood test. Is there anything that should be maybe changed or modified based on the Urine Albumin-Creatinine Ratio?

Member Fadden: I was just going to say I'm not certain that's correct. This is actually a test on a spot urine for a quantitative amount of albumin in the spot urine.

So, there is very rarely a need to do formal 24-hour urine collection anymore for GFR.

Member Verzone: This is Ana Verzone, my understanding is that a random spot urine protein-creatinine ratio also has very high correlation with the 24-hour.

Co-Chair Rask: Thank you for those clarifications. Any other thoughts or comments?

In the chat, Miriam Godwin from the National Kidney Foundation has shown they may have Optum data that show rural providers are able to report.

But she will need to follow up. Other comments or questions on this measure?

Ms. Godwin: I apologize. Is it okay for me to add something?

Co-Chair Rask: Go ahead.

Ms. Godwin: I just wanted to clarify that this measure, kidney health evaluation, will replace an existing endocrine measure that is NQF-endorsed and also is used in MIPS and other clinician and plan-based quality programs, which is Medical Attention for Diabetic Nephropathy.

So, we will be going through the NQF endorsement process to just clarify that this new measure will replace that existing measure in 2022.

Co-Chair Rask: Thank you. Any other comments or discussion on this measure? Chelsea, am I missing anybody?

Ms. Lynch: I think we're good to go to the polling question.

Co-Chair Rask: Thank you.

Ms. Young: The poll is now open for MUC 2021-090 kidney health evaluation within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

The poll is now closed for MUC 2021-090 within MIPS. Zero members strongly disagreed, two members disagreed, five members were neutral, nine members agreed, and one strongly agreed.

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

Ms. Lynch: Thank you, all, we'll go ahead and move on to the next measure under consideration, which is MUC 2021-127 about kidney disease, age inhibitors, or ARB therapy.

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

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

Co-Chair Rask: We'll move to our discussants. Rena, do you have any thoughts on the measure?

Member Sackett: Yes, thank you so much. So, as was mentioned, this is an evidence-based process measure promoting use of ACE inhibitors or ARBs in patients with CKD, the goal of decreasing rate of kidney failure, cardiovascular outcomes and mortality.

And it also was mentioned that the measure was initially endorsed by NQF in October of 2015 and is being submitted as endorsed by NQF.

It's currently used in a variety of areas, professional certification, verification programs, public reporting. There's also interest in incorporating this in the nephrology MIPS value pathway.

So, just some thoughts on rural setting considerations, the measure was found to be an average burden on provider work flow overall. I didn't see anything specific to rural settings, so feasibility would be interesting to see.

Also, low patient volume in rural settings may impact reliability and validity. Unintended consequences, there were particular concerns about lower EGFRs and hyperchloremia had potentially led physicians to reduce the use of these meds.

So, just keeping that in mind, the side effects would

need to be monitored to determine if increased rates of each occurred as a result of this measure.

But overall, it seems reasonable, it's important clinically, and it seems reasonable to support the measure based on the potential to improve outcomes.

Co-Chair Rask: Thank you. Stacy, your thoughts on this measure?

Member Scroggins: Sorry, I didn't unmute. I am supportive of this measure. I think that often as a clinician, we look at diabetic patients and they are commonly on ACE inhibitors or ARB therapy.

But I think this would help provide some attention to detail and trying to reduce and hopefully prevent progression on chronic kidney disease.

So, I like this measure and I do think from a rural aspect that I don't see any problems with implementing it or a major interruption or a burden to the patient.

It piggybacks on the previous measure that we discussed with the Premeria and just measuring the chronic kidney disease. So, I'm supportive of it.

Co-Chair Rask: Thank you. We'll open it up for other comments. I see in the chat that Collette asked do the measure rates demonstrate opportunity for improvement?

And the response from the measure developer is the current Hanes data shows that only 40 percent of patients are on this treatment, therefore, there is an opportunity for improvement in performance.

Any other questions, comments, or thoughts from the other Advisory Group members? If I'm not hearing further discussion, does that mean we're all ready to move to the polling?

Ms. Lynch: I believe so.

Ms. Young: The poll is now open for MUC 2021-127, Adult Kidney Disease: ACE Inhibitors or ARB Therapy within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-127 within MIPS. Zero members strongly disagreed, zero members disagreed, three members were neutral, seven members agreed, and five strongly agreed.

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

Ms. Lynch: Thank you so much.

We'll move on to the next measure under consideration, which is MUC 2021-105, Mismatch Repair or Microsatellite Instability Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma.

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

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

Co-Chair Rask: First, I'd like to congratulate Chelsea for reading through that accurately. That was not written at the third-grade level that we're

recommending.

Now for the important questions, Jessica, what are your thoughts on this measure?

Member Schumacher: So, thinking about this from the rural perspective, we know that rural patients on average are less likely than their urban counterparts to receive guideline core care for colorectal and other cancers.

And so this measure that has a goal of improving care quality is relevant to patients. My concern about this measure is more in the availability of data for rural centers in the integration of claims and clinic information.

So, the denominator population and exclusion criteria, my understanding is registry-based or information that's pulled from pathology reports.

My experience with these reports, especially in rural areas, these are often scanned in and not as readily available as they might be in urban centers that are able to pull this directly from the EMR or another electronic registry-based data source.

So, I think the heterogeneity in the reporting in some of these pathology reports can also make this a challenge when you're actually looking for key terms.

Especially given many rural clinic settings don't have onsite pathology, so it's often outside of the center.

Those were my primary concerns, the methodologic route but I do think this is an important measure.

Co-Chair Rask: Jorge, your thoughts on this measure?

Member Duchicela: Yes, I agree with Jessica as far as the importance of this measure and I also agree with her about how difficult it would be for us to

collect this data.

I could see, let's say, in the case of dermatitis where the physician is right there, you get a very simple tool and you score it and you're done.

With this, it's more complicated, especially in the rural areas where we send our pathology reports out to different cities, to Austin, Houston, Indiana.

So, it may take weeks to get back and it's a very asynchronous process, and asynchronous in terms of weeks, not days but weeks, so it makes it really hard for the rural areas.

And a lot of times we think of rural areas and we think of clinics or critical access hospitals and things like that. But there's a lot of us who are independent, real practitioners and we just don't have the wherewithal to be able to follow all these things.

So, that puts the patient at a disadvantage. It's sad to say that because it's a very important measure and it's very useful, but the reality is that --

I don't know so much about what the unintended consequences would be but I can tell you that the process of trying to measure like this would be harder for us.

Dr. Cardona: Good morning, my name is Diana Cardona, I am a pathologist at Duke University. I'm here representing the College of American Pathologists, who is the steward of this measure.

Just to clarify a point on the measure, I think all your concerns are quite valid which is why the measure actually was created as a recommendation and not actually confirmation of the testing.

And so in that pathology report, what we're trying to do is have the pathologist, A), understand what the most recent guidelines are because the number of cancer types that are now included in the

recommendation have expanded.

And so A) so that they update their practice in recommending the appropriate molecular testing is done.

Because often times, the option to actually do the testing, as you guys have nicely illustrated, is not within their control, especially within the rural practices or in small practices.

So, this really is as far as a data for the measure and just for the measure, we've tested it, it's quite feasible because it's within the control of the pathologist to document the recommendation for testing.

We also thought this was a great way to interface more with the patient so that they're more aware of, hey, these are things now with this diagnosis of cancer that you need to follow up with with your oncologist or your primary care physician to make sure that it's getting done as well.

So, from a data perspective, absolutely, you guys or on point, which is why we didn't make it an actual performance of testing, but the recommendation of testing in the pathology report.

Co-Chair Rask: Thank you for that clarification. Jorge and Jessica, any further questions regarding that?

Member Schumacher: One additional clarification point.

So, in terms of the clinical information that's needed and the exclusion criteria, et cetera, would that come from the clinic or would all of that be available to the pathologist?

This would be reporting at the pathologist level?

Dr. Cardona: Correct, this measure really is primarily intended for pathologists.

We did get endorsement from the American Gastroenterology Association because there are obviously a lot of GI endoscopy groups that have pathology embedded.

And so they fully endorse it as well because their practices could potentially report on this measure as well.

But as far as the exclusion, the pathologists would have to have access to that information, whether it was that the patient was refugee or whatnot.

But that's why, again, it's not performance of the testing, it really is just recommendation of the testing. So, we don't really have a lot of exclusions per se because of that reason.

Co-Chair Rask: Thank you. Looking at some comments from the chat, the measure developer said this measure has been submitted for NQF endorsement.

And Karen asked whether the measure might stimulate the availability of these tests in the future, which I think relates to some of the other points that were shared.

Dr. Cardona: Absolutely, I think since the guidelines have been submitted a couple of years ago, now updated, we've seen more smaller practices actually performing the immunohistochemistry piece of testing, the four different teams that you see written on the screen, in house.

Or sending it off and then having the test interpreted locally. So, I think this does drive improvement and access to these types of tests out in the rural community as well.

Co-Chair Rask: Are there any other comments or questions on rural applicability from other Members of the Advisory Group? Chelsea, any hands raised I'm not seeing?

Ms. Lynch: I do not see any hands raised.

Co-Chair Rask: Ana, welcome back.

Ms. Lynch: We can go ahead, Susanne is going to open the poll.

Ms. Young: The poll is now open for MUC 2021-105, Mismatch Repair for Microsatellite Instability Biomarker Testing, Status and Colorectal Carcinoma, Endometrial, Gastroesophageal or Small Bowel Carcinoma Within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-105 within MIPS. Zero members strongly disagreed, one member disagreed, six members were neutral, six members agreed, and two members strongly agreed.

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

Ms. Lynch: We have our last measure pre-lunch break and that is MUC 2021-058, Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors.

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

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

Co-Chair Rask: Stacy, can you share your thoughts on this measure?

Member Scroggins: Yes, when I read through this, one concern that I have from just a rural perspective is just about the actual number of patients and the data that we could obtain from this.

Because I think that some of this is more of a specialty and it says that it is geared towards outpatient as well as some hospital.

But my concern is that I just don't know how much we actually see those patients and some of the diarrhea that comes as related to their treatments and what they actually present with that, that we actually see in a rural population.

Co-Chair Rask: I do see we have some representatives from the measure steward that have joined the call.

Would either of them like to comment on their perspective in terms of data availability and challenges that might place upon rural providers?

Dr. Pai: This is Sara Pai from Mass General Hospital here as a representative for SITC. We developed this measure for exactly the reason that Dr. Scroggan is talking about.

We're seeing that immunotherapy is having a significant impact on cancer patients and we are seeing the trend towards immunotherapy as people are gaining more experience and comfort with this new category of drugs, that it is being administered in the community.

We also wish means that more cancer patients have access to these very effective drugs.

And so one of the reasons that we wanted to develop this measure was, one, to increase accessibility of these new drugs to cancer patients,

wherever they may live.

We're seeing the trend that immunotherapy is being administered outside of academic centers, and we want to make sure the drugs are being administered safely so that more cancer patients can get the drug as physicians get more comfortable with the use of the side effects from these drugs.

And so one simple adverse event which is recognizable is diarrhea and this measure is just stating that as part of the patient coming in for their infusion, just assessing whether they may be having Grade 2 diarrhea or colitis, and whether that would be the time to, okay, let's hold the drug at this time.

Co-Chair Rask:Any other thoughts or comments from other Advisory Group Members about usability of this? I see a comment from Sandi, the measure specified that data collection was feasible with some data elements defined in electronic sources.

If implemented, it may be necessary to give a long lead time for implementation, for rural providers to get changes made to their electronic sources.

So, I think that's reiterating the concern about availability of data sources in some rural settings.

Dr. Pai: Most of the history of a patient having Grade 2 colitis or diarrhea would be coming from the physician's clinic visit note prior to their infusion.

So, we do believe this is compatible with various sources of capturing physician information or assessment of the patient prior to treatment.

Co-Chair Rask: Thank you. I understand that Rhonda has her hand raised?

Member Robinson Beale: This is not specific to this measure but it is specific to the use of electronic medical records. I live in Idaho and what I've come

to understand is that physicians, primary care as well as specialists, will work at several different sites.

But I don't know if those sites always have connectivity so that a physician can use the patients at the various site as part of their measure in an easy fashion.

So, I bring that up because it's a very common piece to see here in Idaho and I can only imagine that it's also come in in other very rural areas or states in that regard.

Idaho is not terribly unique but it does have 15 frontier areas and several counties where there are no physicians at all. And so in order to give medical care, physicians need to travel or be part of a telehealth platform.

I just don't know, how does one balance that if they're on a telehealth platform that has its own medical record that might not be interoperable through other sources that you have?

I'll stop there.

Dr. Pai: Thank you for that comment. I guess the question that gets raised, though, is would the patient go to the same site for their infusion of cancer drug?

Because it would be at that visit that the information of any adverse events associated with their prior infusion that the decision would be made whether to give them the subsequent dose that day or not.

Member Robinson Beale: I can't answer that question other than to say how would this work if the physician is presiding over several sites that have different electronic medical records?

How does that physician bring all the patient data together? That's the question.

Co-Chair Rask: I see Collette in the chat has also mentioned about concerns about data availability being in progress notes. Would that be chart abstraction?

Again, is this part of the MIPS program so physicians would choose to report a measure like this?

And presumably a physician who chose to report a measure like this cares for patients for whom this is the appropriate step and would have chosen that they have the ability, collect the information that they would need.

But to all points, in terms of rural suitability, we would want to raise that question to the broader Workgroup that depending on the interoperability of electronic health records and depending on the ability to coordinate information, that may disadvantage some rural providers in whether or not they might choose to select this as a measure to be monitoring.

Co-Chair Rask: Other thoughts, comments, questions about this measure? I'm not hearing any. Am I missing any people, Chelsea? If not, then I think we can move to polling.

Ms. Young: The poll is now open on MUC2021-058: Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors within MIPS.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-058 within MIPS. Zero members strongly disagreed, two members disagreed, eight members were neutral, five members agreed, and zero strongly agreed.

Ms. Lynch: Thank you, everyone, that was a nice

long block of discussion. We have three more on the docket for later today but we will go ahead and break for lunch.

We will still do a 20-minute lunch so we request that everyone return at 12:50 p.m.

Co-Chair Rask: I think we also have to have a big round of congratulations to the NQF Staff who clearly are very experienced that they're able to estimate within five minutes exactly how long it would take all of us to discuss these measures.

That's very impressive.

Ms. Lynch: Thank you so much. Enjoy your lunch break and we will see you back at 12:50 p.m. Eastern time.

So, it could be a mid-afternoon or morning breakfast break for you depending on where you are, especially our Alaskan colleagues.

Thank you so much and see you at 12:50 p.m. Eastern.

(Whereupon, the above-entitled matter went off the record at 12:21 p.m. and resumed at 12:50 p.m.)

Medicare Parts C & D Star Ratings

Ms. Lynch: Welcome back, everybody. I hope you had a nice lunch. We will go ahead and get started. Let's go ahead and advance to the next slide, please.

Wonderful. We're going to continue our review of Measures Under Consideration for clinician programs. The next set of measures under consideration are for the Medicare Part C and D star ratings. This is a quality payment program and used for public reporting.

For Medicare Advantage, the incentive structure is public reporting with quality bonus payments and

for standalone prescription drug plans, the incentive structure is public reporting.

The goals of this program are to provide information about plan quality and performance indicators to beneficiaries to help them make informed choices and to incentivize high-performing plans.

MUC2021-053: Concurrent Use of Opioids and Benzodiazepines

The first measure under consideration is MUC 2021-053, Concurrent Use of Opioids and Benzos, COB. This is a fully developed process measure that assesses the percentage of Medicare Part D beneficiaries 18 years or older with concurrent use of prescription opioids and benzos during the measurement period.

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

Co-Chair Mueller: Thank you, Chelsea, for that introduction. Could we hear from Cody on your comments on this one?

Member Mullen: Yes, good afternoon and good morning, I guess, depending on where you are since you are in the twilight hour, as we do global calls or international calls.

This is a great measure looking at concurrent use of opioids and benzos. There's a lot of discussion in the documents that were provided looking at how this measure really interacts both with respiratory distress and other negative outcomes from overutilization of opioids as well as risk of substance use disorder and addiction that may lead to that. It is all measured off Part D data so there is no additional reporting necessary by the clinician as part of this.

There is a little bit of concern, and it's recognized

throughout, that there are patients with a high utilization of pain items is needed -- pain drugs, sorry; I can't speak after lunch -- pain drugs are needed that may not be represented like sickle cell or cancer, so that's been recognized and I'd love to hear the other reviewers thoughts on that as well.

Co-Chair Mueller: Thank you, Cody. Rena, would you like to add to that?

Member Sackett: Yes, thank you so much. Like Cody mentioned, probably low burdensome for the rural setting in terms of data pulling since the primary data source is Part D and it's readily available.

I'm not aware of any specific methodological issues for rural facilities. The measure promotes coordination of care so if there are any logistical barriers to care coordination for rural measures, those might be relevant to consider.

And then, like Cody mentioned, unintended consequence, patients receiving pain management and hospice care and those with cancer or sickle cell disease, they have unique therapeutic goals, so those patient populations were excluded, which makes sense.

But there may be patient populations who do need a high dose of opioid-benzo combination for their pain management.

I would say from the flip side of that, just putting my pharmacist hat on, extreme care does need to be taken when tapering long-term opioids and benzodiazepines, is what I would just comment there looking at de-prescribing those medications.

Safe opioid use is a cross-cutting priority regardless of setting but especially in the rural setting, there is a high need for this measure and program. So, I am in strong support of this measure.

Co-Chair Mueller: Thank you both. We're open for additional comments from others in the group. I have one quality comment that applies across the board.

I know we're talking about Part D and the star ratings for Part D plans, but we should note that this is not going to reach or not going to be inclusive of all rural Medicare beneficiaries.

It will only be those who are enrolled in a Part D plan, which will miss some percentage of beneficiaries. And there's a higher percentage of rural not enrolled in Part D plans than there is in urban.

Are we seeing any hands raised? I don't have the full gallery here.

Ms. Lynch: Not yet.

Co-Chair Mueller: Assuming that we're pretty much all back, scrolling through, it looks like we are, so I will propose that we move to a vote on this.

Ms. Lynch: There's a hand raised but I'm having a hard time seeing the name.

Mr. Dickerson: Hi, this is Bob Dickerson. I think I may be the person that raised my hand.

Ms. Lynch: Yes, it is, thank you. I needed to move some things around.

Mr. Dickerson: Are you taking public comment questions at this time or is that for another time?

Ms. Lynch: Typically, we try to keep public comments to the end of meeting just to make sure we can cover all of the measures under consideration. But if it's a quick question, we might be able to do that.

Mr. Dickerson: I hope it's a quick question. As you mentioned, this is really a cross-cutting measure,

this type of measure is very important. I know there are similar measures in other programs.

Do you have a sense for how this measure is, for example, harmonized with other similar types of measures?

I know you mentioned there are exclusions for cancer patients, and I can't remember the others, which is consistent with the other measures.

But that's really what I just want to get a sense of, efforts at harmonization with other measures and that's it.

Mr. Shirley: This is Ben Shirley with BQA, the developer and steward. I'm happy to speak up if that's appropriate.

Co-Chair Mueller: Sure, go ahead.

Mr. Shirley: It's a great question. PQA has developed and stewarded several opioid measures that are used in various CMS programs. This COB measure, for example, concurrent use of opioids and benzodiazepines, was also used in the Medicaid Adult Core Set.

And so harmonization really I think has been an important priority for us, I think you noted a lot of the exclusions that are clinically appropriate across all of these measures are included.

That also applies to the way we're defining clinical concepts, the way we're defining denominators, and the way we're identifying these events in the Part D data.

So, I think the short answer is these measures really are harmonized to the extent possible because we know that we want to be reducing burden and increasing alignment across programs as much as possible.

So, this measure, like several other of the opioid

measures that we developed, are aligned across programs and the potential addition of this measure to stars would only increase that cross-program alignment.

Is that helpful?

Mr. Dickerson: Yes, thank you, very helpful.

Mr. Shirley: Great question.

Ms. Lynch: And just for a little bit of context, especially from you, Mr. Dickerson, when you look at harmonization, that is more the workgroup level.

So, in this measure it's discussed by workgroup next week and they will have a clearer distinction, a clearer view of the entire program. So, we really just look at the measures with overall perspective.

But a great question and thank you for asking it and thank you, Ben, for providing that explanation as well.

Co-Chair Mueller: Are there other comments or questions? Seeing and hearing none, are we ready for a vote?

Ms. Lynch: This is Susannah, can you please pull up the polling questions?

Ms. Young: The poll is now open for MUC 2021-053, concurrent use of opioids and benzodiazepines within the Medicare Part C and D star ratings.

Please submit your response to show whether you agree or disagree that this measure is suitable for use for rural providers within the proposed program.

I'll give it a few more seconds. The poll is now closed and locked for MUC 2021-0953 within the Medicare Part C and D star ratings.

Zero members strongly disagreed, zero members disagreed, one member was neutral, six members

agreed, and seven members strongly agreed.

Co-Chair Mueller: Thank you, everyone. We're ready to move on to the next one.

MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

Ms. Lynch: The next measure is MUC 2021-056, Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH).

This is a fully developed process measure which assesses the percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic medications during the measurement period.

This measure is at the health plan level of analysis. It is not endorsed by NQF, it is not risk-adjusted or stratified.

Co-Chair Mueller: Thank you. Rena, your comments on this?

Member Sackett: Thank you again. So, as mentioned, this is a process measure designed to promote safe and prescribing practices of anti-cholinergic medications in older adults.

As we know, anticholinergic burden can lead to increased risk of cognitive decline, falls, hospitalization, and decreased quality of life.

And also, as was mentioned, it's not currently endorsed by NQF but it has been used in CMS programs including Medicare Part D: Patient safety, and then Medicare Part C and D: Display Page.

So, thinking about it from the rural perspective, I'm not aware of research suggesting that anticholinergic burden is higher in rural settings versus urban but certainly, polypharmacy and med safety is cross-cutting regardless of area of setting.

And we know a high anticholinergic burden is associated with risk of cognitive decline. Patients experiencing that negative outcome may need more care.

It's difficult sometimes in the rural areas to get that access to care and we see increased falls, hospitalizations, rehabilitations. These are all important things to keep in mind in why this is such an important measure.

Similar to the last one, data collection sits at the health plan level so primary data source is Part D, readily available. And then also similar, methodological issues, I'm not aware of any for the rural setting besides coordination of care.

For unintended consequence, there may be certain scenarios where concurrent use of multiple anticholinergics may be appropriate in older adults and de-prescribing could negatively affect patient care.

But just because of past response to a particular agent, an anticholinergic benefit may outweigh the risk.

So, it just takes a collaborative approach between all care providers to address the patient's meds and needs individually.

And poly-pharmacy is an issue but we need to be mindful of an appropriate way, also similar to the last one with opioids and benzos, in how to de-prescribe appropriately if doing so.

Overall, I think this is a great measure and it seems reasonable to support it.

Co-Chair Mueller: Thank you, Rena. Jessica, your comments?

Member Schumacher: I agree with everything you just said in terms of it being a really critical issue. I was looking at the prevalence and use of these

medications is about 12 percent in older adults.

And so the burden is high and we would expect, just given the age distribution in rural areas, that this would be a particular issue in rural areas.

I echo everything you've said about the data and it's a readily available and straightforward measurement for rural sites. I agree with you, it seems to be a good measure.

Co-Chair Mueller: Thank you.

Collette raises a question that I had myself too, is are there challenges with data collection because anticholinergics are over the counter, many of them?

And this measure, because you're relying on our D data set is only going to have the prescribed meds in it. Any comment or reaction to that question?

Member Schumacher: That is true, we would only be able to get what is available in claims.

Mr. Shirley: This is Ben Shirley from PQA, I can jump in here as well if that's appropriate?

Co-Chair Mueller: Sure.

Mr. Shirley: That's correct. Since this is a Part D measure it's going to be calculated using Part D claims data, meaning OTC medications will not be captured.

But I think that being said, what that really means is that this measure is just going to be a conservative estimate and the burden could actually be even higher than indicated by claims.

So, I think from our perspective, we are limited in what we can do in this program with claims in this data. I think it actually means it's even more important.

So, I think that's our perspective.

Co-Chair Mueller: It goes back to my comment on the previous one as well, that the limitation here, in addition to not including OTC, is not including beneficiaries who are not enrolled in a Part D plan.

We had another question come in through chat from Karen James, will the data include information about whether the patients are in nursing homes or in a private home?

Do you know the answer to that?

Mr. Shirley: This is Ben.

The measure would not stratify results in that way, it's inclusive often all outpatient prescription claims so whenever patients are filling these prescriptions out, these would be captured.

But it's not broken out by --

Co-Chair Mueller: Are medications administered in the nursing home paid for as an outpatient or is that then a payment to the nursing home so it wouldn't show up in the claims data for the patient?

Anyone know the answer to that?

Mr. Shirley: This is Ben. I believe that it can vary depending on length of stay. Whether that ultimately is paid under the Part B or Part D program, I don't know if we have Part D to speak to that?

I know we've spoken to them before about some of the intricacies of payment there. I do believe at some point you go from being a short stay to a long stay and that triggers a change in the payer for medications in that setting.

But I'm not sure if the Part D team is on. If not, we're happy to follow up.

Co-Chair Rask: If there's not somebody from Part D that would be a more recognized expert, I can speak to that 100 days which limits the Medicare coverage and that is to another payer.

So, that is my understanding also, that some medications in the nursing home are captured and some are not.

Co-Chair Mueller: Other comments or questions? Anything coming through the hand-raising that I'm not seeing?

Ms. Lynch: No hands raised.

Co-Chair Mueller: Then I believe we're ready to go to a vote for this.

Ms. Young: The poll is now open for MUC 2021-056, Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults within the Part C and D star rating.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-056 within the Part C and D star ratings. Zero members strongly disagreed, zero members disagreed, four members were neutral, seven members agreed, and four members strongly agreed.

Co-Chair Mueller: Thank you. We'll move on to the next measure.

MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System-Active Medications in Older Adults

Ms. Lynch: The next measure is MUC 2021-066, Polypharmacy: Use of Multiple Central Nervous System-Active Medications in Older Adults.

This is a fully developed process measure that assesses the percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of 3 or more unique central nervous system active medications during the measurement period.

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

Co-Chair Mueller: Thank you. Karen, your comments on this?

Member James: I think the major issue with this is patients that are in nursing homes, whether it's rural or not rural.

But it probably is more of a problem in the rural situation and unless you can capture data from nursing homes compared to patients who are getting their prescriptions from this primary care personal physicians, I don't know what data we'll be able to show that will have any effect on this.

Co-Chair Mueller: Thank you, Karen. Rhonda? Is Rhonda back with us? Let me check.

Member Robinson Beale: I was having a little trouble getting off mute there for a second.

Co-Chair Mueller: Go for it.

Member Robinson Beale: As it relates to this, I think this is a very important area as it relates to those who are geriatric population and the use of multiple medications.

What I would wonder with this one, since it was mentioned that this would include individuals in nursing homes, I again look at the practicality in a rural area where nursing homes many times in the rural area are stacked by the primary care physicians and not necessarily by physicians who are primarily servicing those in the nursing home.

So, again, I wonder about the ability when physicians are stretched between several different venues with different record-keeping methodologies, whether or not one would have enough of a volume to be able to substantially be able to measure.

Mr. Shirley: This is Ben Shirley with PQA, I can jump in there if it's helpful.

Co-Chair Mueller: Go for it.

Mr. Shirley: Just to clarify, this would be measured at the health plan level rather than that individual provider.

So, those sorts of concerns for denominator sizes, et cetera, are typically going to be less of a concern in this type of measure at the health level.

Co-Chair Mueller: The discussion is reverting back to the previous one again.

And where some follow-up would be helpful as this moves forward in terms of how much of the medication use in the nursing home is captured by the claims data to Part D plans versus the payment mechanism is a Part B payment to the nursing home.

Mr. Shirley: Yes, that's absolutely something that our team will follow up with our colleagues over at Part D to make sure that information gets out.

Dr. Cho: We are here from Part D. It is complicated, as mentioned. Generally, Ben and I guess the person who shares where we're at, we're generally correct.

But it really has to do with the discovery of if facilities stay versus a long-term stay in a nursing home and who's paying for it. Is it Part D or Part A?

And this measure really only rates plans that cover those drugs that a patient gets under the plan.

Co-Chair Mueller: I think you make an important point in remembering that all three of these measures we've been working through with the setup here was these are used for the star ratings of the plans.

A lot of what we're commenting on I think has to do with how helpful they are in really addressing the needs of the beneficiary population, whether or not that's showing up in claims data.

And the purpose here is to generate the star ratings for the health plan, so it's all related back to Part D.

Other comments? Hearing and seeing none, we are ready for a vote on this.

Ms. Young: The poll is now open for MUC 2021-066 Polypharmacy: Use of Multiple Central Nervous System-Active Medications in Older Adults within the Part C and D star ratings.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed programs.

The poll is now closed and locked for MUC 2021-066 within the Part C and D star rating. Zero members strongly disagreed, two members disagreed, two members were neutral, eight members agreed, and four members strongly agreed.

Co-Chair Mueller: Thank you, and we're ready to move on to hospital programs. Take it away.

End-Stage Renal Disease Quality Incentive Program

Ms. Lynch: Thank you, Keith. Now we will be discussing some measures under consideration for hospital programs.

For this section we'll focus on three programs, End-State Renal Disease Quality Incentive Program, Hospital Inpatient Quality Reporting Program, and

PPS-Exempt Cancer Hospital Quality Reporting.

Please note there will be additional hospital programs discussed in the later section with measures that are under consideration for multiple programs.

So, we'll start with the End-State Renal Disease Quality Incentive Program. This is a pay-for-performance and public reporting program. As of 2012, the incentive structure is set to reduce payments to dialysis facilities if a facility does not meet or exceed the required total performance score.

These payment reductions are on a sliding scale and could amount to a maximum of a two percent reduction per year.

The goal of this program is to include the quality of dialysis care and produce better outcomes for beneficiaries.

MUC2021-101: Standardized Readmission Ratio for Dialysis Facilities

The measure under consideration is MUC 2021-101, Standardized Readmission Ratio for Dialysis Facilities.

This is a fully developed outcome measure that provides standardized readmission ratio for dialysis facilities.

This ratio represents the number of observed index discharges from acute care hospitals from dialysis facilities that resulted in an unplanned readmission to an acute care hospital within 4 to 30 days of discharge to the expected number of readmissions given the discharging hospitals and the characteristics of the patients, and based on the national norm.

This measure is based on Medicare-covered dialysis patients and is at the facility level of analysis. It is

not endorsed by NQF and is risk-adjusted.

Co-Chair Mueller: Thank you. Sandi, your observations, comments on this?

Member Hyde: Thank you. The thing that stood out to me the most when reading this was that it failed the endorsement.

So, that does give me some pause but I do believe that it's an important measure for the patients.

Co-Chair Mueller: Bill, do you want to add to that? Is Bill not back yet? I think he had to say something. Let's open it up. I'm sorry, what?

Ms. Lynch: I was just saying I see him on the platform but he may not be at his computer. So, yes, I agree with opening it up.

Co-Chair Mueller: Let's open it up for discussion. Comments from others? I see something in the chat. Never mind. Comments from others?

Question from Collette, do we know the reasons why they failed endorsement?

Ms. Lynch: It failed on validity. Any additional information I would have to defer to my NQF colleagues. It does look like Rhonda has her hand raised.

Co-Chair Mueller: Rhonda, go ahead.

Member Robinson Beale: As I look at this from a rural perspective, it just seems to me anytime you're dealing with a service that requires travel, rural area members are disadvantaged.

And if I'm understanding this correctly, this is looking at readmissions after being in an acute care hospital and being admitted to a dialysis facility.

First of all, in rural areas, I don't know about in other states but any times dialysis facilities are

between, some patients can travel long distances to get to them, which is a peril in itself.

And because of that, this might be a measure that would, because of distance and the lack of resources, be a disadvantage for rural hospitals and dialysis facilities.

Co-Chair Mueller: Thank you, Rhonda. I know someone was trying to get in? No? Other comments?

Ms. Lynch: There's another question in the chat from Karen.

Co-Chair Mueller: Does the data include whether the readmission is due to renal failure as opposed to falling and breaking a hip? So, are the data specific to readmission because of renal failures is at the core of that question.

(Simultaneous speaking.)

Member James: The only thing I see is it is an unplanned readmission and the only exclusions, what I'm seeing in what they shared, was cancer, mental health and rehabilitation.

So, my assumption based on that is it's an unplanned readmission, which I assume falling and breaking a hip would meet that requirement.

Co-Chair Mueller: I agree, I'm not seeing that readmission for codes would be related back to renal failure.

There could be other hospital admissions within that timeframe, but that would be a fix they could do. You could get their reason for admission. Other comments?

Ms. Lynch: Collette has her hand raised.

Co-Chair Mueller: Collette, go ahead. Member Cole: Thanks, I just have a technical question on the

assumption that most dialysis is occurring in outpatient centers.

So, maybe it's just the way the description is worded but is the interim event, or does the sequencing go like there is an acute care admission to a hospital for a patient that's receiving dialysis services, not necessarily discharged to a facility with dialysis, and then tracking a readmission within 4 to 30 days. Would that be a correct interpretation? Dr. Messana: This is Joe Messana from University of Michigan KECC. We're the measure developers and as laid back, but if you would like us to address those two questions, we could briefly.

Co-Chair Mueller: Please do.

Dr. Messana: This is an all-cause readmission measure so I think that answers the first question. It's not specifically for only renal-related diagnoses because I believe the intent here was to create a shared accountability for care.

And the dialysis facility is often, not always but often, the medical home for some dialysis patients.

I believe Collette was correct in saying that a patient is potentially in the denominator for the measure if they are end-stage renal disease and they have a discharge from an acute care hospital.

And then the observation period is between 4 and 30 days after the discharge to determine if they're readmitted to an acute care hospital for all-cause or any-cause.

Co-Chair Mueller: Thank you for the clarifications, Joe. Collette also replied with, thank you for that. Other comments? If not, then we're ready to go to vote with this one.

Ms. Young: The poll is now open for MUC 2021-101 standardized readmission ratio for dialysis facilities within the end-stage renal disease quality incentive

program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-101 within the end-stage renal disease quality incentive program.

Zero members strongly disagreed, five members disagreed, one member was neutral, eight members agreed, and one strongly agreed.

Co-Chair Mueller: Thank you, we're ready to move to hospital and patient quality reporting program.

Hospital Inpatient Quality Reporting Program

MUC2021-106: Hospital Commitment to Health Equity

Ms. Lynch: This is a pay-for-reporting and public reporting program.

Hospitals that don't participate in the program or participate and fail to meet program requirements receive a one source reduction of the applicable percentage increase in their annual payment update.

The goal of the program is to provide our best to our paying providers based on the quality of others and the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care.

The first measure under consideration for this program is MUC 2021-106, Hospital Commitment to Health Equity.

This is a structural measure that is still under development and it assesses hospital commitment

to health equity using a slate of equity-focused organizational competencies in achieving health equity for racial and ethnic minorities, people with disability, sexual and gender minorities, individuals with limited English proficiency and rural populations.

The measure will include attestation-based questions, each representing a separate domain of commitment. A hospital will receive a point for each domain where they attest to the corresponding statement for a total of five points.

This will be at the accessibility level of analysis, it is not endorsed by NQF, and no risk adjustments or stratifications have been identified.

I will note that I believe our colleague from the Michigan Center of Rural Health was able to join but was not here for our initial introduction.

So, if you are here before you speak, if you could just introduce yourself and your organization if you have any disclosures.

Over to you, Keith.

Co-Chair Mueller: We'll start with Bill, if you're back at the computer and ready to help us here with your comments? It looks like maybe not.

Then we will turn to the Michigan Center of Rural Health, starting with the disclosure response that was requested.

Member Barter: So, this is Crystal Barter with the Michigan Center of Rural Health. We're the state office of rural health in Michigan and I have no disclosures.

For this particular measure, as was noted, this is a measure really focusing on reducing healthcare disparities. I think everyone on the line would know that's incredibly important, including in rural areas.

And it's essentially a baseline of hospitals self-attesting where they fall on a five-point scale. From a rural perspective, I don't see any sort of huge burden in terms of reporting.

It sounds like the measure developers are still trying to figure out exactly what that reporting structure would look like. But it would be electronic through some sort of web portal.

The burden might come from the actual assessment of the questions, the hospital leadership figuring out where they fall within that five-point scale, but not so much a burden of reporting.

The elements discussed within the question seem fairly appropriate for rural settings.

I think the major concerns is just when we look at the impact of this measure on quality of care and the justification for the measure, we are not seeing any evidence in the literature that closely links the elements in this measure to clinical outcomes.

So, I think from there is where there would be an element of concern. Thank you.

Co-Chair Mueller: Thank you, Crystal. We're open for other discussion. Anyone have additional comments here?

Member Barter: I guess I would also say I'm not clear on whether the performance on the elements would directly correlate with payment under the IQR program or if hospitals would essentially get credit for completing the assessment.

So, that would be nice to get some clarification on.

Co-Chair Mueller: That's similar to Sandi's question in the chat of do we know if they plan to require this through existing reporting platforms or a new platform?

Co-Chair Rask: I can say there are other measures

in the IQR program that are structural measures so isolation presume the pathway for this would be similar to those.

And because it is in the IQR program, the penalty is if you do not report it, it is not for the results of what you're reporting but the fact of if you do report.

So, reporting equals success.

Co-Chair Mueller: I would note that in the unintended consequences of the report that we received, and I think it's important to recognize, hospitals that don't meet the five areas, and a lot of those questions are yes, no, we have this capacity, we have this data analysis, this could create a burden to address the measurement area and move resources from other areas of focus.

And because it is a structural measure, there's no direct assessment on improvement and quality on the basis of these actions.

However, intent of measurement is to support hospitals making needed investment in leadership data and culture to advance equity.

Ms. Lynch: Collette has her hand raised and there's also a question from Karen in the chat.

Co-Chair Mueller: Who did you say had the hand raised?

Ms. Lynch: Collette.

Co-Chair Mueller: Collette, go ahead.

Member Cole: I have a process-type question and then just a comment about the collection of demographic data that includes race, ethnicity, and language.

I just wonder what is our consideration of evaluating a measure that's currently in

development?

But I wanted to point out that even though it's in development in a structural measure, we've had great experience in collecting race, ethnicity, and language demographic data and applying that to our clinical quality measures to stratify and understand disparities and outcomes.

So, just a comment. Thank you.

Co-Chair Mueller: Karen asked the question, is anything included that will indicate whether the patients are communicated with in their primary language?

I'll go back on the detailed questions and see if I can help answer that.

Dr. Balestracci: Susannah Bernheim is here from the Yale CORE team if you have any questions you want us to directly answer.

Co-Chair Mueller: I'm not finding anything in the questions to Karen's question about do they address communication and primary language? Nothing that specific, there are a couple of items about training and communication broadly.

I would assume that a detailed plan within need to address that but I don't see it embedded in this particular instrument. If anybody else does, I'm happy to take a correction to it while I'm looking at it.

Dr. Bernheim: Hi, I'm just going to try again because I couldn't tell if you could hear me. This is Susannah Bernheim from the Yale CORE team. Can you hear me? Okay.

I'll just say very briefly to that question, we don't directly include a question about what language the goal has some possibility because hospitals have such a range of populations that they care for.

So, the key elements have to do with identifying priority populations and having a strategic plan to address healthcare disparities, data collection engagement, and quality improvement focused on healthcare equity, use of stratified measures, and leadership engagement in those measures.

But there's purposely some flexibility knowing that different hospitals will have different populations and different strategic plans they put in place to meet the needs of their community.

Co-Chair Mueller: Thank you. Other comments or questions?

Member Finerfrock: This is Bill Finerfrock, I was delayed in getting back so I've missed all the conversation. I don't want to anybody to have to go back over but I think this is an important component.

One thing also, I think these should be incorporated into our evaluations when they come out with various best hospitals in America and so forth. I think this simply one of the measures against which they are evaluated in terms of their ranking.

If you look at the current measures and who are ranked as some of the top hospitals and then you look at them from a health equity standpoint, they tend to be very poor and I think we can incorporate that into that as well.

I think these rare important things to consider.

Co-Chair Mueller: Thanks, Bill. Other comments? Hearing nothing seeing none, we're ready to go to a vote here.

Ms. Young: The poll is now open for MUC 2021-106, Hospital Commitment to Health Equity within the hospital inpatient quality reporting program.

Please submit your response to share whether you agree or disagree this measure is suitable for use

with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-106 within the hospital inpatient quality reporting program.

Zero members strongly disagreed, one member disagreed, three members were neutral, seven members agreed, and four members strongly agreed.

Co-Chair Mueller: Thank you. We're ready to move to the next measure.

MUC2021-122: Excess Days in Acute Care After Hospitalization for Acute Myocardial Infarction

Ms. Lynch: The next measure is MUC 2021-122, Excess Days in Acute Care After Hospitalization For Acute Myocardial Infarction.

This is a fully developed outcome measure that estimates days spent in acute care within 30 days of discharge from an inpatient hospitalization for an acute MI.

This measure is intended to capture the quality of care transitions provided to discharge patients hospitalized with an acute and myocardial, collectively measuring a set of diverse acute care outcomes that can occur post-discharge including emergency department visits, observation stays, and unplanned readmissions at any time during the 30 days post-discharge.

The measure is at the facility level of analysis, is endorsed by NQF and is risk adjusted.

Co-Chair Mueller: Thank you. Anisha, your comments?

Ms. Lynch: It is possible that B has neither discussants. A few people called in but we're not seeing them on the platform.

Co-Chair Mueller: I'll pause a moment to see if one of those two, either the American College of Emergency Physicians or AHA?

Member Slabach: This is Brock here, I'll quickly jump in on this one. I don't have a problem with the measure, I think it's totally appropriate but it's certainly not rural-relevant.

Most all patients with acute myocardial infarction presented to emergency departments are transferred, so all the care for this problem is taken care of in the outpatient setting in a rural hospital.

And then often, if not always, transferred for definitive care, either balloon angioplasty or surgery, or whatever the outcome would be there.

So, I would support the measure but just want to make the comment that I don't know how relevant this would be in a rural setting.

Co-Chair Mueller: Other comments on this one?

Member James: I think that's a fair assessment, it probably means the care provided in the rural setting would contribute to or take away from the rating of the hospital that received the transfer as opposed to the rural facility itself.

So, I agree with your assessment that it's likely not to impact a lot of rural providers.

Member Slabach: I agree. It raises an interesting question.

If I was the referring facility I would be looking to coordinate care after discharge in those communities that are rural and need to have input in terms of these patients.

Great point.

Co-Chair Mueller: Other comments or questions? Hearing and seeing none, we are ready to vote.

Ms. Young: The poll is now open for MUC 2021-122, Excess Days in Acute Care After Hospitalization For Acute Myocardial Infarction within the hospital IQR program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-122, within the hospital IQR program. Zero members strongly disagreed, two members disagreed, two members were neutral, 11 members agreed, and one member strongly agreed.

Co-Chair Mueller: Thank you. We have one more measure in this category.

MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty

Ms. Lynch: That's correct.

The next measure under consideration is MUC 2021-120, Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty.

This is a fully developed cost/resource use measure that estimates hospital-level risk standardized payments for an elective primary total hip or total knee arthroplasty episode of care, starting with an inpatient admission to a short-term acute care facility and extending 90 days post-admission for Medicare fee-for-service patients who are 65 years of age or older.

This measure has a facility level of analysis and is risk adjusted.

The measure is endorsed by NQF although this version of the measure includes 26 new ICD-10

codes which were not a part of the specifications when the measure was submitted for NQF endorsement.

Co-Chair Mueller: Thank you. Crystal, your comments?

Member Barter: Thank you.

So, as we heard, the measure is fully developed and essentially, this is just an update to an existing measure where the measure stewards did update it with the 26 ICD-10 codes that represented mechanical complications.

From a rural perspective, reporting burden, this measure does use administrative claims data so don't necessarily see any data collection burden there to hospitals or providers.

There was no feasibility challenges in the prior NQF endorsement review. Reliability testing, I guess here might be a point of conversation from a rural perspective.

The minimum number of denominator cases per measured entity for public reporting is 25. In Michigan we have a wide variety of hospitals that are doing this work and the number of procedures that they're doing every year does vary.

So, that would be hospital-specific but I would assume that many rural hospitals might not be performing that 25 per year. So, that would be my comment from a rural perspective.

Thank you.

Co-Chair Mueller: Thank you, Crystal. Perry, your comments?

Member Payne: Yes, same comment there. Also, I was reading in one study that critical access hospitals seem to cherry-pick patients to a certain degree and it seems to be that the more complex

patients for the more urban centers so that's something to consider when you think about the use of this measure in a rural setting.Also, there is some not-transferred-in language as an exception, so this idea that with them being transferred in to another facility then you're excluded.

I just wondered about that and whether the measure developer could just think more about that within the rural context, in fact within the excluding some rural patients unintentionally because they transferred in, because of essentially what I was saying before.

And I think, yes, in the numerator there's a list of facilities. They didn't really call out any facility that I thought was a rural facility and I just wondered about that.

They didn't call out critical access hospitals, although, it could be descriptions under some of the general categories. That's it.

Co-Chair Mueller: Thank you, Crystal and Perry. We're open now for comments from others and questions.

Member Finerfrock: This is Bill. To your comment about cherry-picking and transferring out, the critical access hospital is set up and that is its model.

They are only also have patients on average for 72 to 96 hours. So, by design the more acute patients are going to be transferred out.

So, I'm not sure why that would be seen as a criticism that they're cherry-picking and getting rid of the more complex patients.

The concept of a critical access hospital is they are not intended or set up to treat those patients.

Member Payne: Yes, I was thinking that was more of a comment with regards to how the measure vies

for them. So, just taking that into account, any measure design spec and being aware of that.

Member Finerfrock: Okay.

Co-Chair Mueller: Other comments or questions? It seems to be straightforward as an update. With that editorial comment, we'll take this to a vote.

Ms. Young: The poll is now open for MUC 2021-120, Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty within the hospital IQR program.

Please submit your response to share whether you agree or disagree this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-120 within the hospital IQR program. Zero members strongly disagreed, one member disagreed, two members were neutral, 10 members agreed, and three members strongly agreed.

Co-Chair Mueller: Thank you. We'll move to the final category within this block of measures.

Ms. Young: Chelsea, are you on mute by any chance?

PPS-Exempt Cancer Hospital Quality Reporting

Ms. Lynch: Yes, I am, double-muting is going to be the end of me today. Sorry, so this is the PPS-Exempt Cancer Hospital Quality Reporting program.

This is a voluntary quality reporting program where the data are published on Hospital Compare.

The goal of the program is to provide information about the quality of care in cancer hospitals, particularly the 11 cancer hospitals that are exempt from the inpatient prospective payment system and the inpatient quality reporting program, and

encourage hospitals and clinicians to improve quality of their care to share information and to learn from each other's experiences and best practices.

MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) Through III HER2 Positive Breast Cancer

There is one measure under consideration for this particular block, it is MUC2021-091: Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer.

This is a fully developed process measure that assesses the percentage of female patients aged 18 to 70 years old with Stage 1 through Stage 3 HER2 Positive Breast Cancer when appropriate treatment is initiated.

This measure has the clinician level of analysis, it's not endorsed by NQF and it's not risk-adjusted or Stratified.co-chair Mueller: Thank you. AFP comments here on this one?

Member Duchicela: Yes, my only comment, well, not my only comment but I'm just trying to see how this pertains to the rural areas.

I guess that's why I'm here, to let you know that I have a hard time understanding how this is to me or someone in the rural areas.

Because it appears that it's mostly geared towards the cancer hospitals. But anyway, that's my observation, I stand to be corrected though by someone else.

Member Verzone: My understanding of this measure, I feel it is applicable to rural areas because from my understanding of reading it, it seemed like they were focusing on medical therapies.

So, while access to advanced therapies like

radiation can be limited in rural areas, my interpretation was it was focusing more on medical -- I thought, my interpretation was that it was the more oral drugs or other more easily accessed medications.

So, maybe we need clarification on that because if it is focused on more the anti-cancer oral agents or IV agents, I feel like that is available in rural areas.

I live in Alaska and we do cancer treatments out in the villages with guidance to tertiary care facilities. So, I know it's possible.

So, is there someone that can clarify what the focus is on this and if we're off on that?

Ms. Drumheller: Good afternoon. This is Caitlin Drumheller from ASCO. We are a measure developer and we're happy to chime in if that's appropriate. That's exactly the correct understanding of the measure.

The numerator action is looking at an adjunct treatment course for these patients that includes both chemotherapy and HER2 targeted therapy, so the course is reflective of the patient's HER2 status.

So, it is medical therapy, it is not looking at radiation therapy or other kinds of advanced therapies that may be more limited in a rural setting.

Member Verzone: With that understanding, I personally feel like I don't see any reason this shouldn't be included for rural areas.

Co-Chair Mueller: Thank you.

Member Duchicela: I have a question. How in the rural areas or for Dr. Verzone in Alaska would a doctor or clinician collect this information and compile it and send it off?

I would think you have a patient with breast cancer

that meets this criteria, so let's say you have five of these patients and that would be your denominator.

And then whoever fits into this criteria then, that would be your numerator. The goal, I was looking here, it was -- maybe I misunderstood what the goal was of this.

But it had to do something with the 11 cancer-only hospitals that this measure was for. And maybe I saw it somewhere else but that's what got me thinking that.

But I'm sure, Dr. Verzone, there are some places in the rural areas they do have this treatment plan and they follow these patients and they provide this chemotherapy to breast cancer patients.

Member Verzone: To clarify, I have a doctorate degree but I'm not a physician. But in the areas (audio interference) with a specialist that prescribes the treatment plan and then the medications are shipped out to the rural clinics. And as long as there's a qualified person, which there normally is nowadays, and then the treatment is administered.

But was there a question about how it's documented or reported, how they would collect this information from the rural clinics?

Member Duchicela: So, the physician writes the order and this would be most likely an oncologist from --

Member Verzone: From Anchorage or something.

Member Duchicela: Right, and that would be, let's say, the numerator because the denominator would be the patients who have the breast cancer that fit to get this adjuvant chemotherapy.

So, this would be the responsibility of the oncologist who is prescribing the medicine. Now, the medicine could be delivered and administered at the point of care, let's say, in a small town in rural Texas.

But the order is initiated and the quality measure, not on the decision of the physician or nurse practitioner who is actually administering the medicine.

It's coming from the oncologist who is overseeing the cancer care of this patient. That's my understanding, so the person who would be the health professional would be looked at as far as the measure in order to promote this.

I think the measure is great, I'm just trying to see how its applicable to the rural areas in the sense that how is it that let's say in my case, I send a patient to the city, to Houston.

The oncologist is seeing them and maybe the oncologist is coming here to a nearby town that has a hospital. And there she prescribes this medicine, well, how does that apply to me in the rural areas?

And usually, the oncologists are not in the rural areas, at least in our area they're not. They usually come from larger urban centers.

So, anyway, that was my comment on the applicability and the relevance as far as the quality measure to the rural areas.

I have nothing to say about the importance of the quality measure and nothing to say as far as to whom you're going to assess or evaluate that quality.

Member Verzone: Can someone answer which facility would be responsible for reporting this data?

Ms. Lynch: Yes, this is being proposed for the particular program that is only for the 11 exempt cancer hospitals, so it would be for those 11 hospitals.

(Simultaneous speaking.)

Ms. Lynch: -- or something like that.

And I cannot tell you where those 11 hospitals are, but some of my colleagues or someone else on the call might be able to.

Member Slabach: They're not in rural, I can assure you.

Ms. Lynch: That's fair.

Co-Chair Mueller: The key term, if you just look at what we have on the slide, is appropriate treatment is initiated and that's the point that was just made.

It's going to be the oncologist in one of those 11 places that initiates the treatment. And yes, the treatment may end up being administered in a rural place but it's not the rural provider that's being held to the measure here, it's those 11 cancer hospitals.

Member Verzone: Thanks, that makes sense.

Co-Chair Mueller: Other comments here? If not, we are ready to vote.

Ms. Young: The poll is now open for MUC 2021-091: Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer within the PPS-exempt cancer hospital quality reporting.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC 2021-091 within the PPS-exempt cancer hospital quality reporting.

One member strongly disagreed, two members disagreed, six members were neutral, five members agreed, and three members strongly agreed.

Member Slabach: Keith, just a quick comment if I could before we move on off of this one?

Co-Chair Mueller: Yes.

Member Slabach: I voted agree with that because I don't think it's rural-relevant because, obviously, it doesn't apply.

The reason why I voted in agreement is because I do believe that kind of data is important to referring physicians and clinicians to evaluate the quality of those individuals that they're referring to.

And so I think from a rural point of view, this kind of information is helpful but I do want to make another comment that, obviously, it's not rural-relevant so I'm in this in between in terms of the voting on this and why I agreed. Co-Chair Mueller: Okay, I believe we are wrapped up for this section.

Ms. Lynch: That is correct, it is time for a ten-minute break. We will break for ten minutes coming back at -- well, I guess it's nine minutes now -- 2:15 p.m. and we'll start on the PAC/LTC program, the measures for that program.

(Whereupon, the above-entitled matter went off the record at 2:07 p.m. and resumed at 2:16 p.m.)

Skilled Nursing Facility Quality Reporting Program

Ms. Lynch: Okay, wonderful. And as people start to trickle back in, we will go ahead and get started. So we are moving on to the Post-Acute Care/Long-Term Care program. So for this section, we'll discuss measures under consideration for the Skilled Nursing Facility Quality Reporting Program and the Skilled Nursing Facility Value-Based Purchasing Program.

Please note that just like before, there will be some additional programs discussed in a later section of measures that are under consideration from hospital programs. So we're going to start with the Skilled Nursing Facility Quality Reporting Program. This is a pay-for-reporting and process reporting program

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

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

MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel

A measure under consideration, MUC2021-123: Influenza Vaccination Among -- excuse me, Influenza Vaccination Coverage Among Healthcare Personnel, this is a fully developed process measure that affects the percentage of healthcare personnel who have received the influenza vaccine. The measure at the facility level is endorsed by NQF and does not include risk adjustment or stratification.

Co-Chair Rask: All right. Thank you. Cameron, do you have any comments on this measure?

Member Deml: Yeah. Hi, good afternoon. Yeah, so taking a look at the measure, I mean, kind of as we're supposed to be evaluating these, is there any burden on facility provider? No, at least from my perspective based on its -- they're getting the data electronically or through records, so probably minimal burden there, obviously rural specific.

I guess one question I had is this is big more straightforward and it's kind of a straight yes or no, up or down vote. You're either vaccinated or you aren't. This clear correlation between those that are vaccinated and obviously kind of the health and welfare of not just the people that are, the workers that are, but also the patients as well as facilities that are offering it onsite versus not.

So getting to my kind of question -- and I'm sorry if I missed it. Is there, I guess, a bigger goal around this measure? Or is it just simply kind of informative and kind of being able to say, hey, make those correlations and essentially just try to get more of

the workers vaccinated?

Co-Chair Rask: I would say -- this is Kim. I'll respond from my perspective from quality work with skilled nursing facilities is that, yes, the intent is to make this information public to help -- to sort of encourage higher vaccination rates among healthcare personnel.

Member Deml: Yeah, yeah, yeah. And that's what I kind of assumed. And I'll admit I will just through this in here for fodder. And I think it's certain circumstantial of the times.

And I know this is not COVID vaccines. But of course, I think everything today surrounding talking about a vaccine as benign as could be, we have kind of entered in kind of a politically fraught area of, hey, why are you asking about vaccinations? I think it's pretty straightforward.

And folks like the folks on the call here kind of understand the value of it. So I'll just throw that in, just knowing how the -- I think fraught is probably the best word. I'll leave it at that.

I don't want to drag us into a fight over the worthiness of vaccines or not. But just I bring that up to comment just because it jumps out at me certainly in light of kind of the current environment, again, not necessary flu vaccines but with the COVID vaccine. So I'll leave my comments to that.

Co-Chair Rask: All right. Thank you. Bill, do you have any thoughts about this measure?

Member Finerfrock: I mean, it's certainly rural relevant. I think Cameron's observation is the elephant in the room that had this conversation occurred two years ago, it would've been a no brainer. Our task here is to identify whether it's rural relevant.

Whether in the larger context societally right now,

this is a topic that someone should broach. I'll leave to people that are smarter than me. But certainly in terms of rural relevance, and we try to do as much as we can to encourage patients to get the flu vaccine. Certainly our Medicare elderly patients, I don't think this should be an issue.

Co-Chair Rask: All right. Thank you. I see a question. Karen is asking, is the COVID vaccination included? Not in this measure. This measure is specifically flu. There is a separate COVID vaccination.

I don't remember -- I don't know if we're discussing it here. But they are separate vaccination measures that are parts of other programs. But this one is specifically only looking at flu. Any other questions, comments, thoughts from other advisory group members? And, Chelsea, let me know if I'm missing any hands.

Ms. Lynch: Sure. Sandi Hyde just raised her hand.

Member Hyde: Hi, thank you. So I definitely believe this is rural relevant. I believe it's an important topic and that healthcare workers should be encouraged to get their vaccinations. My only concern right now and hearing from our folks is that given the current COVID-related staffing challenges, the collection of this data and the entry of this data with the turnover that we've had in rural communities has been a challenge for both vaccines, not just COVID.

Co-Chair Rask: Thank you. Other thoughts or comments?

Member Finerfrock: This isn't a thought or a comment. There's been reference to raising your hand and that it's in the reactions button. And I don't see that on my screen. Can someone help me identify where I would find that? Normally, I don't have any trouble finding it. But here, I'm not seeing anything.

Ms. Lynch: So at the bottom, it's the little smiley face with a clock next to it. Or if you open up the participants and you find your name, you can raise your hand that way as well.

Member Finerfrock: Okay. All right.

Ms. Lynch: Does that help?

Member Finerfrock: I think so. Okay.

Ms. Lynch: Okay.

Member Finerfrock: Yeah, I don't have the smiley face, but I can certainly find my name. Okay.

Ms. Lynch: Okay.

Member Finerfrock: All right. Thank you.

Co-Chair Rask: Other thoughts or comments related to this measure?

If not, I think we're ready for the poll.

Ms. Young: The poll is now open for MUC2021-123, Influenza Vaccination Coverage Among Healthcare Personnel within the Skilled Nursing Facility Quality Reporting Program. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC2021-123 within the Skilled Nursing Facility Quality Reporter Program. Zero members strongly disagreed, zero members disagreed, zero members were neutral, 7 members agreed, and 8 members strongly agreed.

Ms. Lynch: Thank you, everyone. We are going to switch it over now to the Skilled Nursing Facility Value-Based Purchasing Program. So this is a value-based purchasing program that awards incentive payments to skilled nursing facilities based on a single all-cause readmission measure that was

mandated by the Protecting Access to Medicare Act of 2013.

The SNF's performance period risk-standardized readmission rates are compared to both their past performance to calculate an improvement score and the national SNF performance during their baseline period to calculating an achievement score. The higher of the two scores becomes the SNF performance score. If SNF has less than 25 eligible stays during the baseline period, only the achievement score will be calculated. If the SNF has less than 25 eligible stays during the performance period, they will be held harmless.

The goals of the program are to transform how care is paid for and be increasingly towards rewarding better value, outcomes, and innovations instead of merely volume and making payments to performance on a single readmission measure. As I mentioned, the SNF VBP program was authorized by the Protecting Access to Medicare Act in 2014. Per the Act, the all-cause measure will be replaced as soon as practical with a potentially preventable readmission measure.

CMS will withhold 2 percent of SNF Medicare fee-for-service payments to fund the program and 60 percent of the withheld funds are distributed as intent of payment. These intent of payments to SNFs began on October 1st, 2018. In 2021, the Consolidated Appropriations Act allows the Secretary to appoint up to nine additional measures such as measures focusing on functional status, patient safety, care coordination, or patient experience for payments for services furnished on or after October 1st, 2023.

MUC2021-095: CoreQ: Short Stay Discharge Measure

The first measure we're going to discuss is MUC2021-095: CoreQ: Short Stay Discharge Measure. This is a fully developed patient

engagement and experience measure that assesses the percentage of individuals discharge in a six-month time period from an SNF within 100 days of admission who were satisfied. This is assessed using an average satisfaction Core equal to or greater than three for the four questions on the CoreQ short stay discharge questionnaire. The measure is both at the facility and resident level of analysis and is endorsed by NQF and does not have risk adjustment or stratification.

Co-Chair Rask: All right. Thank you. Has Reverend Bruce Hanson been able to join us?

If not, then Michael, your comments or thoughts on this measure?

Member Fadden: I apologize for the delay. Couldn't find the right buttons. Never happens to any of you, I'm sure. Yeah, I mean, I looked at this and I thought pretty straightforward. I think it's just -- if I understood the full discussion of it, it's basically just elaborating on a current measure. And it seemed to me reasonable and probably applicable across rural communities as well. Did I understand that correctly?

Co-Chair Rask: It looked to me like this would be a new measure. Currently in the value-based purchasing program, there's only one measure, readmissions. And they're looking at adding some other measures in order to be able to get something that has to do with resident satisfaction in the nursing home.

(Simultaneous speaking.)

Member Fadden: Well, what I was trying to say, and I didn't say it well, is that this would be part of a currently used tool, the CoreQ --

(Simultaneous speaking.)

Ms. Lynch: Yes, it is an existing tool. Yes, it's an

existing tool.

Member Fadden: So it didn't seem to me like it'd be much burden to increase the questions to specifically target this. And I felt as though it wouldn't have any adverse rural impact.

Co-Chair Rask: Okay, great. Thank you. Are there other thoughts, comments, questions from the advisory workgroup on this measure?

I don't see anything in chat. And, Chelsea, are there any hands raised that I don't see? I'll give another moment for feedback. And if not, we'll move on to the poll.

Member Slabach: Kim, this is Brock here. And maybe I missed it. Has this been NQF endorsed, this measure?

Ms. Lynch: Yes, it is.

Member Slabach: Okay. Thank you.

Co-Chair Rask: All right. Well, let's move to the polling then.

Ms. Young: The poll is now open for MUC2021-095, CoreQ: Short Stay Discharge Measure within the Skilled Nursing Facility Value-Based Purchasing Program. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC2021-095 within the Skilled Nursing Facility Value-Based Purchasing Program. Zero members strongly disagreed, zero members disagreed, four members were neutral, ten members agreed, and two members strongly agreed.

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

Ms. Lynch: Okay. Thank you. We'll move on to the next measure with is MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities. This is a fully developed outcome measure that estimates the risk adjusted rate of successful discharge to community from an SNF with successful discharge to community including no unplanned re-hospitalizations and no death in the 31 days following SNF discharge.

This measure is both at the facility and stay level of analysis. It's endorsed by NQF, and it's risk adjusted. Measure developers provided some updates to this submission about the split sample reliability testing that was included. So I'm going to turn it over to Acumen to provide more details about this update before we open it up to the lead discussant.

Ms. Mattivi: Thank you, Chelsea. This is Kris Mattivi with Acumen. And I just wanted to thank you for the opportunity to provide this additional information to the committee members.

The results that you have in your materials are the ones that were used when the measure was endorsed by NQF in 2019. And so since that time, Acumen has updated those empirical testing results for ATC using more recent claims data. And both testing results are very similar to those NQF endorsement results that you see in your materials.

And the interpretations for validity and reliability remain unchanged. In addition, for this round of testing, Acumen applied several approaches that split sample reliability testing to account for the reduction in Sample 5 that occurs during that process. Regardless of the approach that we use, the reliability ranged from 0.78 to 0.88 which again is consistent with the level that was observed during NQF testing.

So that's the extent of the information that I wanted to share with the committee. We have other members of our team present on this call if the committee members have any additional questions that need clarification. Thank you.

Co-Chair Rask: All right. Thank you. Sandi, your thoughts on this measure?

Member Hyde: Thank you. So as Chelsea mentioned, it is NQF endorsed. If I read it correctly, there does not appear to be any additional reporting burden since they're using data from administrative claims and the minimum data set. And I could not think of any unintended consequences for rural providers with this measure.

Co-Chair Rask: Thank you. And, Chelsea, am I correct? I believe Holly is not with us.

Ms. Lynch: I don't believe she's joined, no.

Co-Chair Rask: Okay. Thank you. So we'll open it up to the other members of the committee. Any thoughts or questions to discuss about this measure and its relevance for rural facilities?

I do not see anything in the chat. Chelsea, keep me honest, that there are no hands being raised.

Ms. Lynch: No hands raised.

Co-Chair Rask: Okay. Last call for comments or thoughts.

All right. Looks like everybody has made up their mind. Let's go to the polling.

Ms. Lynch: Oh, I actually did see Rhonda raise her hand. Sorry about that.

Co-Chair Rask: Rhonda, go ahead.

Member Robinson Beale: Sorry I raised my hand so late. My question is in terms of risk adjustment. Is

there any consideration of distance to care for the rural patient?

And the reason why I raise that is that if they're in an area where there is limited access to care that would help stabilize them in the community. This could be an unfair disadvantage to rural providers. So I'm just wondering if that's part of the risk adjustment.

Co-Chair Rask: Would any of the measure developers like to respond to that question?

Mr. Nagavarapu: Sure. This is Sri Nagavarapu from Acumen. Yeah, right now there is not a risk adjuster for, like, distance to providers. It a point that our team and CMS is cognizant of and been concerned about.

And so in testing, we've looked at sort of the performance of providers in different types of areas, different provider size. And interestingly, what you actually see is that on risk adjusted rates with fiscal year 2018, 2019 data that rural providers tend to perform slightly better than urban providers by a little bit less than a percentage point. But it's something that we're actively interested in and will continue to keep track of as the measure evolves.

Member Robinson Beale: Thank you.

Co-Chair Rask: Great question. Any other comments or thoughts before we move?

Sounds like we're ready.

Ms. Young: The poll is now open for MUC2021-130, Discharge to Community-Post Acute Care Measure within the SNF VBP. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC2021-130 within the SNF VBP. Zero members strongly

disagree, 1 member disagreed, 1 member was neutral, 14 members agreed, and 1 member strongly agreed.

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Ms. Lynch: Thank you, everyone. We'll move on to our next measure under consideration which is MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization. This is a fully developed outcome measure that estimates the risk adjusted rate of healthcare-associated infections that are acquired during skilled nursing facility care and result in hospitalization. The measure, both at the facility and stay level of analysis, is not endorsed by NQF and is risk adjusted.

Co-Chair Rask: All right. Rhonda, do you want to share your thoughts on this measure?

Member Robinson Beale: Thank you. In terms of skilled nursing facility and associated infections requiring hospitalizations, I think this is a very important area. And it's an area where as a health plan is one of the reasons we see hospitalizations occur. And so being able to stimulate skilled nursing facilities to be able to address infections I think would be a very powerful way of motivating careful care in this regard.

Co-Chair Rask: Thank you. Opening it up to the rest of the advisory group. Any other thoughts or comments on this measure? I have one. I believe did you say, Chelsea, that it is not NQF endorsed?

Ms. Lynch: That is correct.

Co-Chair Rask: Okay. And do we know, or the measure developers, is there an intent to put this forward for endorsement? Or was it declined endorsement or just what that process is or was?

(Simultaneous speaking.)

Ms. Lynch: I don't believe it was ever submitted. Oh, sorry. Go ahead.

Mr. Nagavarapu: Sorry. Yeah, this is Sri Nagavarapu from Acumen. It's a recently developed measure. It just went to the MUC under the SNF QRP last year, and there's every intent to submit it to NQF. But yeah, it's just a recently developed measure. And so that's the only reason it hasn't been yet.

Co-Chair Rask: Great, thank you. Any other thoughts or questions or comments from the workgroup? I see a comment from Sandi in chat. This is very important, and I fully support driving HAIs to zero. However, small rural sites could have two infections with one and a half and have an SIR that's higher large SNFs with 15 infections and only 13 predicted.

Thank you. Any considerations for low volume? Measure developer, so this is not a SIR. Is that correct? But it is a risk adjusted numerator?

Mr. Nagavarapu: That's right. It is a risk adjusted numerator. The method or risk adjustment uses a hierarchical model that tries to reduce the instability in numerators like a lot of CMS NQF endorsed measures do. The low volume concern is an interesting and important one to look into.

We have some testing results that we routinely do with this and other measures that I could pull up here. So it looks like if we look at fiscal year 2019 data and impose the reporting threshold of 25 stays and we take the facilities that have stay counts between 25 and 49 as the first category, 50 and 79 as a second category, and 80 to 199 as a third category. That accounts for most SNFs. That's about 83 percent.

Fortunately, it seems like the average risk adjusted HAI rate is stable across those three categories. So

they're respectively 5.9 percent, 5.94 percent, and 5.91 percent. So it does look like low volume facilities do have average rates that are very similar.

There is, of course, as you note a concern about maybe additional noise. And as I mentioned, the way that the numerator is handled with predicted readmissions uses a hierarchical approach that attempts to reduce that noise a bit. And this is something, again, that we can actively keep track of going forward as well.

Co-Chair Rask: Thank you. Did that address the concerns and questions? All right. I see a nodding head. Any other thoughts or questions that the group would like to raise at this point?

I'm not hearing anything. Chelsea, am I missing any -- no hands up?

All right. Final opportunity or we will move to the voting.

Sounds like that's it.

Ms. Young: The poll is now open for MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalizations within the SNF VBP. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The pool is now closed and locked for MUC2021-124 within the SNF VBP. Zero members strongly disagreed, 1 member disagreed, 3 members were neutral, 8 members agreed, and 4 strongly agreed.

MUC2021-137: Total Nursing Hours Per Resident Day

Ms. Lynch: Okay. So our next measure under consideration is MUC2021-137: Total Nursing Hours Per Resident Day. This is a fully developed

structural measure that assesses the total nursing hours per resident day. The measure is at the facility level of analysis and is not endorsed by NQF. It is a case mix-adjusted based on the distribution of minimum data set assessment by resource utilization group.

Co-Chair Rask: All right. Thank you. Ana, your thoughts on this measure?

Member Verzone: I'm going to admit the skilled nursing facilities are not area of expertise. But I'm sure that there are staffing issues, particularly in rural areas. And I think in terms of appropriateness for rural areas, it seemed like it.

But again, this is not my area of expertise. I have some issues with they include as nursing care. But I think that's not the question here. So yeah, I'll defer to Rhonda if they have different opinions or more expertise on this.

Member Robinson Beale: Thank you, Ana. It's not my area of expertise either. But here are my comments on this. One of the things that I have come to understand in rural areas, particularly hospitals and SNFs that there is a need for a use of non-RNs and non-LPNs to fill in some of the gaps because of the lack of skilled personnel. And so peers or other trained individuals end up taking up some of the slack and get trained to do some of the things that nurses would ordinarily do.

I don't know how pervasive that is. But it certainly to me seems to be a factor that needs to be taken into consideration. So I wonder whether or not there is a baseline in terms of looking at the number of RNs and LPNs in a service area for that facility because that can make a big difference in terms of whether or not they're going to be able to meet the total number of nursing hours per resident.

Co-Chair Rask: That's a great point. Certainly staffing challenges are an issue. It looks to me as

though this measure is a single number that totals RN, LPN, and nurse aides.

And if that's the case, then it would capture the total number of hours. It may be, to your example, that there would be more nurse aide hours and fewer RN. But at least as I read the measure, that would not be -- it's not recorded separately. It's the total nursing hours.

Member Verzone: That is the total nursing hours. And I mean, one of the other issues I have with how they're measuring it is administrative time is included. So it's not actually direct patient hours that's only tracked.

Like, nursing directors and other administrative staff count towards that. But again, I think I'm not sure that's the question here. The way it's reported which I believe they're using payroll hours that it would be fairly easy to track.

Co-Chair Rask: All right. Opening it up to the rest of the workgroup. Thoughts about some of these questions about concerns for this being a challenge for rural facilities?

Ms. Lynch: There's a question from Karen in the chat. I'm just asking if this is applying to hospital, SNFs, or who? With the current staffing issues everywhere, but especially in rural areas, what is this intended to do? I will just add that this is for the skilled nursing facilities for this particular program.

Co-Chair Rask: And I would presume that the purpose of this is to -- would be to make it very transparent how many nursing hours per resident day and allow comparisons to be made across different facilities who might have different rates of nursing hours per resident. Other thoughts or input on this measure?

Member Slabach: This is Brock here. Just quickly, I

mean, again, I don't see a distinction between urban or rural nursing facilities being able to or not being able to do well under this particular measure. So I don't know that it's -- it's not rural specific for sure. But I don't think it's difficult for this to be calculated.

I'm just always concerned just as a matter of point that this has to be taken, I think, by someone looking at this data online or publicly in a corpus or in a body of information because this alone may not be the deciding factor in terms of a selection of a facility. So I just -- I mean, I know this is difficult. Staffing is important. But I just always have been nervous about these kinds of -- this kind of data and being a proxy for quality.

Co-Chair Rask: Thank you. Great point. If there's no other discussion, then are we ready to move to polling question?

Ms. Young: The poll is now open for MUC2021-137: Total Nursing Hours Per Resident Day within the SNF VBP. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program. I'll give it about five more seconds. The poll is now closed for MUC2021-137 within the SNF VBP. Zero members strongly disagreed, 5 members disagreed, 5 members were neutral, 5 members agreed, and zero members strongly agreed.

Co-Chair Rask: Chelsea, I just want to draw your attention to Ana's comment in the chat. And I don't know what you think is the best way to handle that.

Ms. Lynch: Yes, actually, we were just looking at that on the back end. It looks like we are, per our annotated agenda, discussing that right at 4:00. And since you're running about five minutes behind, I think, Ana, you should be fine.

And we can -- it's really close to being at the right

time. And so if you're not back, we should be able to make that work. So thank you for letting us know.

Okay. So we are now -- things are going to change up just a little bit here because now we'll be discussing measures under consideration for multiple programs. So the structure for this section is -- so it'll include an overview of the measure. So instead of doing the program and the measure, we're going to do an overview of the measure and an overview and discussion for each program the measure is being considered for.

So since the measure -- this will be very similar to last year's COVID discussion where we had a robust discussion on COVID but then kind of realized there wasn't much distinction between the different programs. And so if we're running into that again, we can pull some of those votes forward. But sometimes they're hospital programs and PAC/LTC programs.

So there might be some distinctions. But if we -- we can discuss everything. But if we feel like the votes are going to be the same, we are able to move that forward as long as it's a unanimous decision. And so if we get to that point and anybody disagrees that we shouldn't pull it over, you can voice that verbally or you can also just share it in the chat if you want to be kept confidential.

MUC2021-136: Screening for Social Drivers of Health

So we've -- go ahead and get started with the next measure under consideration which is MUC2021-136. This is Screening for Social Drivers of Health. This is a process measure that is currently under development and assesses the percentage of beneficiaries 18 years or older that are screened for food insecurity, housing instability, transportation problems, utility health needs, and interpersonal safety. The measure will be used for the commission

group facility and beneficiary population level of analyses and will be stratified. The measure is under consideration for two programs.

Co-Chair Rask: All right. Brock, your thoughts on this measure.

Member Slabach: Well, the first thing I will point out as I'm looking for the document. Oh, here it is. The first thing I will point out is that it's not NQF endorsed as I understand it and as previously stated, which gives me great concern on this one because although I'm extremely sensitive to food insecurity and I think that's an important element of what we are looking at in terms of measurement, if I'm looking at this correctly. I'm just hoping that this -- the scientific validity of the results of this are going to be important enough for us to be able to discern any kind of actionable outcomes.

And I guess I just -- I would like to see a little bit more robust development of this maybe. And I don't want to see providers getting data that has no solution or outcome that's actionable. So anyway, that's just my only comment to start. And the NQF part is really troubling on this one for me.

Co-Chair Rask: All right. Thank you, Brock. I see that we do have someone from the measure steward on. Let's have Cody, if you want to share your comments and your concerns at this point. And then we can see whether they're able to offer any responses to those questions.

Member Mullen: Yeah, I'll just agree with everything Brock said and not repeat that. My other concern is in the rural setting, while it's great to know this information, there's a limit in the number of nonprofits or other agencies that may tend to support these. And so I'm a little concerned.

Are we screening for data's sake? Are we screening to support people? And if we call attention to something that clinicians cannot support, are we

causing more harm, both to the clinician who know they're not doing their best of their ability as well as the patient, not getting the support they need? So I'm just a little concerned about how that's going to work out, if this is collected on all patients.

Co-Chair Rask: All right. Thank you. Would someone from the --

Dr. Price: Yes, I'm Dr. Gary Price, the current president of The Physicians Foundation and a major developer. I am an attending surgeon and clinical assistant professor of surgery at Yale New Haven Hospital. And I'm the past president of the Connecticut State Medical Society.

Today, the notion that social factors influence health outcomes is no longer controversial. We know that racial and geographic equity and health outcomes can only be achieved if we both reduce disparity in clinical care but also address drivers of health. Yet there are still no driver of health measures in any federal healthcare payment or quality program.

As a practicing physician, I know that food insecurity, for example, is not just a social factor but a clinical comorbidity that impacts quality care and drives health disparities. Further, social drivers of health drive physician burnout and create increased financial risk for providers caring for affected patients. This is why we at The Physicians Foundation which is directed by physicians from 21 state and county medical societies across the country submitted these measures.

These physicians practice in a variety of context, including deeply rural areas in North Carolina, Texas, and elsewhere. The propose social driver of health measures will make visible the impact of social drivers of health on rural practices and their patients, creating an opportunity to direct resources to areas where patients have the greatest need. These social driver of health measures are currently in use in CMS innovation center's Accountable

Health Communities Model where they've been effectively tested and implemented over five years with over a million CMS beneficiaries in 600 clinical sites, including many rural areas.

We are cognizant that CMS is committed to address health equity and to closing the stated measurement gap of developing and implementing measures that reflect social and economic determinants. Of the 44 measures submitted to the MAP this year, these are the only patient level measures in the health equity domain and the only patient level measures addressing social drivers of health. We feel that this would be the first ever social drivers of health measures in any federal payment model.

The goal is to lay the groundwork for potential future measures that focus on navigating patients to resources and addressing their drivers of health needs, collecting standard baseline data via these measures on a percentage of patients who screen positive for food insecurity, housing instability, et cetera, will be crucial to inform the design of future measures and enable CMS to set appropriate performance targets. Regarding NQF approval, it's my understanding that the Measure 136 which calls for screening has been endorsed by NQF. And my technical experts can confirm this for me on the call.

I understand they did not endorse the second measure, 21-134, which calls for reporting positive rates. We feel -- it is our very firm opinion that if only 21-136 was adopted, a measure which captures screen rates only, without a meaningful attempt to quantify the results of that screening as in 2021-134 would be at best a tragically missed opportunity. To do so would be asking our physicians and other providers to screen for data which would essentially remain invisible at a federal policy level at the very time we become acutely aware of the critical need to assess and address the impact of social drivers of health on our nation's

health.

Policy to effect change in this domain will require sound data as a prerequisite. On behalf of physicians across the country, we strongly urge the MAP to recommend both these measures as a powerful expression of CMS' commitment to health equity and to enacting measures that are truly meaningful to both patients and providers. And thank you for giving me the opportunity to speak.

Co-Chair Rask: Thank you. One of the questions that has been raised is, is this -- one of the things that we consider on the rural side is burden -- data burden. So is this information that is being -- using the application of Z codes on claims data? Or is this a separate survey tool that providers would be asked to administer?

Dr. Price: I'm going to ask one of our technical advisors, Mr. Perla, to chime in on that one if you could.

If not, any of our other technical people? Yes, Rebecca?

Ms. Onie: Rocco, are you on mute?

Well, this is Rebecca Onie, the health initiative, and would be glad to speak to this. The first thing that I think is important to note here and I think this is in one of the comments is that these measures are really about starting the standard collection of this important information and being able to actually collect the baseline data that will allow for a subsequent set of measures that accounts for the issues that were raised before with respect to navigation of patients to community resources and candidly the identification of resource gaps in communities. These are -- it's important to note that these are optional measures.

So this is essentially saying that if rural practices are either already doing this or have appetite to

better understand the needs of their patients, then they will -- that that will be acknowledged within the quality framework. And there will now in the first instance be a measure tied to that. The clinical practices will have discretion with respect to how they collect this data.

That is, that would be left, again, to the discretion of the practices. There is no required tool for this. And so the practices have an enormous degree of flexibility about how they would satisfy this requirement again if they were to opt into these measures.

Co-Chair Rask: Okay. Thank you. That helps. So if I'm understanding this properly then, in terms of using it for the merit-based system, that would be physician-based practices who would choose to want to report this metric.

Ms. Onie: Exactly.

Co-Chair Rask: It's not being -- pardon me. It's not being collected off of automated systems. So they would have to use -- have some kind of a survey or some approach to do it.

And it is not standardized. So on the one hand, there's tremendous -- there's flexibility for the practice in how they choose to collect this information. But because of that flexibility, is it accurate to say it may be -- interpreting results will be complicated by the fact that everyone collects it differently?

Ms. Onie: Rocco, do you want to speak to that?

Dr. Perla: Sorry. I had just a bad connection and I'm back. It's a great question, Kimberly. And I'm sorry if I missed any of what was said. But I think I got the gist of the question.

So practices can use whatever approach system that they want to log this, these screening

approaches that have been built into EHRs right now and have that functionality. But others could use another approach that they are doing to collect this data through the account that health communities pilot. CMS has established a platform that links the screening data files when that gets submitted to them, the claims and enrollment data through the CMS chronic conditions warehouse.

So they're able to do and standardize a lot of the analysis relative to impact like on readmissions, total cost to care, and other kinds of outcomes that can begin to provide information that will be crucial for practices and providers in rural areas to understand how that data actually has an impact on their patients' outcomes and cost and utilization and things like that. The other point I'll make briefly because someone brought up the excellent point around validity, validation, and psychometric testing. I think it's important to point out that over the last five years, the AHC screening tool that's been used to generate the measure has undergone pretty rigorous psychometric testing, both at the item and the domain levels.

So specifically looking at the food measure, the housing measure, the transportation measure, as well as at the tool level, aggregating all of the questions from the perspective of the entire tool, and demonstrated evidence of both reliability and validity, both concurring and predictive. And that includes comparisons to other similar tools. As people are aware now, there are lots of tools that are being used in clinical practice.

And the reliability statistics are pretty good. The Cohen kappas are generally above 0.6 which is great. Sensitivity and specificity is also been demonstrated. In some cases, the sensitivity has been in excess of 95 percent when asking the question, how reliable does an instrument, for example, capture the patient that's actually food insecure?

Co-Chair Rask: Okay. Thank you.

(Simultaneous speaking.)

Ms. Onie: This is Rebecca. And I would just add one last piece here relative to the Accountable Health Communities pilot to Rocco's point that 6 of the 30 AHC sites, Accountable Health Community sites, were rural. They have cumulatively tested or used the screening tool that he's referencing with hundreds of thousands of beneficiaries over the past five years in rural areas. One of those rural areas, for example, reported that 63 percent of the navigated patients utilized appropriate services. So again, this is just crucial from our perspective relative to establishing baseline data that would then be able to inform the questions that were raised in the initial presentation of the measure.

Co-Chair Rask: All right. Thank you. So looking at the comments, Collette has commented that it's important to start the standard collection of this information. Karen asked how the data would be collected if the program that we're discussing right now is Merit-based Incentive Payment System. So that would be at the clinician and clinician practice level. And then I understand that Keith has his hand raised.

If you're speaking, Keith, we can't hear you.

Co-Chair Mueller: Under the unintended consequences discussion here, I'm struck by that because I've heard this in the field that an unintended consequence is health systems and hospitals collecting the information which you can do with an intake survey. And it is being done more than just in the AHCs around the country. But then because they haven't done a lot of preliminary work or pre-work matching up to community resources and not really being able to follow through.

The best models that I've seen are models where you administer an instrument to collect the data

about social determinants and then you're able to refer people out to the appropriate agency. And you track that back. That's the testing part of the AHC model under CMMI, and it's being done in other places. So I have a little concern -- probably more than a little -- of putting it out as a national -- nationwide effort to collect the data and having this consequence of in some places they'll get excited about collecting the data but not be prepared to act on it afterwards.

Co-Chair Rask: All right. Thank you, Keith. Any other questions or comments from the other workgroup members related to rural use of this tool. And then Rebecca, I'll let you respond to that.

Ms. Lynch: Collette has her hand raised.

Co-Chair Rask: Oh, thank you. Collette, go ahead.

Member Cole: Thanks. I so much appreciate all of the comments, both from the measure developer and the last person who spoke. I really support this kind of as the next evolution. But I have some concerns because I think we have a great opportunity for some (audio interference), and I'm not putting this back on the measure developer or anybody.

But we have found the most success in implementing what I call first level race, ethnicity, and language in having standard data collection across all the entities. And then we can use that information for understanding our clinical quality as well as driving actions with patients which is super important. But for all those reasons, I love this measure. And I just don't know where we need to elevate the -- if we could start standardizing some of these social drivers of health, I think it would be really beneficial.

Dr. Perla: I can take that last question, Kimberly, if that's okay. It's a great question, and it's one that we've been talking about, I think, and for those

who've been working in this space for a long time. I think one of the things we realize is the opportunity is the moment this is actually introduced -- and again, it'll be an optional measure for MIPS. It's going to force that conversation.

Others are going to begin to sort of collect this data if they choose. And we can begin to have that conversation of what should the standard be. If we don't do that, we won't have the imperative to actually have that conversation, I think, in earnest. We'll continue to keep this as a side of the desk kind of a project, special model kind of approach versus recognizing and sending a market to the industry that this is how we think about high quality safe care.

Knowing if you're diabetic and food secure is also a clinical comorbidity, not just a social one. So it's a great question. And I think there's an opportunity right now, especially at this moment in time, especially in rural communities to begin asking these questions and signaling that we want to incentivize that conversation and that question using this tool to do it, on the path to moving towards a national standard which I think we need to get to.

Member Cole: Thank you.

Ms. Onie: If I may just speak to Keith's prior comment which also I really appreciate the concern around folks getting, as you said, excited and then not necessarily having the structures in place to be able to follow up on this. I would say two things on that. One is that, again, just emphasize that these are optional measures here.

And so we anticipate the practices that would opt into these measures would choose to do so, both to your point because they want to better understand their patient population. They recognize, as most practicing physicians do, the profound impact of these issues on their patients and want to make

that visible and because they are committed to acting on what they find and that the collection of this data and this screening will prompt those clinical practices to begin building the relationships that they need with their community partners in order to create these resource connections. And as we mentioned before, also illuminate where resources need to be directed to ensure that communities actually have what they need to be healthy.

I would say that because so many clinical sites across the country are functionally doing this. But without the benefit of a CMS measurer that in practice what has been found is that clinical sites, in fact, do develop systems to be able to connect patients to resources. There is, of course, a learning curve of how to do so but that in practice clinical sites aren't just actually collecting the data but beginning to understand how to do that navigation, including what are the workforces that are required and the community partnerships that are necessary.

Co-Chair Rask: All right. Thank you. I know we need to get moving along a little bit. And I want the rest of the advisory group members to be able to share their thoughts. Brock, I know you have your hand raised.

Member Slabach: Yeah, thanks, Kim. I guess I'm still confused about the NQF endorsement. And the NQF documents that were supplied to us indicate that it was never submitted for endorsement nor has it been approved. And the second part to my question is if it was submitted for endorsement, would some of the data collection -- I guess just say disparities be solved through the rigor of that process? And I think that would be a good thing actually if that was the case.

Co-Chair Rask: Chelsea, can you clarify the endorsement part?

Ms. Watford: Yes, I'm happy to. So it is not NQF

endorsed. It's still under development. I think there might be confusion between the NQF preliminary recommendation for conditional support for the measure for the program going into -- pending NQF endorsement. So I think that might've just been the confusion there.

Co-Chair Rask: Thank you. And Mike, you also had your hand raised?

Member Fadden: I just wanted to sort of second the idea here that putting this in effect will challenge rural areas to figure it out. I've practiced in a rural area for many, many years. I can tell you that they're up to the challenge.

Co-Chair Rask: All right. Thank you. Chelsea, any other hands raised?

Ms. Lynch: No other hands raised.

Co-Chair Rask: Okay. From the workbook, any -- workbook -- workgroup, any last thoughts, comments, or questions before we move to the polling question? And I guess, Chelsea, let me make sure I understand. This first -- our first response would be for the Merit-based Program or tell me how do we work them now. Sorry.

Ms. Lynch: Yes, that's correct. So I'm supposed to go to the next slide. Just to remind everybody, so the first program is the Merit-based Incentive Payment System which you may remember from the very start of our day that we talked about.

So a clinician level quality payment program with a pay for performance incentive structure with the four different connected performance category. So the first question will be rural perspective for suitability for this measure for the Merit-based Incentive Payment System. We'll have Susanne pull that up.

Ms. Young: The poll is now open for MUC2021-136:

Screening for Social Drivers of Health within the MIPS. Please submit your response to share whether you agree or disagree that this measure is suitable for use within rural providers within the proposed program. The poll is now closed and locked for MUC2021-136 within MIPS. Zero members strongly disagreed, 2 members disagreed, 4 members were neutral, 8 members agreed, and 1 member strongly agreed.

Ms. Lynch: Thank you. And the next program is the Hospital Inpatient Quality Reporting Program. A reminder, this is the pay for reporting, public reporting program. Hospitals that don't participate in a program or participate and fail to meet the program requirements will receive a one-fourth reduction in the applicable percentage increase in their annual payment update.

So if there's any additional discussion related to kind of the hospital level, we can do that. And then we can either go straight to vote or if we think it will be very similar, we can make a motion to carry the vote forward. So it would be the same as what we just did.

Co-Chair Rask: This is Kim. I'm going to make a -- I don't think that the vote should move forward for this. And my grounds for saying that is under the MIPS program it's a voluntary measure. Under inpatient quality reporting, that would be a mandatory measure.

And the fact that we don't have a standardized definition for all these, I think would be problematic to ask all hospitals to report without providing standardized metrics and reporting it publicly where they'd be compared to all other hospitals. So I would just like to voice those thoughts. Other feedback from the workgroup?

Member Slabach: Thanks, Kim. I agree with you on that. And secondly, I'm struggling on the method of collection, just looking at the inordinate amount of

material that has to be surveyed and collected on the admission of a patient.

I guess you could do this at discharge. It's just a volume of things that have to be done. And I mean, this is an important one. I don't get me wrong. But yeah, I don't know. I hadn't thought through this. This is a good question.

Co-Chair Rask: Other thoughts from workgroup members? Sandi expressed her agreement. I don't see any hands up. But Chelsea, keep me honest.

Ms. Lynch: I don't see any hands yet either.

Member Fadden: I was just going to chime in. Mike here. If I understand what the question in front of us is, it's the very same issue as to whether or not screening will be accomplished by the hospital for social determinants of health. Is that right?

Co-Chair Rask: It is the screen. But the difference is that for the MIPS program, physician practices choose which measures they want to report on. So they have the option of choosing this measure. If it's a measure that's in the Hospital Inpatient Quality Reporting Program, then every hospital is required to submit the data. And if not, they will have their annual payment update reduced.

Member Fadden: I understand. Well, I mean, I think the contrary view then would be that absolutely they should do this because we're already talking about somebody who's ill, somebody who is being discharged. And if you do not understand what they're discharged to and the challenges they'll have with taking care of themselves and that environment post-acute, then you will see them back again. So I mean, I think fundamentally this is probably more important when it is in the provider level.

Co-Chair Rask: All right, great. I see Collette has her hand raised.

Member Cole: Yeah, I just wanted to comment, kind of piggybacking on what Mike just said. When I looked at this particular program, setting the requirements aside, I think that hospitals are oftentimes more equipped to start steering those patients to resources. And they have a social worker onsite or someone that could kind of put that patient during that hospital stay. So just a thought.

Co-Chair Rask: All right. And from our perspective from looking at this, an impact on rural providers, do we have any concerns or don't have concerns about the data collection for this measure? I am reading a comment from Sandi. I think it would need to be standardized reporting. And if we are not sure what the collection methodology or collection burden might be for providers, it's difficult to agree although important to collect and act upon.

Dr. Perla: Yeah, Kimberly. Just on behalf of the measure developer, I just want to say that I think this is where the results from AHC are actually quite important. We have empirical data.

We've now got five years of data of this measure actually being implemented effectively across 600 clinical sites as we mentioned also in rural sites that the measure would be standard. The mechanism by which the data would be collected would be left at the discretion of the practice or the entity. And one of the things if we look at the year one evaluation from the results is that the clinics that were involved in the study made it clear that they weren't being incentivized.

In a model, you are incentivized to do this. But I think this actually -- I don't know who said it initially. But I think it's actually more important than the prior one. I think that's the perspective of the measure developer given the intense research that we've done across thousands of clinics.

The CPC plus primary care initiative has two tracks. One of the tracks does not require screening. Yet 85

percent of the practices -- this is over a thousand practices -- are doing it voluntarily because they know it has an impact on their patients, even though they have no requirement to do it, there are no incentives to do it.

So I think in some sense, this is really calling a question around what do we want to incentivize. Again, the measure would be standard. The mechanism by which --

Co-Chair Rask: It looks like they may be having connection difficulties. Welcome to the virtual world. Well, other thoughts from workgroup members? Anything else you want to raise as a consideration as we think about applying or voting on this measure for the IQR? And Brock, I see you've got your hand raised.

Member Slabach: Yeah, Kim. And Rocco sadly left us. But I'm just curious when he talks about Accountable Health Communities, the AHCs, did hospitals actually do the data collection for this or was it all clinical sites? Because there's a big difference.

Ms. Onie: No, no, no. Actually, if I can just jump in here. That's a great question. So the Accountable Health Communities pilot had a mix of hospital emergency departments, hospital inpatient facilities, and clinical sites across the country. So this measure has been well tested across all of those clinical sites in both urban and rural areas.

And so it's a great question. But part of our confidence in the implementation of the measure is that AHC did testing so extensively. This measures polls directly verbatim from the AHC measures and was extensively tested in the inpatient setting.

So your point, Brock, to be able to really establish, like, this is actually too burdensome to be able to implement upon inpatient admission or discharge. And that was not a barrier that was encountered in

the model. And obviously, of course, implementation is always implementation. So I'm not going to romanticize it, but it's a great question.

Member Slabach: Thank you. Yeah, no, that's a good point. Thanks.

Co-Chair Rask: All right. And Perry?

Member Payne: Yeah, I just wanted to say there are a variety of measures out there and ongoing research in this area too. And so it's possible that a hospital to take a measure that's fairly low in terms of burden. I mean, that's been here quite a few times.

So I think you could take a low burden strategy for doing this. Most hospitals have a social worker or, you know, have discharge nurses that are already asking lots of questions anyway. So they can include it into their existing workflow to reduce burden. So I just wanted to make those points because I do think there are options out there. And there's peer learning that they can benefit from and so on, right?

Co-Chair Rask: All right. Thank you. Other thoughts from the workgroup? Are we ready to take a vote on this measure for the IQR program?

I guess we are.

Ms. Lynch: I think so.

Ms. Young: The poll is now open for MUC2021-136: Screening for Social Drivers of Health within the Hospital IQR Program. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program. Give it about five more seconds.

The poll is now closed and locked for MUC2021-136 within the Hospital IQR Program. One member strongly disagreed, 3 members disagreed, 1

member was neutral, 6 members agreed, and 3 members strongly agreed.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

Ms. Lynch: Okay. Thank you, everyone. We're going to move on to MUC2021-134. This is Screen Positive Rate for Social Drivers of Health. This is a process measure that is currently under development and assesses the percent of beneficiaries 18 years and old who screen positive for food insecurity, housing instability, transportation problems, utility health needs, or interpersonal safety using a standardized, validated screening tool.

The measure will be for the clinician group facility and beneficiary population level of analyses and will be stratified. This measure is under consideration for the same two programs, so MIPS and IQR. We'll start with MIPS.

Co-Chair Rask: Thank you. Crystal, your thoughts on this measure?

Member Barter: Yeah, thank you. So if I'm understanding this correctly, essentially this is the same discussion that we just had but we're wrapping up the findings of the screening tool. So this is a numerator-denominator measure.

For the numerator, it's the number of beneficiaries 18 and older that screen positive for those elements that were just described. And then the denominator is the total number of beneficiaries 18 and older that were screened. So this is essentially, in my opinion, a lot of the same conversation that we had previously, but we're talking about actually giving the screening a positive rate at this point.

So I think the big question that I have for the workgroup members and/or the measure developer is we did note that there was some autonomy at the organization level in how the screening happens and

essentially the tool, how that information gets collected. So would there be any discrepancies on how the definition of positive I guess comes about at the organization level? Or would that be standardized?

Co-Chair Rask: Let's go to our next discussant, and then we'll open it up and let the measure developers respond to that question.

Member Deml: Hey, guys. This is Cameron. Yeah, I'll admit I don't have anything material to add. I think Crystal posed a good question. And Kim, really I'm only going to add on and also echo maybe just because I'm a health plan guy, what are any direct consequences or unintended consequences of this measure? But otherwise, I think we've had a lot of this discussion. I'm curious to see what workgroup members will say.

Co-Chair Rask: All right. So before opening it up to the other workgroup members, would somebody from the developer team like to address the question of whether or not a positive screen is standardized.

Dr. Perla: Yeah, Kimberly. I'll jump in. I think the short answer there is yes because it has to be linked to the measure. So whoever is doing the screening, whatever tool they use, they have to be able to attach or to be able to map back the result with the actual measure. Otherwise, there's inconsistency. So it's the measure that is really going to drive the standardization, particular for those five domains that are the focus of the measure.

Co-Chair Rask: Okay. So if someone -- yeah, if I'm understanding, so it's the -- so whatever tool and organization uses, they would be expected to use the cut point for that tool.

Dr. Perla: Exactly.

Co-Chair Rask: Understood. Thank you. Other

questions, thoughts from the workgroup? I'm not hearing any. I do not see anything chat. Chelsea, help me if I'm missing any hands. Okay. Collette has asked a question. Could you explain the RA variables? I'm not sure I understand that.

Ms. Lynch: I'm guessing risk adjustment. Is that right, Collette?

Member Cole: That's correct. I was trying to type fast.

(Laughter.)

Dr. Perla: I'll jump in real quick. I love that question. The challenges, this is not included in any risk adjustment model. It's not part of the hierarchical condition category approach. Part of the reason it is not is because we do not have the data on beneficiaries.

There are thoughts that we can do that analysis with the AHC beneficiaries and it would provide some tremendous learning, for example, understanding if beneficiaries with comorbidities also have these as complicating conditions and to illuminate that. It's such a great question because without collecting the data, we'll continue to ask, what is the impact on risk adjustment? And the answer will be we don't know because we aren't collecting the data.

(Simultaneous speaking.)

Member Cole: One -- oh, I'm sorry. I have one suggestion, Rocco, just based from our own experience. We use a ZIP code-based deprivation index that is using census data and kind of capturing level of poverty.

And my first thought as I'm thinking about, yes, it'd be great to have rates for these social drivers of health. And then I start think of some of our hospitals and our healthcare systems that are in

really economically disadvantaged areas. And their rates are going to be out of bounds with everyone else.

Dr. Perla: Yeah, great point. And the other -- there's two sides to that. One is looking at the geographies that we know are going to be problematic. But the other is once we get the screen positive data, a clinic, a practice can begin doing some pattern recognition around ZIP codes where there's a high prevalence of screening positive beneficiaries. There's also a high prevalence of other clinical comorbidities that can begin to be addressed which gets to the actual action that can be taken on the data.

Member Cole: Thank you.

Co-Chair Rask: And Keith, I understand you have your hand raised.

Co-Chair Mueller: Yes, I did. And I typed it into the chat as well because I was wondering if my had raise was working. And I had a question about if the rate is above the cut point and particularly when we get to the discussion of the two payment programs, what's the consequence in the payment program if the rate is either above that cut point once or it increases to a rate above the cut point.

Dr. Perla: I think the position of the measure developer, Keith, this is a great question, is that initially a need to collect data. So this should be in the pay for reporting sort of domain. So on the MIPS side, this is going to be an option measure linked to quality. So it'll probably the 40 percent aggregate score. And so the focus initially is actually not on linking directly to financial incentives but establishing baseline data that could be used to understand what would performance improvement look like moving forward.

Co-Chair Mueller: I have a couple of comments for consideration was if the emphasis is all around

collecting the data, then I don't understand the reason to call out reporting a rate because that would've been in the data collection under what we just discussed. I'm simply doing the data collection and making it available. If the rate is publicly reported, if you're in the quality reporting arena and it's publicly reported, I worry about the same experience we had early on with reports of medication errors that were actually trying to uncover as much of this as possible.

In that case, med errors, in this case, a need to address social determinants and a reporting system that makes it even appear -- I know it's not the intent, but makes it appear that a provider, be it a clinic or a hospital, is not being responsive to the community because the rate is high. I worry about that because I can see again med errors parallel here, an increase in that rate as we get better and better at surveying a wider population and getting the data out there.

Co-Chair Rask: All right. And I see his Mike has his hand raised also for a comment.

Member Fadden: Yeah, I guess I just want to understand that if we're going to do the first of these, is there any additional burden to actually reporting the data? I can't see that there would be. Any reaction to that?

Dr. Perla: We don't believe so either. Just a really important point here just in terms of the psychometric validation is that these instruments, the AHC included but others as well, are based on screening and knowing the result. You can't do psychometric studies, reliability, validity any of that without actually knowing the results.

So these are two that kind of go hand in hand. The measure developer separated them because they are still two discrete activities. One is to ask the question and the other is report the data. But they are interrelated and interdependent in a number of

different ways, not just in terms of clinical application and action but also in terms of reportability and validity.

Member Fadden: And to Keith's point, again, don't want to sound contrarian here. But medication errors happen to the patient. And this is actually reporting environmental conditions in which the patient operates their body and therefore has a direct impact on how well they do. It would seem to me that the data to validate a clinician's viewpoint that, hey, in this community, I take care of the sickest and most difficult patients to manage.

Dr. Perla: Just real quick on that, I want to stick this point in because it's super important. Number of studies, recently a published study in JAMA, demonstrated that clinicians that care for patients with increased social risk has worse MIPS scores. And so higher rates have a number of different ways that can be interpreted.

But one of them is also looking at the challenge of the patient population. And because this isn't routinely captured, wide scale, not standard across the system, that information is lost. So it signals a lot of different things relative to the burden and the challenges for practicing physicians as well.

Co-Chair Rask: All right. Thank you. I would like to just note kind of to the rest of the workgroup members just looking at the calendar -- calendar, looking at the clock. As you can see, we are getting progressively further behind and we have a lot of measures that we still need to finish before we're able to call this day over.

I see that Dr. Price has raised his hand. If you have a very brief comment to make, we'd be open to hearing it. Otherwise, we would like to keep moving on the measures.

Dr. Price: Thank you. I was going to amplify the exact comment that Mr. Perla made. And I really

appreciate the time you've devoted to this discussion. Thank you.

Co-Chair Rask: Thank you. Rest of the workgroup, any other thoughts for discussion or anything you'd like to share before we move to thinking about the voting on this for the MIPS program? All right. Then let's go to the polling.

Ms. Young: The poll is now open for MUC2021-134: Screen Positive Rate for Social Drivers of Health within MIPS. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program. The poll is now closed and locked for MUC2021-134 within MIPS. Zero members strongly disagree, 2 members disagreed, 3 members were neutral, 7 members agreed, and 1 member strongly agreed.

Ms. Lynch: Thank you. So the next program is the hospital IQR.

Co-Chair Rask: And so our first question to the workgroup here is based on the conversation, do we want to pull forward the votes that we just took on MIPS and apply those to our same rating for the hospital IQR program? Or would we like to have some further conversation about any differences in our votes for one program versus the other?

Chelsea, are there any hands raised?

Ms. Lynch: I don't see any hands raised. And just for clarity, if anybody disagrees with this, feel free to voice your opinion. Or you can also -- if you remain anonymous, you can chat privately to me.

And I see no hands raised or dissenting comments. So I think we can go ahead pull those votes forward to the IQR so they will match the MIPS. And we can cover our next measure in the two programs before we take a very short break so we can try to catch up.

MUC2021-084: Hospital Harm -- Opioid-Related Adverse Events

But this is MUC2021-084: Hospital Harm -- Opioid-Related Adverse Events. This is a fully developed outcome measure that assesses the proportion of inpatient hospital encounters where patients age 18 years of age or older had been administered an opioid medication, subsequently suffered the harm of an opioid-related adverse event and are administered an opioid antagonist, naloxone, within 12 hours.

This measure excludes opioid antagonist administration during the operating room setting. This measure is at the facility level of analysis, is endorsed by NQF and is not risk adjusted or stratified. It is being considered for the hospital inpatient quality reporting program and the Medicare promoting interoperability program for hospitals.

Co-Chair Rask: And did our American Hospital Association representative join the call?

Ms. Lynch: I don't think I see him on the platform.

Co-Chair Rask: Okay. So I know the reverend was not able to join us. In terms of rural applicability for this measure. What I can say to it is it's similar to other quality measures which are out there in terms of looking at opioid use followed by use of the naloxone as an indicator for some kinds of adverse symptoms and that it does -- with explicitly excluding the operating room, that addresses some of the concerns that others have had with that as a quality measure. I don't see it as being particularly -- I don't see it disadvantaging rural facilities in my assessment but open to thoughts of other members of the workgroup on the applicability of this measure for rural settings.

Member Fadden: Thanks, Kimberly. I'll just comment. I'm quite familiar with this kind of thing.

As a matter of fact, in my professional role, I've spent a lot of time developing some opiate-related toolkits for electronic health records. This is a good measure. And I don't think it will have any adverse effect of rural institutions.

Co-Chair Rask: Great. Appreciate your input. Any other comments or thoughts from other members of the workgroup?

I don't see any hands being raised. Am I missing any, Chelsea?

Ms. Lynch: I do not see any.

Co-Chair Rask: All right. Last call for comments or thoughts on this opioid measure?

All right. I guess we're ready for a vote.

Ms. Young: The poll is now open for MUC2021-084: Hospital Harm -- Opioid-Related Adverse Events within a hospital IQR program. Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program. Give it a few more seconds.

The poll is now closed and locked for MUC2021-084 for the hospital IQR program. Zero members strongly disagreed, zero members disagreed, zero members were neutral, 11 members agreed, and 3 members strongly agreed.

Ms. Lynch: Okay. Thank you. And since we haven't talked about the Medicare Promoting Interoperability Program for Hospitals, I'll give a quick overview of that program before we decide if we want to carry the votes forward or vote again. But this is a pay for reporting and public reporting program. In this program, eligible hospitals that fail to meet program requirements including meeting the clinical quality measure requirement will receive a three-quarters reduction for applicable percentage

increase. The bill is to promote interoperability using certified electronic health record technology to improve patient and provider access to patient data.

Co-Chair Rask: So the question to the workgroup is do we want to pull through the same votes for using this for the hospital inpatient reporting as well as this interoperability program? Or do we want to have some more discussion about the applicability or impact of this measure on rural facilities for the interoperable program. And if anyone has -- I see some yeses in the chat. If anyone has any objection to doing that, please privately chat Chelsea and if you wish to remain anonymous.

Ms. Lynch: Yes, and feel free to send me a quick no and then you can follow the direction if you feel so inclined because I know sometimes typing can take a little bit of time. So we'll give it about 30 more seconds just to give anybody that opportunity.

Okay. Seeing no raised or anything in the chat, I think we are good to pull those votes forward. Thank you, everyone. We'll take, sorry, just a quick five-minute break and come back at the very convenient time of 3:58.

And then we will try to catch up and get through the measures. But it's been a really great discussion so far. I really appreciate everyone's engagement and wonderful questions. So we'll see you in five minutes.

Co-Chair Rask: Thank you.

(Whereupon, the above-entitled matter went off the record at 3:53 p.m. and resumed at 3:59 p.m.)

Ms. Lynch: So we are running just a little bit behind, but we'll try to wrap up the Measures Under Consideration discussion by 4:45. So you're able to have the full hour, but if you go into it a little bit, we'll try to make sure you have plenty of time for your presentation and to get feedback.

So we'll go ahead and get started. So we will be continuing with our measures that are under consideration for multiple programs, so we'll kind of do a similar fashion.

MUC2021-118: Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty

So the next measure is MUC2021-118. This is the Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty.

This is a fully developed outcome measure that estimates a hospital-level risk-standardized complication rate associated with elective primary TKA and/or THA.

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

Measures at the at the facility level of analysis and is risk-adjusted.

The measure is also endorsed by NQF, but the version of the measure under consideration includes 26 new ICD-10 codes that were not included in the NQF-endorsed evaluation.

This measure is being considered for two programs, the hospital IQR and the Hospital Value-Based Purchasing Program.

Co-Chair Mueller: Thank you for the presentation. Sandi, your comments?

Member Hyde: Thank you. This is NQF-endorsed.

It's an update to an existing measure. I don't see any undue consequences for rural hospitals with these updates.

Co-Chair Mueller: Okay. Mike, anything to add?

Ms. Lynch: Mike let us know that he had to sign off, so I think we could open it to the rest of the advisory group.

Co-Chair Mueller: All right. Open it up for discussion.

All right. Fairly straightforward. So, I think we can just move it along to the two separate -- or one vote carried forward, however we do that.

Ms. Lynch: Okay.

Yeah, I don't see any hands raised or anything, so the first measure it is being considered for is hospital IQR, which I think we've already did an overview for, so I think we can move ahead, unless anybody has a question.

Ms. Young: The poll is now open for MUC2021-118, Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA within the hospital IQR program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed measure.

I'm going to give it about ten more seconds.

The poll is now closed and locked for MUC2021-118 within the hospital IQR program. Zero members strongly disagreed, zero members disagreed, one member was neutral, seven members agreed, and two members strongly agreed.

Ms. Lynch: Thank you, everyone. The second program, the measure is under consideration for is a Hospital Value-Based Purchasing Program.

This is a pay per performance program where the amount equal to two percent of base operating

diagnosis-related group is withheld from reimbursements of participating hospitals and redistributed to them as intended payments.

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

Co-Chair Mueller: Okay. Now, are we okay with just pulling forward the previous vote?

Anybody want to chime in on that, or do we need to discuss this?

Ms. Lynch: Okay, we'll give it about another 15 seconds or so if there's any disagreement with pulling the vote forward.

Okay, I see no hands raised or any comments in the chat.

MUC2021-131: Medicare Spending Per Beneficiary Hospital

I think we are okay to move those votes forward and move on to the next measure under consideration, which is MUC2021-131, Medicare Spending Per Beneficiary (MSPB) Hospital.

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

The measure is not condition-specific, and uses standardized prices when measuring cost.

Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who are

discharged between December 1 and January 1 in a calendar year, from short-term, acute hospitals paid under the Inpatient Prospective Payment System.

The measure is at the facility level of analysis, it's endorsed by NQF, and it's risk-adjusted and stratified.

The measure is under consideration for the Hospital IQR and the Hospital Value-Based Purchasing Program.

Co-Chair Mueller: Okay, thank you for that. Perry, your comments?

Member Payne: Yeah. This is a little tricky.

So this focuses on hospitals that are paid through the Inpatient Prospective Payment System, so that sort of by design eliminates a number -- I think the majority of rural hospitals, critical access hospitals, so you know, I guess my question is whether or not there's an equivalent for rural hospitals for this measure, or, you know, is there -- because the other comment here is that this measure was removed from the IQR in 2020 because of duplication.

And so, I'm sure the workgroup will kind of work through whether or not they want to include it or consider it again.

But I think, you know, because of that duplication, there might be some room for figuring out whether this other measure or measures are better for rural hospitals, so there should be some discussion around that, too.

And I'm not sure if one of those is not so IPPS focused.

So those are my concerns, that this is really not addressing the needs of a number of rural hospitals.

And maybe it shouldn't, maybe I'm just looking for

another measure, but that's the sort of obvious implication there.

Co-Chair Mueller: Okay. Thanks, Perry. Collette?

Member Cole: Thanks, Perry. I just want to say I appreciate the periods that were defined as part of the measure construct, and I don't have anything else to add.

Co-Chair Mueller: Okay, we're open for discussion by the workgroup members.

Ms. Lynch: I don't see any hands raised or comments in the chat.

Co-Chair Mueller: Okay, then. Any responses back to Perry and Collette, anything that you raised that you were hoping to get an answer to or comment on?

No? Okay, then I guess we're ready to move on.

Member Cole: This is Collette. Oh, sorry.

(Simultaneous speaking.)

Member Payne: Yes.

Mr. Ruiz: Can you hear me?

Member Payne: Yes.

Mr. Ruiz: Hi, this is David from the measure developer. Just one thing to note. Yes, the episodes that are initiated under critical assess hospitals are included.

That does leave some rural hospitals within the measure that aren't measured, and we see that they perform pretty similarly to the urban hospitals on the measure on average, although they do have sometimes a slightly lesser risk-adjusted payment.

I would also note that this measure was updated this past year, and went through NQF endorsement

most recently in this year with the updates to it.

And there was a comprehensive reevaluation, you know, a process which allowed us to consider stakeholder comments, literature.

Another empirical analysis, we convened a TEP, you know, to consider potential changes to the measure specifications, and the updated measure was reviewed and endorsed by NQF in August 2021, so very recently by both the standing committee and the subject SMP.

And there was a comment about it being removed from the IQR program previously, and this was in the final rule for Fiscal Year 2019 just to kind of provide more information on that.

It was determined that the costs did outweigh the benefit of having this measure using the program, specifically, you know, if I were to quote from the regulations, that removing this measure from the hospital IQR program would eliminate costs associated with implementing and maintaining the measure, in particular, development and release of duplicative, potentially confusing CMS feedback reports, and also noting that it might be costly for healthcare providers to track these measures.

What I would also note though, is that the -- and but duplicative aspects of the measure is also recorded in the Hospital VBP Program.

But what I would note is that for its reintroduction into the Hospital VBP Program, it needs to go back in through the IQR and public comment.

And so, that's why it's being considered in this MAP.

Co-Chair Mueller: Thanks.

(Simultaneous speaking.)

Co-Chair Mueller: And that covered the comment that Ronique also put into the chat, so. Thanks.

Other comment on this one?

All right then, I think we can proceed to the voting.

Ms. Young: The poll is now open for MUC2021-131, Medicare Spending Per Beneficiary Hospital within the hospital IQR program.

Please submit your response to show whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

All right, I'll give it about ten more seconds. The poll is now closed and locked for MUC2021-131 within the hospital IQR program.

Zero members strongly disagreed, zero members disagreed, three were neutral, seven members agreed, zero members strongly agreed.

Co-Chair Mueller: So, same question as before about -- do any of the workgroup members want to discuss separately the Hospital Value-Based Purchasing Program use of this, or should we pull our vote forward?

Co-Chair Rask: I agree with pulling it forward.

Co-Chair Mueller: Okay, this one was really straightforward, so we will do that.

MUC2021-104: Severe Obstetric Complications eCQM

Ms. Lynch: I don't see any comments in the chat not wanting to do that, and no hands raised, so I think we can move on to the next measure under consideration, which is MUC2021-104, Severe Obstetric Complications eCQM, which is an electronic clinical quality measure.

This is a fully developed outcome measure that assesses the proportion of patients with severe obstetric complications which occur during the

inpatient delivery hospitalization.

The measure is that the facility level of analysis is not endorsed by NQF and is risk-adjusted and stratified.

It is being considered for the hospital IQR and the Medicare Promoting Interoperability Program for Hospitals.

Co-Chair Mueller: Okay, thank you. I believe Anisha is still not able to join us. Am I right?

Ms. Lynch: I don't think I see her on the platform, but hopefully Ana was able to join us.

Co-Chair Mueller: So we're -- Ana, if you are with us -- come back with us, would you lead us on this?

Member Verzone: I am back, yes. So, okay. Thank you.

You can hear me, right? Yeah, so, you know, just in terms of a couple of concerns that came to mind as I looked over it.

You know, one is that in rural areas, there tend to be a higher prevalence of comorbidities in rural communities, like obesity, poorly controlled diabetes, hypertension, which impacts obstetric outcomes, as well.

So, you know, it would be ideal if they could take into account population prevalence of the comorbidities, but I don't know how realistic that is.

But at the same time, I also feel that we have high maternal mortality and morbidity rates in the U.S., and you know, this does give us an opportunity to discuss those, because, you know, here in Alaska, we had one of the worst before, and then to the creation of the regionalization of our perinatal program, we really turned those numbers around, and have way better outcomes now than many other areas that have seemingly a lot less rural

areas in their states.

And so, it seems like the literature from when I read through it, tried to account for potential disparities and comorbidities.

A further concern I had was that it said that blood transfusions were one of the severe outcomes, or one of the serious procedures, and just in my experience, you know, we do a lot of blood transfusions, or we recognize the benefit of doing them earlier, rather than later, in helping people recover, and sometimes people need transfusions, not necessarily because of a complication.

So I'm not sure about that particular measure, and they did point out that said, per report from CDC, the overall rate of SMM increased almost 200 percent, and it was mostly driven by blood transfusions, which increased by almost 400 percent, and if you exclude blood transfusions, there was still a marked increase in 22.4 percent.

So I just sort of wonder about that particular measure being in there because there are various reasons why people give them, and I don't think you necessarily wait until something is severe, because we've seen the benefits of earlier intervention.

Co-Chair Mueller: Okay. Thank you, Ana.

Dr. Balestracci: Hi, this is Dr. Balestracci, representing the measure developer, so I can speak when it's appropriate to respond to those concerns.

Co-Chair Mueller: Okay, let's see if anyone else wants to enter the discussion now, and if not, then we'll turn to you for response.

Any other members in the workgroup may inject something at this point.

Ms. Lynch: One quick question from Karen in the chat.

Co-Chair Mueller: Oh, and you just scroll down, okay. Does this apply to Medicare patients?

So I'll turn it to the developer with both that question and any comments on Ana's questions.

Dr. Balestracci: Yes, thank you so much. Again, Dr. Balestracci.

This is a measure that is an all-payer measure, the cohort are women eight years old or greater up to age 55, so it's not a Medicare population, obviously to except for the small extent on those who receive Medicare for non-age related reasons.

It is a measure that was tested in both rural and urban hospitals, and is risk-adjusted.

I appreciate the comment of population-level factors, but as an EHR-based measure and eCQM, these data are patient-specific coming directly from a facility's EHR system.

I do want to note of importance that this is a measure that is intended to be reported both as a severe obstetric complications measure, as fully defined, but also with an outcome that would exclude patients who reach the numerator only because of a transfusion.

So, it is intended to report two outcomes, the outcome that includes transfusion and transfusion-only cases, but also an outcome that excludes encounters for which transfusion is the only numerator event, for the reason that the committee member expressed -- or I'm sorry, that the subject matter expert expressed, that we recognize that transfusion may be delivered for a number of reasons, and for less severe complications, and we want to be able to measure both of those things.

Co-Chair Mueller: Okay. And there is another question. Could we list off the included complications?

Dr. Balestracci: I'm happy to do that, if you wish. There are 21 complications.

This measure is based on the CDC's surveillance definition of severe maternal morbidity.

So, the complications include anemia. Oh sorry, I'm in the wrong -- sorry, hold on, I'm in the wrong part of the form here.

Co-Chair Mueller: Oh, I can --

Dr. Balestracci: Please forgive me. It's a long form.

Co-Chair Mueller: Well at the beginning of the -- is it the severe maternal morbidity diagnoses in the categories of cardiac hemorrhage --

Dr. Balestracci: Yes, right. So it's acute heart failure, acute myocardial infarction, aortic aneurysm, cardiac arrest, ventricular fibrillation, heart failure and arrest during procedure or surgery, disseminated intravascular coagulation, shock, acute renal failure, adult respiratory distress syndrome, pulmonary edema, sepsis, air and thrombotic embolism, amniotic fluid embolism, eclampsia, severe anesthesia complications, peripheral cerebrovascular disorder, sickle cell disease with crisis, and then five procedures, blood transfusion, conversion of cardiac rhythm, hysterectomy, temporary tracheostomy, and ventilation.

Again, anyone can get this list obviously from some of the documentation you may have, but it is based on the CDC working definition of severe maternal morbidity.

The additional definition for the numerator is a patient who expires during the delivery hospitalization.

Co-Chair Mueller: Other comments, questions?

Ms. Lynch: I don't see any hands raised at this

point.

Co-Chair Mueller: Okay, I don't see anything in the chat box, so we are ready to proceed toward voting.

Ms. Lynch: So the first measure is the hospital IQR program -- excuse me, the first program for the measure under consideration is the hospital IQR.

Ms. Young: The poll is now open for MUC2021-104, Severe Obstetric Complications eCQM, within the hospital IQR program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

I'll give it about ten more seconds. The poll is now closed and locked for MUC2021-104 for the hospital IQR program.

Zero members strongly disagreed, zero members disagreed, zero members were neutral, ten members agreed, and one member strongly agreed.

MUC2021-098: National Healthcare Safety Network Healthcare-associated Clostridioides difficile Infection Outcome Measure

Ms. Lynch: Thank you, and the next program is the Medicare Promoting Interoperability Program for Hospitals.

Co-Chair Mueller: It's the same process. Are there members that would like to discuss this, or if not, we will pull forward the previous vote.

Ms. Lynch: So again, if there's anybody who is opposed to pulling the vote forward, please let us know, and you can send that to me via private chat, if you'd like.

Okay, seeing no hands raised or comments in the chat, we can pull the votes forward and move on to

the next measure under consideration, which is MUC2021-098.

This is the National Healthcare Safety Network Healthcare-associated Clostridioides difficile Infection Outcome Measure.

This is an outcome measure that is currently under development and tracks the development of new C. diff. infections among patients already admitted to healthcare facilities using algorithmic determinations from data sources widely available in electronic health records.

This measure improves on the original measure by requiring both microbiologic evidence of C. diff. in stool and evidence of antimicrobial treatment.

The measure's at the facility level of analysis is not yet endorsed by NQF and will be risk-adjusted.

If you can go to the next slide, we have quite a few programs for this one. There are four hospital programs and three PAC/LTC programs.

The hospital programs are the Hospital-Acquired Conditions Reduction Program, the Hospital Inpatient Quality Reporting Program, the Medicare Promoting Interoperability Program for Hospitals, the PPS-Exempt Cancer Hospitals Quality Reporting Program, and then for PAC/LTC, we have Inpatient Rehab Facility Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, and the Skilled Nursing Facility Quality Reporting Program.

Co-Chair Mueller: Okay. If we can hear from Collette, your comments on this?

Member Cole: Yes, thank you.

I agree that the measure construct is a better construct than the previous measure, and I don't see any issues with implementing this in a rural healthcare setting.

Co-Chair Mueller: Okay, thank you. Brock?

Member Slabach: Yeah, thank you. I agree with Collette.

This is an improvement on the currently applied measure through NHSN and CDC, so I believe that's good.

The problem that many rural facilities face with this one is volume of cases, and the reporting issues related thereto.

I know that many rural hospitals have actually had lower Care Compare ratings because of the HAI basket of analysis, and so this one is subject to small volume problems, and I would always encourage us to think more creatively how we can solve that problem.

Co-Chair Mueller: We've had a question come in from Sandi in the chat box.

Is this measure different from the current C. diff. NHSN data collection? Can anyone answer that?

Dr. Dantes: Yes, this is Ray Dantes. I'm representing the CDC. I'm happy to take that question, if you'd like.

Co-Chair Mueller: Okay.

Dr. Dantes: All right. So yes, we are the measure stewards, you know, for this measure, and the current C. difficile measure.

This measure is an improvement over the existing measure, taking into account feedback that we've had from many users, and the idea that collecting evidence of treatment for C. difficile is a good proxy for a C. difficile test result that was judged to be a true infection, rather than accidentally picking up C. difficile colonization, for example.

Co-Chair Mueller: Okay, and before I turn to Sandi,

who has her hand raised, there was one other question that came in from Karen.

Does the data include the number and type of antibiotics the patient has had prior to developing C. diff.?

Dr. Dantes: So this particular measure will not take into account the previous antibiotic treatment that the patient has received, but it will take into account the antimicrobials that they received for treatment of C. difficile.

Co-Chair Mueller: Okay. And Sandi, you're on.

Member Hyde: Thank you.

And I think it was Brock that mentioned the concerns about low volume, and I share that concern, especially when we're talking about HAC penalty because if you're a small volume hospital, you almost always have enough volume to get C. diff., but you may not qualify for scores in the other areas.

And so, some of the small rural sites may get the HAC penalty for having, you know, two C. diffs over a two-year period, when they were predicted to have 1.67.

And so, those small volumes can contribute, even though two over a two-year period, you know, is higher than what they were predicting, it's still not -- you know, you have hospitals with way more C. diff. infections not getting the penalty.

So, it's hard to explain in those small rural communities why their hospitals are getting HAC penalties for two events.

So anything that you can do to help adjust for a low volume, that would be fantastic.

Co-Chair Mueller: Thank you. Other comments?

Okay, I don't see any additional hands raised, or other comments in the chat.

Ms. Lynch: Okay. No, I don't either, so since we haven't discussed this one yet, the first hospital program the measure is being considered for is the Hospital-Acquired Condition Reduction Program.

This is a pay-for-performance and public reporting program where the worst performing 25 percent of hospitals in the program, as determined by the measures in the program, will have their Medicare payments reduced by one percent.

The goal of this program is to encourage hospitals to reduce hospital-acquired conditions through penalties and link Medicare payments to healthcare quality in the inpatient hospital setting.

So unless there's any questions there, we can go ahead and go to polling for this particular program.

Co-Chair Mueller: Okay.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated Clostridioides difficile Infection Outcome Measure within the Hospital-Acquired Condition Reduction Program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

I'm going to give it about ten more seconds.

The poll is now closed and locked for MUC2021-098, within the Hospital-Acquired Condition Reduction Program.

Zero members strongly disagreed, one member disagreed, two members were neutral, eight members agreed, and zero members strongly agreed.

Ms. Lynch: And the second hospital program MUC2021-098 is being considered for is the hospital IQR program.

Co-Chair Mueller: Okay, do we want to consider pulling the previous vote forward?

And I would suggest both for this and the interoperability program? And the next two then in one decision.

Ms. Lynch: Okay, so if anybody is --

Co-Chair Rask: I would agree with that since it's the same settings.

Ms. Lynch: Okay, perfect.

If anybody disagrees with pulling forward the votes that we just did for the Hospital-Acquired Condition Reduction Program into the Hospital Inpatient Quality Reporting and the Medicare Promoting Interoperability Program for Hospitals, I did receive some comments about concerns with doing that, so we will vote on them individually.

So we can start the Hospital Inpatient Quality Reporting Program.

If there's any discussion we want before, or we can just go straight to the vote, and we just know what you want to vote, but it's just different than what it was before.

Co-Chair Mueller: Okay, any further discussion on this?

Ms. Lynch: Collette has her hand raised.

Co-Chair Mueller: Collette?

Member Cole: Yeah, I had a question. Originally I thought, this is a great measure, but I really kind of took to heart Sandi's concerns about the low volume, and I guess I just want to understand that

better, how frequently penalties are occurring because of the few cases, and maybe that's not a question that can be answered.

Co-Chair Mueller: Can someone help with that?

Member Slabach: This is Brock here. I'll take a start.

So, critical access hospitals do not participate in the IQR, so the 1350 hospitals that are critical access would not be subject to this reporting requirement and potential penalty, but it would apply to rural PPS hospitals, of which there are about 650 of those that are about 100 beds or less.

So there is a potential for that in those facilities, and I agree.

For those hospitals, this can be problematic if they get an abnormal number of these cases.

But then again, I come back to the fact that HAIs are extremely important to monitor and to correct, so I would come down I think in terms of the inclusion of this in the IQR.

Especially updated, which I do like the more updated method, as well.

Ms. Snyder: Hi, this is Grace Snyder from CMS.

I can add a little bit more background information about the Hospital-Acquired Condition Reduction Program to add to what Brock was saying.

I don't have any specific numbers on penalties, however, just to provide a little bit more background, so this program we currently use six measures to determine the total HAC score as we call it.

And five of those measures are CDC, National Healthcare Safety Network infection measures, of which C. diff. is one of them.

And then the sixth measure is a composite measure of patient safety and adverse events.

So, our hospital that has enough data for all six measures, they're equally weighted in the score, however if there are any measures where a hospital does not have enough data, they don't meet the minimum data requirements, then we use the remaining measures that there is sufficient data for, and re-weight the measures.

So, it is certainly possible if there's -- in rural and other small hospitals, they might not have data for, you know, some of the measures right then.

Essentially the other measures that there is data for would sort of contribute more to the total score.

So, you know, certainly we appreciate all of the feedback that we've been hearing.

We know low volume has definitely been a concern I think since the beginning of the program, and so, you know, definitely interested in working with all of you to find ways to try to, you know, better improve the low volume issues.

Member Cole: Thank you.

Member Payne: Are there scenarios where a hospital cannot report any of them? Does that happen sometimes?

Ms. Snyder: I don't have any data at the top of my head.

We can certainly look into that and see if there are any, and what those numbers might look like.

I don't think it's out of the realm of possibility, I just don't have the data with me.

Co-Chair Mueller: Other comments?

If not, we'll proceed with voting on this one.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within the hospital IQR program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

I'll give it about ten more seconds. The poll is now closed and locked for MUC2021-098 within the hospital IQR program.

Zero members strongly disagreed, zero members disagreed, one member was neutral, nine members agreed, and zero members strongly agreed.

Ms. Lynch: And the next program is the Medicare Promoting Interoperability Program for Hospitals.

Co-Chair Mueller: Discussion?

I think you can proceed to the polling on this one.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within the Promoting Interoperability Program for Hospitals.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

About ten more seconds. The poll is now closed and locked for MUC2021-098 within the Promoting Interoperability Program for Hospitals.

Zero members strongly disagreed, zero members disagreed, one member was neutral, nine members agreed, and one member strongly agreed.

Ms. Lynch: Thank you. And the fourth and final hospital program MUC2021-098 is being considered for is the PPS-Exempt Cancer Hospital Quality

Reporting Program. And, again, this is particularly for the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program.

Co-Chair Mueller: Discussion?

And proceed to the vote.

Ms. Lynch: I don't see any hand raises or comments in the chat, so yes, I think we can go ahead and go on with the polling.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within PCHQR.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

About ten more seconds. The poll is now closed and locked for MUC2021-098 within PCHQR.

Zero members strongly disagreed, zero members disagreed, one member was neutral, eight members agreed, and one member strongly agreed.

Ms. Lynch: Okay, thank you. And switching over to the PAC/LTC programs, MUC2021-098 is being considered for the Inpatient Rehab Facility Quality Reporting Program.

This is a pay-for-reporting and public reporting program where inpatient rehab facilities that fail to submit data will have their applicable IRF Prospective Payment System payment update reduced by two percent.

The goal of this program is to address the rehab needs of the individual, including improved functional status and achievement as successful return to the community post discharge.

Co-Chair Mueller: Discussion?

I'm not seeing any.

Member Slabach: I may have been not paying attention, but is this NQF endorsed?

Ms. Lynch: Let me go back and look at -- it's the -- we were just talking about it.

I don't believe so because it is a new measure that is -- let me go back to my notes so I'm not misspeaking.

Dr. Dantes: Yeah, this is Ray Dantes from CDC. Well, we weren't planning to apply for NQF endorsement.

Member Slabach: Oh, okay. Thank you.

Ms. Lynch: Yeah, I know since it has the new specification, I wasn't sure. Thank you.

So the same measure as what we were just talking about for a hospital, but now for the inpatient rehab facility.

I'm not seeing any comments in the chat or raised hands.

Co-Chair Mueller: I don't see any.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within the Inpatient Rehabilitation Facility Quality Reporting Program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

About ten more seconds. The poll is now closed and locked for MUC2021-098 within the Inpatient Rehabilitation Facility Quality Reporting Program.

Zero members strongly disagreed, zero members disagreed, one member was neutral, nine members agreed, and one member strongly agreed.

Ms. Lynch: Thank you. And the second program is the Long-Term Care Hospital Quality Reporting Program.

It is a pay-for reporting and public reporting program for long-term care hospitals that fail to submit data will have their applicable annual payment update reduced by two percent.

The goal of this program is to furnish extended medical care to individuals with clinically complex problems.

Co-Chair Mueller: Discussion?

Not seeing any. I think we can proceed.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within the Long-Term Care Hospital Quality Reporting Program.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

A few more seconds. The poll is now closed and locked for MUC2021-098 within the Long-Term Care Hospital Quality Reporting Program.

Zero members strongly disagreed, zero members disagreed, zero members were neutral, nine members agreed, and two members strongly agreed.

Ms. Lynch: Thank you.

And the final program for this measure is the Skilled Nursing Facility Quality Reporting Program, which we talked about previously, so a very similar

structure, but just for the skilled nursing facilities.

Co-Chair Mueller: Okay. Discussion?

I think we're all ready to just pull this forward and vote on it.

Ms. Young: The poll is now open for MUC2021-098, NHSN Healthcare-associated C. difficile Infection Outcome Measure within the SNF QRP.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

The poll is now closed and locked for MUC2021-098 within the SNF QRP.

Zero members strongly disagreed, zero members disagreed, zero members were neutral, nine members agreed, and two members strongly agreed.

MUC2021-100: National Healthcare Safety Network Hospital-Onset Bacteremia & Fungemia Outcome Measure

Ms. Lynch: All right, thank you.

And we are to our final measure under consideration for this year, so MUC2021-100, the National Healthcare Safety Network, NHSN, Hospital-Onset Bacteremia & Fungemia Outcome Measure.

This is an outcome measure that is currently under development that tracks the development of new bacteremia and fungemia among patients already admitted to acute care hospitals, using algorithmic determinations from data sources widely available in electronic health records.

This measure includes many healthcare-associated infections not currently under surveillance by CDC's NHSN.

Ongoing surveillance also requires minimum data collection burden for user. The measure is at the facility level of analysis.

It is not endorsed by NQF, and will be risk-adjusted. It is being considered for four hospital programs, the Hospital-Acquired Condition Reduction Program, the Hospital Inpatient Quality Reporting Program, the Medicare Promoting Interoperability Program for Hospitals, and the PPS-Exempt Cancer Hospital Quality Reporting Program.

Co-Chair Mueller: Okay. Perry, you have comments on this for us?

Member Payne: I mean, it's very similar to the last discussion I think. A small number of concerns that exist, particularly for the denominator where, you know, the developers predicting what the denominator should be, what they expect the number of infections to be.

I just think that's going to be really hard for areas with smaller numbers, but I'm sure the workgroup will work with them on that, but that's something that definitely needs attention in a rural environment.

We already said it's not NQF endorsed, so to the degree people are concerned about that.

I'm sure as you stated before, they're likely to be going down that road, and then there are duplication concerns, but I think those duplication concerns will be dealt with if this measure is successful and that they are trying to move forward and actually replace the existing measures.

I think that's what's going on here. The developer I think can confirm that. And that's about it. That's all I had.

Oh yeah, one more comment, sorry. So the data -- the sort of pathway to getting the data to CMS, I

wondered about because data needs to be reported to the CDC, then that then goes to CMS, and I just wondered about the role of facilities actually getting the data to the CDC in a timely manner, and given all the stress that facilities are under with COVID and a bunch of other things going on, I really wondered how well that worked and if that is really a smooth route for communicating this information -- or if there's some burden there. Okay.

Co-Chair Mueller: All right, thank you, Perry. I don't believe we've been joined by anybody from AHA, so I'll throw this open for discussion among other members of the group.

Co-Chair Rask: My understanding is that reporting to NHSN is optional for critical access hospitals, as I think we mentioned before, so to what extent that balances burden.

It doesn't mean it'll always be optional.

Member Slabach: Very true. Yeah. And then it's reported to CMS --

(Simultaneous speaking.)

Ms. Lynch: Oh, I'm so sorry.

Member Slabach: Oh, I'm sorry, go ahead.

Ms. Lynch: No, I'm sorry, Brock.

Member Slabach: No, it is -- goes on to -- then to CMS for calculation and care compare, but there's no penalties associated with these measures.

Ms. Lynch: And you --

Dr. Dantes: I'm happy to reply to some of the questions directed towards the measure developers.

Co-Chair Mueller: Okay, go ahead.

Dr. Dantes: So yes, we are planning to apply for NQF endorsement for this measure, as well, and as

you had -- was also alluded to, the intention of this measure is that we think it'll be an improvement, an evolution over some of our existing measures.

So particularly, a central line-associated bloodstream infection, which would actually be a subset of this measure, and the MRSA lab ID measure, as well.

And so the construct for this measure is that we've actually seen improvements in many of these healthcare-associated infections, and we think it's time to zoom out a little bit and try to account for some of these healthcare-associated infections that are actually not counted by some of our existing national healthcare safety network measures.

Co-Chair Mueller: Other comments or questions?

Ms. Lynch: Sandi had her hand raised. Sandi?

Member Hyde: Thank you. So I am not clinical, but I did lean on my cohort here who is the director of infection prevention for all of our hospitals. She is concerned about the reporting burden.

She stated that -- and I may not pronounce this correctly, the fungemia can take several weeks to develop, and that also in our rural hospitals, our infection preventionist may also be the work force health coordinator. They may also be, you know, a part-time ED director.

So they're not necessarily doing infection prevention full-time, so I would just ask that you keep that in the back of your mind when considering the impact of potential burden on rural communities with this measure. Thank you.

Dr. Dantes: I can comment to that point, an excellent point.

It's our intention, you know, with this measure and many of our other NHSN measures in development, our goal is to reduce reporting burden because

infection preventionists have so much on their plate. We think that, you know, this has some distinct advantages over, for example, a central line-associated bloodstream infection reporting, which does take a considerable amount of infection preventionists' time to determine and report, and this can be determined algorithmically using data in electronic health records.

Co-Chair Mueller: Any other comments or questions?

I believe we can proceed then to the voting.

Ms. Young: The poll is now open for MUC2021-100, NHSN Hospital-Onset Bacteremia & Fungemia Outcome Measure within HACRP.

Please submit your response to share whether you agree or disagree that this measure is suitable for use with rural providers within the proposed program.

I'll give it a few more seconds. The poll is now closed and locked for MUC2021-100 within HACRP.

Zero members strongly disagreed, one member disagreed, one member was neutral, eight members agreed, and one member strongly agreed.

Ms. Lynch: Okay. And to Brock's comment in the chat, if there is an interest in pulling the votes forward or if anybody is opposed to pulling the votes forward for the subsequent programs, which again are the hospital IQR, the Medicare Promoting Interoperability Program for Hospitals, and the PPS-Exempt Cancer Hospital Quality Reporting Program.

Anybody is opposed to pulling those forward, please let us know, and again, feel free to share that in the chat with me privately, if you'd like.

I'll give you a few more seconds, just in case anyone's still typing.

Okay, so seeing nothing in the chat and no hands raised, we are going to pull those votes forward to the subsequent -- measure hospital programs, and with that, our review of the measures under consideration for the 2021, 2022 pre-rulemaking cycle is complete.

But we have more to come, which is great, and very much looking forward to this next session.

Discussion of Rural Emergency Hospitals

Definitely changing gears a little bit here, so we're going to hand it over to Timothy Jackson, Grace Snyder, and Vinitha Meyyur to provide an overview of a new rural emergency hospital program that is under consideration, and they'll lead the discussion to obtain your feedback on the information that they share.

So I'll go ahead and turn it over to CMS.

Ms. Snyder: All right, thank you very much. Hi, I'm Grace Snyder, and I am the director of the Division of Value-Based Incentives and Quality Reporting at CMS.

Sorry, if you can go to the next slide, please?

And so we really appreciate this opportunity to bring forth the topic of -- we're actually very excited about this new rural emergency hospital quality reporting program that we'll be adding to the portfolio of quality programs.

And so we appreciate the opportunity to talk about this new program that we'll be standing up over the next several years, and this is really kind of early stage, but we really wanted to bring this topic to the experts, really get your thoughts, ideas, and really the conversations we've had all day today have been very informative and are all things that we'll be taking into consideration as we stand up this new program.

So next slide, please.

And I know this is the last substantive topic before we can finish our day, so I'll try to just kind of hit the main highlights of the slides, and so we can have enough time for some discussion afterwards.

But just wanted to provide some summary information that's really -- this is all information from the Consolidated Appropriations Act of 2021 that establishes this new provider type of a rural emergency hospital.

Next slide, please. Okay.

And so the types of hospitals that will be eligible will be rural hospitals with less than 50 beds, or a critical hospital -- critical access hospital, excuse me, that would be able to convert from being a CAH to a rural emergency hospital. And as the name suggests, main services that would be provided are emergency services and observation care.

Next slide, please.

All right. The law also allows the REH to have a distinct part that offers skilled nursing facility services, as well, but would also have to be able to meet those requirements to operate and get paid as a SNF.

And in terms of payments, so as a rural emergency hospital, they'd be eligible for an additional five percent, as well as an additional facility payment. So that's the payment aspect of it.

And then on this slide, just I think some additional requirements in terms of staffing, that it would be staffed on a 24 hour, seven days a week basis, and meet similar staffing requirements as critical access hospitals.

Next slide, please. All right.

Some additional requirements that the law requires,

that the transfer agreement with a Level I or Level II trauma center, and that they're meeting the requirements for providing emergency services and EMTALA requirements, as well.

So, next slide, please.

So this past summer and into the fall, through our Outpatient Prospective Payment System rule, we did put out a request for information to start getting stakeholder feedback on various aspects of this new provider type, the REHs, and so we really asked I think a whole pretty broad set of questions around health and safety standards, payment policies, certainly quality measurement, and so just I think trying to start off with sort of a broad set of -- get some broad feedback, so we really appreciate all the stakeholders who had taken time to submit comments to us, and today we are, you know, continuing to keep the conversation going, and to make sure that we're getting as much stakeholder feedback as we can.

And then also to let you know for future rulemaking, we will be proposing the health and safety standards as part of a condition of participation, and what those details will be for rural emergency hospitals.

Next slide, please.

Okay, so I'll turn it over to my colleague, Vinitha Meyyur, to talk more specifically about quality measurement. Thank you.

Dr. Meyyur: Thank you, Grace. Good afternoon. This is Vinitha Meyyur from CMS to thank you for your time, and we look forward to the discussion and thank you for your feedback in advance.

So, as Grace mentioned, we are trying to stand up this new program, and a big part of the program is the quality measures and the quality reporting piece, and we thought today would be a good

opportunity to kind of get feedback from you on, you know, a very high level discussion on what types of concepts, you know, you would like to consider for this program, if you want to discuss like specific domains or measures, or, you know, we're just open to discussion and feedback.

And so this slide just kind of basically lays out the quality reporting piece, and if we could move to the next slide?

What we are focusing on is, you know, in quarter 4 of this, you know, 2022 and next calendar year, we plan to solidify the measurement portfolio for this quality reporting program.

And so really coming up soon would be our pre-rulemaking, which is the MUC List in the spring, and so we wanted to open the conversation and have a discussion in terms of, you know, to encourage stakeholders to submit measures to the MUC List, as well as have a discussion on measure concepts that would be relevant to this setting, what types of measures, meaning should we start with process type of measures and move to outcome measures, what type of data submission methods would be applicable, or more actually feasible for the setting.

So basically it's open discussion, and we'd love to hear your feedback.

Member Slabach: Oh. Is there more comments?

Dr. Meyyur: No, I believe that's the last slide in the slide deck.

Member Slabach: Okay. I just didn't want to start diving in if we were transitioning.

Dr. Meyyur: Please go ahead.

Member Slabach: Is that okay? Okay, yeah. This is Brock here with National Rural Health Association.

And thank you for the attention you guys are going

to be paying to this subject because I think this is going to be really important for this program and its success going forward.

One of the other bigger questions of course will be payment and how these will fair financially after implementation.

But on the subject of quality, this will be paid under the OPPS, so they will be submitting billing that's going to go through OPPS, so that makes it convenient for, you know, attachment of quality measures.

And I'm just curious. Obviously this will be an outpatient facility. I know that we have the emergency transfer communications protocol, or the ETCP.

Some of the others on the call may have a lot more currency in terms of that measure, but it basically does a nice job, and what I wanted to underscore here was how well the facility stabilizes and transfers patients to their referring site.

So that's the subject of what they do, that's what their role is.

And so we need to be -- we need to have measures that actually measure that element of their work, and not apply measures that may not be that helpful in terms of understanding the quality of the work that they're assigned to do.

But I just gave you an example of one measure set that would fill that void and maybe give you some items there.

I believe the ETCP is NQF endorsed, and it's used in the critical access hospital program, and it may still be the MBQIP, the Medicare Beneficiary Quality Improvement Project.

And so, you know, it could be easily adaptable in this context, but I -- but there may be other

measures too, and I would really like to hear from some of my colleagues about that.

Maybe there's nobody left on the call. Maybe we're all --

Ms. Lynch: There's quite a few participants, so.

Member Slabach: Oh, I'm fine.

Dr. Meyyur: Yeah. But I am familiar with that ETCP measure. It's part of the MBQIP Program with HRSA.

Member Slabach: And this might be a good example of what I -- you know, I've been talking a long time and as part of the -- it's not frustration, it's just the challenge that we have in this environment right now is that when we go through the entire measures under consideration that we went through today, it's from the frame of all of the reporting programs that are in existence now and the needs that they have, and we're just kind of looking at what's rural relevant, but there's nothing core relevant to rural that we're discussing as its own set.

And I think we have an opportunity here, and I would think that -- I don't think we have a lot of time for measure development between now and January 1 of 2023, but I think we need to look at the story that we want to tell in terms of quality outcomes in an REH.

What's that story, what's the construction of metrics that's going to tell a story about the quality of that facility, in terms of its complete operation?

So ETCP would be one set possibly that would be at the emergency room point. And then going into the other services that they're offering.

So obviously maybe optional sets of measures if they're doing a rural health clinic, for example, as an attachment to this facility.

And offering rural health clinics the ability to participate in some quality measurement program as part of this operation.

And I think that you could look at the skilled nursing facility. They would be distinct parts, so they would be required to report those measures that we've already discussed today.

But thinking about this in kind of a holistic fashion I think would be really interesting and a challenge for us, and we have an opportunity I think at this point, so I appreciate the input that you're asking for.

Co-Chair Rask: In terms of domains of measures, thinking about two of the aspects that you would hope are, you know, for quality in these settings, are that people who present to the setting are assessed or, you know, managed in a timely manner, thinking of some of the measures that we currently have for emergency departments that might be appropriate for this setting, and then secondly, as Brock already mentioned, the appropriate transfer of people to a higher level of care as needed, and that, you know, measures that relate to that, to appropriate transfers.

So thinking about the function that you'd hope to have that setting be really good at, and then measures that can capture that. And it would be more around process.

When I think about these settings, I find it more difficult to think maybe about the outcome measure because I'm not sure that someone spending a lot of time in this area, that this is -- I don't want to just sort of say triage, but it's kind of, it's an intermediate setting, so it's thinking about what are some of those timeliness and appropriateness measures that are currently being used in the ED setting that would be appropriate for this use, as well as care coordination measures that would promote the linkage of those relationships with the next level of care, should that be required.

Another area that I'm not as familiar with, and I don't know if others would think that if there is a vision or a thought that these entities are going to be delivering care in some ways that are different from what an urban emergency department would see, then is there an opportunity to capture that if it's -- if these entities are providing more, even more that's routine care, do we actually want to include some routine care type measures, because that would be the first site of care in their communities.

Just a few thoughts.

Dr. Meyyur: What about the patient safety measures? I know MBQIP has patient safety measures, they have the NHSN measures, and some of the ones we just discussed this afternoon, so. Do you think that's a good domain to add?

I know I understand the sample size issues, but.

Member Slabach: I think the -- I like NHSN. The problem is you're not going to have inpatients in this facility, so it's -- I'm trying to think about the set now.

It's been a while now since I've looked at those, but to the extent that they would apply in an outpatient -- really this is a freestanding emergency room essentially, so it's like what would apply from that in this setting.

And I think that, yeah, and I think that that would be some good material to think about.

Co-Chair Rask: I'm thinking in general though a lot of them are facility onset, and so facility onset for a facility that keeps people a very short period of time, I mean, unless there's some of the specific procedure-based ones, if we anticipate that these facilities would be doing procedures, then a procedure related one would be from -- that is likely to be done very commonly in the area might be one

just, you know.

Member Slabach: I do want to put a plug in for process measures. I think we've talked around this -- about this a little bit.

They are very helpful and effective I think in these facilities -- in all rural facilities, actually. I know we kind of want to move towards evidence-based or outcome-based measures, but in a small volume environment, those are, as I think Kim mentioned a second ago, are difficult, but process measures are things that rural facilities can understand and they can implement and do well if given the correct instructions.

So I would look at process measures, and to the extent possible, evolve into outcomes, and maybe tie those to somehow into volume expectations with those.

Co-Chair Rask: And I would absolutely agree with that.

(Simultaneous speaking.)

Co-Chair Rask: Sorry.

Ms. Lynch: No, it's all right. I was just going to say Collette also has her hand raised.

Member Cole: Go ahead, Kimberly. I'll go after you.

Co-Chair Rask: I was just agreeing with Brock to saying that approach.

You know, especially with a new entity, it's easier to get buy-in from the participants, as well as interpretation of the results of the measurement if you're able to look at things that come a little bit closer to unequivocal, yes, this is what should happen, this is what we would expect to happen, while every time we move into outcomes, even though that is so important and that's what matters to patients, by the time you start talking about risk-

adjusting, making sure you've got the right inclusion exclusion criteria in small numbers where we expected these different entities depending on their geographic location, as well as the communities they're in are likely to be very different, I think you might spend more time with people arguing about the results, rather than using it to drive improvement.

So I would echo focusing on the process measures would then, to my mind, for a couple of years, and then thinking about where there are opportunities. Thank you.

Member Cole: This is Collette. I just -- putting my measure developer hat on, I just wanted to put a plug for if there's new measure concepts or new measures that could be constructed, to consider building measures based on data that we know is in structured, reportable fields.

There's a wealth of measures that can be built using vital signs, medications, diagnoses, time elements within the chart. I just, I think it's important to keep an eye to building measures that can be truly less burdensome for providers.

Ms. Lynch: And there's also a comment in the chat from Natalia.

Just going back to the NHSN measures that a number of patient safety measures reported through NHSN, such as CLABSI, have presented issues in terms of standardized infection ratio calculations for CHAs, and just wanted to mention that in case it helps.

I wanted to make sure the entire group was able to see that comment in case it does help.

Member Slabach: I would like to do a reminder because in fact it's caused me to want to go back and look at some of the documentation already generated by the NQF and its rural workgroup

starting in 2015, I think, with the rural report, and then we had a couple of years later the introduction of a measure set that we proposed from the rural workgroup for consideration in the clinical and in the hospital space. So in the clinic and hospital space.

So I'm thinking I should have done that before today, but I didn't realize that we were having this conversation until last week, so I didn't have time, but we have a lot of good material that the NQF has helped to produce on the subject of reporting in rural and small volume environments.

Ms. Lynch: And just to piggyback on Brock's comment, that same core measure set I believe is scheduled to be looked at over the next year as well, so I think more to come there.

Member Slabach: I'll just throw out here --

Dr. Meyyur: Thank you for your feedback.

Member Slabach: Oh.

Dr. Meyyur: Yeah. No, if there are no other questions or, you know, feedback, you can certainly write to us anytime, email us, and we'll be happy to engage with you.

Ms. Lynch: Brock, did you have one final thing?

Member Slabach: Oh, no, I didn't. It was just a thought that passed.

Public Comment

Ms. Lynch: Understood. Well, thank you all for your time, and certainly appreciate getting this information on the new rural emergency hospital -- emergency program.

If there are any thoughts that come to mind, we are happy to put you in touch with our CMS colleagues to make sure that information gets shared, so please feel free to use our team here at NQF as kind

of that bridge over.

And before we open it up for comments from the public, I did just want to make sure that everyone saw my comment in the chat that, just a point of clarification regarding all of the MUCs that were -- or all of the measures under consideration for the promoting interoperability program.

These would be applicable to the CHAs. I think there was some question during our comment -- during our discussion, so just wanted to clarify that they would be applicable to those critical access hospitals.

So if that causes any need for additional discussion or anything, let me know. But otherwise, we will go ahead and open it up for any comments from the public.

So feel free to raise your hand, you can put comments in the chat, or if you are on the phone, you can go ahead and unmute, as well.

Okay. And I know sometimes there is problems unmuting, so I'll leave that open for another 30 seconds or so just to make sure if anybody -- welcome to speak publicly.

Okay, so seeing no comments or raised hands, or hearing anybody trying to unmute, I will go ahead and turn it over to Victoria for next steps.

Next Steps

Ms. Freire: Thank you, Chelsea. If we could go to the next slide? Thank you.

Okay, so now that we have finished our meeting for this cycle and reviewing our measures under consideration, we have public commenting period which ends tomorrow, and then we have the remaining workgroup review meetings, the feedback from this meeting will be incorporated and will be shared with the Clinician Workgroup, Hospital, Post-

Acute/Long-Term Care, and the Coordinating Committee.

Those will take place over December and January. And then we will have a second public commenting period that'll last from December 30 through January 13, and then the final recommendations to CMS will take place by February 1, 2022.

Just for a reminder, here's our timeline. We are currently in December going through the advisory group and workgroup review meetings this week and next week, and then in January, the MAP Coordinating Committee will have their review meeting to finalize recommendations, and then like I said, February 1, the final report will go to CMS HHS.

And here is contact information. There is our project page where you can always go to see meeting materials or download the final reports. We have the Advisory Group SharePoint site and our email to contact us if you have any questions.

And I will turn it back over to Chelsea.

Ms. Lynch: Okay. Thank you all for your time today. It was truly a marathon and got in under the wire, which was great. Incredible discussion, incredible engagement.

I'll turn it over to our co-chairs, but certainly from NQF, thank you for your time today.

I know how much the workgroups value -- the workgroup and the Coordinating Committee and CMS really appreciate all for your feedback and your time, so thank you.

But I will go ahead and turn it over to our co-chairs to see if they have any closing remarks as well.

Do you want to start with you, Keith, this time, and we'll have Kimberly wrap up?

Co-Chair Mueller: Okay. Thanks to everyone. This was a very productive day, and I was really impressed with how robust the discussions were when they needed to be, and how we were incredibly efficient when we had the opportunity to be efficient.

And I join Kimberly in the shoutout to the staff, both in everything that was done to prepare us and in writing an agenda that we actually got through and pretty much on time through all the sections.

I will call on you for advice on how to do that in the future when I have to write those agendas. Thank you.

Co-Chair Rask: I'd just echo thanks to the NQF staff, thanks to the workgroup members, and really what you offer, it's not just the numerical average of approval for each of the measures, but those qualitative comments that came in really help inform the little paragraph that goes to the workbook -- the other workgroups, and really gives them, you know, kind of an input on the rural spin, on how to think about some of these measures.

So that's really useful, and thank you all for keeping your attention all day.

Adjourn

Ms. Lynch: All right. And with that, we will adjourn our meeting today. Looking forward to seeing all of you in 2022.

Have a wonderful holiday, and a very happy start to your new year, and we look forward to engaging with you next year.

(Whereupon, the above-entitled matter went off the record at 5:34 p.m.)