National Quality Forum
Measure Application Partnership (MAP) Post-acute Care/long-term Care (PAC/LTC) Workgroup
Thursday, December 16, 2021

The MAP PAC/LTC Workgroup met via Videoconference, at 10:00 a.m. EST, Gerri Lamb and Kurt Merkelz, Co-Chairs, presiding.

Present:

Gerri Lamb, PhD, RN FAAN, Arizona State University; Co-chair
Kurt Merkelz, MD, Compassus; Co-chair

Members Present:

Larry Atkins, National Partnership for Healthcare and Hospice Innovation
Alice Bell, American Physical Therapy Association
Desiree Collins Bradley, ATW Health Solutions
Jill Cox, National Pressure Injury Advisory Panel
Mary Ellen Debardeleben, Encompass Health Corporation
Nicole Fallon, LeadingAge
Anna Kim, American Geriatrics Society
James Lett, National Transitions of Care Coalition
Dheeraj Mahajan, the Society for Post-acute and Long-term Care Medicine
Ben Marcantonio, National Hospice and Palliative Care Organization
Cheryl Phillips, SNP Alliance
Pamela Roberts, American Occupational Therapy Association
Debra Saliba, American Geriatrics Society

Individual Subject Matter Experts (Voting):

Dan Anderson, PhD
David Andrews, PhD
Paul Mulhausen, MD, MHS
Sarah Livesay, DNP, APRN, ACNP-BC, ACNS-BC
Terrie Black, DNP, MBA CRRN, FAHA, FAAN

Federal Government Liaisons (Non-voting):

Raymund Dantes, Centers for Disease Control and Prevention
Andy Geller, Centers for Disease Control and Prevention

Alan Levitt, Centers for Medicare and Medicaid Services
Michelle Schreiber, Centers for Medicare and Medicaid Services
Brenda Akinnagbe, Office of National Coordinator for Health Information Technology

NQF Staff:

Dana Gelb Safran, President and CEO
Matthew Pickering, Senior Director
Susanne Young, Manager, Measurement Science and Application
Ashlan Ruth, Project Manager
Becky Payne, Senior Analyst
Gus Zimmerman, Coordinator
Taroon Amin, NQF Consultant

Also Present:

Andrea Benin
Thomas (T.J.) Christian
Tricia Elliot
David Gifford
Alexandre Leberge
Megan Lindley
Sarah Livesay
Cindy Massuda
Sri Nagavarapu
Jennifer Riggs
Evan Shulman

Contents

Welcome, Introductions, Disclosures of Interest & Review of Meeting Objectives 6

CMS Opening Remarks 22

Updates on the Hospice Outcome and Patient Evaluation Assessment Tool 38

Overview of Pre-Rulemaking Approach 47

Cross-Cutting Measure: MUC2021-098 National Healthcare Safety Network Healthcare-Associated Clostridioides Difficile Infection Outcome Measure 61

Pre-Rulemaking Input 62

- Skilled Nursing Facility Quality Reporting Program 63
- Long-Term Care Hospital Quality Reporting Program 78
- Inpatient Rehabilitation Facility Quality Reporting Program 92

Skilled Nursing Facility Value-Based Purchasing Program Measures 111

- Updates to the SNF VBP 112
- Pre-Rulemaking Input 118
- MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization 120
- MUC2021-137: Total Nursing Hours Per Resident Day 134
- MUC2021-130: Discharge to Community Post-Acute Care Measure for Skilled Nursing Facilities 145
- MUC2021-095: CoreQ: Short Stay Discharge Measure 157

Skilled Nursing Facility Quality Reporting Program Measures 165

MUC2021-123: Influenza Vaccination Coverage among Healthcare Personnel 165

Summary of the Day and Next Steps 197

Proceedings

(10:00 a.m.)

Welcome, Introductions, Disclosures of Interest & Review of Meeting Objectives

Dr. Pickering: So good morning, everyone. My name is Matt Pickering. I am a Senior Director here at the National Quality Forum also working on the PAC/LTC Workgroup.

I want to welcome everyone. It is 10:00 a.m. Eastern. And so this is the start of the MAP PAC/LTC Workgroup meeting.

So thank you all very much for joining. I also just want to draw your attention to the slide. If you're on the web platform, there's just some housekeeping items we wanted to kick off with before we go into today's proceedings.

We are using Webex. There is a platform you can use and open up. And on that platform, there are several features that we'll be going through here briefly.

One is as all virtual types of meetings and any phone calls, we just ask that you keep yourself on mute if you're not speaking just to prevent any background noise so that we can go through the proceedings pretty well and everyone can hear one another.

Second is on the web platform with Webex, and if you've used other web platforms before, there are certain features such as a chat feature and raised hands for being called upon for discussion. Those are also within this Webex platform so you have that opened up.

The chat box is this little icon towards the bottom right of that platform. So you can open that up, and you can monitor the chat as well, message everyone or people individually, including myself and NQF staff members.

There's also the participant list to raise your hand. So next to that little chat icon, that little call out bubble, there is sort of a figure of a person and that's the participant list.

Your name should be the first name on that participant list as you pull it up. To raise your hand, if you hover over your name with the mouse, there's a little hand icon that pops up. And if you click that, that will allow you to raise your hand.

And so we will encourage you to use both of those during the discussions today, especially when it's open for workgroup discussion. If you raise your hand, we will call on you and go down the list accordingly as you do raise your hands.

If you do have any technical difficulties with the platform or anything with today's proceedings, please don't hesitate to email the project box, which is MAP, M-A-P, and that's pac-ltc@qualityforum.org. And so we will definitely monitor our inbox to see if there are any technical difficulties.

I'll mention it just now, and we'll mention it again when we get to that portion of the slides, earlier this morning you were also sent a survey -- excuse me, a Poll Everywhere link, the voting link, to today's proceedings.

Please go ahead and find that in your emails. We will be touching base with the workgroup again later today to do a voting test, but this is the platform we will be using to vote on the measures for consideration. So please go ahead and locate that email.

We will definitely follow-up later on when we do the voting test. If there's any technical difficulties there, we'll sort of work through those. But that email was sent out early this morning, so please check your inbox for that voting link. It's a Poll Everywhere link.

Okay. So we'll go to the next slide. So, again, welcome, everyone, December 16. This is our third MAP meeting this week. We've had clinician and hospital and today we're concluding with the best of the best, which is PAC/LTC, right? Gerri, our co-chair, thumbs up there. Thank you, Gerri.

But thank you very much to the workgroup members for your time and participation in this important work in informing pre-rulemaking and the measures to be included in federal programs.

I also want to thank our CMS colleagues who support this work. We have several of them on the call today, some of which you will hear from today in presentations. They worked closely with NQF on getting all the materials ready for us today.

Thank you to the developers as well for all of their work in contributing to the Measures Under Consideration as well as to members of the public who are participating. And we have opportunities for the public to also weigh in on the Measures Under Consideration.

And lastly I do want to give a big thanks to the NQF team in preparing all the materials and getting us ready for the proceedings today.

If we go to the next slide, I'll just touch on our agenda. So we'll start with welcome and introductions as well as disclosures of interest. So with the disclosures of interest, you've received emails from us asking you to please complete this form, which is just to disclose any potential conflicts you have with the measures today. We'll go through those disclosures of interest and then we'll review the meeting objectives.

Dr. Michelle Schreiber is on the call today. She will also be providing some opening remarks as well as Alan Levitt. Dr. Alan Levitt will also be providing some opening remarks as well.

And then we have an update to the Hospice Outcomes and Patient Evaluation Assessment tool or the HOPE tool. So we have some presenters to provide an update on that tool. That is of interest to this workgroup.

We will then follow with an overview of the pre-rulemaking approach. So this is just going through our preliminary analysis algorithm as well as our decision categories. So those four decision categories that you will also be assessing the measures against, we will be going through those.

And then touching on two advisory groups that we've convened prior to these meetings. The Rural Health Advisory Group, which has convened previously in years past, which are inputs that will be added to the preliminary analysis or have been added for your consideration.

The second advisory group, which is new this year, is the Health Equity Advisory Group. And they are really looking at the measures from the sense of health equity. And these measures actually decrease health care disparities and promote health equity.

Those inputs in a very similar fashion have been added to the preliminary analyses for the MAP's consideration. And we'll be touching on those today as well.

We do have time for lunch, about 30 minutes. So we'll break for lunch before we actually go through the Measures Under Consideration. So we'll reconvene and start out with those Measures Under Consideration. We have a few breaks built in.

And as we evaluate those measures, for those members of the public who have seen the agenda, there is an opportunity before the MAP actually votes on measures for the public to actually weigh in and provide input for the MAP's consideration before voting on the measures.

That is different than the last opportunity for public comment that you see listed there. We do have space built-in at the end of the meeting for the public to also provide comments.

If we do have time prior to the opportunity for public comment at the end, we will have a gaps discussion for programs that did not have measures submitted to them for PAC/LTC. So we do have some slides at the end of our slide deck. Time permitting we will do a gaps discussion of the programs that did not have measures submitted to them.

And then after public comment, we will then do a summary of the day and the next steps before we adjourn and wish everyone happy holidays.

Before I proceed, I'm just wanting to make sure are there any questions thus far from the workgroup? Okay. So I will go to the next slide, and I will turn it over to our CEO, Dana Safran, who will provide some welcoming remarks to everyone. So, Dana, I'll turn the floor to you. If we could go back one slide, there we go. Go ahead, Dana.

Dr. Safran: Thank you very much, Matt, and good morning, everyone. It's truly a pleasure to welcome all of you today to our MAP Post-Acute Care/Long-Term Care Workgroup review meeting in the 2021-2022 MAP cycle.

NQF is absolutely honored to continue our partnership with the Center for Medicare and Medicaid Services and the MAP PAC/LTC Workgroup in this very important work.

This is really where the rubber meets the road looking at the ways that measures will be used and providing advice and input to CMS as they consider measures for use in public reporting and performance-based payment programs.

As all of you know very well, MAP brings together a

unique multi-stakeholder group that represent quality measurement, research and improvement, purchasers, providers, public and community health agencies, health professionals, health plans, consumers, suppliers and subject matter experts.

And through gathering this diverse set of stakeholder voices, it really enables NQF to support the federal government in receiving varied and thoughtful input as it considers measures for final rulemaking.

I really want to highlight the work of the Rural Health and Health Equity Advisory Groups that Matt mentioned. As Matt said, they completed their review last week of all measures for clinician, hospital and PAC/LTC consideration.

The Rural Health Advisory Group has been providing input for a number of years. And the Health Equity Advisory Group is new this year and has shared insights on each measure's ability to identify disparities and to further promote health equity.

The meetings last week were very full and robust. And the input they've provided, I think, will enhance today's discussions significantly.

Finally, I will just add my thanks to the thanks that Matt shared. Thank you to our workgroup members and federal liaisons for the time and effort that they put into this work. We know it is a significant demand on your time and attention, and we are so appreciative.

Also a particular thanks to the workgroup chairs, Gerri Lamb and Kurt Merkelz, for their leadership of this work and for all that they need to do to prioritize this in their own schedules and to-do lists.

Finally, I'd like to thank the members of the public who are taking the time to participate and offer their comments here in the meeting or online during our public comment period. Your feedback is really

important to this process. And we really thank you for your time and attention as well.

So looking forward to today's discussion on six Measures Under Consideration for PAC, one from care and your feedback on the federal programs under consideration. And with that, I will turn it back to you, Matt.

Dr. Pickering: Thank you so much, Dana. And I'd like to turn it over to our co-chairs, Gerri and Kurt, to provide some welcoming remarks as well. So, I'll start with Gerri and then we'll go to Kurt. Gerri?

Co-Chair Lamb: Thanks, Matt. And thanks so much, Dana, for your welcome. I am absolutely delighted to be with all of you today. Good morning to everyone. And to add to Matt and Dana's welcome to everybody who is on this call with us, the workgroup members, the measure developers who are joining us, our NQF team, who is absolutely wonderful, CMS partners, who has been a pleasure to work with over the years and certainly our public members who have joined today to be an important part of this discussion. All of you have really important voices. So Kurt and I are looking forward to facilitating that with you today.

I am especially pleased to be back as your co-chair and to work with Kurt. Kurt, it's just a pleasure working with you. And I'm looking forward to the whole discussion today. I wish we could be there in person. It would be great to see all of you again in person. And I'm really excited about making recommendations in the discussion ahead. So, Kurt?

Co-Chair Merkelz: Yeah, thank you, Gerri. I'm very happy to be back with everyone. Happy to see everybody. Welcome, again, also to CMS, the measure developers and certainly all the members of the workgroup and anybody from the public who is attending.

I also want to wish everyone a, you know, safe

holiday season on the days ahead of us. It's been a truly challenging year, not the least of which has been COVID.

You know, I just want to do just a quick call out to all of us to make sure we keep a lookout for what I think should be our North Star as we look at measures, patient reported outcomes.

We need to encourage support and really drive, I think, measures of care that are really focused on what patients receive and maybe not take as hard a look, you know, as we have been doing about what the health care system is delivering.

We're really making a very healthy provider, but the patients are still very much needing the services we provide. So just give a call out to keep our North Star patient reporting outcomes.

Again, welcome to everyone. We look forward to today. And I'll turn it back over to you, Matt.

Dr. Pickering: Great. Thank you so much, Kurt and Gerri, for those welcoming remarks. We'll now go to the next slide. And we'll go through the introductions and disclosures of interest for our workgroup participants as well as our subject matter experts and federal liaisons.

So as a reminder, NQF is a non-partisan organization. Out of mutual respect for each other, we kindly encourage that we make an effort to refrain from making comments, innuendoes or humor relating to, for example, race, gender, politics or topics that otherwise may be considered inappropriate during the meeting.

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

We'll combine disclosures of interest with introductions. We'll divide the disclosures of interest into two parts because we have two types of members. We have organizational members, which you can see listed here, and subject matter experts. So right now we'll start with the organizational members.

And as a reminder, organizational members represent the interests of a particular organization. We expect you to come to the table representing those interests.

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

So we'll go around this virtual table, beginning with the organizational members only first. I'll call on anyone on the meeting who is an organizational member. When I call on your organization's name, please unmute your line, state your name, your role at your organization and anything you wish to disclose.

If you do not identify any conflicts of interest after stating your name and title, you may add, I have nothing to disclose. So we'll reserve our co-chairs for when we get into our subject matter experts. So I'll just go down the list in alphabetical order here. I'll start with AMDA, The Society for Post-Acute and Long-Term Care Medicine.

Member Mahajan: This is Raj Mahajan. I'm an internist geriatrician, representing the Society for Post-Acute Long-Term Care. And I have no conflicts.

Dr. Pickering: Thank you very much. The American Academy of Physical Medicine and Rehabilitation. Anyone from the American Academy of Physical Medicine and Rehabilitation? Okay. We'll circle back.

The American Geriatric Society? The American Geriatric Society? Okay. The American Occupational Therapy Association?

Member Roberts: Pam Roberts. I'm on the Quality Committee for the OTA. And I have no conflicts.

Dr. Pickering: I'm sorry. Can you mention that one more time?

Member Roberts: Yes. I'm on the Quality Advisory Committee for the American Occupational Therapy Association, and I have nothing to disclose.

Dr. Pickering: Great. Thank you. You were just coming a little faint there. But thank you very much. The American Physical Therapy Association?

Member Bell: Good morning. This is Alice Bell, representing the APTA. I am a physical therapist and on staff as a senior payment specialist at the APTA. I'm happy to join the meeting. And, I'm sorry, no disclosures.

Dr. Pickering: Thank you. Okay. ATW Health Solutions. So Desiree Collins Bradley, ATW Health Solutions is here. Can you introduce yourself and disclose any potential conflicts? I think Desiree is having some technical issues. So, Desiree, we'll try to circle back with you about some technical difficulties there and see if we can at least get some of your disclosures read off so thank you.

Okay. Encompass Health Corporation?

Member Debardeleben: Hi. Good morning. this is Mary Ellen Debardeleben. I'm the National Director of Quality for Encompass Health. I've been employed with Encompass Health and have nothing to disclose.

Dr. Pickering: Thank you. Kindred Healthcare? Kindred Healthcare? Okay. Leading Age?

Member Fallon: Hi. This is Nicole Fallon with Leading

Age. I am the Vice President of Health Policy and Integrated Services. I lead our Quality and Risk Management Advisory Group and monitor all of the quality initiatives for our provider members. And I have no disclosures.

Dr. Pickering: Great. Thank you. The National Hospice and Palliative Care Organization?

Member Marcantonio: Good morning. I'm Ben Marcantonio. I'm the Chief Operating Officer for National Hospice and Palliative Care Organization. And I have no disclosures.

Dr. Pickering: Thank you. The National Partnership for Healthcare and Hospice Innovation?

Member Atkins: Hi. This is Larry Atkins from NPHI. I'm the Chief Policy Officer. And I have no disclosures.

Dr. Pickering: Great. Thank you. The National Pressure Injury Advisory Panel?

Member Cox: Yes, hi. My name is Jill Cox. I am on the Board of Directors of the National Pressure Injury Advisory Panel. And I have nothing to disclose.

Dr. Pickering: Thank you. The National Transitions of Care Coalition? National Transitions of Care Coalition? Okay. And the SNP Alliance.

Member Phillips: Hi. This is Cheryl Phillips. I am a geriatric physician. My clinical career for 20 years at least was in post-acute and long-term care. And I am now the President and CEO of the Special Needs Plan Alliance. And I have nothing to disclose.

Dr. Pickering: Great. Thank you. I'm just going to circle back once more. So the American Academy of Physical Medicine and Rehabilitation. Is anybody on the line? Is it James Lett from --

Member Lett: Are you able to hear me now?

Dr. Pickering: Is that James?

Member Lett: Yes. Are you able to hear me now?

Dr. Pickering: I am yes. It sounds like there's a little bit of an echo, but I'm able to hear.

Member Lett: Okay. Good. I've been having some technical problems. Are you still able to hear me now? I shut off my phone.

Dr. Pickering: Yes.

Member Lett: Okay. My apologies for all the technical issues. That is not my strong suit. This is Jim Lett. I'm the President of the Board of Directors for the National Transitions of Care Coalition and have nothing to disclose. Thank you.

Dr. Pickering: Thank you so -- thank you very much, Jim, for working through the technical issues. Is there anyone from the American Academy of Physical Medicine and Rehabilitation on the line? How about the American Geriatric Society?

Member Kim: Yes. This is Anna Kim. I'm the Manager of Public Affairs and Advocacy. I support the Quality Performance and Measurement Committee. I have nothing to disclose. Thank you.

Dr. Pickering: Great. Thank you. ATW Health Solutions? I think that was Desiree. So, Desiree, if you could in the chat box, it looks like we can see your chat. If you can just put your name, your role in your organization and if you have anything to disclose, I can read that off.

And I'll go to Kindred Healthcare, anyone on the line?

Member Bradley: I'm here. This is Desiree. I didn't mean to jump in. Can you hear me now?

Dr. Pickering: Oh, yes. Yes, Desiree.

Member Bradley: Yes. Okay. I was having so many technical difficulties. My apologies. Desiree Collins Bradley, ATW Health Solutions, Application Engagement Network lead. And I have nothing to disclose.

Dr. Pickering: Thank you so much. And I'll go back to Kindred Health Care. Anyone from Kindred Health Care? Okay. Well, thank you for those disclosures. Now we'll go to the disclosures of our subject matter experts. Because subject matter experts sit as individuals, we ask you to complete a much more detailed form regarding your professional activities. When you disclose, please do not review your resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of the workgroup's work.

We are especially interested in your disclosures of grants, consulting or speaking arrangements but only if it's relevant to the workgroup's work.

So just a few reminders. You sit on this group as an individual. You do not represent the interest of your employer or anyone who has nominated you to this committee.

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

Finally, just because you disclosed does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency. So please tell us your name, what organization you're with and if you have anything to disclose. And I'll call your name so that you can disclose. So I'll begin with our co-chairs. Gerri Lamb?

Co-Chair Lamb: Gerri Lamb, I'm a professor at Arizona State University. And I have no disclosures.

Dr. Pickering: Thank you, Gerri. And Kurtz Merkelz?

Co-Chair Merkelz: Yes. I do sit on the Quality Committee for the American Medical Directors Association and for the American Academy of Hospice and Palliative Medicine. I have nothing to disclose.

Dr. Pickering: Great. Thank you. Thank you, Kurt. So now we'll move to our other subject matter experts. Dan Andersen?

Member Andersen: Hi, everybody. During the day I work at RELI Group. The only thing as I mentioned last time we met that I wanted to disclose is that I manage one of RELI's subcontracts where we do UAT, like validation of the information that goes up on CMS websites, including Care Compare for IRF, LTCH and SNF. So we're a subcontractor of Acumen, who is also a measure developer. So I just wanted to disclose that.

Dr. Pickering: Great. Thank you. Thank you, Dan. And David Andrews?

Member Andrews: Hi. David Andrews. I'm a retired college professor, independent patient advisor with no formal connection to any organization. I've been involved in a number of NQF activities. Perhaps most pertinent is the one that is developing a roadmap for converting PROMs to PRO-PM measures as well. And I have nothing to disclose.

Dr. Pickering: Thank you very much. And Paul Mulhausen?

Member Mulhausen: Hi. Thank you. I'm Paul Mulhausen. I'm a physician, geriatrician. I am employed by Iowa Total Care, a health plan subsidiary of Centene Corporation. I have nothing to disclose.

Dr. Pickering: Thank you very much. And Sarah, I apologize. Is it Sarah Livesay or is it Sarah Livesay?

Ms. Livesay: That's pretty perfect actually. Livesay works. So Sarah Livesay here. I am a nurse practitioner by training. I am the assistant dean at Rush University's College of Nursing in terms of my job.

In terms of disclosures, I do consulting work with largely hospital organizations seeking stroke certifications through a company called Lombardi Hill.

And I am on the Quality Committee for the Neurocritical Care Society and help to develop their performance measure set, mostly inpatient although I mention it just in case there was any kind of overlap that could be perceived as a conflict. Thank you.

Dr. Pickering: Thank you. Thank you so much, Sarah. And Terrie Black?

Ms. Black: Good morning. I'm Terrie Black. I'm a clinical associate professor at the University of Massachusetts. And I have nothing to disclose.

Dr. Pickering: Great. And that was nothing to disclose. Is that right, Terrie?

Ms. Black: Correct.

Dr. Pickering: Okay. Great. Thank you so much. I'd also just like to recognize our federal government liaisons to see if anyone is one the line. From the CDC side, Centers for Disease Control and Prevention, do we have our CDC representatives on the line?

(Simultaneous speaking.)

Dr. Geller: Hi. This is Andy Geller.

Mr. Dantes: Go ahead, Andy.

Dr. Geller: Oh, Andy Geller, CDC.

Mr. Dantes: Also Raymund Dantes, medical advisor for CDC and associate professor of medicine at Emory University. No disclosures.

Dr. Pickering: Great. Thank you. I know we have a few colleagues from the Centers for Medicare and Medicaid Services. We had mentioned Dr. Michelle Schreiber is on the line as well as Dr. Alan Levitt. There are most likely others so we won't go through all of the names of the folks on the call, but thank you very much from our CMS colleagues on the line.

And I'll just check in as well if we have anyone from the Office of the National Coordinator for Health Information Technology, or ONC. Anyone from ONC on the line?

Ms. Akinnagbe: Yeah. This is Brenda Akinnagbe from ONC with the Office of Policy.

Dr. Pickering: Great. Thank you so much. So thank you, and I'd like to remind you that if you believe that you might have a conflict of interest at any time during the meeting please speak up. You may do so in real-time at the meeting. You can message one of the co-chairs who will go to NQF staff or you can directly message the NQF staff.

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

Do you have any questions or anything you would like to discuss based on the disclosures of interest made today?

Again, you can use the chat box or you can raise your hand or just take yourself off mute. Okay. Hearing none, we'll keep going. Thank you all.

So we'll go to the next slide. And, again, I'm just wanting to thank our NQF staff that are listed here. We have Susanne Young, who is our manager, Ashlan Ruth, who is our project manager, Becky Payne, our senior analyst, and Gus Zimmerman, our coordinator, as well as Taroon Amin, our consultant, who have all been very instrumental for this work. So thank you to the staff.

And we'll go to the next slide and also just thank our CMS partners as well, Kimberly Rawlings, our contracting officer as well as Gequencia Polk, as well, who is also involved with this as partners for this work. So thank you to both of them.

And then going to the next slide, just to touch on the objectives for today. We will review and provide input on the MUC measures, the Measures Under Consideration, for the respective MAC PAC/LTC programs.

And as mentioned, we will also do a gaps discussion as well including gaps, if we have time, in the programs or measures that were not submitted to those this cycle. So we'll be doing that towards the end.

So thank you. And then we'll go to the next slide. And now I'd like to turn it over to Dr. Michelle Schreiber. She's the Deputy Director for Quality and Value to provide some welcoming remarks. So Dr. Schreiber?

CMS Opening Remarks

Dr. Schreiber: Thank you. First, let me start with sound check. Can you hear me?

Dr. Pickering: Yes, we do.

Dr. Schreiber: All right. Well, good morning to everybody. It is a pleasure to be here. For those of you at NQF, you will understand this is the fifth meeting in approximately one week for the various

MAP committees. And so my first congratulations to the NQF staff, actually, for really working very hard -- there's a tremendous amount of work behind the scenes here -- and for really a very successful past week.

We are delighted to be here at the post-acute care MAP meeting. And it is a pleasure. We look forward to all of your comments today.

I know many of you. I have worked with you for the past several years. But for those of you who don't know me, I am, as Matt pointed out, the Deputy Director of the Center for Clinical Standards and Quality at CMS and also Director of the Quality Measurement and Value-Based Incentives Group.

I was a practicing general internal medicine physician actually in the City of Detroit for many years and have a long history of quality background. I've been at CMS for the past three years.

In terms of the thanks you's, really to the committee members. The work that you put into these committees, which is voluntary, and the insights that you have is extremely helpful to CMS. And we really appreciate all of your time and efforts.

In particular, to Gerri and Kurt, who are the co-chairs, thank you very much. I am just going to issue the same challenge I issued yesterday to the Hospital Committee. You know, the Clinician Committee ended 11 minutes early. So just so you know it's out there as, you know, the challenge.

I already thanked the NQF staff, but I'd like to take a special moment to actually say thank you and welcome to Dana in her new role as CEO.

So, Dana, the staff has completed, really, the whole cycle, almost, of the MAP meetings and congratulations for that success. I know you've only been at NQF for several months. I know it probably

on one hand feels much longer and on one hand feels much shorter. But we think that you've certainly already set a wonderful direction for NQF and on behalf of CMS, really welcome you in your new role.

Speaking of CMS, I'd like to also acknowledge there are a number of CMS staff on the phone today. They are here to answer any questions that you may have. And, again, there's a lot of behind the work scenes as well as the measure developers who join us to answer your questions.

To our patient advocates in particular and then to the public, your input is really very important. And so it's very heartening to see patient advocates and to hear the public comments as well.

At the end, I have another special introduction to make, but we'll wait until we get through a couple of slides. So, Matt, if we could advance forward, please? Next one. Thanks.

So I think we all know that the measure application partnership is really a group of convened experts. You are the experts who provide recommendations to us at CMS about whether or not these measures that we brought that are under consideration should indeed be included in the various CMS value-based programs.

This is obviously a multi-stakeholder group with extensive experience. And that's why we are particularly heartened to hear from all of you.

MAP, as you know though, does make recommendations to CMS but does not have the final authority for the decisions that do go into rule writing and are available to the public. But I want to assure you that the MAP recommendations are always strongly considered and do assist and change the course often of CMS' decisions about measures that go in the program.

This year we actually had, as you heard, several new committees with the MAP process. One is the Equity Subcommittee that we heard from last week, which looked at all of the measures and made their recommendations about whether or not there's an equity impact to those measures. It was a great conversation.

And also new this year was the measure set review that the MAP Coordinating Committee did on measure removal. So you make recommendations for measures to be included. We now have a process of hearing about measures to be removed. So this back and forth process, I think, will really help to continue to shape the CMS quality programs.

Next slide. For the post-acute care MAP in particular, obviously, you are making recommendations for those specific value-based programs. And they include several.

There's the skilled nursing facility quality reporting program, the skilled nursing facility value-based purchasing program, which will get a lot of attention today, the hospital quality reporting program, home health quality reporting program, long-term care and, of course, inpatient rehab.

These are a mix of pay for performance as well as pay just for reporting. And some of these are also used in the calculation of nursing home stars and almost all of these are publicly reported.

Next. This year under the new administration, the CMS strategic priorities have been released to the public. HHS and CMS are all developing their strategic priorities. And I wanted to make sure to share these with you so that you can understand the directions that are important for CMS. That CMS first serves the public as a trusted partner and steward, really dedicated to advancing health care equity, expanding coverage and improving health outcomes.

Bullet number 1, as you can see, then is advancing health equity. And you'll be hearing that in the various conversations. It was part of the reason for an Equity Committee, which we were thrilled about. And I think in coming years, you will be seeing more and more about how is it that we close the disparity gaps and really promote equity in health across the country?

Second is expanding access to quality, affordable health care, engaging our partners and communities in policy-making, driving innovation, protecting the sustainability of the Medicare trust and then within CMS fostering an inclusive workforce.

Next slide. There are, though, very specific key focus areas for quality. The first, of course, the COVID pandemic, which we have all been dealing with for the last two years. A few more comments on that, but that of course is at the top of the priority list for CMS.

But after that, as I already mentioned, equity. And it's not just equity in a given area, but for access and outcomes and referrals and experience and really closing those gaps that we haven't seen highlighted so much in the COVID pandemic. We knew that they were there. But they really have come into, you know, stark realization.

There's a lot of focus on maternal health and safety. Probably not that much in the post-acute care setting, I wouldn't think, but it is a high priority issue for CMS and for HHS. Mental health as well. And there's a Cross-Health and Human Services Workgroup looking at how we can improve mental health.

Other issues that are particularly important include resiliency and emergency preparedness, many lessons learned from the past several years about how we can strengthen the country's ability in emergency preparedness and our resiliency.

Safety also has risen again to the top. It has always been there in quality considerations. It's not just patient safety though, but it's also workforce safety and the safety of the facilities that we're in.

Sadly over the past two years, we've seen degradations in some of the safety metrics including around healthcare acquired infections and falls and pressure ulcers and realize that we all need to be recommitting to our fundamental principles, our own safety.

Several years ago, CMS made the commitment to move towards digital quality measures. And so the digital transformation is also important as we look at measures and choose which ones to put in the programs because this is really a use case of digital data, which we have learned is very important to be able to have digital data that is interoperable that we can all be able to access.

Rising to the top of the agenda in this administration is also climate change. So I think you'll start seeing more and more around how in these programs we can use them to influence improvements around climate change and finally, of course, always driving the value proposition.

Next slide, please. Probably more than any other group, the post-acute care group really felt the COVID pandemic. And I want to take an opportunity to thank all of you for your heroic efforts on the parts of your staff taking care of patients, keeping our community safe.

We know that we've seen that the vast majority of COVID deaths have been in the elderly population greater than 65. I know that that's affected probably all of you. And, again, our really deep and sincere thanks to the heroic efforts that all of you and your organizations have made.

I did speak of the worsening quality and safety

performance that we've seen and that we really need to recommit and focus on the future resiliency, emergency preparedness and really our workforce.

This year we finalized several proposals in the value-based programs, which we'll talk about in a moment, including measure suppression so that we weren't penalizing facilities for circumstances really beyond their control, such as the COVID pandemic. And we also, of course, introduced the COVID health care personnel vaccination measures. And you know of the history of the COVID vaccination mandate that was finalized but is currently being re-evaluated.

Next slide. You know, as we look at what made organizations successful in COVID, there are some key enablers that I think we all have to keep in mind first and foremost, our leadership culture and governance. And we know that those are always foundational as to how organizations and individuals respond.

A dedication to infection prevention and control, I think a lot of facilities had to really re-up, renew and focus on infection prevention and control. And I know that we're starting to see more and more, not only regulation around that, but measures around it as well.

Local planning and coordination, not just internally, but really regionally and statewide. We're also a key enabler for success.

And there were obviously some challenges and lessons learned that we all have, including really focusing on the underserved and vulnerable population that disparities have become strikingly clear.

There are also challenges in data reporting and technical assistance and in managing the various ways of approaching the COVID pandemic and opportunities to improve on all of these.

Next slide. So what was new in the post-acute care, long-term care rules? I think one of the biggest things that we will be considering measures today for is the expansion of the SNF value-based purchasing program.

So as you know, the SNF VBP program has had but one measure in it and that's readmissions. Congress recently authorized us to expand this to 10, up to 10, that's the maximum number of measures, for this SNF value-based purchasing program. We're really very excited about this. And we'll bring measures today for your consideration and use in this expanded program.

We're doing this in a step-wise fashion. So you'll see over the next several years that we bring measures forward and really look forward to your recommendations today.

The other thing that's very exciting that was introduced in rule writing is that the home health model, which has been a model in nine states, designed by the Centers for Medicare and Medicaid Innovation is now expanding to a new national program. And we're very excited by that expansion because its initial success can now be translated to the country.

I'm sure all of you are aware of measure suppression in particular for the SNF value-based purchasing program. We did suppress the readmission measure. And all skilled nursing facilities were held neutral.

And finally, the finalization of the COVID-19 vaccination measures, I know that nursing home facilities have been reporting on a weekly basis and that data has really been extremely helpful. So thank you, everyone, for doing that.

Next slide. Some potential future directions I think I've alluded to already, safety, including patient and workforce safety, including staffing and staffing

levels, mental health, reducing disparities, a continued focus on infection control. And today we'll be talking also about the HOPE tool for hospice performance.

Next. So, again, thank you. Thank you to the Committee and all of your deliberations that you're going to have today and really for your important voice -- and the slide didn't get changed, but it was for post-acute care -- and you're really heroic efforts for the COVID pandemic.

Again, we look forward to successful day. And on behalf of CMS, I'd like to really wish each and every one of you a very happy holiday.

Before we close, though, from CMS, there is one other person that I have a special thanks for, and I think you will, too. And he will be taking over in part for my role today in this Committee. And that's Dr. Alan Levitt.

Many of you know Dr. Levitt. He's been at CMS for nine years. He's been part of the CMS team on this Committee for a very long time. Alan is a geriatrician who had deep experience, actually, in running geriatric facilities. He came to CMS, as I mentioned, about nine years ago and has really been instrumental in not only enacting the IMPACT Act but in shaping the programs for post-acute care.

Alan announced to us recently his retirement in July. We are very sad to see him leave. But we are delighted for his future rest and relaxation and retirement. And if you get him talking about horse racing, I think you'll find some of his passions. But with that, a very special thanks from CMS to Alan and introducing Alan, and I know he has a few comments as well. Alan, I turn it over to you.

Dr. Levitt: Thank you, Michelle. And thank you for the recognition you just gave the PAC community during the challenges they've had during the pandemic and

public health emergency.

As Michelle just said, this is my ninth year as the federal liaison representative on the workgroup, and it will be my last. I am retiring in July. While I'm proud of the work that the team has accomplished here at CMS, I'm particularly proud of the work we've done here.

I believe our workgroup represents the definition of the public/private partnership. Quality measurement work in health care is hard work. Caring for and advocating for our patients and our residents in post-acute care is particularly hard work.

Putting those two together, well, for all of us sitting around this virtual table, we've done this for our professional lives. To quote Hyman Roth, this is the business we've chosen. It's particularly challenging work. But despite that, we've accomplished a lot together.

Just one example is the feedback loop that we present every year. And truly this morning, I have more feedback to give to you. Just yesterday the White House announced findings from vaccination and COVID data submitted by long-term care facilities, through the NHSN, that demonstrate the importance of booster vaccinations in long-term care residents. In this example, it demonstrated that boosters, those residents that got boosters were more than 10 times less likely to get COVID than unvaccinated residents.

Our data, our measures, our work here matters. I want to thank Michelle who leads all the quality work on our end, the CMS team, the contractors, NQF staff, Co-Chairs Gerri and Kurt, all of you on the workgroup, for all of the work we have done over these nine years.

This may be my last dance with all of you, but let's

make it a good dance. So let's get going and back to you, Matt.

Dr. Pickering: Thank you so much, Alan and Michelle, for those welcoming remarks.

Alan, you definitely will be missed. And I can only speak in the limited capacity I have worked with you, but it's been such a pleasure. And I'm sure it's the same for the other workgroup participants, including our Co-Chairs Gerri and Kurt. But thank you both so much.

We have a few minutes to see if there's any questions that the workgroup has for what's been presented, see if there's any questions that you have before we go to our next presentation. So I'll pause now to see if there's any questions from the workgroup.

You can use the chat feature obviously. And we'll keep an eye on that and monitor that. Or you can use the raise hand feature or just take yourself off mute if you'd like to. But if you have any questions, we have some space to do that now.

Member Mulhausen: I would like to say something. Paul Mulhausen here.

Dr. Pickering: Sure, Paul.

Member Mulhausen: This is not a question. It's a comment. I've had the privilege of being part of this group for years. And I am honestly heartbroken to see Dr. Levitt retiring and departing.

He has simply been a pillar of quality improvement in the post-acute long-term space that is -- I don't have words to articulate the impact he's made.

So, Alan, I'm sorry to see you go but glad -- actually honored to have had the opportunity to participate in your last dance with this workgroup so. When we're all done, good luck with everything you end up doing

in retirement.

Dr. Levitt: Thank you, Paul.

Member Mahajan: This is Raj. And I want to jump right in after Paul. You beat me to it. Alan, thank you so much, not just what you have done here. But I just want to tell everybody that when COVID hit and we were all in post-acute long-term care, and I get very, very emotional talking about it, you know, we would talk and text and just, you know, the support overall you gave was just -- there's no words for it.

And, of course, everything you've done here to make the difference, you know, the physicians, especially myself who is in a private practice setting, coming to these meetings, sometimes it's a little disconnect. But you have really shown how it truly is that private/public, you know, partnership that can be something that guys like us, who are still out there doing the field work, find useful. Thank you so much, Alan.

Dr. Pickering: And, Gerri, you have your hand raised?

Co-Chair Lamb: I do. So like Paul and Raj, Alan, I'm so excited for you to be able to retire. But I have to say to start the meeting with hearing about your retirement is very sad. It's been one of the highlights working on this Committee with you for so many years.

And Kurt and I certainly have our work cut out for us today that we are going to capitalize on having you with us for the last meeting. And we're going to do our damnedest to make this a good dance. So thank you for so many years of just wonderful, wonderful dialogue.

I do have a question for Michelle. And Michelle, thank you for the overview. And it's been fantastic working with you as well.

I wondered as we get started today, as you talked about the key focus areas, if you could just say a few more words about kind of the mindset of CMS related to equity. It's such a huge and important area. And certainly huge implications for measurement and risk adjustment and so on and so forth.

So any thoughts that you have as we launch into probably what will be years of looking at this? Any words of wisdom from CMS in terms of how we think about the MUC measures related to equity and then another question is you had encouraged us to look at safety and the recommitment to that.

As we talk about gaps, you know, there's so many other areas, you know, that we also need to be looking at down the road. So perspectives on equity from CMS and then how we look at safety and the real call for the recommitment as well as moving the needle forward.

Dr. Schreiber: Those are big questions, Gerri. Thank you for asking. Let me start with equity. Equity is clearly going to be a multiyear process and frankly to some degree an entire, I don't want to say, change of mind, but a shift because we really haven't made the same kind of improvements in equity as we have made in other aspects of quality.

So if we all think back 20 years to those domains and, you know, to err is human, so to improve timeliness, to improve safety and, yeah, equity was clearly there. But equity hasn't made the same gains. And some of you may have seen National Academy of Medicine actually convened a group of people who put out a white paper about the call towards committing to equity.

I think it's going to have multiple strategies. The first one really has to be around data collection. The reality is that we don't have good patient reported data around the aspects that we need to be stratifying our data at and looking at our program

performance and outcomes by. So even CMS does not have good patient reported data on race and ethnicity let alone sexual orientation and gender identity, other things that we would want to stratify for.

So I think number one is you'll start seeing a coalescence of how do we actually collect the data? What is the right data that we need to collect? How do we collect it in a way that we can make it standardized and interoperable? And so I think that's one focus.

I don't know that that's for this Committee, but just to say, we have to start there because we have to make the -- we have to define what it is we want to look at and then make sure that we are all collecting the data in a way that we can all use it.

The second I think is going to be stratification. And this might be actually a very interesting question for this committee in particular. What are those measures that rise to the top of your list that you would want to see stratified, first back in confidential feedback reports to facilities, for example, and then really that might be publicly reported or even tied to payment? And the payment eventually may be something like closing the gaps in equity.

And I'll just give you a for instance for example. SNF VBP was a readmission measure. If we were to stratify that by dual eligibles or by other ways of stratification, there are many ways of stratifying as I just pointed out, and if there are gaps rewarding for closing those gaps for example.

So I think for measures, one good question for the committee is what might be your priority measures for stratification?

I think other things that are obviously going to have to come up is payment policy. I know the quality measures aren't really payment policy, but clearly

that's going to have to rise to the top as well.

Measures including access, how do we ensure that people are getting the right access to care, the right referrals to care, the right coverage for care? And so this is so multidimensional and multipronged. But I think that the quality measurement programs can actually be important in number one, making some of these issues transparent in how it is we're performing, and number two, eventually tying into payment. But I think a lot of what we will be looking at in the coming years is stratification data.

The second around safety is, you know, we've had a lot of focus on safety over the past decade or so. Certainly, you know, the CDC has brought a lot of focus around health care acquired infections. And these really degraded in the past two years.

Many of you may have seen CDC's reports that the gains of the last 10 years were almost wiped out in the past couple of years. And that is really a sad commentary. Now I know that there is many reasons for that, obviously, you know, just the challenge of taking care of COVID patients itself.

But it also, I think, speaks to a deeper fundamental issue of were our safety processes and our reliability processes deeply enough embedded to kind of sustain a change, and really a catastrophic change, but still to withstand a change? And how do we rebuild with resiliency so that we ensure that we don't back step in our processes, I think, around resiliency, reliability, the commitment to that? The processes for that, I think need to have continued focus.

But, Gerri, you're absolutely right, there are a lot of other areas to focus on as well, many of which you will be hearing today.

I'm actually really excited because I think the post-acute care community has led the way, actually, in some of its tools, its functional assessment tools, its

OASIS tools for actually asking the questions around social determinants of health and race and ethnicity.

And so I think to some degree the post-acute community can actually lead the way in using those tools, showing others how to use them, how do we translate them across the continuum of care and make sure that we're providing the best care for all of our beneficiaries.

So I know I was a little long winded. Sorry. But thank you for the question.

Co-Chair Lamb: Thank you. That was excellent stage setting, Michelle.

Dr. Pickering: So it's just about 11 o'clock Eastern. I'm going to keep us moving. So thank you very much, Dr. Schreiber and Dr. Levitt. I will just say, you know, Dr. Schreiber, you start out with this challenge of us trying to finish early and then you let us know -- or Alan lets us know that he's retiring. So it's quite a bomb to drop. But thank you both very much for the welcoming remarks. Dr. Levitt will be around throughout the day to answer any questions as they come up. So thank you, Dr. Levitt. And, again, once again, thank you, Dr. Schreiber.

So I'm going to keep us moving forward. On our agenda, next we have the updates to the HOPE tool. So we do have some presenters here that will walk us through this discussion and presentation today.

So we have Cindy Massuda, who is the program lead for the Hospice Quality Reporting Program at CMS. We also have from Abt Associates, we have Jennifer Riggs and T.J. Christian, who will also be presenting with Cindy. So I'll turn it over to Cindy, maybe you, to kick us off, or maybe it's T.J.. I'm not really 100 percent sure on who is going to kick us off. But the slides are ready to go so just say next slide, and we'll proceed through that accordingly.

Updates on the Hospice Outcome and Patient Evaluation Assessment Tool

Ms. Massuda: Good morning, Matt. It's Cindy Massuda. I'll kick it off. Next slide, please. So I'm Cindy Massuda. And I'm the Hospice Quality Reporting Program coordinator for CMS. I'm joined today by the two task leads for our contractor supporting the quality reporting program, Jen Riggs, T.J. Christian of Abt Associates.

Next slide, please. So Jen Riggs will be discussing the development of the new hospice outcomes and patient evaluation also known as HOPE, which is a hospice patient assessment. And T.J. Christian will discuss measure concepts that could be developed with the new information that will be collected using HOPE.

We greatly appreciate this opportunity to present the draft HOPE and discuss this new patient assessment plan for use in Medicare certified hospices. To provide a robust discussion, the three of us are presenting the HOPE update and leaving time for your questions.

Next slide, please. So the HOPE development process, to get to where we are today, which is national beta testing, is the result of successive phases of testing. Sorry.

Those phases that we're in, we've done cognitive, we've done pilot testing and we've done alpha testing. Each phase has informed revisions to the HOPE assessment in the national beta test.

The draft HOPE is designed to assess patient needs throughout the hospice stay. It captures caregiver key time points that follow the hospice model.

Draft HOPE comprises nursing, psychosocial and spiritual disciplinary assessments. HOPE-based quality measure concepts were discussed with the technical expert panel. And lastly HOPE must go

through rulemaking prior to implementation.

Next slide, please. So the current approach for collecting data uses a data collection tool called the hospice item set. So as you can see, we have our program currently, which is the Hospital Quality Reporting Program, using the hospice item set, CAHPS and claims.

And the hospice item set is the current way that we collect our data for patient assessment. And HIS provides basic information about the patient and their hospice stay, but it's only admission and discharge. So that's why the hospice item set data is extracted from clinical records and admission and discharge.

The data from the HIS at present supports one hospice quality reporting program process measure and that's the NQF endorsed 3235, the Comprehensive Assessment of Hospice Admission.

However, the HIS is not designed as a patient assessment that can support outcome quality measures. So to progress the Hospice Quality Reporting Program to better serve the needs of patients, families and our aging population, HOPE expands the information collected and the range of quality measures that can be calculated.

CMS has contracted with Abt Associates and its partners to develop HOPE. Next slide, please. I'd now like to turn the conversation to Jen Riggs, who will discuss further development of HOPE. Thank you.

Ms. Riggs: Thank you, Cindy. Next slide, please. The HOPE assessment is intended as a patient-centered assessment that encourages increased patient engagement in their care and provides hospices with real-time patient assessment information to better understand patient's care needs throughout their hospice stay.

Hospices may also use the HOPE assessment data in their quality improvement activities. CMS can use HOPE assessment data in development of multiple types of quality measures, including outcome measures to provide a meaningful set of quality measures for the hospice quality reporting program, to assess the results of care experienced by patients and to show more variability across hospices for public reporting and publicly reported quality measures to support patient and family choice of a hospice provider.

Next slide, please. HOPE is a patient assessment designed to be completed during patient care. In this way, HOPE is different from the hospice item set, which is designed to be a review of the record after care is completed.

The HOPE assessment is not a comprehensive assessment. It's designed to be part of the comprehensive assessment, a subset of assessment items.

The HOPE assessment is aligned with the hospice conditions of participation to support patient safety and hospice quality improvement initiatives.

HOPE is multidisciplinary. It consists of three distinct disciplinary assessments, a nursing assessment completed by the registered nurse, a psychosocial assessment completed by the social worker and a spiritual care assessment completed by the chaplain.

HOPE may be completed at multiple time points throughout the patient's stay. HOPE is unique in that regular assessments at hospice admission at interim reassessments may trigger a follow-up HOPE symptom reassessment.

This design is specifically to support potential outcome quality measures related to pain and symptom management.

Next slide, please. The development of the draft HOPE assessment has involved multiple iterative and overlapping phases of information gathering, drafting and testing.

Up to this point, successive drafts of the HOPE assessment have undergone cognitive, pilot and alpha testing and results from each phase of testing informs CMS decisions on the next version of the assessment.

Results from the current phase of testing, the beta test, will inform CMS decisions about the final draft of the HOPE assessment.

CMS will propose the HOPE assessment in rulemaking prior to any national implementation.

Next slide, please. The draft HOPE assessment, as I mentioned, includes three different disciplinary assessments.

HOPE assessment items are derived from multiple sources, including existing impact standardized patient assessment items, other CMS existing items, Office of Minority Health social determinants of health items, external hospice specific assessment items and more items developed specifically for HOPE, including standardized assessment items in the instrument that are also used in CMS post-acute care instruments supports CMS' goal for interoperability.

In addition, the inclusion of Office of Minority Health standardized items for ethnicity, race and language support CMS' objectives to advance data collection to identify health disparities, which address health equity.

Next slide, please. Now I'd like to turn over to my colleague, T.J. Christian, who will discuss measure concepts that could be calculated from HOPE.

Mr. Christian: Thanks, Jen. And I guess we can go to

the next slide. All right. So as Cindy mentioned earlier, we had discussed HOPE-based quality measure concepts with our technical expert panel, or TEP, to the items needed for measure calculations we collected at multiple time points across a patient's stay through the multiple assessments, which Jen just talked about.

The not yet calculated quality measures but, you know, as noted we will be entering the beta phase of item testing. And with the upcoming beta test, we will monitor our data collection for the feasibility of also using this item test data which, of course, was intended for item reliability to QM testing.

Potential items we discussed with the TEP include the symptom impact, pain screening, pain active problem and patient desired tolerance level for symptoms or the patient preferences for

symptom management items in HOPE.

Next slide, please. As described in CMS' publicly available 2020 TEP summary report, our TEP supported the following measure concepts that could be calculated from HOPE items.

So first would be a timely reduction of pain impact, which reports the percentage of patients who experience a reduction in the impact of moderate or severe pain.

The second, reduction in pain severity, which reports percentage of patients who had a reduction in reported pain severity.

And third, timely reduction of non-pain symptoms impact, which measures the percentage of patients who experience reduction in the impact of symptoms other than pain.

Next slide, please. CMS continues to develop and refine these three candidate quality measures for

further down the line. In recent rulemakings, CMS also expressed interest in additional concepts, that includes preferences for symptom management, spiritual and psychosocial needs and medication management and outcomes of care.

And then next slide, please. Okay, great. So thanks for allowing us to present on the state of HOPE and HOPE-based quality measures. At this point, I just want to pass the presentation back to Cindy.

Ms. Massuda: Thank you, T.J. Before we conclude, I just wanted to extend an invitation to attend our public Hospice Quality Reporting Program Forum, Quarterly Series. And these are typically focused on HOPE updates.

And we've provided the web pages here that can keep you updated regarding HOPE, the provider and stakeholder engagement web page, which also provides you access to our TEP reports in the download section. And then also we have our HOPE updates web page, which is the HOPE web page shown at the bottom here.

With that, I really want to thank you for the opportunity to present on this important work. We've been working very hard on this over several years. So I would like to now address any questions you might have and give you that opportunity at this meeting.

Dr. Pickering: And thank you, Cindy, Jennifer and T.J., for walking us through an update here on the HOPE tool. If you have questions, if the workgroup has any questions for our presenters today, please feel free to take yourself off mute or raise your hand or use the chat feature, which we'll monitor. So if you have any questions, please feel free to take the floor. I see David, David Andrews, has his hand up.

Member Andrews: Yeah. This is sort of outside of the frame that you're operating in. But I think it's

important as you move forward to consider something that's rarely considered in any of these evaluations, that is patient, family or caretaker opinions of things.

As an old person, there are a lot of people that I experience who don't have a very good handle on their own situation whereas often caretakers that have been around them quite a bit have a much better focus on how they're responding to the situation.

So I would hope as all of this moves forward in the future, there could be some expansion to evaluation of caretaker or family member perceptions.

Ms. Massuda: Sure. Thank you. I think as you will look through our TEP reports and our work with the TEP, we are looking at things like patient preference and looking at issues like that.

I think that, you know, work that -- and I'll turn to Jen and T.J. to chime in, related to thinking about that in terms of our quality measures and ways that we can think about patient preference in our work.

And I'll turn it over to T.J. and Jen for further answers to your question. I very much appreciate your question.

Mr. Christian: I could just say -- I would probably just echo what Cindy said. Thanks for the kind consideration. We'll kind of continue to, you know, think about that aspect in, you know, quality measurement development.

Co-Chair Merkelz: I just want to, you know, share, I appreciate Cindy, T.J. and Jen taking time to explain where we're at right now with the HOPE. It's very exciting to see the continued development.

I certainly would echo what David Andrews is pointing out. I think being able to get into some of

the caregiver preferences throughout the course of the care, not just the preferences that we currently run now that takes place several months after the care through CAHPS level surveys.

And I certainly applaud their looking at the quality concepts of interest, specifically preferences of care throughout the stay of the individual patient. And, you know, we've talked about previously, Dr. Schreiber talked about from the safety standpoint, looking at medication reconciliation and best practices. So much can be done for the benefit of the patients to improve processes for medication reconciliation. I would love to see that further expanded. Thank you.

Ms. Massuda: We are looking at issues like that. And we actually -- we do keep a HOPE mailbox available. And we're always looking for people's input as we're looking at, you know, developing HOPE. So I appreciate your feedback in all of that.

Member Marcantonio: Excuse me. This is Ben Marcantonio with NHPCO. Cindy and team, I'm wondering, being new to this group and the process on this side of it, wondering where we are with the HOPE tool and how it will interface with EMRs and if you can comment at all at this point.

Ms. Massuda: Sure. So HOPE per se is in national beta testing right now. So that process will continue through about July and then we have to go through analyses of that data so it's the better of a year, the 2020 year.

But from that, the idea of HOPE is that it can be incorporated into the electronic medical record. It's meant to be, you know, it's meant to be used. And I think Jen was talking about this during the presentation, it's meant to be the trifecta of the hospices using it for their patient care, for plan of care, for families using it for decision-making, for CMS using it for data to develop the quality

measures.

So it's meant to be the win-win of, you know, the assessments so that it can be useful, and it's real-time data and to help really progress both in the important work the hospices are doing and the quality measure program.

Member Marcantonio: Thank you.

Dr. Pickering: Any other questions or comments from the workgroup?

Member Atkins: I'd just like to ask about the Timetable 4, going from the beta test and the finalization of the instrument to the development of the quality metrics.

Ms. Massuda: So, I mean, we are looking -- we look at the data that we have in beta testing to see what we have in beta testing for being able to develop quality measures. And then we have to -- based on -- we have to look at the analyses of the work to see what our next, you know, being able to fully develop the quality measures.

Member Atkins: Like, do you have any sense about how long that process is likely to take before we have quality metrics in the draft form?

Ms. Massuda: Really, it depends on the analyses from beta testing. It will help us determine our ability to be able to specify the measures.

Member Atkins: Okay. Thanks.

Dr. Pickering: Any other questions or comments? Okay. Hearing none, I do want to thank Cindy, T.J. and Jennifer once again for providing an update on the HOPE tool. Thank you so much for all of your work. We'll now keep going. We're about 10 minutes ahead of schedule. That's perfectly okay as we have to keep to Dr. Schreiber's challenge, right?

All right. So next we have a presentation on the overview of the pre-rulemaking approach. And my colleague, Susanne Young, will walk us through our preliminary analysis and our decision categories and then also the advisory groups and how that input is worked into the PAs. So I'll turn it over to Susanne to kick us off.

Overview of Pre-Rulemaking Approach

MS. YOUNG: Thanks, Matt. We will now review the pre-rulemaking approach. I know we do have some returning members. We've also had great attendance during our orientation meetings in October. So some of this context may look a little familiar to you.

Next slide, please. First, we want to start with the preliminary analysis.

Next slide. So each Measure Under Consideration receives a preliminary analysis. We also refer that -- we refer to that as a PA also. The preliminary analysis, or PA, provides MAP members with the profile of each measure. And this serves as a starting point for the discussion.

The NQF staff utilizes an algorithm developed from the measure selection criteria to evaluate each Measure Under Consideration. And we're going to go over that algorithm in the next few slides.

Next slide. So this slide and the next few slides indicate the PA algorithm utilized by the NQF staff.

On the left column, this indicates the assessment criteria, of which there are seven. The center column indicates the definition of the corresponding assessment and then the right column is the outcome that results from the assessment.

So starting with the first assessment, this indicates whether the measure addresses the critical quality objective, not adequately addressed by the measures

in the program set.

The outcome is either a yes or no answer. And so for this first assessment, if the answer is no, the measure receives a do not support outcome in the assessment end.

The second assessment is whether the measure is evidence-based and is either strongly linked to outcomes or an outcome measure. Again, if the answer is no to this assessment, the measure will receive a do not support outcome.

The third measure addresses the quality challenge. Again, if the answer is no to this assessment, the measure will receive a do not support outcome.

Next slide, please. Continuing with the PA, the fourth assessment indicates whether the measure contributes to the efficient use of measurement resources and/or supports alignment of measurement across the programs.

Again, the outcome is a yes or no answer. If the answer to this assessment is no, the highest rating potential is do not support with potential for mitigation.

The fifth assessment indicates whether the measure can be feasibly reported. Again, if this assessment answer is no, the highest rating potential is do not support with potential for mitigation.

And going on to the sixth assessment, which addresses whether the measure is applicable to and appropriately specified for the program's intended care setting, level of analysis and population. If the answer is no to this assessment, the highest rating potential is conditional support.

The seventh and last assessment addresses implementation. If the measure is in current use, no unreasonable implementation issues that outweigh

the benefits of the measure have been identified. If implementation issues are identified, the highest rating potential is conditional support.

We will cover more specifics of the decision categories in the next slide. But let me pause here to see if there's any questions regarding the algorithm.

Okay. Let's move on to the next slide. Now we will go over the voting decision categories.

Next slide. Let's start with the MAP decision categories. The left column is the four decision categories. The center column is the definition of the decision and then the right column is the evaluation criteria.

Starting with support for rulemaking, MAP supports the implementation of the measure as currently specified.

Next, conditional support for rulemaking. MAP supports implementation of the measure as specified but has indicated certain conditions or modifications ideally addressed prior to implementation.

Next, we have do not support for rulemaking with potential for mitigation. MAP does not support implementation as the measure is currently specified. MAP agrees with its importance but has suggested modifications. Such a modification could be considered a material change to the measure.

And finally, do not support for rulemaking. MAP does not support the measure. Again, let me pause here and see if we have any questions about the MAP decision categories.

No questions? We'll keep moving on. Next slide, please.

And now, let's go over the MAP voting process. Next slide, please. Here are the key voting principles, starting with quorum, defined as 66 percent of the

voting members of the committee present for live voting to take place, a quorum is established prior to voting.

The process is one, by taking roll call as Matt completed earlier in our meeting today, and two, determining if a quorum is present.

At this time, only if a member of the Committee questions quorum is it necessary to reassess the presents. If quorum is not established during the meeting, the vote will be held via electronic ballot after the meeting.

For the record, we have quorum today. And Matt has established the consensus threshold of greater than or equal to 60 percent of voting participants voting positively and a minimum of 60 percent of the quorum voting positively. Abstentions do not count in the denominator. And every Measure Under Consideration will receive a decision.

Next slide, please. The key voting -- let's review the voting procedures. So Step 1, after public commenting opportunity for all measures within the program, the staff will review the PA for each Measure Under Consideration using the MAP selection criteria as was discussed earlier.

At this time, the staff will also review the input from the MAP advisory groups and from public comments submitted to NQF during the online commenting period.

Step 2, the co-chairs will ask for any clarifying questions from the workgroup. This includes lead discussants who may also have clarifying questions.

Workgroup members and lead discussants should withhold their comments at this time. In the web environment, the co-chairs will address questions one by one. Measure developers will respond to clarifying questions on specific specifications, and

NQF staff will respond to questions on the PA.

Next slide. Step 3, after clarifying questions, the co-chairs will open for vote on accepting the preliminary analysis assessment. This vote will be framed as a yes or no vote to accept the workgroup's decision.

If greater than or equal to 60 percent of the workgroup members vote to accept the PA assessment, then the assessment will become the workgroup recommendation. This will end the discussion of this measure, and the workgroup will move on to the next measure.

If less than 60 percent of the workgroup votes to accept the preliminary analysis assessment, further discussion will now open on this measure.

Next slide. Step 4, if the workgroup did not vote to uphold the staff recommendation on the measure in Step 3, the co-chairs will then open discussion and voting on this measure.

The co-chairs will first ask lead discussants to review and present their findings. The co-chairs will then open discussion among the workgroup. Workgroup members should participate in the discussion to make their opinions known, however one should refrain from repeating points already presented.

After discussion, co-chairs will open the measure for a vote. Co-Chairs will summarize those major themes within the discussion, and co-chairs will determine what decision category will be put to a vote first, based on a potential consensus emerging from the discussion.

If there's not a consensus position to use to begin voting, the workgroup will take a vote on each potential decision category one at a time starting with support for rulemaking.

Next slide. And Step 5, if a decision category put forth

receives greater than or equal to 60 percent of the votes, the motion will pass and the measure will receive that decision.

Now if no decision category achieves greater than 60 percent to overturn the PA, the preliminary analysis will stand. And this will be marked and noted for the Coordinating Committee's consideration during their January meeting.

And now we would like to pause to conduct a test question on the Poll Everywhere platform. As Matt mentioned, you received an email this morning, or voting members received an email, with that link. So we would like you to pull up that link, and we're going to pull up a test question.

Member Cox: Can I just ask a question --

Ms. Young: Sure.

Member Cox: -- before we get started. When the Poll Everywhere opens, it asks for a name. Should we be putting our names in there or --

Ms. Young: Yes.

Member Cox: -- or in the -- okay. All right. Thank you.

Ms. Young: You're welcome. Any other questions before we go to the test question? Okay. The test question is open, and you should be able to vote on do you like coffee, yes or no. And, again, let us know if you're having any problems.

Dr. Pickering: It looks like we have 15 results in. Is anyone having difficulties?

Member Atkins: Yes, that's me. How do we activate -- I'm trying to figure out how to activate with this link, the voting. Do you put it in just a regular browser and it's supposed to activate it or do we put it somewhere on this page to activate?

Ms. Young: It is a link, you use it in a browser, yes.

Member Atkins: But any browser because it didn't recognize it in the browser I was using.

Member Mulhausen: This is Paul Mulhausen. I have a question. And that is, how do we know you got our vote?

Ms. Young: It will -- it makes a color. I believe it shows up as blue.

Member Mulhausen: Okay. So the blue reassures me you got a vote from me?

Ms. Young: Yeah. And it's still open and also I want to make that note. While the vote is still open, you can clear your answer if you happen to answer something that you did not want to and change your answer. While it's activated and until we lock it, you can change your answer.

Member Mulhausen: Thank you.

Ms. Young: You're welcome.

Dr. Pickering: There we go. Anyone else having any difficulties?

Member Roberts: Can you re-send the link? I can't find the link. Sorry.

Dr. Pickering: Is that Pamela Roberts?

Member Roberts: Yes, please.

Dr. Pickering: Yup, sure. We shall re-send it.

Ms. Young: The team is going to re-sent that link to you, Pam.

Dr. Pickering: That would be our 18th. Okay.

Ms. Young: I'm excited to hear the results of this test question.

Dr. Pickering: I think everybody else is, too. I was wondering if we were going to do, like, a holiday themed question. But do you like coffee will be good. Okay.

DR. LEVITT I'm trying to sway the vote here with my pictures while the voting is going on.

Dr. Pickering: I'm not sure you should do that on the CMS side there, Alan.

Member Fallon: Would it be appropriate to just ask clarifying questions about the voting process while we're finishing this up --

Dr. Pickering: Sure.

Member Fallon: -- or would you rather I wait?

Ms. Young: No.

Dr. Pickering: No, please.

Member Fallon: So I'm new to this so I apologize if this is obvious. So if we as a group decide to accept the PA, then that essentially is a vote in favor of the measure moving forward, and we don't do any other steps. Is that right?

Ms. Young: Correct.

Member Fallon: Okay.

Dr. Pickering: Yes.

Member Fallon: So any questions or concerns, the only way to get to debate is to not vote to accept the PA.

Dr. Pickering: Yes. That's correct. So just to clarify there. So if the PA, which in this case there aren't any do not supports, but, you know, sometimes a PA could say do not support for rulemaking. So in that case the measure, you know, would not move forward, if you will.

But you are correct in that if it is support for rulemaking or conditional support for rulemaking and the condition sometimes is NQF endorsement, if the Committee does decide to uphold those preliminary analysis decisions, then there's no more discussion for that measure, and we move on to the next program or the next measure.

So if the committee does not wish to accept that rating in a preliminary analysis, less than 60 percent of the committee need to vote in favor. So it would not be accepted. And then it opens up for further discussion on a different decision category that would be placed on that measure.

Member Fallon: Okay. I think I got it.

Dr. Pickering: It's okay. We'll definitely go through it as many times as needed throughout the day. And usually after the first measure or the first couple measures, the workgroup usually starts getting into that groove of how this process works. But we'll definitely go through it again if need be. So please feel free to ask questions.

Member Fallon: Okay. Thanks.

Dr. Pickering: Mm-hmm. And it looks like, Pamela, your vote is in for 18. Thank you.

Ms. Young: We have a high majority here that like coffee. So after each question, we will then give the responses and thank you. Go back to the slides.

Co-Chair Lamb: Susanne, this is Gerri. Is 18 the number we're working off of.

Ms. Young: Eighteen is the number we're currently working off of. We do have one that may be stepping away at times. And we're noting that. And Matt will note that at the beginning of each vote.

Co-Chair Lamb: Great. And, Nicole, I just want to echo, Matt. You ask all the questions you want. I have

co-chaired this for a long time. And I still write a workflow before the meetings because there are just so many steps in this.

Dr. Pickering: Thanks, Gerri.

Ms. Young: Thanks, Gerri. Next slide, please. So now we do want to talk about the review of the Measures Under Consideration by the MAP advisory groups. And we mentioned these groups earlier today. And they met last week to review all measures.

Next slide, please. The first of the two advisory groups is the Rural Health Advisory Group. And the charge of this particular group is to provide input on rural specific measurement issues, chair rural perspectives relevant to the selection of quality measures for MAP and provide input on priority rural health issues, such as low case volume challenges.

Next slide, please. The Rural Health Advisory Group will review all the Measures Under Consideration for all three workgroups and provide feedback to the setting specific workgroups, which you will hear today.

The Rural Health's review included relative priority in terms of access, cost or quality encountered by rural residents, data collection challenges for rural providers, methodological problems of calculating, potential unintended consequences and gap areas.

And the Rural Health Group, they don't vote, but they take a poll. And they poll on whether the measure was suitable for use with rural providers within the specified program of interest.

Next slide, please. And this is the

first year for our second advisory group, the MAP Health Equity Advisory Group. And for anyone who may have attended or listened in to the meeting last week, it was a day full of robust discussion.

The charge of this group is to provide input on the Measures Under Consideration with a lens to measurement issues impacting health disparities, also to provide input on the Measures Under Consideration with a goal to reduce health differences closely linked to social, economic or environmental disadvantages.

Next slide, please. Again, the Health Equity Advisory Group will review all the Measures Under Consideration and will provide feedback to the setting-specific workgroups, which you will hear today.

Health Equity's review included relative priority in terms of advancing health equity for all, data collection challenges regarding health disparities, methodological problems of calculating, potential unintended consequences and gap areas.

And, again, they don't take a vote, but they take a poll. And they were polled on the potential impact on the health disparities if the measure is included within the specific program of interest.

Next slide, please. And the feedback from both advisory groups is provided to the setting-specific workgroups through the following mechanisms. Within the PA is a qualitative summary of the discussion during the advisory groups and the average polling results.

The polling results are a five point record scale and as follows. The Rural Health Advisory Group's perception of suitability from a rural perspective and the Health Equity Advisory Group's perception of the potential impact of health disparities.

And finally, a summary of each advisory group's discussion will be provided during our meeting today. And Matt will review that as he reviews the PA.

Are there any questions on the policy or are there

any questions regarding our advisory groups? And let me go back and pause, are there any questions about the preliminary analysis, any more voting questions?

I think I will turn it back to you, Matt.

Dr. Pickering: Great. Thank you, Susanne. So as Gerri had mentioned, and I mentioned as well, as we go through the process, please feel free to ask questions on how the process is to proceed as we go through it or any clarification on the decision categories, et cetera.

As you saw, Step 2 of our voting process is an opportunity for clarifying questions as Susanne mentioned. That's clarifying questions to the measure developer if needed on any of the measure specifics and specifications but also questions to NQF on the decision categories and preliminary analysis. So I will have opportunities throughout our process for the questions and we encourage you to do so.

We are ahead of schedule, but recognizing that MAP is really -- there's a lot of stakeholder input with MAP, including public comment. And so as I mentioned, we have public comment built into the reviews of these measures and also at the very end of the proceedings today.

So there are those members of the public that are keeping an eye on our agenda and most likely will be joining us at 1 o'clock for the first set of measures.

So with that, since we are ahead of schedule, I will still reconvene at 1:00. Right now we have a lunch built-in. So we'll reconvene at 1:00. That's just about 45 minutes for lunch, and we'll come back at 12:30 -- excuse me, not 1 o'clock, 12:30. Thank you, team, for reminding me. Yesterday was 1 o'clock MAP Hospital. Today's different.

Today we'll reconvene at 12:30 p.m. That's still a 45 minute lunch. So at 12:30 p.m. Eastern, we'll

reconvene and start out with our first measure. So it's a cross-cutting measure, and we'll talk a little bit about that when we reconvene. So see everyone at 12:30 p.m. on the dot.

(Whereupon, the above-entitled matter went off the record at 11:45 a.m. and resumed at 12:30 p.m.)

Dr. Pickering: Thank you all for coming back from a little bit of an extended lunch, or breakfast for some, beyond what is included in our agenda.

But I just wanted to make sure that we have members of the public kind of keeping an eye on our agenda, all again to provide inputs on respective measures.

So, we're reconvening now and we're going to start with our first set of measures, which are cross-cutting measures. And our co-chair, Kurt, will be facilitating this discussion.

If we can just go to the next slide, I just wanted to touch on why this is indicated as cross-cutting for the measures.

The reason being is because this specific measure 098 was submitted to multiple programs. It was actually submitted to three programs. So, that's why it's sort of cross-cutting.

There will be an opportunity for this workgroup to carry over the votes to other programs after evaluating the first program, which the first program up will be the Skilled Nursing Facility Quality Reporting Program, or SNF QRP.

The other two programs that this measure was submitted to was the Long-term Care Hospital Quality Reporting Program, and the Inpatient Rehabilitation Facility Quality Reporting Program.

So, after the workgroup evaluates the measure for the skilled nursing facility, if this workgroup sees that

the discussion points, and also the decision category, and conditions, if the conditions are placed on it, is the same for the other two remaining programs that LTCH and the IRF programs, we can carry over the votes to those programs.

So, we will do that after the evaluation of the first program. And then, we'll see if there's an opposition to carry over those votes.

It only takes one of the workgroup members to oppose a carryover, for us to then have a re-vote on those programs. So, if you are opposed to carrying over those votes, we'll then go through the voting processes for those programs.

So, that opposition, all it takes is just one workgroup member. You can voice up during the call when it's time to do so, you can raise your hand and be recognized if you'd like to, or you can send a chat, either publicly to everyone, or you can direct chat to myself if you oppose.

So, if you wish to not have your name recognized as opposing the vote, you can directly chat myself, and then it just takes one person to oppose a carryover, for us to vote separately on those programs.

So, again, we'll go through the first program, and then there'll be an opportunity for us to carry over those votes, if you choose to, to the other two programs. And again, it just takes one member to be in opposition of that carryover to voice that up for us to vote separately on this program.

I do also want to just pause, because I believe we have Deb Saliba on the call from AGS. Is that correct? Deborah, are you on the line?

Member Saliba: Yes.

Dr. Pickering: Great. Hi, Deb. I know that we sort of missed you a little bit earlier, but thank you for

joining.

We did some disclosures-of-interest earlier for the rest of the workgroup participants. And since you had joined, we also wanted to make sure that you have an opportunity to disclose any potential conflicts.

So, if you could just state your name, your affiliation, your role in that organization, as well as any potential disclosures that you'd like to present for the workgroup today.

Member Saliba: Thank you, Matt. I am representing the American Geriatric Society. I'm a member of the Public Policy Committee and the Quality Metrics Committee, for AGS.

I am also a Professor of Medicine at UCLA, where I direct the Borun Center for Gerontologic Research, I'm a physician-scientist in the Veterans Administration, and a Senior Natural Scientist and the Rand Corporation.

I don't have any direct conflicts with any of the measures that are being discussed today.

Dr. Pickering: Great. Thank you so much, Deb. Okay, so with that, I'll kick it over to Kurt. And then, we can get started with our proceedings. So, Kurt, I'll have you sort of direct through the slides, and whenever you're ready, you can kick it back to me.

Co-Chair Merkelz: Yeah, sure. So, thank you. Welcome back everyone. Hope everyone had a good lunch and breakfast.

Cross-Cutting Measure: MUC2021-098 National Healthcare Safety Network Healthcare-Associated Clostridioides Difficile Infection Outcome Measure

Let's get started with our cross-cutting measures, our Measure Under Consideration, 2021-098, the National Healthcare Safety Network, Healthcare Associated C. difficile Infection Outcome Measure.

And this measure tracks the development of new C. difficile infection among patients already admitted to healthcare facilities.

At this time, do we step over and open it up to public comment on this cross-cutting measure?

Dr. Pickering: Yeah, let's go to the next slide. And that's the public comment. That's correct, Kurt. We'll open it up for public comment.

Pre-Rulemaking Input

Co-Chair Merkelz: And as we open it up to comment and start getting individuals' feedback, I certainly want to draw your attention to the fact that let's limit our comments to the Measure Under Consideration, specifically, this 2021-098, or anything in the Long-term Care Health Quality Reporting Program, or the IRF, the Inpatient Rehab Facility Quality Reporting Program, and limit your comments, if possible, to two minutes.

Dr. Pickering: And for those members of the public, you can see some instructions in the chat. You can use the raised-hand feature to be identified if you'd like to provide some public comment, or you can put some comments into the chat.

So, now's an opportunity to do. We'll pause for a few seconds for public comment on 098, the NHSN Healthcare Associated C. diff outcome measure.

Co-Chair Merkelz: I don't see any hands raised on the platform at this time yet.

Dr. Pickering: I don't either. And nothing in the chat. So, once again, last call for any public comments on this measure?

Member Fallon: I'm sorry, I just want to double-check on what the parameters. Is this limited to IRF and LTCH right now, or are we discussing SNF as well?

Dr. Pickering: It's for SNF as well. So, since this measure also applies to LTC and IRF, this opportunity provides the public to comment on this measure with respect back to all three programs, including LTC and IRF.

So, that's why there was just that specific mention of it. So, for SNF, QRP, LTC, HQRP, as well as IRF QRP.

Member Fallon: Okay. And I know we've already submitted our comments on this particular measure. So, I don't know that you need me to restate them.

Dr. Pickering: Sure. Thank you. And we'll definitely cover those comments that we submitted as well. We'll just sort of highlight sort of common themes or concerns with those comments. Thank you.

All right, seeing no hands raised, nothing in the chat, not hearing anyone chime in, Kurt, I think we can proceed.

Co-Chair Merkelz: We'll go through the first program. Yeah.

Dr. Pickering: All right.

Skilled Nursing Facility Quality Reporting Program

Co-Chair Merkelz: Let's proceed on to the first program. And if you'd like to go ahead and review the preliminary analysis, the Public Comments Advisory Group that centers around Skilled Nursing Facility Quality Reporting Program --

Dr. Pickering: Certainly.

Co-Chair Merkelz: -- the background SNF QRP.

Dr. Pickering: Yes. Thank you, Kurt. So, as we mentioned previously, the first program up is the Skilled Nursing Facility Quality Reporting Program, or SNF QRP.

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

And the goal of this program is to increase transparency, so that patients are able to make informed decisions.

So, going to the next slide is a description of the measure. And this measure tracks the development of new C. diff infection 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. It's at the facility level of analysis. And for the preliminary analysis -- so this is NQF recommendation -- it was conditional support for rulemaking.

So, this measure does add value to the SNF QRP set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing a similar measure.

The updated specifications of this measure are intended to mitigate unintended consequences by only counting those cases where there's evidence of both a positive test for C. diff and a treatment administer, which may have led to historical undercounting of observed healthcare-associated C. diff infections.

Healthcare-associated infections are important for SNFs, as seen by recently adopted Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalizations Measure, and measuring healthcare-associated infections remains a high priority for the SNF QRP, and safety is a CMS Meaningful Measure 2.0 focus.

So, currently, this measure is not NQF-endorsed, so that's why it received a conditional support for rulemaking.

So, the condition here is NQF-endorsement. And just a reminder for the workgroup, NQF endorsement includes an evaluation of the evidence, it includes the evaluation of reliability and validity testing, it also includes an evaluation of the feasibility of the measure and usability of the measure.

So, those components, thinking about its unintended consequences if it used, which currently we're evaluating that, but also the feasibility and reporting of the measure.

So, NQF endorsement includes of those assessments of the measure for an endorsement. So, just wanted to note that.

In case some folks wanted to add additional conditions of testing, testing would be kind of underneath the NQF endorsement condition.

So, that is the condition that is placed on the measure from the NQF recommendations.

I'll just touch on the Rural Health and Health Equity. So, for Rural Health, on that one-to-five scale, five being the highest, meaning it's relevant to Rural providers, or have some sort of impact on Rural providers, the Rural Health tolled at 4.0 out of five.

So, some of the comments shared there with healthcare-associated infections, or acquired infections, are extremely important to monitor.

There was some concern for low case logging as a potential challenge. In the measure calculating reporting, the advisory group really encouraged the developer to account for small volume providers.

And for critical access hospitals, they do not participate in IQR -- this is for the hospital setting,

hospital IQR -- but it does apply to other hospital settings.

For the Health Equity on that one-to-five scale, thinking about five being that the measure can promote Health Equity and reduce disparities, they evaluated this at 3.5.

I'll touch on some of the public comments. So, there really weren't any supportive comments. We did receive two non-supportive comments for this measure, mentioning that this measure did not -- questioning the reliability and validity of this measure as well. And the measure justifications, specifications, descriptions, all related to the hospital long-term care setting, and none for the SNF setting.

This measure does not appear to exclude or take into consideration C. diff cases that are required in the hospital prior to discharge to a skilled nursing facility, and the risk adjustment of this measure is not specified in earlier versions of this measure. Only risk-adjusted for facility characteristics, not patient characteristics.

Lastly, this measure also requires Level 3 SAM certification to submit data to CDC National at NHSN Network.

There was a recommendation that this measure is to become part of the SNF QRP, that this measure's captured the existing data, such as the MDS or Claims, instead of the additional administrative burden in reporting through NHSN.

So, there's some implementation concerns with this measure reporting on the NHSN, recommending to use other data sources, like the Minimum Data Set, or Claims.

So, that's just a very, very high-level summary of the public comments received for this measure. Again, two non-supportive. And them, at this time, I'll turn

it back to Kurt and we'll open it up for any clarifying questions from the workgroup. Kurt?

Co-Chair Merkelz: Absolutely. And what about the comment from LeadingAge? Were you going to give a summary of that, or --

Dr. Pickering: So, the comment from LeadingAge --

Co-Chair Merkelz: I think Nicole Fallon had mentioned that had previously been submitted.

Dr. Pickering: Yes. I was trying to summarize --

Member Fallon: You can cover that.

Dr. Pickering: -- all the comments there.

Co-Chair Merkelz: Oh, you've got it all fully covered. Okay, very good.

Member Fallon: Thank you, Kurt. I'd appreciate that.

Co-Chair Merkelz: So, any --

Member Fallon: Can I ask --

Co-Chair Merkelz: Yes, please go ahead.

Member Fallon: Can I just ask one other clarifying question? Do we know why this was proposed, when we also had the healthcare-acquired infections resulting in hospitalization measure? Why we were digging down, particularly, here?

And obviously, this doesn't require hospitalization. But I didn't know why we were getting more specific.

Dr. Pickering: So, So, is that a question that maybe our developer, or potentially CMS, could address, why this measure is being considered, versus the other measure that's currently in existence?

Dr. Levitt: Hi. This is Alan.

Dr. Pickering: Sorry, Alan. If you're not speaking, could you please put yourself on mute. This is causing some feedback. Thank you. Go ahead, Alan.

Dr. Levitt: Okay. This measure was put on the MUC list really, as an additional measure. The SNF HAI measure is more of a global performance measure overall, of HAI prevention and management activities within a SNF.

And certainly, some of the comments that we've gotten when we proposed that measure, was that the addition to that for a more robust group of measures within the SNF QRP, and particularly within infection prevention domain, is to start to look in to add more specific HAI measures that would be going on within the SNF itself. And so, that's why it was part of your CP workgroup for consideration.

Co-Chair Merkelz: We do have some hands raised, and we can actually go over to Jill Cox.

Member Cox: Yes, thank you. So, I have a question actually regarding time parameters for determining that the C. diff infection occurred in that particular setting.

So, for a patient who's transferred from acute care to any of those settings, and let's say the patient was exhibiting symptoms, but they did not test the patient or start treating the patient for a C. diff, and they go into a SNF long-term care, and day two now they have positive C. diff.

How do we account for that then? That that may have occurred prior to admission to the SNF, but it's now going to reflect on their quality reporting?

So, I don't know if there is anyone that could clarify that. If there is a present-on-admission sort of indicator within a certain time frame in which that would be declared that this infection occurred prior to.

Ms. Benin: Yeah, this is Andrea Benin -- I don't know if you can hear me -- from CDC's International Healthcare Safety Network.

The way this measure works and the way -- there's an existing C. difficile measure that's used in the LTCH centers and in the hospitals right now, and this new measure would work in the same way, which is that the testing that happens after day four. So, it's day four and later, into the facility stay, if you will. And that's how we handle that.

And the current risk adjustment and the current measure accounts for testing that happens in the first three days.

So, we use that as part of the risk adjustment, so that the community incident, or the pre-existing incident, is accounted for in the risk adjustment, so that if you're in a place where maybe there's just tons coming in, that is accounted for as part of the risk adjustment.

But to answer also the previous question as to why would one pull out C. difficile, or why would one pull out any facility-acquired condition, when there's a global hospitalization type of metric that also exists.

C. difficile causes substantial morbidity in folks that may not always require hospitalization, but can cause substantial impact to quality of life and substantial impact to morbidity and experience with the extent of the diarrhea that can happen with C. difficile, especially in an environment where antibiotic use may have somewhat less stewardship, depending on the level of stewardship of antibiotics, but it's all kind of interrelated.

So, we do think that it's very important to understand the infections that are happening.

And being able to have the opportunity to get these problems under surveillance so that we can truly

understand the magnitude of the problem becomes really critical.

Co-Chair Merkelz: Gerri, you have your hand raised.

Co-Chair Lamb: I do. I have one question for Matt and NQF about conditional support, and then I have one for the measure developer.

Matt, the conditional support preliminary recommendation is pending NQF endorsement, as well as additional reliability and validity testing.

I just wanted to check, even though the R&D would be part of the review at NQF, that would be specified as well, because that seems like a critical piece of this, is that it needs to be tested in the specific environment.

Dr. Pickering: That's correct. So, the testing that was stated in the preliminary analysis was really going in line with NQF endorsement.

So, the testing of the specific program, the population of interest, the data sources that would be specified for use of the measure, all of that would get evaluated within the testing that would be submitted to NQF for endorsement, and submitted to NQF, which would convene a separate standing committee of stakeholders to evaluate the measure against those components and those criteria of reliability and validity.

Co-Chair Lamb: Thanks, Matt. And then, my other question is related to the risk adjustment. It says in the documentation that we received, that social determinants are built into the risk adjustment.

And given kind of our spotlight, increasingly on equity and disparities, can you speak a little bit about what about SDOH is in there?

Ms. Benin: Yes. Thanks, Gerri, for those questions. And I can clarify on the first question as well.

We're coming to the end of very extensive reliability and validity testing across multiple different facilities in the hospital setting right now, and are in the process of lining up -- we've received the feedback loudly and clearly, that we need to be able to test in other environments as well.

And so, we're in the process right now of getting testing lined up for hopefully early 2022, to get testing in these other environments, and the SNF, LTCH and IRF environments. So, that will be forthcoming.

The question about risk adjustment is part and parcel of the ongoing work that we're doing.

The current metric adjusts for facility-level factors. And some of the evaluation that we're looking at right now relates to the approaches that could be used, whether we need patient-level data, or whether there are things that could be done with Social Vulnerability Index and other things, without needing patient-level data.

Depending on the feasibility studies that we're able to pursue, will determine the types of data that we'll be actually able to use for social determinants of health.

Because, as I'm sure you can appreciate, in order to do proper risk adjustment, we need the social determinants of health data on the entire group.

And particularly in these LTCH, IRF, and SNF environments that may have some more limited electronic capabilities, that can be a pretty burdensome ask, to try to obtain all of that.

So, we're working through some testing, and to looking at some proxies , and ultimately potentially being able to develop the ability to stratify and look at that information over time.

But I'm not anticipating that we're going to have that built into the risk adjustment for this metric coming out of the gate for sure.

But it's extremely high priority for us to be able to evaluate and work with, and potentially even provide stratification of facilities, and can provide a more global understanding. But that's a little bit beyond, I think, the strict nature of the quality metric, in and of itself.

So, it's in our mandate around the surveillance aspect of this to understand what's playing out. That is, knowing that in the context of there ultimately needs to be a single-quality metric that goes into a program.

But we're attentive to it in the more global context of the program, if that makes sense. But we're not currently proposing very specific risk-adjustment aspects of that in these environments. But we're taking a look at it, if that makes sense.

Co-Chair Merkelz: James, you did have your hand previously raised. Just want to make sure any clarifying you had were previously addressed.

Member Lett: It was actually addressed after I put my hand up. It was around attribution with the side of the infection.

And when I worked with the Office of Inspector General on the patient harm study and post-acute sites, including stillness of facilities, we did talk with the CDC and got exactly the same answer, I'm happy to say, of three days.

If it breaks out three days, within three days of transfer from the hospital, attribution is to the acute site. If it's after that, then the albatross hangs on the post-acute facility.

Ms. Benin: And, Matt or Gerri, if there's anything that

you'd like me to address from the comments that you delineated, I can potentially address some of the ones that I can remember.

I didn't take notes quickly enough, but it's helpful at all for me to address any of the notes that you were sharing, I can comment on a couple of those things as well, probably.

Dr. Pickering: So, Kurt, I think Alan has his hand raised, as well as Paul.

Co-Chair Merkelz: Dr. Levitt.

Dr. Levitt: Thanks, Matt. Paul, do you want to go first?

Member Mulhausen: Sure, Alan. So, I like this measure. As a practitioner, C. difficile is a vexing, vexing problem for me, as a nursing home resident physician.

And I have admired CMS's efforts to get a better handle on what was going on with its surveillance efforts.

NHSN is very hard to use. I want to reflect on that. I'm excited by the potential to tap in to other sources of information. But fundamentally, my experience with putting data into NHSN is that it is not easy. And it's especially challenging in work settings where the staffing is so unstable.

But here's my sort of more, to me, interesting question about what do we want to promote in terms of quality?

And when I hear, Andrea, you talk about antimicrobial stewardship, I go, well, I want to promote that.

My one worry is the way this measure is constructed. And I think it would be useful to think through this with your testing. And that is, it kind of incentivizes

you not to do the standard of care.

So, by including the testing of the stool, the treatment of the illness, and in the numerator of a quality measure, a measure of the quality of care we're delivering in our nursing home -- or post-acute setting, let's say -- I mean, I hate to say this about people like, me, colleagues, but I've watched it happen over and over again, where all we ended up doing was pushing them into practices that I would either say was equally bad or worse.

And I worry that this measure has some risk of doing that. That the unintended consequence would be, oh, they've got some diarrhea, don't study it yet, because if you find their -- we'll get dinged.

And that's a very simplified way of saying it. But I think, keeping an eye on the unintended consequence of this particular quality measure, as opposed to a surveillance point, I think is important.

Ms. Benin: Yeah, Paul, we couldn't agree with you more. And we certainly have a situation -- you know, the current measure uses just the testing, without the therapy.

And we see, for example, that there are places to do a lot of testing on days one through three, and then after day four, they only use treatment. They don't test again, right? And that causes some problems.

So, this creation of this metric where it combines a lot of testing, plus the C. difficile antimicrobials, which are limited, which it makes it a little bit more straightforward to design the measure, but it's an attempt to address that.

In particular, one of the things that we're doing as part of this program, if you will, is pairing in a measure of oral vancomycin without testing.

So, that wouldn't be the quality measure, but it will

enable us, as part of surveillance, to be able to monitor the potential unintended consequence of people just treating.

In the preliminary data that we've looked had so far, which again is hospital data, but in that preliminary data, we're not actually seeing as much oral vancomycin without testing as we had expected, but we are really alert to what is the best way to pair in those analyses, and to be able to monitor that for those unintended consequences, because we certainly worry about that as well.

And I think by doing it this way, our effort to use antimicrobial, to use the oral vancomycin or one of the other C. difficile drugs, is a proxy for kind of decision-making in that space, so if you have a lab test and you also treated it, you probably really thought it was C. difficile. And so that's where we're headed with that.

I will say that we received some feedback about how folks can struggle to log in to NHSN.

We're certainly in a situation right now where all 15,000-plus of the nursing homes are logging in every week and using NHSN to report their COVID-19 data.

So, they've gotten more practice at it, and we have done our best to make NHSN as usable as possible. And we're always trying to push forward efforts to make it increasingly usable.

One of the advantages of having folks logging in every week is that almost all of them -- over, I think, 14,000 of them -- have been able to achieve their SAMs Level 3 access, which I know is noted in one of the barriers.

And certainly, in addition to that, the CDC OCIO -- which the IT department essentially at CDC who kind of controls that, that's outside the purview of NHSN,

how all that works, which is neither here nor there for your purposes, but it impacts our day-to-day.

There's a new practice for SAMs Level 3 access. So, that is very, very exciting to us and we're finding that the turnaround to get Level 3 access, it only takes a day now. Right? It takes a few -- half-hour, it takes a much shorter turnaround time than previously, where maybe it had been weeks and applications were hard to figure out.

But there's a brand new process that uses identity encrypting through Experian and some other things.

So, the CDC OCIO heard us all loud and clear, and that aspect of it, it's hopefully better. I'm not going to promise that everything is unicorn and roses, but it's substantially better, the feedback that we're getting.

Co-Chair Merkelz: Thank you.

Dr. Levitt: Matt, is it okay for me to talk?

Dr. Pickering: Sure. Go ahead.

Dr. Levitt: I'm just glad that Paul asked his questions first, because actually, Paul's really important comment, concern about unintended consequences that could potentially happen with this measure -- really, with all of our measures in our program -- we need to really think up front.

Whenever we're proposing measures, what do we think is going to happen. It's almost like a chess game, with trying to figure out what it is, and to be able to, well, what could potentially be the unintended consequences. How are we going to monitor that?

So, the monitoring evaluation is a very important question, so always asked here. And then, actually, in NHSN's response, that was going to really come to what I was going to just comment on or mention to

the workgroup, is that there is an existing NQF-endorsed NHSN quality measure for C. difficile, which this eventually would actually end up replacing that version of the measure.

And that would be like -- well, we discussed it later on in the IRF and LTCH. That measure, 1717, is already adopted in those programs. And so, this is a measure -- and again, as Andrea explained, is a measure that's actually -- we believe is better, in terms of reflecting C. difficile. And so, that's why it's being brought forward.

But within the SNF QRP, which does not have that existing measure, this would be a new measurement approach. I apologize for my comment.

Co-Chair Merkelz: -- chat at this time? If that's the point, then we can actually move on to vote on the acceptance of a preliminary analysis. Matt?

Dr. Pickering: Okay. And yeah, I don't see any other questions in the chat box and no other hands raised.

So, at this time the workgroup is now going to vote on whether or not you want to uphold the decision category that's in the preliminary analysis, which is conditional support for rulemaking. And that condition is NQF endorsement.

So, if you do not wish to uphold that decision category, you would vote no in this case. If you do wish to uphold it, you would vote yes.

And I'll turn it over to the team to run through the polling.

Ms. Young: We are now open for MUC2021-098 NHSN Healthcare-associated C. difficile infection outcome measure. Do you vote to support the staff recommendation as the workgroup recommendation?

Dr. Pickering: Okay. The poll is -- excuse me, the

vote, I'm still working on last week -- the vote is now closed for MUC2021-098 for use in the SNF QRP program.

Sixteen members voted yes and three members voted no, for 84 percent.

Dr. Pickering: Okay. Eighty-four percent voted positively to uphold the staff recommendation. So, that will hold for conditional support for rulemaking, and then the condition is NQF endorsement. Great.

Co-Chair Merkelz: At this point then, that recommendation becomes the recommendation of the group. We can actually move on to the next reporting program.

Long-Term Care Hospital Quality Reporting Program

Dr. Pickering: Okay. So, the next program that's up for this measure, is the Long-Term Care Hospital Quality Reporting Program, or LTCH QRP.

So, this is a pay-for reporting and public reporting program, which long-term care hospitals, or long-term care settings, that fail to submit data, will have their applicable annual payment update, or APU, reduced by two percent.

The goal for this is furnishing extended medical care to individuals with clinically complex problems. So, you can see the examples listed there.

So, again, this measure is cross-cutting into this program. So, if there's similar -- if you'd like to carry over the vote for this, we're able to do so.

But I'll go through the PA on this, as the decision category is the same. That's why we're able to carry over the votes, if you wish to do so.

So, the description of this measure is the same for this program. It is a facility-level measure.

The NQF recommendation on this is conditional support for rulemaking, and that condition is NQF endorsement.

So, this Measure Under Consideration would modify that existing measure, as Dr. Levitt has mentioned, that existing healthcare-associated C. diff surveillance measure that's currently within the program, and it modifies it by only counting cases where there was evidence of both positive test and treatment.

So, this may mitigate potential unintended consequences from the current measures design, counting a case-base on a positive test only, which may have led to a historical undercounting of the observed healthcare-associated C. diff infections.

So, this updated measure is consistent with the program's priority to measure healthcare-associated infections, and the patient safety Meaningful Measures 2.0 area. Currently, it's not NQF-endorsed, so that's why conditional support for rulemaking.

I just highlight that the Rural Health and Health Equity were similar in their assessments of this measure for this program.

So, Rural Health, out of that one-to-five scale, rated as four. Similar concerns with this program about low case volume for this measure, but recognizing that these healthcare-associated infections are extremely important to monitor.

For Health Equity, on a one-to-five scale, is 3.5. We did not receive any comments for this measure, for this program, and from the public, leading up to today's proceedings.

So, in this case everything else is very similar, as to the SNF QRP program. So, at this point, Kurt, if we can pause to see if anyone opposes any carryover, or if there's any clarifying questions that the workgroup

has for the developer or for NQF related to this measure, for this program.

Co-Chair Merkelz: Any clarifying questions? I see Mary Ellen has her hand up. Mary Ellen, are you there? You're on mute, Mary Ellen.

Dr. Pickering: Yeah, are you on mute?

Member Debardeleben: All right. All right, I think I'm officially off of mute.

We don't have a low rate here. And by requiring an additional step, which is clinically relevant, it could decrease the reported rates even further.

And I know that this is an issue that's going to come up in IRF as well. But does it -- one of the NQF standards about the burden of reporting, if this like shrinks the number of C. diff cases even further, of what value is it going to cost in burden of reporting.

And so, thinking about the numbers behind that, I don't have the LTCH data, but I know in IRF it's relatively low incident. And so, hearing that earlier on the LTCH side is something that I think is important.

Because we tend to think, well, if we measure it, it's a good thing. But there is a significant cost to collecting and reporting these measures.

And if there isn't public value because the rates are so low, which in NHSN it all means that the vast majority of LTCHs or IRFs are not going to have data, because there's just not enough of value there.

And so, reporting it is good. But when you get into the details of it, if there's not substantial enough data for the LTCHs to have a rating on Care Compare, or just to have no data, then it doesn't tend to justify the measure itself.

Dr. Pickering: Kurt, I don't see any other hands raised, or any other questions in the chat box.

Co-Chair Merkelz: At this time then, do we feel, as a group, workgroup support of it then, of carrying over the voting decision? Any opposition to carrying over? Either raise your hands, comment, put it in the chat.

Dr. Pickering: And if you'd like to remain anonymous, you can directly chat myself. It just takes one workgroup member to oppose carrying over the votes, SNF QRP to the LTCHQRP.

Again, that's a conditional support and the condition is NQF endorsement. So, if you oppose, now is the time to oppose.

Thank you, Paul. Last call, if you oppose the votes, or the carryover, please do so now.

Member Debardeleben: Just to clarify, the national average for C. diff and LTCH on Care Compare right now is .537. And this change of measure would take that even significantly lower.

Member Mulhausen: I have a question around those comments. If I don't have the floor, it's okay.

Dr. Pickering: No, please.

Member Mulhausen: So, those are bragging rights in my mind. And for some reason, I'm a little confused about why, if I'm running an LTCH and I have no C. diff, why I don't want to be reporting that and get great star ratings. I mean, help me understand that.

Member Debardeleben: Yeah. I don't have the LTCH values. But on the IRF side it's a few million dollars a year across the system to report that data.

And it's not as simple as taking the electronic medical record. We're not in a fire or electronic quality measure data world yet. It takes infection control hours.

And even if you don't have a C. diff infection, you have to go in and actively report data on your

hospital, that you didn't have a C. diff infection.

You have to set up a monthly report, you have to enter all this data in. If you don't enter the right data, you can be at risk for non-compliance.

So, it's not just as simple as, oh, I had one C. diff this year, I need to report that. It's an ongoing reporting process. It takes time and effort from infection control practitioners, whether there are already these infections or not.

And infection control hours are already something that hospitals take very preciously, and when you add in a public health emergency, like we've been going through the past two years, it's even more so where do we want that time spent?

Do we want that time spent going in and reporting data into a system because nothing happened? Or do we want to actively use that time to prevent other infections?

Co-Chair Merkelz: Paul, does that -- okay. Paul says thank you for the comment.

Member Mulhausen: I thought that was very helpful contextualization. I confess I've never actually had to put anything into the NHSN database.

I used to go around and talk about it but I never actually did it. And so, what you're saying is very helpful. Thank you.

Co-Chair Merkelz: Alan, before you wanted to comment.

Dr. Levitt: Thank you. First of all, thank you Mary Ellen. These are very important questions. I mean, these are things we need to think about and talk about, in terms of what measures are within our programs, and measuring move of criterion.

This is actually something that we follow. As Mary

Ellen was talking, I went back and I pulled spreadsheets. And I actually try to look at this data, because I want to make sure we have measures that are meaningful.

And just to go back, I mean, I was looking at data that I pulled that was publicly reported in December 2020, of some of the data lately, because of the public health emergency, I terms of trying to update it more, may be more difficult.

But with LTCHs, out of the 353 that actually ended up reporting, the average was, over that year, they had 7.34 C. diff episodes in the numerator.

There was a maximum. I mean, the LTCH that had 59 within that year. And the NHSN, in terms of calculating, we have an SIR that ranges from zero up to 3.44. And so we do, within the existing quality measures, certainly note the performance gaps that are occurring within this measure.

Co-Chair Merkelz: And so, we put it into the group one last time, whether or not we have any objections to carrying forward.

Dr. Pickering: Yes. I will say that Pamela Roberts had sort of a question, I think, when we get to the IRF program. Do you have the same information for IRF? I believe that was directed towards Dr. Levitt.

So, maybe we can follow up with that when we move to IRF. But at this time we'll do the, again, calling out to see if there's any opposition to carrying over the votes from the SNF QRP for this measure to this Long-Term Care Hospital Quality Reporting Program for the same measure.

So, if you're opposed, please speak up, put it in the chat, or you can direct-message myself if you oppose. And thank you, Paul, that you do not object. Okay.

And Kurt, I do not have any direct chat about opposition, nor do I see any in the chat, and no hands raised. So, I think we're good.

Member Debardeleben: I planted that. I'll oppose and I'll propose a new vote.

Dr. Pickering: Okay. So, we have an opposition to not carry over. So, in this case, if there's no other clarifying questions related to this measure for this program, we will open it up for a vote. And this is to vote on the same decision category with the same condition, NQF endorsement. Any remaining questions?

Member Lett: Yes. Sorry, I couldn't find to get my hand up. This is Jim Lett. I would just appreciate knowing the reason for the opposition.

Member Debardeleben: Yeah. So, Dr. Levitt just said, and correct me if I'm wrong, Dr. Levitt, that LTCH had an average of seven CDIs in -- is that a calendar year?

Dr. Pickering: I believe that was yes, Dr. Levitt?

Dr. Levitt: Yes, and that was based on the numerator. I follow the way it numerates. Yes.

Member Debardeleben: Yes. I think having a denominator would be helpful there. You know, seven out of how many patient days? It's a lot of patient days, given the average is .5.

The change to this measure would actually shrink the number of events, because it's harder to get a C. diff case by having to meet the definition of both of these.

So, let's say an LTCH provider now reports all this data for an average of two or three reported events a year. And this has a cost. I mean, any measure reported into the NHSN is going to cost the system half a million, a million dollars of infection control hours. And those hours are limited.

And so, even a small-in-size of less than four in a month, those are important events. And in a long-term care setting, those can be even more indicative.

In a short-stay setting, like in a patient rehab environment, the provider that reports into the C. diff may not even be responsible for the C. diff itself. It could have come from the acute provider.

But what we're doing is saying, like, we're going to spend all of that infection control hours on something that was actually going to shrink the numerator by the basis of adding an additional requirement.

And we talk a lot about measures that matter and making measurement effective. And this is more clinically relevant, in terms of the definition of a C. diff.

In reporting it, it would make the already very small pool of reportable events even smaller. And does that justify the burden of reporting? So, that is the basis of my opposition.

Ms. Benin: Matt, it's Andrea. Do you want me to make any comments or clarifications on any of the numbers?

Dr. Pickering: So, I'll turn it back over to the workgroup. Does the workgroup need any further clarification from the developer?

Member Andersen: This is Dan Andersen. Can you hear me?

Dr. Pickering: Yes. Dan Andersen? Yes.

Member Andersen: Yeah, I have a question maybe the developer can answer. I mean, I'm getting a little -- I mean, when we talk about shrinking the numerator, I mean, that's not what this measure does, right?

I mean, it sounds like it's getting at a more accurate

rate. So, we're just maybe reducing the number of false positives when we have this extra requirement? Can you confirm?

Ms. Benin: That's correct, Dan. Thank you for that clarification. Yeah, the idea here is to make sure that we're really getting at the preventable fraction, if you will, and moving away from some of the concerns that the laboratory base alone for this metric was potentially pulling up people who are colonized and who wouldn't need to be treated.

So, the idea of adding the therapy is that it's pulling out people who needed treatment. And I don't think we know yet how much the point to reduce it by.

I think that's work in progress for us to identify how much that'll reduce it by. And especially, I think, it will depend a lot on the extent to which facilities may have already dropped their testing practices and put in diagnostic stewardship practices.

So, it'll probably vary facility-by-facility. I just pulled up the numbers for 2020. And again, 2020 -- and Alan can correct me if I'm wrong -- I think -- I'm not sure, I can't remember -- if everybody ended up reporting, and there are 397 facilities that reported, so I knew there were potentially -- that may not be the whole ball of wax, but for the LTCHs, the observed hospital onset events that happened, or facility onset events that happened, were 1,888. So, close to 2,000 events happening in 397 reporting facilities during 2020.

And 2020, again, was a weird year, right? And I do think that these are important facility-acquired infections, and they're important parts of a holistic view of how well a facility is going with their infection prevention activities. And having a measure to drive for it is what we're hoping to do to support those programs.

Co-Chair Merkelz: Gerri?

Co-Chair Lamb: Yeah. I appreciate, Mary Ellen, your comments and your thinking about this. And for me, it's suggesting that there isn't as strong a gap issue as with perhaps other settings.

I'm wondering -- and Andrea, I don't know if -- or Ellen, you can address this -- is the timing issue. Michelle talked about that we are seeing dramatic changes in safety measures. And it concerns me to not move something forward this important, in the midst of seeing those indicators lose some ground.

Do we have any indication that that's happening in LTCH?

Ms. Benin: In general, I have to pull up the LTCH data for that. Just give me a minute. Hang on just a second.

In general, the measures that have been worsening are the measures around central line-associated bloodstream infections, and the measures around -- hang on, I'm just pulling up the table. For some reason, I don't have it right here -- and the measures around MRSA.

As the C. difficile measure has not been worsening across the board in this time period, although -- let me just see if I can pull up the -- you know, one of the challenges has been, with C. difficile, because of how facilities have been making decisions around changing test pipe and other things that we're trying to address with this new measure, there's a little bit of our questions around how much does the changing test pipe impact the fact that the measure has been improving overall?

And so, we're still in the process of analyzing the details of that and what's been happening over the past year or so in the face of the changing test pipe.

But suffice it to say that C. difficile is not one of the ones that has been worsening. That has been, by and large, the CLABSI and MRSA, and the ventilator-associated infections are the ones that have been really -- the ventilator-associated infections prominently.

But those are the three that have been worsening. And C. difficile has not been in that category of the worsening ones during the pandemic.

Co-Chair Lamb: Thank you.

Co-Chair Merkelz: Mary Ellen, you wanted to respond?

Member Debardeleben: Yeah. The way that the NHSN measures are publicly reported, is called a SIR. And we've talked about that a little bit, the standardized infection ratios.

And so, what .5 means, it's a ratio of observed events over expected events. And so, with the CDI SIR of national average of .5 -- I mean, there's some decimals in there that I can go back and look at -- that means we're actually seeing half the infections in LTCH that we would expect to observe.

And so, by further refining this and making it a more true reflection, we would expect, like the developer said, I don't know how much further down it would go, but we expect it to change. Otherwise, there wouldn't be a value proposing this, that the number of infections would go down. And that SIR would continue to go down.

And this is also a depression about measure burden and winter retire measures. We've retired other infection measures in post-acute care, that the burden of reporting didn't outweigh the very few number of infections that ended up on Care Compare.

And so, just the fact that we're an LTCH and IRF, the

ratio's about the same. We're seeing about half of what we would expect to see. And it's going to get smaller with this type of change.

But what's nice about that standardized infection ratio, is that levels out for volume and cases, and adds in a risk adjustment. And so, that kind of outweighs the need to look at the end sizes and how does that compare, what was the denominator, what was the actuality of events, compared to the expected of events. And for both IRF and LTCH, it's already below one percent, half of one percent. I'm sorry, not one percent. Half of one.

Member Andersen: This is Dan Andersen. I have another comment. Can you hear me?

Co-Chair Merkelz: Yes, please.

Member Andersen: Yeah, I won't speak to the evaluation of whether this is worth retiring or not. That seems like a separate conversation.

But I just wanted to go back to the original back-and-forth. I mean, it seems to me like if I'm putting my consumer hat on, I would be a proponent of this new measure if it's getting maybe a lower incidence or standardized incidence ratio, if it's reflecting true cases, rather than colonization.

Because that's what I'm going to use to more accurately choose between providers. So, with that perspective on, I would be a proponent of the switch. But I'm not --

(Simultaneous speaking.)

Member Debardeleben: When it gets too low, what will show up on Care Compare is, there's no data to report. And that's something that we see in some of these measures that we report, is that when the end ties get so low that you can't calculate a SIR anymore, you don't get better, no different, or worse,

on Care Compare. You get, we don't have data on this hospital. We don't have data on this record.

Member Andersen: I should know this, but is this measure, is it reported as a category worse than additional average? Or is the actual rate reported? Because if you get too few cases to report, it's a ringing endorsement, in my opinion, for the facility.

Member Debardeleben: So, in this measure, it has better, no different, or worse, as with the ratio and the national average. However, if you can't calculate the SIR, you don't get a categorical rating.

Member Andersen: Got it.

Co-Chair Merkelz: Do we have any other comments from the workgroup?

Mr. Dantes: This is Ray Dantes from CDC. I'm happy to address some of these questions about the shrinking of the measure.

So, as Andrea Benin pointed out, the amounts that the numerator would shrink depends on the testing practices and how tight those practices are within the individual facility.

In a lot of facilities in our initial scientific evaluations, for many of the facilities the number of events was actually very similar, or even identical, to the initial measure.

But in some other facilities where there's not as much control or safeguards against testing, we do see a shrinking of the measure. So, it does vary by place to place.

I will say, of course, as a clinician who's occasionally on a couple of times a year, received a positive C. diff test on a patient who no longer had diarrhea by the time the test came back the next day, this improvement of the measure does get rid of that fraction where he received the most important

feedback of that.

Hey, I received a positive test. This patient clinically doesn't have C. diff anymore. Why are we still counting this?

Co-Chair Merkelz: At this time, I think we should go ahead and move to vote on the preliminary analysis. And we can always open up further discussion based on the outcome of that voting. Matt, can we move to voting on the preliminary analysis of this for Long-Term Care?

Dr. Pickering: Sure. I think we can definitely do that. So, I think we've had some discussion here and opposition to carry over. So, in this case, what we're voting on is to uphold the NQF recommendation, which is conditional support for rulemaking. And that condition is NQF endorsement.

So, if the group does not uphold that vote, there can be further discussion by the lead discussants on this measure, and another decision category identified for voting.

So, I'll turn it back over to Susanne to go through the voting process. Go ahead, Susanne.

Ms. Benin: And Matt, it's Andrea. I did add into the chat the information on the numbers that haven't updated to get an annual SIR. So, folks can take a look at that too.

Dr. Pickering: Great. Thank you, Andrea. I see that is 391 and 397 had enough data to get an annual SIR for the LTCHs. Thank you. Susanne?

Ms. Young: Voting is now open for MUC2021-098 NHSN Healthcare-associated C. difficile infection outcome measure for the Long-Term Care Hospital Quality and Reporting Program.

Do you vote to support the staff recommendation of the workgroup recommendation?

Dr. Pickering: I know we had a couple of folks step away, so that is probably why our numbers dropped to 17. But just last call for your vote. There we go. Okay. I think we can lock it, Susanne.

Ms. Young: The vote is now closed for MUC2021-098 for the LTCHQRP Program. Fifteen members voted for yes and three members voted no.

Dr. Pickering: And so, with 15 members voting yes, that's 83 percent. So, the NQF recommendation holds for this measure, for this program. So, Kurt, back to you and we'll go to the next program.

Co-Chair Merkelz: Yeah. And with that, I'll absolutely pass it back to you, so we can get to the final program.

Inpatient Rehabilitation Facility Quality Reporting Program

Dr. Pickering: Thanks, Kurt. All right, so the final program for this measure is the Inpatient Rehabilitation Facility Quality Reporting Program, or I-R-F-Q-R-P, or IRFQRP.

The program type is a pay-for reporting and public reporting program. So, IRFs that fail to submit data will have their applicable IRF prospective payment system payment update reduced by two percent. Excuse me.

And the goal for this program is to address the rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community, post-discharge.

If you go to the next slide, it's just a description of that measure. Again, nothing has changed for this program. Again, it's at the facility level. The NQF recommendation and the preliminary analysis is also conditional support for rulemaking. That condition is NQF endorsement.

So, this Measure Under Consideration would modify the existing healthcare-associated C. difficile surveillance measure in the IRFQRP, by only counting cases where there was evidence of both a positive test and treatment.

So, again, similarly to the other programs, this may mitigate potential unintended consequences from the current measure design, counting the case based on a positive test only, which may have led to a historical undercounting of observed healthcare-associated C. difficile infections.

So, this updated measure is consistent with the program's priority to measure healthcare-associated infections, and the patient safety meaningful measures 2.0 area. Again, it's not NQF-endorsed. And so, that condition, again, is endorsement.

For Rural Health and Health Equity, similar inputs, and also rating, once again as the other programs, so, Rural Health, on the one-to-five scale, was 4.0, and Health Equity on the one-to-five was 3.5.

Rural Health, specifically, we noted some concerns with low case volume as a potential challenge for measure calculation and reporting in rural settings.

As far as the public comments received, there were none for this measure, for this program, so no public comments. And I'll turn it back over to Kurt to see if there's any clarifying questions for this measure with this program, before we do the carryover vote decision.

And I believe Pamela Roberts had asked about some of the data that Dr. Levitt was reporting out for the LTCHs, if they had it for IRF as well. I think that was one question. But I'll turn it back to you, Kurt.

Co-Chair Merkelz: -- that discussion right now. And if any of the members of the workgroup have any other questions or any opposition to carry over the vote

that we just did on Long-Term Care over to the Inpatient Rehab Facility. But if we want to comment regarding data?

Dr. Pickering: So, I see Mary Ellen has her hand raised. And then, maybe we can see if Dr. Alan Levitt has those data.

Member Debardeleben: Yeah. I have more data relatable on our side. And so, talking about what is a value to report what's out there on Care Compare, there are 1,172 IRFs out on Care Compare right now.

And 273 have no data available, which is a bit more than the LTCH side. Seven hundred fifty two are no different than the national standard. So, those two groups combined are almost 88 percent of IRFs out there.

One hundred thirty-five, which is just about ten percent, are considered better. So, you can find out if you have a very small chance of like possibly being better on this measure -- probably about the same -- I think what consumers really want to know is, is there a risk?

Is there a danger to their loved ones for reporting this, based on the reporting of this data? And there's only right now on Care Compare, 11 IRFs out of 1,172, which isn't even one percent, they have a worst category on this measure. Incidence is just generally low.

The most IRFs are matching up with the national average. If you are doing very well in this and there's just a tiny, tiny handful that are having enough C. diffs to be considered worse than the national average. So, that's less than one percent out there.

And again, from calculations eight years ago, between a half million and a million dollars to report these measures by infection control practitioners,

and you do have to report ongoing data for the measure, regardless of whether you have them or not.

So, thank you, Andrea. Andrea just noted that about half of IRFs were able to have a SIR calculated. And so, like the CDC mentioned, we don't know how it will change. But there wouldn't be value of making a change if we didn't think it would be more accurate. And more accurate does mean less infections.

So, approving this is clinically relevant. But it just kind of erodes away at the value of these measures, if the point is to put them out on Care Compare.

Only half in 2020 had enough data to get a SIR enough, and it keeps shrinking. So, I feel like by approving this, we're really just kind of moving the dial forward to kind of showing how some of these measures might be topped out and in need of kind of retirement from the program.

Because even as it stands right now, it's not that compelling of a picture in IRFs for provider quality.

Member Andersen: This is Dan Anderson again. Isn't it possible that the small percentages that are worse and the small percentages that are better, that might be a result of the current measure might have a little bit of noise from colonization, rather than active infections? And that could potentially improve. I'm not saying it will, but that's an area of potential with going to this measure.

Member Debardeleben: Yeah. Another issue with this measure in the IRFs environment is that it's such a short length of day. And so, the providers that have the CDI in their setting are the ones that are reporting it.

But many of these may have come to the IRF already halfway there. So, they may not have acquired the CDI infection at the IRF. It could have been acquired

at the acute care and the IRF is the one that ends up reporting it, because it's such a short length of day.

So, that's another consideration in this environment that likely lead to, how many of these are acquired in the IRF. It's unclear, as opposed to a true kind of hospital-acquired infection, or was it acquired at the prior setting and the IRFs are just the ones kind of downstream reporting.

Ms. Benin: This is Andrea again. Just go ahead and let me know if you want me to make any clarifications about the metric I can make, if that's helpful.

Co-Chair Merkelz: First, does the workgroup have any additional questions?

Dr. Pickering: Hey Kurt, I see Dr. Levitt has his hand raised.

Dr. Levitt: I just didn't know whether you want it. Again, my data is back from when it was reported in December 2020. And so, it isn't as, I guess, as current as whatever the NHSN would record.

But just to be consistent with what I already know it said, the average for IRFs, the, I guess, 1065 that actually we were able to report in, the numerator was 2.1 for the year.

But the maximum IRF was 51 episodes, or CDIs, that were reported in during that year. And the SIR did range from zero up to 3.55. So, there was a performance gap for those IRFs that were reporting the measure.

Co-Chair Merkelz: Comments? Comments we can actually put up again and the questioning any opposition, the carrying over the vote that we did for Long-Term Care to the IRF.

Dr. Pickering: And again, the message can be directed to the chat. And I have received a message directly, Kurt, that they would like to have a separate

vote on IRFs.

So, we will see if there's any other clarifying questions. And we can then vote on the current NQF recommendation. So, if there are any other clarifying questions for NQF, as far as the PA process, as well as to the developer, on any of the measure specifications, etc.

Ms. Benin: And I did just put in the chat the way that the standardized infection ratio works, is a compare of the observed infections. It's the ratio between the observed infections and the predicted infections. It's based on a 2015 baseline to calculate the predicted infections.

So, it's not a comparison to the current national average. It's really a way to look at the comparison to the past, if you will. Right?

So, it's in comparison to how things were in the past. So, the absolute number of infections in this setting was, I think, close to 1,500, and whatever I put in the chat there, was the number from the annual report.

The standardized infection ratio is not reflecting any facility's comparison to the current national average, but it's how that facility has performed over time in comparing to the original benchmark, if you will. Just to clarify that if that was unclear.

Co-Chair Merkelz: Paul, you have your hand raised?

Dr. Pickering: Paul, if you're there, we're recognizing your hand is up, you might be on mute.

Member Mulhausen: I'm off mute now. I apologize. So, this has nothing to do with the question on the vote, but I feel compelled to share my thinking on this at the moment.

So, I'm old enough to remember when C. difficile was

novel. I think I an almost remember the first case of it I ever saw. And the massive amount of intrigue that we felt when we diagnosed the case when I was a very young physician, and we were all sort of looking for zebras.

And by the time I left my full-time practice, it was a daily occurrence. And when I use the word vexing, it's not hyperbole.

So, within the course of my career, which I guess by some measure has been long, but not that long, the numbers have changed dramatically.

And I'm just not sure that a low rate now predicts the future. So, I like the measure. We've already talked about my concerns about it. But just in general, do I think it's smart for us to be monitoring this?

As a clinician and interested stakeholder, I do. I think the question here is something just for the programs to continue to work on, and that is how do we make reporting easier. How do we make reporting less difficult?

How do we improve the flow of information from provider to CMS to CDC, and back and forth and -- and I think having the CDC and the NHSN sort of created a new element of complexity and reporting, and additional barriers to sort of being able to provide a super-direct feedback loop to, oh, this is hard and expensive.

So, I'm actually very sympathetic to the arguments that this is hard and expensive. I think that's real.

I still think the measure ought to be included. I still think it's wise for us, as the Medicare plan, to be monitoring this. I don't object to the notion that my practice environment should be judged on it, with the caveats that I've already thought about.

So, although I understand exactly what's being said,

I think the take-home message to CMS from me is, keep working on making that reporting structure easier and less expensive for those of us out in the trenches.

So, that's where I'm at and why I'm voting the way I'm voting over these last three rounds.

Co-Chair Merkelz: Yeah, thank you so much, Paul. That's very well said. Do we want to go to voting, Matt, at this point in time, on the preliminary analysis?

Dr. Pickering: Sure. I'll just recognize Mary Ellen had a question for Andrea in the chat. Do you have enough discharges from the same timeframe? Andrea responded with an annual report link. Mary Ellen, do you have any other questions?

Ms. Benin: Yeah, I don't have the number of discharges there. We have patient days. Oh, actually I have the number of admissions. But am I looking at the right thing?

In that report, it has all of those numbers. And you can pull them up. If you scroll down to the bottom there, and then Excel spreadsheet there for folks.

Member Debardeleben: What was the admissions over that same period of time where there were 1,400 events?

Ms. Benin: So, and just to remember that the way that this measure happens is a comparison of just those numerators.

So, it compares the observed count to the predicted count. But the total patient days for laboratory identifies C. difficile is 6,500,000 and change. So, about 6,503,960 is the total patients.

Oh, sorry. Excuse me, that's the total patient days. I'm looking at the wrong column. It's 496,000. Sorry, I'm looking at the patient days. So, there's a lot of

patient days.

Member Debardeleben: This conversation of, we need to be reporting, and there's no doubt that this is very clinical relevant to all of these disciplines.

In my mind, the question is, of what value is it to report, and then once we report on the public reporting side, if we're getting smaller and smaller facilities that have data to be posted, the value of reporting gets smaller and smaller.

But at no point is anyone suggesting that these aren't extremely relevant clinical events. And by saying that we're not reporting them, doesn't mean that they're not very clinically relevant each time they occur, every time there's an incident, but also, it's just not feasible to report every clinical event until move into more of an electronic quality measure environment, which hopefully is sooner, rather than later.

Ms. Benin: Right. And these measures are specified electronically, for electronic data capture, for facilities that are able to do that, for sure. Yep, that's the goal. Absolutely. You know our understanding --

(Simultaneous speaking.)

Member Debardeleben: Yeah, you still have to like -- the burden piece says you still have to electronically report a lot of data, even if you have no infections. You have to report the data on a monthly basis. You have to create a monthly reporting plan.

All of that has to be done even if you had zero infections. So, you get a zero infection and fail to report the data about no infections, and be penalized under the program.

Dr. Pickering: Kurt, I think you might be on mute.

Co-Chair Merkelz: I was, yeah. Alan, you wanted to make a comment there?

Dr. Levitt: Sorry. I just wanted to make a comment just to say that, first of all, these really are very important topics, in terms of, first of all, measure appropriateness, and also for program.

And the also, in terms of even if measure's appropriate, continuing to look at better ways of collecting data and better approaches to doing this.

But I just wanted to mention that in terms of the data, like the data I just presented to you, this wasn't magic data that CMS or CDC has. You can actually go yourselves to -- just go to the beta.cms.gov.

You can actually pull all this data, just like I have been doing, in terms of spreadsheets of data, to look yourselves, if you're interest in, what's the numerator for a particular infection, like I just was reporting on. That's right there.

You can actually go there and go to the IRFQRP, pull the archive data, and look at that.

If you want to know the patient days or the admissions, all these questions that we're kind of asking, are there. It's publicly available. Please use it.

If you notice something, have questions, that's the point of having it all there.

Co-Chair Merkelz: Nicole?

Member Fallon: Thanks. I appreciate -- and can you hear me okay? I appreciate all the comments that have been made. I know Paul acknowledged that the reporting burden is something that should be looked at.

Regardless of whether it's for IRF or LTCH or SNF, it sounds like there's evidence to suggest that the IRF and LTCH reporting is burdensome.

I'm concerned about that being added to the SNF

now. And nobody's questioning the relevance from a clinical standpoint. But I don't feel like we've got this quite right if the burden is overwhelmingly more than what we're trying to resolve.

At the same time, we've now voted on two of the three. And one of the goals around quality reporting, I think, is to have alignment around the measures themselves.

And my last point is, what we're voting on is conditional support of rulemaking, and the conditions being NQF endorsement. There's no condition about reporting burden being reexamined as part of it being one of those conditions.

So, I know it's too late to vote on everything else. I don't know if there's a way to revisit that in totality. But I think my main concern is we're moving towards something with high reporting burden, especially in a time frame where we're really struggling on the staffing front.

Co-Chair Merkelz: Matt, time to take a bat to the vote?

Dr. Pickering: Right. So, I do want to just comment on that, Nicole. Are you proposing to add a condition to this decision category?

Member Fallon: If I did that, I would suggest that we would have to revisit the other two sites of service as well, to add the same condition.

I mean, it seems, to me at least from the conversation, that there doesn't seem to be disagreement around the clinical importance of the measure.

The question is, are we seeing enough variation to justify the reporting burden, which is one of our tasks, I believe, is to look at that. And I don't know if others would entertain that idea of adding that as

a condition.

Co-Chair Merkelz: James, you have -- Go ahead.

Dr. Pickering: Jim, do you have a comment? Question?

Member Lett: A comment, yes. With respect to Nicole and Mary Ellen, instead of trying to append something to each and every one of the measures that we've discussed, it might be even a gap to think about what is the expiration date, if you will, for lack of a better term, on these types of measures and reporting?

That is, if the number of cases is so small -- I'm not saying every case isn't important. It is.

But if the burden exceeds what we're actually learning regarding quality by reporting, perhaps there should be some point at which we say, you know, we're not going to report this anymore. Just a consideration in general, not through a specific measure.

(Simultaneous speaking.)

Member Debardeleben: And we have had infection-related measures retired in the IRF environment in the past. So, that happened.

Dr. Pickering: So, I was going to chime in, Nicole, to your question around implementation burden. The NQF endorsement criteria evaluate burden of implementation.

In our use and usability criteria, which is under the NQF endorsement criteria, that is assessed, whether there is unintended consequences for the implementation of a measure, that would include potential reporting burden.

There's also a feasibility component within our criteria as well. So, that is the feasibility of actually

implementing it and reporting the measure. So, it's a little bit different than the unintended consequences, but it's just about how feasible it is to actually report it in the data systems that it's being implemented, or the program is being implemented into.

So, with the condition comment that's sort of already underneath the NQF endorsement, under that umbrella of endorsement, is that the standing committees would evaluate, not just for the scientific acceptability, but also these unintended consequences of implementation.

And if they're okay with that, we wouldn't have to go back to the other two measures that we've already voted on, because it's already included within NQF endorsement.

Member Fallon: Thank you for that. Can you just clarify, when they look at reporting burden, or how they look at that, is it the amount of time, is there a monetary value assessed to that? And is there a threshold from whence they won't approve something because of burden?

Dr. Pickering: So, there are assessments of, if there's any costs associated with implementing. It's not necessarily looking at how much does it cost to actually report out, but any sort of licensing issues related to the measure, if you have to purchase a license to report the measure, those types of costs.

There aren't any thresholds of assessment. What NQF standing committees look at is if there's any unintended consequences from stakeholders that are being held accountable to the measure.

So, for those facilities or providers that are reporting on the measure, are there unintended consequences that have been reported to CMS or to the developer, related to the implementation of the measure.

So, those unintended consequences could be to the

patient, but also to the actual providers themselves, whether it be a high cost to actually report the measure, or other implementation challenges.

So, this is somewhat of more of a qualitative assessment. There are some data points that may be submitted and actually provided to the standing committee around this, but there's no threshold necessarily for, this is the level of burden that we accept or not accept.

So, it is assessments that are conducted by the standing committees, but there's no actual threshold, if you will, around, this is the level of burden we're accepting.

It's really looking at if the benefits really outweigh any of these potential risks, and those risks could be that unintended consequences or implementation challenges.

Member Fallon: Okay.

Co-Chair Merkelz: Nicole, you had a follow-up to that?

Member Fallon: No. I'm just trying to determine whether -- it seems that NQF hasn't endorsed this, at least for SNFs, in the past. And so, I know that IRFs and LTCHs already have this measure.

I'm conflicted, I guess, at this point, because I feel like there needs to be alignment.

And there seems to be pushback on the LTCH and IRF side for the amended measure, and there hasn't been support from NQF, for endorsement at least, on the SNF measure previously. So, I'm not sure how to vote at this point.

Co-Chair Merkelz: Larry, you have a comment you want to make?

Member Atkins: Well, yeah. Just with regard to

burden and the measure of retirement. I was just following up. It was my understanding that this measure was replacing, essentially, a previous measure, and that the previous measure would be retired. Is that the process, or is this just amending the previous measure?

Dr. Pickering: We have had, in the preliminary analysis, that it was to replace the current measure. But I don't know if anyone from -- Alan, I don't if that's something you wanted to comment on.

But in our preliminary analysis, we had indicated that it was a measure that was to, yeah, to improve the current measure.

(Simultaneous speaking.)

Dr. Levitt: So, a couple of things. The answer is, yes, that this measure is currently adopted in the IRFQRP. As Mary Ellen reports in the chat, MRSA, for example, was retired a few years ago. Which is something we do all the time.

As part of our meaningful measures, we have measure-removal criteria. And so, when the existing measure the NQF endorsed, like 1717, which was about that time, is looked at the same time as the MRSA and COWDI, and other measures in IRFQRP, as they are with all the other QRPs, this measure was felt, we believe that it still was a measure that should remain in the program, and therefore, we did not propose to remove it like we did MRSA, which we proposed to remove, and then that was finalized after public comment.

But in terms of rulemaking for this particular measure that we're talking about on a MUC list, if we propose this measure within the IRFQRP, it would propose as a replacement for the existing C. difficile measure, which is currently adopted in the program.

Member Atkins: So, is a measurable increase in

burden to report this measure, as opposed to the one that was already being reported?

Dr. Levitt: It's part of any measure that would either be, I guess, proposed in the program, or proposed to replace in the program. Part of that, in terms of our proposal, includes the burden estimate that would be required for it.

I'm not sure, I don't know if NHSN colleagues can give any sort of ideas to whether or not the burden estimate would be greater, lesser, or the same, for this measure, versus the currently adopted measure in the program. Andrea raised your hand.

Ms. Benin: Yeah, we don't have formal burden estimates yet, Alan. I think the burden would be probably very similar, but I think we can -- we don't have to look through the formal burden estimates.

I think that the extent to which when facilities are certainly doing their investigation of these cases and making determinations about treatments, how much additional work is that to make sure that that information is put into NHSN, especially because the drive is going to be to have these metrics set up for electronic submission in facilities where they have electronic capacity. So, some of that is setting it up the first time. But the formal burden estimates just haven't been done yet.

Dr. Levitt: And if I could just comment on burden estimates in general for NHSN proposals, because it's something I've kind of looked at since I've been here for a long time, is that we also include burden estimates for filling out for the events.

And so, if it turns out, as it's been for many of these NHSN measures, we've actually overestimated the number of events in our burden estimates.

So we've actually, for some of these existing NHSN measures, have actually vastly overestimated the

burden versus what it may end up being, particularly if there are less events that are being reported.

Co-Chair Merkelz: Comments are in the chat from both Raymund, regarding the instance both previously with MRSA and currently with C. diff, and Mary Ellen also has an additional comment in the chat.

So, I believe the comment regarding the condition has probably been addressed then, in that it's -- the meaningful measures aspect is the measures were appropriately removed at the right time. I would go back then to you, Matt, on whether or not we move forward with a vote on the preliminary analysis.

Dr. Pickering: Great. Thanks, Kurt. And thank you for the work and for a lively discussion. Again, the condition would be NQF endorsement.

Endorsement does take into consideration unintended consequences of implementation of the measure. That would include that consequences (audio interference) but also to facilities or providers reporting the measure. So, that is an assessment that NQF endorsement will do, so the condition would cover that.

Even though there's no threshold of burden that is assessed, it's more of that qualitative type of assessment that is something that is evaluated under NQF endorsement.

So, at this stage we do have to move to a vote on this decision category. And if the group does feel they do not want to uphold that decision, you can vote to do so, and then we can have further discussion, and then determine if there's another decision category that the workgroup would prefer having for this metric.

So, seeing there's no other hands raised and no other questions in the chat, I'll ask the team to pull up the

vote for 098, which is the NHSN Healthcare Associated C. diff Infection Outcome Measure, and this is for the IRFQRP.

Once again, that's conditional support for rulemaking. The condition here is NQF endorsement, which would also consider unintended consequences of the use and implementation of the measure. Susanne, I'll turn it over you.

Ms. Young: The vote is now open for MUC2021-098 NHSN Healthcare Associated C. difficile Infection Outcome Measure, for the Inpatient Rehabilitation Facility Quality Reporting Program.

Do you vote to support the staff recommendation as the workgroup recommendation?

Give it a few more seconds. Okay, I think we can close. The vote is now closed and locked for MUC2021-098 for the Inpatient Rehabilitation Facility Quality Reporting Program.

Fourteen members voted yes to uphold the workgroup recommendation, and two members voted no.

Dr. Pickering: Okay, so with 14 voting yes, that's 88 percent of the total vote. So, that means the condition holds. Or, excuse me, the decision category holds for this measure, for this program.

And then, I know that next is a gap discussion. Right now, I'm just time checking. We're at 2:20. Would the group want to kind of continue on with the gaps discussion, and maybe take a five-minute break afterwards? Or would you rather someone take about a five-minute break now, and then come back to the gap discussion.

We can keep going, and then do a five-minute break, or do a break now. Are we okay to keep going? Hearing no opposition --

(Simultaneous speaking.)

Co-Chair Merkelz: Yeah, keep going.

Dr. Pickering: Yeah, I think silence is the consensus.

Co-Chair Merkelz: It's like, keep going. Very good.

Co-Chair Lamb: Well, Matt --

(Simultaneous speaking.)

Member Saliba: I'm sorry, this is Deb. It seems like some of the gap discussion, given that we still have several other inception-related metrics to talk about, maybe it's not a bad idea to defer it until -- just to combine it with other discussion that we're going to have.

Dr. Pickering: So, Deb, are you suggesting to defer the gaps discussions for all the programs at the end of the call today?

Member Saliba: Or at least after we do the HAI measure. Because we're going to do an HAI measure next. So, maybe we could just combine the infectious disease discussion items.

Dr. Pickering: So, the gap discussion we have next is only related to IRF and the Long-Term Care Hospital.

Member Saliba: Okay.

Dr. Pickering: So, yep. So, we could either do it for those two at this point, because there's no other measures that are being evaluated for those programs --

Member Saliba: Oh, I got you.

Dr. Pickering: -- or we can -- yeah.

Member Saliba: Apology. Sorry.

Dr. Pickering: Oh, no worries. No worries. Yeah.

Co-Chair Lamb: Matt, I'm just going to build on what Deb was saying. And I'm thinking, for me five minutes doesn't do the gaps justice. So, what if we kind of defer the gaps. And if we have time at the end, we do the programs together.

Dr. Pickering: And if nobody opposes that, we can definitely do that. So, what we can do, if that's okay with everyone, we'll do a break now, and then we'll come back at 2:30 Eastern, and finish up with the rest of the measures, and then go to the gaps discussion on all the programs if time permits. I'm seeing some head nods, agreement there.

Co-Chair Merkelz: I second it.

Dr. Pickering: There's a second. Thanks, Kurt. Okay. All right, so thanks, Mary Ellen. Looks like for the gaps piece, we'll kind of talk about that towards the end of the day today.

So, we'll take about an eight minute break. We'll come back at 2:30 p.m. Eastern and we'll pick back up with the next series of Measures Under Consideration. Thank you all.

(Whereupon, the above-entitled matter went off the record at 2:22 p.m. and resumed at 2:31 p.m.)

Skilled Nursing Facility Value-Based Purchasing Program Measures

Dr. Pickering: Welcome back, everyone. We're going to continue on with the Measures Under Consideration. Up next is the skilled nursing facility value-based purchasing program.

We have another presenter, Alex -- is it Laberge? Yes, okay, thank you, Alex, from CMS, that will talk a little bit more about the expansion of the program before we go into the Measures Under Consideration.

So, again, this is the SNF value-based purchasing program we're going to be talking about next. And

then we'll go to the next slide, just a reminder of this program's structure. If we can click to the next slide, there we go. This is a value-based purchasing program. The SNF VBP awards payments to SNFs based on a single all-cause readmission measure, which you can see is NQF No. 2510, as mandated by the Protecting Access to Medicare Act of 2014.

So, SNF's performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score, and the national SNF performance during the baseline period to calculate an achievement score. The higher of the achievement and improvement scores becomes the SNFs performance score.

So, SNFs with less than 25 eligible stays during the baseline period will not receive an improvement score. These SNFs will be scored on achievement only. And SNFs with less than 25 eligible stays during the performance period will be held harmless.

So, the goal of this program is transforming how care is paid for. So, moving increasingly away from quantity to value, improving outcomes, and innovations instead of merely volume of payments or services, and linking those payments to performance on quality measures in a single readmission measure that's currently within the program.

So, with that introduction of the program, I'll turn it to the next slide. And again, thank you very much to Alex for walking us through the expansion of this program for SNF VBP. So, Alex, you'll just say next slide, and the team will progress when you're ready.

Updates to the SNF VBP

Mr. Laberge: Thank you very much, Matt. I'm Alex Laberge, I'm a senior policy advisor for the Post-Acute Care Value-Based Purchasing Program. Currently working with some great teams that are responsible for the expansion of both the Home

Health Value-Based Purchasing Program, as well as the expansion of the SNF Value-Based Purchasing Program. Next slide.

So, to start, I just want to go over some of the current CMS quality initiatives, because there is a little bit of interfacing between them as we consider SNF VBP adding measures to the program. The SNF Nursing Home Quality Initiative, Five Star, and Care Compare, of course, are programs involve public reporting of quality measures such that beneficiaries are able to make informed decisions in identifying SNFs to receive better care.

The SNF Quality Reporting Program is a way that CMS is able to collect data. Through pay-for-reporting, we're able to get some data elements in our assessments, which is used, of course, to support the Nursing Home Quality Initiative, and Five Star, Care Compare, because we have measures for them to report. But also it will help SNF VBP as it goes on and adds measures for the program.

As Matt articulated in the prior slide, the SNF VBP program involves tying quality to payment. One thing is that the SNF VBP is not required to use the measures that are in the Five Star, and Care Compare, and so it has the ability, or measures being collected by the Quality Reporting Program, but of course those measures would be easier to use, because they are more readily available.

Next slide. Thank you. So, going back in time, going back to the origin, the Protecting Access to Medicare Act of 2014, Section 12-215 of the PAMA legislation required the Secretary to establish a SNF VBP program. PAMA specified that under the SNF VBP program, SNFs are evaluated by their performance on the single hospital readmission measure, are scored on both improvement and achievement, receive quarterly confidential reports containing information about their performance, earn incentive payments based on their performance.

And as required by statute, the CMS withholds two percent of SNF's Medicare fee-for-service Part A payments to fund the program, which CMS redistributes 50 to 70 percent. The level that has been set apparently redistributes 60 percent in the current program. This is, of course, different from something like Home Health Value-Based Purchasing or Hospital Value-Based Purchasing, which are more designed as budget neutral.

Next slide. So, the SNF VBP program, the current measure is a skilled nursing facility 30-day all-cause readmission measure. This was established at the beginning and is NQF-endorsed. And the PAMA legislation also provides opportunity to provide a new measure, which wasn't available at the time, but potentially preventable readmission after hospital discharge measure, which was finalized in the FY 2017 rule, but is currently still being worked on, and hopefully will be incorporated into the program very shortly.

Next slide, please. So, if we fast forward to 2021, Section One of the Consolidated Appropriations Act of 2021, which was the legislation which allowed us to expand the measures, Section 111 of the Consolidated Appropriations Act of 2021, allows CMS to consider expansion of the program measures to a total of ten measures beginning on or after October 2023.

Previously, the program was limited to single readmission measure. It may include a functional status, patient safety, care coordination, and patient experience, but I think the language at least as written in the legislation says "may," so it's not absolutely required that it has to be -- of course, Allen can correct me if I'm wrong, but that's open to interpretation.

And then it also importantly develops a process, has CMS develop a process to validate the measures and data, as appropriate, similar to potentially the

validation of the inpatient hospital measures. Next slide, please.

So, the goals of the expanding VBP is to provide an opportunity to measure -- to include measures that cover the depth and breadth of long-term care facilities, which includes both SNFs and nursing facilities, and by including short stay and long stay measures.

This, of course, would be regardless of payer, and would best represent the quality of care provided to all Medicare beneficiaries in the facility. This is also -- the goals is also to be able to add meaningful measures from multiple data sources, such as MDS, claims, survey, and the PBJ. It also opens the door for us to add measures that were included in the IMPACT Act, and importantly the validation of data will ultimately improve the accuracy of the measures in the program.

Next slide, please. So, the work of the MAC work group is very important, and helps guide CMS to make decisions on what measures to include in the quality programs like the SNF VBP. So, I'd like to touch base on some of the points that were made in the final report of the MAC 2021 consideration for implementation, implementing starting measures of the federal programs.

The first was that the MAP -- and this is done in March 11th, 2021, we received this report. The MAP strongly encouraged CMS to engage patients and care givers in the discussion of concepts, and the four measures they would find most valuable with a ten measure limit. The MAP discussed priorities and methodologies. Some workgroups encouraged CMS to pursue composite measures similar to the Hospice Care Index that would encompass the quality of care across the continuum of the patient's stay. While, interesting enough, other workgroups expressed concern that a composite measure could dilute the impact of such a measure.

And I think one of these things is that both of these recommendations have a strong sense of accuracy, that are true, and it illustrates that the work of measurement selection requires us to carefully walk a tight rope and consider, sometimes, things that are on the opposite ends of the spectrum in order to identify the best measures for the program.

The MAP expressed support for continued work in infection control, which they identified as one of the highest stakes areas, the patients. I think this is all in the front, with the COVID and such. And then the MAP also felt that it needed to access care that may not be represented in claims data, including direct cost to patients and families, such as copays and out of pocket.

So, this is also the presentation of potentially other measures that aren't in our mind's eye right now, of potential future ideas that would be great measures for the program. Next slide, please.

So, CMS had a recent RFI that released a bunch of Measures Under Consideration that can be found. These measures, some of them are already NQF-endorsed, others are also IMPACT measures. And each of them, I think, when you're looking at them, have a different level of readiness. As I mentioned early on about using measures that have already established by Care Compare, those measures are -- because they're already readily available, it would be easier to add, or more -- it's not necessarily the choice of whether we use the measure or not, or how soon we'd be able to incorporate a measure into the program.

So, measures that are readily available, such as Care Compare, are far more readily available and can be incorporated than a measure that would either require us to add data elements to the SNF QRP or potentially have to build an infrastructure to collect new data, such as survey data.

So, just something to keep mindful of as we select measures. We're looking for validity, reliability, the ability for the measure to address the clinical needs of the beneficiary within the Skilled Nursing Facility, but also other factors as well, especially when it comes to timing.

Next slide, please. So, these are other measures that are on, including the PROMIS, the CoreQ short stay survey measure, discharge measure, and the PBJ nursing staff hours per day. Next slide, please.

Finally, we have other considerations and priorities within CMS that we need to consider. Looking along, one good example is the IMPACT Act. The act required the submission of standardized data by long-term care hospitals, SNF stays, home health agencies, and inpatient rehab.

But the work to meet the intent of the IMPACT Act supports the CMS meaningful measures initiative, and this standardized data is to be used to generate quality measures that can ultimately be used in SNF VBP.

So, next slide. So, I thank you for your attention, and any questions?

Member Andersen: Alex, this is Dan Andersen, nice to hear your voice again. I'll go first. I mean, I just wanted to say I see that the idea of using staffing -- and we've mentioned that on a previous call about gaps, it was in another program, but I'd echo just the importance of that. As you well know, it's just such an important indicator right at the heart of quality, but we often treat it separately from quality.

Mr. Laberge: Also, I would like to also add that that RFI wasn't the be-all/end-all measures that we were ever considering, and that this is the first step that we included. So certainly staffing, I agree, is an important measure that certainly was on that front list. But there are potential for future measures, of

course, as we go on in time.

Co-Chair Lamb: Alex, thanks for the introduction. It's very exciting that there's this opportunity now to add new measures beyond the admission, the readmission measure. I'm not seeing any other questions at this point. I think people may be just anxious to start reviewing the measures, and have the conversation about it. So, Matt, should we just move forward?

Dr. Pickering: Yes, we can. Can you hear me okay?

Co-Chair Lamb: I can, yeah.

Dr. Pickering: Great, I had to switch to my phone just to make sure that I'm coming through okay, so apologies for that. So, if we can go to the next slide.

So, at this point we're opening up for public comment. And I'll turn it back to you, Gerri. And just a reminder that this is an opportunity for the public to provide comments on any of the measures that are up for the Skilled Nursing Facility Value-Based Purchasing Program.

So, that measures MUC measure 124, 137, 130, and 095. So, any of those Measures Under Consideration for the program, now is the opportunity for public comment. So Gerri, I'll turn it back to you.

Pre-Rulemaking Input

Co-Chair Lamb: Thanks Matt, and we're very interested in having public comment. As Matt was saying, there's an opportunity now to talk about the SNF VBP measure set that we're going to be launching into, and reviewing. And as with the previous public comments, please limit your comments to two minutes, and if you would limit your comments also to the VBP program. So, you can do it in chat, or you can unmute yourself, and make your comment, or actually I'm not sure if we can put up

hands.

Okay, Gus, you said we can. So, any way would be just fine. Okay, another call for public comments, I'm not seeing any hands raised, and I'm not seeing anything in chat, just want to make sure I'm not missing anything.

Dr. Pickering: Gerri, I'll second that, I'm not seeing any hands raised, and nothing coming through the chat, but maybe we'll give it a few more seconds.

Co-Chair Lamb: Okay.

Dr. Pickering: Last call for public comment, before we proceed to the measures under this program. So, thanks Nicole for some clarification. So, this is an opportunity for members of the public to comment. Members of the work group, you can make your clarifying questions during the evaluation of the measures for the program. So, if you have any clarifying questions, or anyone from the work group, that'll be after we present the preliminary analysis for any clarifying questions related to the specific measure for the program.

No worries Nicole, thank you. Okay Gerri, I don't see any other questions, and no hands raised. So, if you're good, I think we can move forward.

Co-Chair Lamb: Let's move forward, and just a quick reminder of process here, we're going to be doing exactly what we did previously. We're going to be focusing on the four measures under the Skilled Nursing Facility value based purchasing. We're going to go one by one through them, and we're going to start with the preliminary analysis, which Matt will provide. Then we'll open it up to work group comments.

Then we'll take a vote on supporting, or not supporting the preliminary analysis recommendation, and then we'll go from there. So, with that, then

Matt, you want to start us off with MUC2021-124, Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization?

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

Dr. Pickering: Certainly, thank you Gerri. So, the description of the measure is on the screen, and this is a measure that estimates the risk adjusted rate of healthcare associated infections that are acquired during Skilled Nursing Facility care, and result in hospitalization. So, this measure is risk adjusted to level the playing field, and to allow comparison of performance based on residence, or similar characteristics between SNFs.

The one year measure is calculated using the following formula, as you see listed, the risk adjusted numerator over the risk adjusted denominator, and then times the national observed rate. It's important to recognize that healthcare associated infections in SNFs are not considered never events, the goal of this risk adjusted measure is to identify SNFs that have notably higher rates of healthcare associated infections when compared to their peers.

This is a facility level measure. The NQF recommendation in the preliminary analysis was conditional support for rulemaking, that condition was NQF endorsement, as this measure does add value to the SNF VBP program by adding an overall measurement of all HAIs acquired within SNFs requiring hospitalizations, and was recently adopted within another PAC/LTC program.

So, the meaningful measures 2.0 indicates safety as a continued focus of CMS in order to build value based care. So, this measure aligns with that meaningful measures 2.0 focus. Infection control, and prevention, and aid in reducing healthcare associated infections within SNFs. There is variation in performance of this measure within SNFs, and

these facilities will have the ability to implement interventions to improve performance.

Currently this measure is not NQF endorsed, thus the condition here is NQF endorsement, which again, we've talked about previously, would include the implementation challenges, or burden assessments, feasibility, evidence assessments, as well as the reliability, and validity testing assessments all under NQF endorsement.

Regarding the advisory groups for rural health, and health equity. So, rural health on a one to five scale scored 3.9, the higher being more relevant to rural health. And for that advisory group, they generally agreed the importance of this measure, and the relevance to rule providers in care settings, and some members really did voice concern around small numbers for healthcare associated with action.

Given the numerator modeling approach, the developer did note during the advisory group meeting that healthcare associated infection rate is generally stable given the testing that has been conducted. Regarding health equity, on a one to five scale, again five being the highest in which it would promote health equity, and reduce disparity, the health equity advisory group rated it as a 2.9.

So, that advisory group noted that this measure is important, but cautions that the risk adjustment should be examined to ensure disparities are not made to be worse. There was discussion on risk adjustment, in which there should be adjustment of factors that are outside of the provider's control, and caution to not over adjust to lower the standard of what quality care should be across populations of social risk.

One way to address these concerns is to track improvement over time, and evaluate how the measure is used. What does scoring well mean? Is it improvement in its own scores over time, or just

compared against other SNFs? So, those were some comments from the health equity advisory group. Moving to the public comments received prior to our meeting today, we received several comments, four of which were non-supportive as not NQF endorsed being an issue, or concern.

And that this measure relies on hospital claims to determine the source of infection, which is notoriously flawed for determining UTIs, or urinary tract infections, and urosepsis, the two most common reasons, along with pneumonia, for triggering the numerator in this measure. There was also concerns with the accuracy of using ICD-10 codes, validity of coding on acute care hospital discharge.

The use of a composite score, so using a composite score makes it difficult to target interventions toward prevention. Concerns related to incomplete culture data upon admission to SNFs that are inappropriately attributed to section, or colonizations to a SNF. There was concerns related to the actual location of attribution, stating that it was very difficult to determine which provider should be ascribed responsibility for the infection that occurs post discharge.

And lastly, a concern for incubation period for infections. So, recommending for including a four day after SNF admissions for determination of an HAI is not reflective of the clinical events involved with an HAI. So, there was some request for some further clarity on the measure regarding the rationale, how it was determined that the measure is initiated four days after SNF admission versus a different time frame.

And then some clarity on what resident characteristics would be used to risk adjust this measure. And then lastly, there was a recommendation in these non-supportive comments that CMS continue to evaluate this measure as part of the QRP before adopting it into the SNF Value-

Based Purchasing Program. And with that summary of the comments, and the preliminary analysis Gerri, I will turn it back to you for any clarifying questions from the work group.

Co-Chair Lamb: Thanks Matt. So, let's open it up to the work group for questions, concerns. Jim, I see you have a comment in chat. Do you -- is this specific to 124, or is this going back to the previous one?

Member Lett: Back to the previous, since I have to leave at the end, and just wanted to document it.

Co-Chair Lamb: Okay, thank you for doing that Jim. So, let's stick with MUC2021-124 comments, concerns from the work group. Okay, Nicole?

Member Fallon: Thanks. First, I just want to ask a few clarifying questions, probably of the folks that developed the measure. One of the discussion points is that the measure is using fee-for-service claims data. That becomes problematic with any of our measures, but gives me particular pause when it comes to value based payment.

There are certain parts of the country, an increasing number of counties around the country where Medicare Advantage is the dominant payer, and as such any claims, or any activity related to MA beneficiaries would be excluded. So, those nursing homes sometimes get disadvantaged in these scenarios because of that low number issue.

So, I wanted to confirm that this is a fee-for-service only measure, and it sounds like it's using hospital claims data as well.

Co-Chair Lamb: CMS folks, might you clarify that?

Mr. Nagavarapu: This is Sri Nagavarapu from Acumen from the measure developer. It's correct that this measure is focused on those in fee-for-service, and the reason for that is concerns about the

comprehensiveness of data for the managed care population, and I think that's something to keep an eye on for the future, for the reasons that you say. But that's the rationale for focusing on the fee-for-service population for now.

And then to identify an infection, we are using hospital claims data, because in the numerator, the counts of infections, or infections that are serious enough to require a hospitalization. Thanks.

Member Fallon: Can I ask another clarifying question?

Co-Chair Lamb: Go for it.

Member Fallon: I don't want to dominate, because all the measures are starting to blur in my head, I don't know about others, but does this start on the fourth day after admission as well, or what's the time frame there?

Mr. Nagavarapu: Yes, this would be the fourth day after admission to the SNF, and that's a mechanism to help avoid attributing infections to the SNF that may be from previous sources.

Member Fallon: And is there a reason why four, versus seven days, I mean I assume there's some sort of evidence behind that as a start point?

Mr. Nagavarapu: Yeah, the four days was an element of the initial testing of the measure, as well as discussions with the technical expert panel that review the measure in order to try, and sort of balance the attribution concerns with picking up enough infections. Thank you.

Dr. Levitt: Yeah, this is Alan, it was just again, as part of the initial development of the measure, which we had actually, CDC were members of the technical expert panel, it was kind of a claims based modification of the CDC criteria of attribution in terms

of previous setting. Besides the four day, we actually also have a repeat infection time window in there too, so certain infections, endocarditis for example has a different time window.

Again, based on CDC, NHSN criteria as to where to do attribution of one infection setting versus another. So, I think --

Member Fallon: Okay, and then --

Co-Chair Lamb: So, Jill?

Member Cox: Sorry, I was muted. So, just to clarify, I may have missed that, and again, this is all sort of running together for me as well, when we're talking about healthcare associated infections, what are we actually talking about? Any infection that is associated with admission, or a stay within the facility? Device related infections? So, just for clarity for myself, thank you.

Mr. Nagavarapu: I can give a quick summary, and Alan if you want to provide more information. So, essentially the HAI conditions are related to infections likely to be acquired during SNF care, and severe enough to require hospitalization. And so examples might be like methicillin resistant staphylococcus infections, but you could also include infections related to invasive, and non-implanted medical devices, so let's say infections associated with catheters, and so on.

It does exclude certain infections that are less likely to be able to confidently attribute to the SNF, such as certain chronic infections, and infections that typically require a long period of time to present, like typhoid arthritis. Alan, I'm not sure if you wanted to add more detail there.

Dr. Levitt: This was all done with technical expert panelists to try to take what infections would, or could likely have attribution associated with care

within the SNF setting, and so that's what we tried to work with. I just think a one minute step back just to give you an idea again. The reason we developed this measure, and chose the data sources we chose, and you may remember this, because we did review, and did conditionally support, and propose some finalized measure in through the SNF QRP in the last year.

I remember a discussion from last year was we chose this claims based approach in using the hospital claims because when we're looking at the data sources that are available to really look at HAIs within the SNF setting, it really was the best, and most reliable approach, and way of looking at things. That doesn't mean that as time goes on, if we can get better EMR, there may be other ways to continue to look at this.

But this is why we chose this approach, because looking at it different ways, whether it was looking at SNF claims for example, and looking at self-reported MDS, looking at it through NHSN reporting that the most reliable approach really to look at these things at this point was to be looking at the hospital claims, because it gave us an idea really of not just whether, or not an infection occurred within the patient, but almost the severity of the infection as well.

What we're worried about a lot would be perhaps a colonization that would end up showing up on a claim as in the SNF, and again, would that end up getting reported, the self-reported issues that may come up within using it within an assessment is related, so that's why we really took the approach that we took in the development of this measure.

Member Cox: So, there is no discrete list of healthcare associated infections that are used in this measure?

Dr. Levitt: No, there is absolutely a discrete list, I mean we can send you --

(Simultaneous speaking.)

Member Cox: Okay, that's what I was asking before.

Dr. Levitt: Yeah, and ICBT10 codes surrounding the --

Member Cox: Yeah, but there's thousands of those in terms of infections, and thousands of body systems, devices, and is there a root cause analysis that facilities can do to determine whether this was related to the healthcare, or just a severely immunocompromised patient that developed an infection? So, I guess that's what I was just trying to understand, is it's such a broad category, are there priorities of infections that are being really targeted in this particular measure? And I guess not.

Dr. Levitt: No, there is, there is absolutely.

Member Cox: Okay.

Dr. Levitt: I mean, first of all, obviously the measure is risk adjusted, the concept of the measure was really to look at global performance of a provider, in this case in the SNFs, in terms of their ability to both prevent, and manage infections. And that was really the goal, and that was how we developed this measure.

We certainly developed it really as looking at both, almost an overall global percent as a performance, but then also we tried to develop measures in many ways almost like money ball, where we're trying to both looking at being able to present results of a certain outcome, but then also what does that really mean? In other words, does that mean it will help in the future?

And what ended up coming up obviously, unfortunately, was COVID. And so what we recognized with this measure, which you've probably seen in your data, is that when we've actually looked

at providers, and how their performance was on this measure, when COVID unfortunately has come to our country, is that those providers that have performed better overall within this measure, also in general have been able perform better in terms of COVID rates, or prevention of COVID within their facilities.

Which again was reassuring to us from the standpoint that it really is a measure of performance.

Co-Chair Lamb: Thanks Alan. Other comments, other concerns about this measure from committee members? Deb, and then Nicole, we'll go back to you.

Member Saliba: Yeah, I do want to say that in the summary of the measure that we received, there is a link to the report, and it includes some of the diagnoses that are being -- it's a really long list of diagnoses that are included. And I think some of the issues that were raised around this measure in the public comments, and also that were addressed, I think Nicole raised some of these in her comments a minute ago.

And I shared them also with my members, so I did want to raise the concerns that they brought up, and one was the risk adjustment. There was some concerns about the risk adjustment, and from my read of the risk adjustment that was in the report, they were not risk adjusting for social drivers of health, and I actually think that's appropriate, in that we don't want to be risk adjusting, and sort of baking in those types of equity challenges.

My members were very interested in eventually seeing these data broken down by different populations, and different social groups. The other, I think, issue that came up a little bit is this whole issue of reliance on hospital claims data. No data source is perfect, and every data source has its limitations.

The question of course was that if you're admitting to a particular -- how much hospital quality confounds

the measure. So, in that the referring hospital may mislabel particular conditions, yes UTI is one that's very common, sepsis is another, and it would be helpful to have some kind of sense. I can't recall from reading the report whether this is going to be benchmarked regionally, how it's going to be benchmarked.

I understood from reading the reports that it's going to be benchmarked across facilities, and not by some predetermined number, which is fine, but how much there is going to be, whether that's occurring on a national level, or occurring just within counties. And finally the other comment that came back a lot from folks in thinking about the implications of this measure, was what the value added -- pardon the pun of value -- was over the already existing readmission measure that was there.

How much it would actually change your sense of facility level performance. Certainly from a quality improvement perspective at the facility level, you want to understand why you're readmitting patients, and what's driving it, but the extent to which using that would really change payment from what you would already be getting with the readmission measure. So, that was a lot of topics, but I just wanted to sort of bring them up.

Co-Chair Lamb: Deb, did you want a response related to your question about bench marking, and whether the expectation is going to go to facility, or not?

Member Saliba: Yes.

Co-Chair Lamb: And did you want a general response to the value added from the measure developers?

Member Saliba: Yeah, I think that would be helpful for people thinking about the measure to understand that. It came up both in the public comments, and in comments from my membership.

Co-Chair Lamb: Okay, so if the measure developer might address comments to bench marking, what the expectation is, as well as perhaps some short few comments about thoughts about value added over the current measures.

Mr. Nagavarapu: Sure, that'd be great. Maybe I could turn to Chang on our team real quick to address the question about the hospital claims, and sort of the testing that's gone on, and how they've identified healthcare infections, and then I will probably circle back to the other questions.

Participant: Thanks Sri, regarding the accuracy of hospital claims while constructing this measure we referred to some reports done by CMS, and RTI in 2019, and found out the coding of the present on omission conditions are pretty accurate, the accuracy is over 90 percent compared to claims records. I also want to mention that this measure being composite score can alleviate some concerns about coding accuracy in terms of identifying UTI, and potentially listing it with CAUTI or urosepsis.

We are treating the HAI event as a composite score, so as long as the event by nature is an infection, and it's included in the HAI list, it will be counted towards numerator. We think it is unlikely that confusion will happen between an infection, and a non-infection event. So, I think in the case of confusion about UTI, that shouldn't be a big concern for this measure.

Mr. Nagavarapu: Thanks, Chang. And then in regards to the other questions, for bench marking, I'll defer to CMS on details for this, but as Alex mentioned in their presentation, in general the notion is that in SNF VBP, there would be both achievement points relative to a national benchmark, and improvement points relative to your own prior history. So, while there's not specifically a regional benchmark, there is a role for improvement relative to your own history, which can take into account those rates of factors.

And then on the question about value added of this measure, I think that's a great topic, really like the focus of this measure is specifically on infection control, and I think that's what makes it really distinctive from the all cause readmission measure, or even the potentially preventable readmission measure. As Alex mentioned in their presentation, infection control is a specific area of focus for CMS here with nursing facilities.

And the correlation of the measure with what's happened with COVID infection rates in nursing homes, as you saw in the measure results, the testing results that you received, I think that is really like a sign of how important having infection control measure in the program could be going forward. Alan, I'm not sure if you wanted to add additional points there.

Dr. Levitt: Well, first of all, Deb, you're right, we are prisoners to the data source I guess, that we have. And to reinforce what Chang just said, was that regarding issues of potentially let's say upcoding of diagnoses by the hospital, which have been noted, I mean there's a lot of studies looking at that, that again, whether it would be urinary tract infection versus sepsis, it really is just a matter of what the principle diagnosis is that comes in.

So, it would be just counted as an event irrespective of what the coding may be on that. And I can't give more, I mean in terms of -- I don't know if there's anyone on the SNF VBP team who can give more on terms of what would be done, but it would be similar in terms of how the VBP program is outlined in terms of national, it would be comparing to a national benchmark, that would be done within our proposal.

Co-Chair Lamb: Thank you. Nicole?

Member Fallon: Thank you. Just a couple other issues I wanted to raise. I guess we're concerned in a couple of ways. One is that this is only going to begin the

data being collected for a QRP for fiscal year 2023, and then we're proposing to add this to the value based payment program. I feel like we need to make sure that the reporting aspects of it are right, and I realize we're using hospital claims data.

But I think if we could get a look at the data first before we start using it for performance, I think that might be helpful, it might be informative as well. I know when our members looked at this, one of their concerns was some of our rural members might have some limitations like they couldn't do an IV, or something like that.

And they would have to send somebody to a hospital, so they might be disadvantaged in certain circumstances because they just didn't have the capabilities to do everything an urban skilled facility might do, so that was a concern. It feels like we're moving a little too fast on this, I'm still concerned about the fee-for-service only data, and I'm not clear, are we looking at both short stay, and long stay for this one? I don't remember.

Mr. Nagavarapu: I'm happy to respond to those questions now, or wait, either.

Co-Chair Lamb: How about if Nicole, you lay out your questions so that we get one answer?

Member Fallon: Sure. That was the main question, I think we just have a lot of concerns with this one, and it feels like it's moving a little too fast for value based payment.

Co-Chair Lamb: Thank you. So, Sri, you would answer that question?

Mr. Nagavarapu: Sure thing. Yeah, fortunately we've been able to do a lot of measure testing on this, and have that be very public in the sense that this measure went to the MAP last year for inclusion into the SNF QRP, and the public had a chance to look at

measure results, measure scores, performance gaps, reliability, and validity.

And then there are questions about the infection list, fortunately the list of infections on all the diagnosis codes used for them are all available in the technical report that I think Debra Saliba mentioned, that's available online on the CMS website. And so fortunately we have had a chance to do significant measure testing, so that there's a lot of knowledge about what this measure does, and how.

For the specific question about rural, and urban, I think that's important question that came up during the rural work group as well. We do have stratifications of measure scores by rural, and urban that could be helpful there. Just looking at the stratification, it looks like the average risk adjusted HAI rate for rural facilities is at 5.82 percent, whereas for urban facilities, it's 5.86 percent, so actually on average rural facilities are doing slightly better, but essentially the same than urban facilities.

And so through testing like this, and the more detailed results, we feel confident that the measure is not biased against rural facilities, but it's something that CMS routinely keeps an eye on as measure monitoring goes.

Co-Chair Lamb: Thank you. All right, I'm not seeing any other hands up, and I think the comment in chat goes back to Jim Lett's question, so Matt, shall we call the question, and take a quick vote to see whether people support the NQF recommendation?

Dr. Pickering: Yes, if there's no other clarifying questions, we will move to vote. Okay. So, again, you're voting on MUC-124, this is Skilled Nursing Facility Healthcare-Associated Infection Requiring Hospitalization in the SNF VBP, and you're voting to uphold, or not uphold the decision category in the preliminary analysis, which is conditional support for rulemaking, and that condition is NQF endorsement.

I'll turn it to Susanne.

Ms. Young: The vote is now open for MUC2021-124 Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization for the Skilled Nursing Facility Value-Based Purchasing Program. Do you vote to support the staff recommendation as the work group recommendation? We'll give it a few more seconds.

Okay, the vote is now closed for MUC2021-124 for the Skilled Nursing Facility Value Based Purchasing, 14 members voted yes to uphold the staff recommendation as a work group recommendation, and four members voted no for 78 percent.

Dr. Pickering: Okay, so the NQF recommendation holds for measure MUC2021-124.

Co-Chair Lamb: All right, Matt, if you would intro MUC2021-137, and do the preliminary analysis?

MUC2021-137: Total Nursing Hours Per Resident Day

Dr. Pickering: Certainly, okay so now next is MUC2021-137 Total nursing hours per resident day. So, the description here total nursing hours, which is registered nurse LPNs, plus nurse eight hours, that's what total nursing hours would be calculated per resident day. The source of the total nursing hours is CMS's payroll based journal system. The denominator for the measure is account of daily resident census derived from the minimum data set, or NBS resident, and assessments.

The measure is case mix adjusted based on the distribution of MDS assessments by resource utilization groups version four. The level of analysis is at the facility level, the NQF recommendation, and preliminary analysis was conditional support for rulemaking, and that condition is pending NQF endorsement. So, this measure adds value to the

SNF VBP program by adding a measure not currently addressed, and aligns across other PAC/LTC programs by working towards CMS's meaningful measures overarching goal of value based care.

Per the Consolidated Appropriations Act of 2021, expansion of the measure set will assess the quality of care that SNFs provide to patients. The CMS reported average nursing staffing hours per resident day increased from 3.85 in 2017 during Q4 of 2017 to 4.08 for Q4 2020. This variation in the performance, there is variation in the performance of this measure within SNFs, and these facilities will have the ability to address process to improve staffing.

So, this measure is not NQF endorsed, thus the condition is NQF endorsement. As far as the rural health advisory group input on a scale of one to five, they rated it as three. And the advisory group generally agreed the importance of this measure, and the relevance to rural providers in care settings, and the advisory group did note that in rural settings that non-nursing personnel are important in these rural care settings, and noted that this measure should be considered in the context of additional measures to get a holistic view of provider quality.

For health equity, health equity on a one to five scale was 3.5. This advisory group noted that this measure is an important quality measure for the care setting. They noted that LPNs are typically the staffing for this particular care setting, and the advisory group was encouraged to see that multiple staff, so RN, plus LPN, and nurse eight hours were included in the measure.

They also would like to see stratification of nursing hours spent by patient demographics. And certain minority communities are more concentrated in for profit Skilled Nursing Facilities which have staffing concerns. As far as the public comments received, there was one supportive comment appropriate, it is

appropriate to access data regarding total nursing hours from the CMS payroll based journal system.

In the future, AOTH, so the comments are similarly recommend that NQF support the development of new measures to monitor total therapy hours per resident as part of the SNF VBP. There was also one non-supportive comment, stating that the Skilled Nursing Facility Value-Based Purchasing Program is designed to measure performance on outcomes, not structural measures of quality.

The measure is not NQF endorsed, and while there is association between staffing levels, and quality, at a certain level of staffing, as staffing levels increase, it's not associated with improved quality. This measure aggregates RN, LPN, and CNA hours into one measure which creates an incentive to use more LPN, and CNA than RN, which is contrary to the literature.

And it's challenging to implement, there are better staffing measures to be considered that directly reflect quality of care. So, that was the non-supportive comment, and the supportive comment. With that summary of the comments, advisory group input in the PA, I'll turn it back to you Gerri for any clarifying questions.

Co-Chair Lamb: Thanks Matt. So, let's open it up to committee comments, concerns.

Member Andersen: This is Dan Andersen again, I wouldn't say a concern, a comment though. I think again, getting staffing information into this program is important, using the total staffing I think is a good idea. I am in partial agreement with one of the commenters that RN staffing is very important, and on the nursing home, like on the nursing home Care Compare, there's an RN staffing by itself, as well as total.

Both of those feed into the five star, so the SNF VBP

might consider that in the future, but I think this is a strongly needed measure regardless.

Co-Chair Lamb: Thanks Dan. Jim?

Member Lett: Thank you. This one -- I think there's a huge unintended consequence here. If you're going to make this part of the value based payment, then what's going to happen is in rural areas, where it's already very difficult for staff with licensed type people in general, and people specifically, and let's talk about infection preventionists, which are becoming non-existent around various parts of the country.

They're so hugely in demand that they're being snapped up by institutions that have a lot of money. So, what's happening then is if we're going to penalize small facilities, rural facilities who are already having a difficult time trying to get the people they need into the building to provide the care we all want for them, then by lowering the reimbursement for penalties, you make it even harder to try, and build up a staff.

So, that's a major concern there, and I was surprised the rural group only rated that a three, I would have rated it a 12 on a scale of five as something to be concerned about. And the second thing is the equity piece. The vast majority of CNAs in the long-term care, and the post-acute care world are number one women, and number two women of color.

And women of color who are working multiple jobs, some of them two, and three at a time, believe it or not, going from shift to shift. So, I see this as a huge equity issue that's got to be addressed, and I don't think you're going to make these things better by ratcheting down reimbursement. You'll only make them better if you put enough financial resources into the system to allow them to expand. So, thank you.

Co-Chair Lamb: Thanks Jim. Pam?

Member Roberts: Just a question, is how does this impact states that have mandated nursing ratios currently?

Mr. Shulman: This is Evan Shulman from CMS, happy to answer any questions. This does not impact any state mandated ratios at all, this is completely independent of the state made ratios.

Member Roberts: Is it in line with current state ratios, or is it totally different?

Mr. Shulman: Well, it's just a measure, it's just measuring staffing, it's not -- it has no impact on what a state may mandate. Maybe I'm misunderstanding your question.

Member Roberts: No, thank you.

Co-Chair Lamb: Cheryl?

Member Phillips: Yes, thank you, a question of clarification. So, does this include, or does this measure patient nursing hours, or merely the presence of each of these disciplines in the facility per resident day? So, in a more simple way of saying it, would this also capture people that are doing administrative functions, people that are doing MDS data entry?

So, it's not necessarily linked to the actual direct patient care, correct? It's just hours.

Mr. Shulman: Yeah, that's correct, we do have hours reported by category, which includes nurses with administrative duties, or directors of nursing. It's important that we always note when bringing this up, is that that's just, those labels of nursing administrative duties are merely labels to sort of break nurses out to different categories.

But just because they have administrative in their title doesn't mean that they are not performing direct resident care, and sometimes quite often. A couple of

examples that I typically use when talking about these types of individuals is number one, in emergencies, these are the individuals that typically step up to help, and provide direct patient care.

And number two, they are often the leaders, and trainers of the other nurses, and I'm sure you all have seen the impact that leadership can have on an organization, and all of these combined in all of the literature still does show relationships between these measures inclusive of all these different discipline with, and without more, or less administrative duties, and other outcomes.

Co-Chair Lamb: Cheryl, that answer your question?

Member Phillips: Yes, thank you, I have a few more, but I'm going to let others go.

Co-Chair Lamb: Okay, thank you. Raj?

Member Mahajan: Thanks Gerri. So, I just wanted to first support this, because in a very raw comment that perfection should not be in the way of progress. So, we all know it's not perfect, but it is a step in the right direction. The other thing that I want to again, and not anything specific, but general in working in all different settings, and with some upcoming legislation around price transparency in nursing homes.

Because we do see there are certain organizations that work around the staffing requirement, and have a huge, huge profit siphoned off before anything else gets done. And then we have the smaller rural facilities that completely understand, and agree that the associations when we talk about these smaller facilities that maybe bear the brunt of this, and always have problems on how they look.

So, I just think that there is probably more with the cost, and the overall organizational budgeting that has to do with the staffing levels, and if there could

be more research done to see what are those things that can link the appropriate staffing level based on whether it's acuity, or other things, but definitely there are organizations that take a lot more profit per resident served kind of thing.

So, being non-operational clinicians seeing this happening, I would love to see what else could be the common link between appropriate staffing, and the operational budgets it sets up.

Co-Chair Lamb: Thanks Raj. Other comments, and while I'm waiting for hands to go up, I have a question for the measure developer Evan. It's striking in the evidence report that the strongest relationship is between the RN staffing, and outcomes, what's the thinking behind continuing to use the combined measure, rather than going directly at the RN staffing?

Mr. Shulman: Well, I think there's nothing that prohibits us from looking at that in the future, and I may ask some of my UDP colleagues to chime in here, but looking holistically, I think we feel that we really want to create the awareness, and incentive of the entire nursing picture in the facility. And that nursing homes, and also stakeholders such as states, and others that impact staffing will use this to do what they can to raise nursing in all domains, CNA, nurse aid, LPN, and instead of just focusing on the RN.

Co-Chair Lamb: Thank you, Nicole?

Member Fallon: All right. I feel like I'm always the negative Nelly here, but while we appreciate the fact that they're using PBJ data for this, that is fantastic, something we're already reporting, that's a simplification. I just feel like the timing of this measure is completely inappropriate.

Measures should be those things, especially when it comes to value, or things that we can impact, and if

anybody has been in a nursing home lately, our ability to have enough staff, and find staff to fill those empty positions is beyond challenging. I mean you've probably heard about the temp agency folks that we're having to bring in, the fact that we can't impact those costs.

The fact that we're taking on those costs, even though we don't have the money to do it. So, our folks when they look at this, they get frustrated, because they're like we would hire all the people in the world tomorrow, but number one they need to exist, and number two, we have to have the money to pay for them, and neither of those things gets acknowledged in this. On top of that, you have to look at the fact that RNs, and nurse staff are important.

That every staff that contributes to the care of that individual, and the wellness, and the feeding of that individual are equally important. I would argue that you could have a bunch of new RNs in a building, but if they've not actually interacted with the residents before, they don't understand their particular issues, that the quality of care is not going to be the same as those that have been there for a while.

So, it's just -- I guess it's not the right measure, and honestly we think that the outcomes that are affected by these individuals are the true measures at the end of the day. Whether, or not the quality is there, whether, or not we're bringing down infections like we've been talking about, whether, or not we're ensuring that there aren't pressure ulcers that we can't control, or that we can control not happening, those are better measures than actually saying we have X number of staff today.

So, we just have a lot of concerns about this one, especially in the given environment. Folks are tapped to a whole new level, so this one just feels a little off base.

Co-Chair Lamb: Thanks Nicole.

Mr. Shulman: This is Evan Shulman again, do you want me to speak to that again, or I don't know what the proper --

Co-Chair Lamb: I think it's going to come up again Evan, so why don't you take it now?

Mr. Shulman: Okay. Yeah, there's a lot in there. The first thing to remember is that at its core, this is just a measure. How the benchmarks are set is an entire different issue, but this is just a measure that regardless of what may be happening in the field, it's really important to know what is actually happening, and bring these things to light.

So, the first thing is when you consider this, we're considering it as a measure of what's happening. The thresholds, or the benchmarks, those happen later through a different view. So, when it comes to yes, nursing homes are struggling with staffing, and I'll come back to that in a minute, it's all relative to each other. So, it's quite feasible that there could be a measure, or a threshold that's selected that considers what has happened, or what is happening in the industry.

So, that is one thing to consider. I do need to say that -- I'll say a couple things on this struggle, the challenge of staffing. There is absolutely no question that there are staffing challenges, and this is to the point about what they can impact. There's absolutely no question that there are staffing challenges that are outside some facilities' control.

I encourage everyone to focus on what we absolutely know for certain based on literature, and scientific, and peer review, it is unclear in every situation what exactly is the challenge a nursing home may have. There are nursing homes that literally probably do not have the resources to provide the staff. There are also nursing homes that do.

That doesn't mean that they can provide as much as

we'd like them to, but there are for example, and this is public, you can do this yourself, there are nursing homes that are in very, very close proximity to each other that have the same makeup as a nursing home that's again, in close proximity to them, that have a much higher level of staff than the other one.

But there are some other things that are different about those two nursing homes, but that doesn't necessarily mean that just because their nursing home is low staff, it is outside of their control. So, we feel pretty strongly that this measure again, from a measure perspective, needs to be part of the VBP program.

How we integrate it in there, that's a different story. But it's not always a given that it is outside of a nursing home's control, although I admit there are certainly situations where it can be. On the topic of if you have --

Co-Chair Lamb: Evan, can we kind of truncate this? Because we've got other comments coming up here. So, let's go to the other comments first, and then we'll wrap back around if there's additional comments. So, Deb?

Member Saliba: It's important when we look at this measure, and Evan was touching on this, that we recognize that facilities are likely going to be compared to each other, and they're going to be facing the same payment, and market challenges for recruitment of personnel. So, I guess I'm less concerned, if we had set an absolute number, as you pointed out, some states have done, that's a slightly different issue, than this one where the comparator is likely to be to other facilities.

I think we talked earlier about the strength of different data sources, and their weaknesses in every potential data source. That in my mind argues for having measures that capture different data sources. So, yes, we could make this all about outcome

measures from administrative data, but we know there are some potential flaws there. We could make it all about MDS data, but we know there are potential flaws there.

We could make it all about staffing, we know there are potential flaws there. So, by bringing them all together, we're actually sort of counter balancing some of the challenges across the different data sources. Obviously we still want to strive to get all of the flaws out, and not take something that's fundamentally flawed, but I think we do have to think about that potential that staffing really adds a deeper sense of what's going on in the facilities.

And data clearly, studies, science, evidence points to there being a relationship, and an association between RN levels, and outcomes both ones that we measure, and some that we don't, and CNA levels. And outcomes, less so with LPN, and it may well be the substitution effect between LPN, and RN, but there's significant support for the validity, not just the face validity, but the actual validity of measuring staffing, RN staffing. So, I'll close with that.

Co-Chair Lamb: Thanks Deb. Other comments?

Member Andersen: I'd echo what Deb said, this is Dan Andersen, I'd agree that staffing is kind of central to everything, and try as we might, we can't measure every important outcome. If staffing is the underpinning of it, I think we should be doing everything we can to address it.

Co-Chair Lamb: Thanks Dan. Alan?

Dr. Levitt: Thanks. I just wanted to make a general comment, really first to Nicole. Nicole, you're not being a negative Nelly, this is exactly what we're supposed to be doing here. Same thing for the CDI measures. I mean if we wanted a rubber stamp, we would have gotten a rubber stamp, that's not what we want here. These are very challenging issues,

these are challenging measures, all these sorts of things.

So, don't apologize for bringing up criticisms. We are our own worst enemies, these aren't things we haven't discussed internally ourselves before in terms of deciding what way to go. So, please keep the discussion as robust as you want.

Co-Chair Lamb: Alan, and I second that. Nicole, in my notes, I had the same thing in terms of timing, so I'm really glad that you raised that. Let's take it to the first level vote of whether we will support the preliminary assessment.

Dr. Levitt: The vote is now open for MUC2021-137, total nursing hours per resident day for the SNF VBP program. Do you vote to support staff recommendation as the work group recommendation? And I think we can close the vote. The vote is now closed for MUC2021-137 for the SNF VBP program, 13 members voted yes to uphold the staff recommendation as the work group recommendation, and five members voted no for 72 percent.

Co-Chair Lamb: Okay, so the recommendation stands, and thank you all for a really important discussion, and I'm really glad that Evan, and Alan, and others are here to hear those concerns, and I'm sure we'll take them into account. So, let's move then into MUC2021-130, and Matt, back over to you.

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

Dr. Pickering: Great, can you hear me Gerri?

Co-Chair Lamb: Yes.

Dr. Pickering: Great. So, we're now going to MUC2021-130, this is the Discharge to Community-Post-Acute Care Measure for Skilled Nursing

Facilities. The description of the measure as you listed there estimates the risk adjusted rate of successful discharge to community from the SNF, with successful discharge to community including no unplanned rehospitalization, and no death in the 31 days following SNF discharge.

The measure is calculated using the following formula, risk adjusted numerator divided by risk adjusted denominator times the national observed rate. The fields below describe the adjusted, or the fields describe the adjusted numerator, and denominator in more detail, the fields within the submission, within the PA, and the measure is calculated using two years of Medicare fee-for-service claims data. It's at the facility level.

The NQF recommendation was support for rulemaking, this measure adds value to the SNF VBP program as set by adding a measure not currently addressed within the program, and this measure aligns with the other PAC/LTC programs utilizing the same measure. The measure aligns with CMS's quality measurement action plan to build value based care by addressing several goals.

Including measures focused on key quality domains aligning measure across programs, prioritizing outcome measures, and implementing measures that reflect social, and economic determinants. So, it is NQF endorsed, thus why it received a preliminary analysis recommendation of support for rulemaking. With respect to the advisory group inputs for rural health on a one to five scale, it received 2.9.

The advisory group for rural health generally agreed with the importance of this measure, and relevance to rural healthcare providers, but did raise some concerns about the distance rural patients may have to travel from SNFs to community based settings, noting that this distance may create negative unintended consequences, and the developer did clarify on the call that in testing rural providers

generally performed better on this measure compared to general population, but would monitor this as an area of concern.

With respect to the health equity advisory group on a one to five scale, it received a 3.5. This group noted that there may be differences in the availability of community resources upon discharge from SNFs, as a measure it may be sensitive to food insecurity, and housing instability. The advisory group did acknowledge that dual eligibility is included in the risk adjustment model, but encouraged stratification of this measure.

And they also agreed that nursing home residents should be excluded, since they are less likely to be discharged from the community, but cautioned that each of the exclusions should be examined from an equity lens. With respect to public comment, there were two supportive comments for this measure. It compliments other measures, such as a 30 day rehospitalization that is already in use, and overall it's a support for the inclusion of this measure in its application to short stay residents in Skilled Nursing Facilities.

However there was some concern, even with the supported comments about the exclusion of Medicare Advantage, and special needs plan enrollees from the denominator, some concern that with smaller denominators, it's just a few cases where individuals aren't discharged the community can skew the Skilled Nursing Facility's performance, and create unfair comparisons with other Skilled Nursing Facilities.

And lastly, even with the supportive comments, there was some clarification request on the resident characteristics that would be used in the risk adjustment for this measure. And there were no non-supportive comments. So, with that summary, Gerri, I'll turn it back to you for any work group clarification, or clarifying questions.

Co-Chair Lamb: Thanks Matt. So, let's open it up for committee discussion, comments. Jim?

Member Lett: Thank you. I was listed as one of the discussants, so I kind of dug into it, and made a list of things, and I wasn't sure whether I should do that, or let the group ask questions first, and then chime in.

Co-Chair Lamb: Actually Jim, I think that your review comes after the vote, so that we would wait for that, if you have questions or concerns, those you can raise now. But otherwise, not your summary. Matt, did I get that right?

Dr. Pickering: That's correct. So, Jim, if you have any clarifying questions, this is the opportunity to raise those now, but any sort of in depth summary of the measure would be held after the vote if the vote does not stand.

Member Lett: Well, I misspoke, it was an in depth summary, I read through everything, and made some notes I had questions, and, or concerns about, so sorry to put that forth in the wrong light. So, should --

Co-Chair Lamb: If you have questions, go for it.

Member Lett: Okay Gerri. You know you can never say that to me, you always regret it.

Co-Chair Lamb: All right, be brief Jim.

Member Lett: I'll do my best. I too was very concerned, and had questions about the absence of Medicare Advantage, which is going to be 50 percent estimated of the Medicare beneficiary population by 2025. So, I think I have concerns, if they were going to be included, I heard in the comments that they're not, and that is a concern.

In the terms of what a successful discharge is, it's defined as you read it Matt, I was curious that you

left out things like readmission to the SNF, or to the emergency department, or observation status at a hospital. And that may be a little too complex for this, but obviously they're not in there that I could see anywhere. And I thought -- didn't hear that these were only the post-acute patients from the hospital.

And if someone's been living in the facility for ten years, then there's a pretty low chance you're going to discharge them to the community. So, I really think you should focus on post-acute people, and I will define that as those who in the current guidelines have their SNF benefit triggered by the three day stay. Now, I know that was weighed with COVID, but I understand it's going to come back.

And we need a triggering reason to be looking at those folks, and I really thought it was the post-acute postulation that we should focus on. And also in long-term care you're responsible, and you should be, for a safe discharge from the facility. And if you have someone with no family, someone who has dementia, someone who has a problem that is outside the parameters of anyone, our social determinants, they're going to have to stay in the facility until that can be adjudicated.

And that's going to skew the population, the numbers a little bit. And in the interest Gerri of listening to you, I'll end, thank you.

Co-Chair Lamb: Thanks Jim. So, let me kind of unpack that, and see if the measure developer can help us with some of that. One is, as I was hearing it Jim, correct me if I'm wrong, is selection criteria, and the issue of not including Medicare Advantage, as well as focusing in on post-acute. So, that's kind of in the ballpark of who is involved in this, and then the question I think is more of a conceptual one, is what is a successful discharge?

And kind of focusing in on the two aspects of this, which is no unplanned hospitalizations, and not

dying. And then I also heard a social determinants of health question related to, and I think the equity committee also raised that, and so where does that fit in in terms of risk adjusting? Because SDOH is not in risk adjustment right now. So, if I need to repeat that for the measure developer, I would be delighted to do so.

Mr. Nagavarapu: No, that's great, but definitely let me know if I miss something. So, for the first issue on Medicare Advantage, definitely this is an important population to think about given growing enrollment. It's true this measure does not account for the Medicare Advantage population, it's focused on the fee-for-service population.

And the reason for that is concerns about data comprehensiveness, and reliability on the Medicare Advantage side. But I think that comment is certainly something that CMS can consider going forward, and I think a lot of what happens going forward will depend on the quality of the Medicare Advantage encounter data, and whether similar definitions can be applied in a reliable way.

On the second point, I think fortunately there is happy news to report for you James, on that question. For the measure exclusions, patients are excluded from the measure, or not included in the denominator if they do not have a short-term acute care hospital discharge within 30 days preceding the SNF admission with the intent of focusing on post-acute care.

And I think the other really big question you brought up in this one was about residents who are baseline nursing home residents, and so for those who are in the nursing home long-term, we should not consider it a failure, right? For them to go back to the nursing home. And this is actually something that CMS, and the measure development team got feedback on in the original version of the measure, and it was refund based on that feedback, and testing.

And so now that the current version of the measure actually excludes from the measure denominator, long-term nursing residents who live in the nursing home in the 180 days prior to the measure for exactly the reason that you allude to. Then the third question was about the social determinants of health. That's correct, as it was mentioned social determinants of health are not currently included in the risk adjustment model.

The risk adjustment model includes age, sex categories, end stage renal disease, and disability as original reason for entitlement. A series of clinical indicators based on principle diagnosis from the prior acute stay, and surgical procedures that happen then, as well as indicators of prior hospital stays and comorbidities based on HCCs.

For the reason you know, we've done extensive testing on the social risk factor side of things here to understand what measures look like when stratifying facilities by presence of social determinants of health. The results are pretty fascinating. The first important point is that most of the differences in performance that you see in facilities that have many duals are really driven by prior nursing home residence.

And that change to the measure that I mentioned to exclude those who are base line nursing facility residents removes most of the influence of dual eligibility on the measure. If you look at the measure, and take the measure as given here, and compare it to a version of the measure where you would risk adjust for dual eligibility, and for race, and ethnicity, the correlation between those two measure scores is about .99.

And the C statistic for that risk adjustment model barely budges, so it increases from .72 to .73 in terms of predictive power. I think again, a lot of that has to do with the fact that the risk adjustment model is really exhaustive. In the time of NQF endorsement, we presented results on this, and the nursing home

exclusion that I mentioned, which I think makes a big difference.

This is certainly though something that is important to track, and we'll be keeping an eye out for this in future testing.

Co-Chair Lamb: Thank you. We have another question for you. Deb Saliba has in the chat how does the measure account for availability of community LTSS? Deb, what's LTSS? All right, we'll hold on that one until we have Deb back, unless you know that one, because I don't.

Dr. Levitt: It's listed in the CAT.

Member Mulhausen: So, I can tell you. So, LTSS is long-term services, and support, so it would be the full spectrum of services available to support a person in the community. Labor programs, home health programs, much of that is run through the Medicaid programs, but that availability for dually eligible Medicare beneficiaries would be really critical to having them discharge out into the community.

Co-Chair Lamb: Thanks Paul. Sri, do you want to respond to that question then?

Mr. Nagavarapu: Sure, I'd be glad to. The measure does not account directly for the availability of a community's long-term services. So, there are not adjustors for specific geographic regions, or anything like this. What we do know are differences in performance by area to some extent. As I was mentioning before, the urban rural comparison for discharge to community suggests that performance is slightly better in rural areas, than in urban areas.

Which is reassuring if there's a worry about availability of LTSS that may be lower in rural areas. And then the other aspect is the social risk factor testing, where if you suppose that particular demographic groups for instance, are associated with

living in areas that may have lower availability of long-term services, and support, fortunately that doesn't necessarily seem to be the case.

So, in fact if you look at the risk adjustment model that I mentioned if you add dual eligibility, and race, and ethnicity, and look at the race, and ethnicity categories, the probability of discharge to community successfully is actually a bit higher for minority groups than the referenced white population, which is an interesting feature of the measure.

So, I'd be happy to talk more about that, but this is something where it doesn't account directly for it, but we think based on the results I've cited so far, that there does not seem to be a resulting bias from that.

Co-Chair Lamb: Thank you. Alice?

Member Bell: Thank you. Just two questions. One is I just want to make sure I understand this is patients in a SNF stay under a Medicare Part A benefit, is that correct?

Mr. Nagavarapu: That's correct.

Member Bell: So, why exclude patients who didn't have an acute stay? And I say that because if their Part A benefit is still going to cover them because there is some type of waiver, what would it matter if they had an acute stay, or not?

Mr. Nagavarapu: Yeah, and I think the idea behind this exclusion is potentially a very different patient population than the one we're looking at. At the time, with the waiver, as you mentioned, I think there's a larger set of people that are subject to that, and I think that sort of distortion as to who that might be, and how they differ in terms of their discharge destination, it could be a bigger concern.

But I think that's an important area to monitor actually, to see who these folks are, and how they

look different on various characteristics.

Member Bell: Yeah, I'd be inclined to just think that through a little bit more, because if we're looking at opportunities for diversion, for instance from the ED, or an observation stay, they could very much be very similar patients that are going in for a short-term, or even direct admit from the community based on certain waivers, or payment models. So, that's just one point.

And then the other thing, I know it's been brought up already, but I would also consider including patients not just with a hospitalization, but with an ED visit, and observation stay. Because they could be in observation for several days, and I think that still would be a highly problematic discharge.

Co-Chair Lamb: Thanks Alice. Cheryl?

Member Phillips: Thank you. Boy, important conversations, and the SNF Alliance certainly supports the idea of a return to community measure. I am worried though, respectfully, that we're confounding a whole lot of variables, and trying to make them fit. So, for instance the rural versus urban. Frankly the rural may in fact be associated with greater access to family care givers than low income isolated urban dwelling people.

So, we may not be even measuring the same populations. Looking at the dual eligibility, and Debra touched on it with the long-term services, and support, but the frank reality, and this is not the nursing home's fault, but for many states, the default position for low income, IE dually eligible individuals who have support needs is something goes wrong, you go to the hospital for three days, and you come to the nursing home for placement.

If that state has not invested in rebalancing, so it's more than just a community issue. It is a state level issue. If they don't have Medicaid benefits adequate

for the support, and they have not invested in home, and community based services, the nursing home is obligated to maintain a safe environment for that individual, particularly if they have no place to send them to in the community.

So, my concern about this is this really needs to be in the context of a holistic policy question, what is the state's priorities for rebalancing? There's not even consistent Medicaid benefits, or eligibility from state to state. The fact that there are limited accesses to low income housing for dually eligible individuals, again, the nursing home becomes the default, and then we penalize the nursing home because they are in fact the only safe place for the individual to be.

So, the commitment to getting people who can go back to the community is correct, but I do worry in our risk adjustment that we may not be taking into account all of the variables.

Co-Chair Lamb: Thanks Cheryl, there's a lot in what you just said. I'm going to move on to Larry.

Member Atkins: Yeah, I just wanted to circle back on that question about three day prior stay in the hospital, because if this gets expanded at some point, which it absolutely should be to incorporate Medicare Advantage, Medicare Advantage does not need a prior authorization, a prior hospital stay to get into a skilled nursing, they can go straight to it. And so that criteria wouldn't really work.

Co-Chair Lamb: Thank you. Ben?

Member Marcantonio: Thank you. Yeah, just two things. One, I just wanted to reiterate the importance of Medicare Advantage of well, it's come up on other measures, but I think particularly related to this one. As the Medicare Advantage plans evolve in phase like palliative care not being defined within them at all, with standards, that's a really important piece of this in helping to keep people in the community with the

quality of life, and sustaining outside of the acute care setting.

Then secondly, I think I just wanted to confirm that the recommendation had been made about excluding hospice from making an exclusion has been done, so thank you for moving that forward, and confirming that that is in fact the case, so thank you.

Co-Chair Lamb: Thank you. Other comments? Jim is that a question you want to bring forward?

Member Lett: That's not why I raised my hand. I was going to say I've been very negative about it, and I apologize for that. It is something that I, and the National Transition of Care Coalition would support, and that is a good discharge back to the community for the transiting people in post-acute care. I think that it's a good concept.

It's simply a matter of that we painted this measure with too broad a brush that doesn't purely acknowledge, and understand the market.

Co-Chair Lamb: Great, thank you. This is a great discussion. I think probably, since I'm not seeing any other hands, Matt, how about if we do our vote, and see where we're at?

Dr. Pickering: That sounds good Gerri, so we'll move to a vote. Again, you're voting to uphold the preliminary analysis rating for decision category of support for rulemaking. So, no conditions here, this is fully support for rulemaking in the SNF Value-Based Purchasing Program.

So, if you disagree, please vote that you disagree. Or if you agree, please vote that you agree. So, Susanne, I'll turn it over to you.

Ms. Young: The vote is now open for MUC2021-130 Discharge to Community Post-Acute Care Measure for Skilled Nursing Facilities. Do you vote to support

the staff recommendation as the work group recommendation? We'll give it a few more seconds. Okay, I think we're good. The vote is now closed for MUC2021-130 for the SNF VBP Program. 11 members voted yes, and five members voted no for 69 percent. So, the work group did support the staff recommendation.

Co-Chair Lamb: Before we move on, I just want to check, what's our quorum number?

Dr. Pickering: Quorum today would be 14.

Co-Chair Lamb: 14, I know because a couple people have said they need to leave early, so if we could just keep an eye on that, so thank you all. That was a wonderful discussion. Let's move on then to MUC2021-095 CoreQ. Matt?

MUC2021-095: CoreQ: Short Stay Discharge Measure

Dr. Pickering: All right, so this is the Short Stay Discharge Measure, so as Gerri said it's MUC 2021-095. This measure estimates the risk adjusted rate of successful discharge to community from a Skilled Nursing Facility with successful discharge to the community including no unplanned rehospitalizations, and no death in the 31 days following a SNF discharge.

The measure is calculated using the following formula. We have risk adjusted numerator divided by risk adjusted denominator times the national rate. The fields within the measure of submission information describe the adjusted numerator, and denominator in more detail, and the measure is calculated using two years of Medicare fee-for-service claims data at the facility level.

This measure also receives a support for rulemaking as this measure does add value to the SNF Value-Based Purchasing Program by adding a measure

that's not currently addressed within the program, and the measure aligns with other PAC/LTC programs by working towards CMS's meaningful measures 2.0 overarching goal of value based care. Then per the Consolidated Appropriations Act of 2021, expansion of the measures set will add measures including those measuring patient experience.

There is a range of variation in the performance of this measure within Skilled Nursing Facilities, which allow these facilities the opportunity to implement interventions, and processes to improve the performance. This measure is NQF endorsed, that's receiving a preliminary analysis recommendation of support for rulemaking. Regarding the input from the rural health, and health equity advisory groups for rural health on a one to five scale, rated a 2.9.

They generally agree with the importance of the measure, but question some of the relevance to rural providers in care settings. For health equity on a one to five scale, received a 3.0, a 3.0. The advisory group for health equity noted the importance of this person centered measure, but cautioned language differences that may result in response bias by race, ethnicity, language, and by payer.

The developer should also consider, this is again, advisory group input, the developer should consider the increased response time, and the role of care givers required for certain sub populations. The advisory group also cautioned that certain sub populations may be discharged to another facility due to the payer, and may be excluded from the measure.

Regarding public comment, there were six supportive comments, zero non-supportive. For the six supportive comments, this measure is very simple, it's based on four simple questions. It has been validated, it is also NQF endorsed. There's some interest in seeing if the responses are dramatically different between those patients in Medicare fee-for-

service, and those who are part of Medicare Advantage, or special needs plans.

As care delivery expectations, and patterns can vary greatly between the two payers with managed care plans limiting skilled days, and discharging at different functional levels. Lastly, a standardized care satisfaction measurement for nursing homes is long overdue, and the shorter CoreQ survey is pleasant for respondents, easier for care providers to implement, and to understand, and still collects the most important data for stakeholders.

So, that is a summary of the public comments in the preliminary analysis, as well as advisory group input. Gerri, I'll turn it back to you for clarifying questions.

Co-Chair Lamb: Great, thanks Matt. So, let's open it up for comments. So just when we're getting the rhythm down, there's no comments? There we go, all right. Pam, go for it.

Member Roberts: I'll just ask one, and I may have just missed this. It can be done by the resident, or by a proxy? I just wanted to clarify that.

Co-Chair Lamb: Can we get a response from the measure developer on that?

Mr. Gifford: Yes, by anyone on your team. It can be completed by the resident, or a proxy helping the resident, but if the proxy is answering on behalf of the resident, they are excluded from the measure because of the data showing proxy answers are not the same as the respondent's answers.

Co-Chair Lamb: Thank you.

Member Roberts: Is that based on, then, just self-report from the resident?

Mr. Gifford: Or whoever fills it out, there is a question on the questionnaire that asks who is completing the questionnaire, where there's a resident, and if they're

getting assistance, or whether someone is answering on behalf of them.

Member Roberts: Okay, can I ask a second question?

Co-Chair Lamb: Sure, go for it Pam.

Member Roberts: And if somebody doesn't speak English, would there be a translator to help them, or would it be in multiple languages?

Mr. Gifford: Currently it's in English, and it is sent to them after discharge, and so it would be whoever they have home to help them with that.

Co-Chair Lamb: David?

Member Andrews: As probably the only person who is here solely because of a patient, I'm thrilled that we're going to have a measure that actually asks patients what they think. This is a great progress. At the same time, I'm absolutely thrilled that this is a relatively simple, and straight forward measure where the question of satisfaction typically counts for nearly all of the variability that you find in much longer surveys like the CAHPS survey.

My one concern about this kind of measure is that, and I say this based on the years of sitting in meetings in a hospital looking at survey results, CAHPS, and others, is that the survey doesn't tell anybody anything about why their score is high, or low. It gives them an overall rating of how they feel about it, but then the question becomes okay, if our score is low, what do we do to bring it up?

Intuitively we have a lot of ideas, but the survey itself doesn't provide information that's helpful in that regard. And I think for future developments, people ought to begin to look at that to make it more helpful to those people who are trying to improve.

Co-Chair Lamb: Thank you. Other comments? I have a comment, or a question. This is an NQF endorsed

measure that would be looked at for the value based purchasing. It was endorsed, if I looked at it correctly, in 2020, or most recently endorsed. Going back to the equity committee, who asked, or suggested that this should be analyzed by different groups going down the road to look at disparities.

I don't know when the next review would go through NQF, but I was wondering if that, you know, if that's something that is going to be looked at down the road.

Dr. Pickering: Gerri, was that a question for developer, or?

Co-Chair Lamb: David Gifford, yeah, either David Gifford, or for --

Mr. Gifford: Yeah, yes, definitely. We have added a question about race, and ethnicity, and been tracking some of that data, and have gotten that feedback from the NQF team on the process.

Co-Chair Lamb: Thank you.

Mr. Gifford: And Nick Castle (phonetic) was one of our developers on it, has been collecting some of the data. Nick, do you have any of the preliminary data for some of that?

Participant: Yes, we've gotten more than 50000 surveys back this year, where we've included risks on the survey, and I can certainly go into detail on what we've found. But we have -- in aggregate you get lower scores for black residents compared to white, but when you stratify by the type of nursing home so you have nursing homes that have groups, or a large proportion of black folks in the facilities, they tend actually to be not the best of facilities.

When you look within facility between black, or white residents, the scores are -- I wouldn't say not statistically different, they're almost identical. So,

that's the kind of analysis we've been doing. But at the moment, we're not finding anything that would show that the CoreQ gives different results based on race.

Co-Chair Lamb: Thank you. Any other comments? All right, so Matt, let's get that vote up.

Dr. Pickering: Okay, so we're moving to a vote. This is for MUC2021-095, the CoreQ measure for rather the work group wants to uphold the support for rulemaking into the Value-Based Purchasing Program for Skilled Nursing Facilities. Susanne, I'll turn it to you.

Ms. Young: Okay, the vote is now open for MUC2021-095 CoreQ Short Stay Discharge Measure for the SNF VBP Program. Do you vote to support the staff recommendation as the work group recommendation?

Dr. Pickering: And sorry, we're just confirming something on our end just quickly about this decision category. Apologies for that. Okay, can you pull that vote screen back up one more time? Okay, and go to the results page once more? Apologies about that once more, we were just confirming what we said was correct.

Okay, so out of 15 yes, so that's 88 percent in favor of supporting for rulemaking. So, we are good to go, sorry about that, we just wanted to confirm internally in our team that we were saying correctly what we're voting on. So, yes, support for rulemaking, 88 percent for this measure, the support for rulemaking. Thank you.

And Gerri, I think we can have, maybe have Dr. Schreiber ask a question first, and if we have time before the break, we can see where we are with going into the gaps discussion, if not we can maybe move it to after the break. Is that okay?

Co-Chair Lamb: That's fine, so I will turn it over to you then.

Dr. Pickering: All right. Dr. Schreiber, did you want to take the floor, and ask the work group a question related to this CoreQ measure?

Dr. Schreiber: Actually Matt, and Gerri thank you very much for the opportunity. Thank you for the support of CoreQ, but CMS has actually been having multiple conversations about CoreQ, which is a very nice measure, and is obviously short as you know versus nursing home CAHPS, which has many measures as you know, but also asks things that are a little bit different, and I don't want to say broader, because CoreQ is actually broader.

But there are differences obviously between nursing home CAHPS, and CoreQ. And I would very much like feedback from this committee about would they have a preference, is there more that they would want to see in a patient experience measure? Is CoreQ with four measures just about enough? So, I would really welcome any feedback that the committee may have.

Co-Chair Lamb: David?

Member Andrews: I am probably going to repeat myself, but I think the CoreQ is excellent, and I applaud you for bringing it forward. My concern however is that as administrators who look at these data, and want to try, and improve their scores, the CoreQ by itself doesn't provide much in the way of guidance. That said, I know the hospital CAHPS well, I don't know the nursing home CAHPS, but I assume it's probably a similar pattern.

And I think that they don't do a very good job of providing those data. But the other problem with those is that the return rate for the longer surveys is really quite poor generally, whereas I think the return rate from this shorter survey would be much better, and provide some useful information. My concern is

that there needs to be something other than this that helps people know what the concerns are, and how they can address them.

Co-Chair Lamb: Thanks David, we have a comment from Pam.

Member Roberts: I think there's pros and cons, I think when you have the shorter survey, as was just mentioned, you're going to probably get -- more likely get people to return them. The longer ones of course will give you more detail. So it depends on where you want to start. I have found in my experience when you get shorter surveys, you change the questions over time, you get a lot more poignant information.

Co-Chair Lamb: Any other thoughts on that? Nicole?

Member Fallon: So, we're supportive of CoreQ because of the brevity, and having been a family care giver that got all of those surveys, I've got to tell you, 40 questions, and 30 questions, and things that often you can't even answer because you weren't the recipient of care, you end up just tossing them in the waste bin unfortunately.

So, one of the things that we like about the CoreQ is the fact that it's short, and to the point. It also really gets at, I think what consumers want to know, right? When you ask your friends, you say do you recommend this nursing home, would you want your mom there? Is that where you would go, and how are the staff?

Whether, or not food is great, we would all like food to be great, but that's probably not the core issue. Having said that, I think -- I know our members have the same concerns that have been voiced by David, and by Pamela, and others that you don't always know what the issue is then, that it was this particular CNA, on that particular day.

But there's nothing that prohibits folks from asking additional questions in their own patient satisfaction surveys as well to get at that, and to make some of those corrections.

Co-Chair Lamb: Any other advice for Michelle? Michelle, do you have any other follow up questions?

Dr. Schreiber: No, I got the feedback I was looking for, thank you all very much.

Co-Chair Lamb: Cool, all right. So Matt, we have about ten minutes before break, is that right?

Dr. Pickering: We do, and I don't think that's enough time to really do the gaps discussion. So, maybe if we did a ten minute break, come back at 4:45, would that be okay with the committee, or the work group? And then we can pick up. From there, I think we can just cover the last measure, and then go into the gaps discussion for the programs if we could.

So, let's reconvene, everybody get a bio break if needed, reconvene at 4:45 p.m. on the Eastern side. And we'll pick up with the last measure before we go into gaps discussion for the day. Thank you all.

(Whereupon, the above-entitled matter went off the record at 4:36 p.m. and resumed at 4:45 p.m.)

Dr. Pickering: Okay, so we're going to pick up from where we left off, so the meeting is now being recorded again.

So, thank you, team. We're going to reserve the gaps discussion until after we get this last measure for our consideration today.

Skilled Nursing Facility Quality Reporting Program Measures

MUC2021-123: Influenza Vaccination Coverage

And so this measure will be facilitated by Kurt, and it's the last measure for the Skilled Nursing Facility Quality Reporting Program. And it's MUC2021-123: Influenza Vaccination Coverage among Healthcare Personnel.

So, again, as you see listed on the slide there, this is the reminder of the program, and its structure, which we've reviewed previously. But you can see that listed there. That's for the Skilled Nursing Facility Quality Reporting Program. And, if we go to the next slide, here is the opportunity for public comment.

So, Kurt, I'll turn it over to you, to see if there is any members of the public that want to comment on this measure.

Co-Chair Merkelz: Thanks, Matt. And again, we are opening up to public comment now for MUC2021-123: Influenza Vaccination Coverage.

(Pause.)

Dr. Pickering: Okay, once again, it's an opportunity for the public to make any comments for this measure.

You can use the raised hand feature, or chat box, or take yourself off mute, if you choose to. Opportunity for public comment.

(Pause.)

Dr. Pickering: Let's give it a few more seconds.

(Pause.)

Dr. Pickering: Okay, I see none, Kurt. I think maybe we can go to the description of the measure in PA?

Co-Chair Merkelz: Go ahead, Matt.

Dr. Pickering: Okay. So, here we have MUC2021, the

last measure we're reviewing today, 123, Influenza Vaccination Coverage among Healthcare Personnel.

The description, as you can see on the slide, is the percentage of healthcare personnel who receive the influenza vaccination. So, this is at the facility level of analysis. And the NQF recommendation in the preliminary analysis is support for rulemaking.

So, this measure does add value to the SNF Quality Reporting Program by adding a measure not currently addressed within the program. And this measure aligns with other PAC/LTC programs utilizing the measure.

Vaccination coverage among healthcare personnel within SNF, SNF is of importance as seen by the recently adopted COVID-19 healthcare personnel vaccine measure.

And vaccination coverage among healthcare personnel within these facilities can decrease its viral transmission, along with decrease in morbidity and mortality among patients.

There is variation in the performance of this measure within skilled nursing facilities, and these facilities will have the ability to implement interventions to improve the performance of this measure.

This measure is also NQF endorsed and thus, receiving a support for rulemaking for this program.

Regarding rural health advisory group input. Out of a 1-5 scale, it received a 4.5.

The relevance and its importance of the topic for rural providers, and healthcare personnel.

The advisory group generally agreed for its importance of the measure, and noted that there may be some concern around vaccination measures in general.

Given the quality challenges, or given the challenges with the COVID-19 vaccination in healthcare facilities, this measure might also be challenging to implement in the rural setting, in particular.

The advisory group also noted that there might be challenges with the workforce and staffing in rural care settings, and encouraged CMS to monitor for unintended consequences to rural providers.

Regarding health equity, on a 1-5 scale, the health equity advisory group rated this at 3.8.

This important public health priority, not sure if there are any equity concerns with this, with this measure. And there was some discussion on what is available for the public, and what is reported to CMS.

The measure steward clarified that what is sent to CMS, and what is publicly reported, is the overall compliance on the measure.

Regarding public comment, there was one supportive comment recognizing that it's an important measure, and should be added to the QRC program since it's already in use in other programs for PAC, for post-acute care.

There was also one non-supportive comment. It said the administrative burden to report into NHSN outweighs the benefits at this time.

Reporting through the NHSN is highly burdensome, and would require additional staffing to track the information at a time when we are already struggling to hire, and retain staff during a pandemic.

So, those are the public comments, as well as the advisory group input in the summary of the PA.

I'll turn it back to you, Kurt, to see if there are any clarifying questions from the workgroup.

Co-Chair Merkelz: Thanks, Matt.

Definitely an important measure to discuss. Let's go to the workgroup and see if there is any questions, or any requests for any clarifying information.

(Pause.)

Co-Chair Merkelz: Yes, we'll go to Nicole.

Member Fallon: I know. See, you didn't even know who I was like, a week ago. Now you're regretting it.

Co-Chair Merkelz: Not at all, not at all.

Member Fallon: Thank you.

Excuse me. Just a couple clarifying questions.

The licensed professionals, can somebody clarify if that's just folks that were contracted with, or is that just any licensed professional that walks into the building and provides care?

So, it could be somebody's personal physician, or nurse practitioner, that does rounds, you know, and coordinates that with the individual resident.

Just because that would pose particular challenges, and just trying to track people down, and track that information down.

And the other thing I noticed is that this measure was discontinued for some of the other programs, and I didn't know if there was more information about why that was discontinued for some of the other programs.

Co-Chair Merkelz: Nicole.

Dr. Schreiber: I can answer some.

Co-Chair Merkelz: Please.

Dr. Schreiber: In the past, you're right. We had these in other programs before. They were discontinued because they were topped out.

There's some consideration again, of bringing them back due to COVID, because of the importance of vaccination.

I don't know if the measure developer is on the line or others know, but I will tell you on the other vaccination coverage among healthcare personnel, it is anybody who walks in the building in that given year. Because --

Ms. Lindley: This is Megan Lindley from -- I'm so sorry, Michelle --

Co-Chair Merkelz: Yes, we do have the -- yes, Megan.

Dr. Schreiber: Wonderful. Thank you, Andrea.

Ms. Lindley: Sorry about that. I tried to speak before and I was double-muted and I only unmuted once, so --

(Simultaneous speaking.)

Dr. Schreiber: Yes, I didn't hear you.

Ms. Lindley: I apologize. Yeah, I was like, why couldn't we talk? Yeah, technology challenges. I do apologize.

And so this is Megan Lindley from CDC. And, yes, for the licensed independent practitioner category, which I think is the one Nicole is asking about, it is physicians, nurses in advanced practice, and physician assistants. And it's anybody in that category who, as Michelle said, is in the facility for one working day or more during the reporting period.

So, that would include people who are contracted, but it would also include somebody coming in to, to round on, or visit a resident for some other reason. And, yes, sorry, I think that was all I have to address. Thank you.

Member Fallon: Okay, that's helpful that clarification.

I would just point out that it's -- and I'm sure others encountered this as well -- really challenging to track down every single licensed professional that walks into your building. Or control their vaccination status when you don't even have a contracted relationship with them. That's going to be more difficult, I think.

Dr. Schreiber: Your point is absolutely correct. In hospitals, actually, it also extends to medical students, and nursing students, and other like therapy students. So, it is quite extensive on the other end, if we think about who comes in contact with the patients, it is all of those folks.

Member Fallon: Absolutely. And we have gathered some lessons from hospitals because they were the first, they've been implementing this since 2012, or early 2013.

So, we have tried to gather some learnings because yes, the point has been made for people that don't have an ongoing relationship necessarily, with the facility, it can be challenging.

But, yes, exactly as Michelle said when thinking about the risk to the residents, and to the providers. That's who it is.

Dr. Levitt: This is Alan. Just to add again, this measure is additionally also adopted in the IRF and LTCH QRPs and used in PAC settings as well. And some of the issues in terms of staffing that may or may, you know, come in regularly or regularly into those settings.

Co-Chair Merkelz: Gerri, you wanted to comment?

Co-Chair Lamb: Yes. I'm piggybacking on Nicole's question. One thing I just wanted clarified, is how the indicator is analyzed. There is employees, there is licensed independent contractors, and then there's the students and learners. And, according to the information we received in advance, the reliability of

some of those groups is lower than the others.

Is this an aggregated measure, or is it always broken out by group?

Ms. Lindley: This is Megan Lindley again. Although it's reported by group, and that is made available to the facilities for internal tracking purposes, what is reported to CMS and what is publicly reported is the aggregate healthcare personnel measures. So, all of those required categories together.

Co-Chair Merkelz: Any other comments?

(Pause.)

Co-Chair Merkelz: Okay again, go through the chat line, email, or, yes? Cheryl, go ahead.

Member Phillips: A clarification question. I realize I'm a discussion on this, but it did, this preceding dialogue raised some questions.

Using the old tenet that you, if you don't take a temperature, you don't have a fever.

So, in reporting this measure, if you are not capturing people who are coming in as providers, or vendors, in your denominator, then you can, I mean, how does, how does this score, or reporting, have meaning if people don't even know who to track in the denominator?

Because if you avoid reporting a physician that comes in once a month, and just don't put them on your list, then you don't even have to report their vaccine status. That's my concern about it.

Although I'm wholly supportive of the importance of documenting vaccine status for staff, so, I'm just curious about the measurement.

Ms. Lindley: To clarify, the question is about enforcement of proper implementation of the

measure in the facility?

Member Phillips: Well, no, actually -- and sorry, I was vague. The clarification of the question is, how can you report, if a facility doesn't report a particular clinician coming into the building, then they don't have to report their vaccine status.

So, their final report may not be complete, but who externally would know that?

So, it's going to be dependent on the facilities to capture the nursing homes, I know facilities is a bad word. The nursing homes to capture those individuals that are coming in, and then reporting on their vaccine status.

So, to Nicole's point, if it becomes very burdensome to track down that one doc who only comes in every 60 days, or once a month, and he slips in and slips out during lunch, and nobody talks to him. If they never report him, then they don't report his vaccine status.

How do we get clarity on what the true denominator is?

Dr. Schreiber: Your point is well taken. There is a degree of trust. The facility does have to track who is coming into their facility.

Now, there's sometimes records especially of anybody who's employed, or who's being paid at all from the facility. But then the question gets to what is enforcement of these? And that gets to, you know, what are validation programs. Does CMS walk in and look at every person who has walked in the, who has worked in the facility? I mean obviously there aren't resources to do that.

But, and so you know, your point is right. We only hope that facilities understand the requirements and are keeping track.

I don't know, Alan, do you want to comment? I know that you have, have thought about this before.

Dr. Levitt: I just agree. I mean that is, it is a challenge.

I mean, obviously when surveyors come in, they try to you know, survey and verify, and validate different information, including such things as you know, necessary staff and stuff.

But again, that is a challenge.

I don't know, Megan, if we have any data on the reliability that we can report on?

Ms. Lindley: Yes, we beyond the initial study, we haven't done formal reliability studies. I realized when I was submitting documentation, we actually did begin an internal analysis that unfortunately, we did not complete prior to COVID.

But examining the sort of correlation of the reported measures, with responses to the survey about program practices that are known to increase vaccination, implement the vaccination in healthcare personnel.

So, I was calling it a pseudo-validation study. And those results were very positive. Which we found encouraging. You know, facilities reporting more practices. Obviously, these were not SNF, these were acute care hospitals.

And I think, for outpatient, we were looking at the ambulatory surgery. But facilities reporting more implemented practices known to increase vaccination, also were reporting higher vaccination rates.

So, it's correct that we have not conducted a formal reliability study, since the initial endorsement process. And I do think Cheryl's point is well taken.

And, certainly, as Michelle said, there's a degree of trust. But I think there's also a degree of hope that in facilities that are providing healthcare, that there's some knowledge of the comings and goings of most of the personnel.

Although understand certainly in a setting like SNFs where there can be a lot of turnover, that that might be a challenge.

Co-Chair Merkelz: I don't see any other hands, or questions, Matt.

Dr. Pickering: I'm here, so if there's no other clarifying questions, I think we can move to a vote.

(Pause.)

Dr. Pickering: Okay, so I'll have the team pull up the vote. Again, you are voting on whether or not to uphold the preliminary analysis recommendation of support for rulemaking of measure MUC2021-123, for the SNF's QRP Program.

I'll turn it over to Susanne.

Ms. Young: The vote is open for MUC2021-123: Influenza Vaccine Coverage among Healthcare Personnel Within the SNF QRP Program.

Do you vote to support the staff recommendation as the workgroup recommendation?

(Pause.)

Ms. Young: Five more seconds.

(Pause.)

Ms. Young: Okay, the vote is now closed for MUC2021-123. And 15 members voted yes to support the staff recommendation as a workgroup recommendation, and one member voted no, for 94 percent.

Co-Chair Merkelz: Good. That's decision making for support rulemaking.

Now it's time to move over into our gap analysis. And we had left some of that on the table before to come back to it.

We're going to start off with the SNF Quality Reporting Program, and discussion of the gaps analysis. It might be helpful, Matt, to bring up the existing Quality Reporting Program measures.

Dr. Pickering: Okay.

(Simultaneous speaking.)

Co-Chair Merkelz: You can continue the discussion.

Dr. Pickering: Yes, go ahead, Kurt.

Co-Chair Merkelz: No, I was saying we can certainly start to opening discussions now to the workgroups, regarding some of the gaps around the SNF Quality Reporting Program.

Dr. Pickering: And if we click to the next slide, there's other measures as well listed there. And, Cheryl, it looks like you have your hand raised. Did you want to comment on gaps?

Member Phillips: Yes, please. And one gap, and I realize that this is a challenge, but other settings of care are struggling to implement, including health plans. And that is a measure of goal-directed care.

We assume that all of the quality that we offer people in nursing homes, is post-acute and long-term care settings, is what they want. Sometimes what they want are other attainable goals.

It could start as a process measure of are we even asking, or including, person-centered, or person-reported outcome measures. Or even starting with asking them what their goals are, and then moving

to PROM measures.

But I think one thing that is clearly missing in post-acute and long-term care, is the expression of goal.

Because we had such heterogeneity in the population served. Some are short stay, their goal is get better and to go home. Others want comfort care. Others want to be supported functionally, for as long as they can.

And unless we integrate that into measurement, we continue to define quality for people, perhaps not in a way that they would do themselves.

(Pause.)

Co-Chair Merkelz: Why don't we go ahead --- David?

Member Andrews: Well, I'll second the prior comment. I think patient goals are a critical part of the success rate. And because they're so variable, they're often not recognized as a value in the whole system.

Beyond that, I'll just repeat myself with hopefully some variation a little bit. I think particularly in the populations we're dealing with here, it's very often the case the patient, that the patient family members or caregivers, have a much greater sense of the quality that's been received, than the patients themselves.

That's particularly true of some of the exclusion groups in some categories. So, I think development of measures that assess the perspective from, or the success from caregiver perspective, is important.

And, lastly but also equally, generally I think we need to have more patient reported outcome measures. And, in particular, I would like to see more of those measures be converted into performance measures.

So, measures that address patient perspective, but

also are used in quality and performance measurement, need to be added to the portfolio.

Co-Chair Merkelz: Gerri?

Co-Chair Lamb: I'll third what Cheryl and David just said, in terms of patient reported measures. I just wanted to make an observation because I think in our workgroup, we've talked about alignment across programs. And when, you know, just in reflecting on that and our discussions today, you know, it seems to me that we've really, or CMS and all of the workgroups, have done a great job on safety and some basic quality stuff.

And I'd like in the SNF, as well as the other programs, to start moving up the Maslow's hierarchy of that. And start looking at patient experience, the PROMs, and also looking at CMS's priorities.

Mental health in the SNF, in relationship to, and this came out I think in our orientation meeting, when people were commenting on what they'd like to see with SNF, is dealing with isolation; dealing with depression.

And then I would just add, you know, I'd like to -- and David I think you said this before -- is transfer to the community whether you're hospitalized, or whether you die, is one thing.

But what is the experience of that transfer? Is it a good transfer? Do you feel successful in being able to manage in whatever setting you're going to?

So, I'd like to see some depth, and I'd really like to start moving up the hierarchy, to really looking at the patient experience.

Member Andersen: Gerri, I would second everything you just said, especially around the isolation

I think we talked about it during orientation, but I would throw out there isolation and loneliness, which

aren't exactly the same constructs, and maybe you know, one step further up in Maslow's would be meaningful engagement.

Co-Chair Merkelz: So, thank you all for those comments. You know, these are have only been heightened during the COVID pandemic. But these were all issues that were problematic well before we were dealing with COVID.

Alice?

Member Bell: So, I am in agreement with everything that's been said here. And I think a couple of things really important to that end, is, and Gerri was going towards this, is the concept of community reintegration. Not just return to a home setting.

Because we're often going from one isolation chamber, to another isolation chamber. And so whether this individual actually has the ability to engage in their community, upon discharge to the community.

And I would also really like us to look at efficiency of movement. We set the bar very, very low on all of our functional performance measures, as it relates to mobility.

And the fact, you know, the issue of whether someone can walk 50 feet is meaningless in terms of meaningful community reintegration.

And what's most important is not just how far they can go, but how efficiently they can do that. Because people who can't do it efficiently won't continue to do it once they return home.

And so really looking at efficiency of mobility in terms of looking at not just distance, but time, velocity, which also is a really great predictor of risk for rehospitalization, and risk for falls.

Co-Chair Merkelz: You know, I agree with all that. I

also think we tend to look a lot at self-reliance measures in home health, and in long-term care.

And I would just really stress the importance of looking beyond self-reliance measures. Especially as we focus on the aging population, which is going to continue to increase at an amazing rate over the next you know, two to three decades.

And the continued focus on you know, individuals improving, needs to really change for this population of individuals, with more of a shift towards how they get their needs met, as opposed to their own ability to achieve these outcomes.

Raj, you had your hand raised.

Member Mahajan: Yes, thank you, and I probably will go back a little bit on I know the HAI measure, when it was being developed initially pre-pandemic had more to do with safety. And then it morphed based on what happened around the pandemic.

I think it's now has, the pandemic has uncovered this huge under preparedness, and lack of resources, when it comes to infection control. And I know we were talking a lot of big things on, on patient satisfaction, and other things.

But I would love to see some kind of a composite score on infection control, preparedness, or overall performance that could be used.

We definitely have realized all the different components, that total up the infection control performance of a facility. This is mainly for nursing homes. And if we could just go back and see if we can use that.

There's a lot of work being done, resources being added whether to ARPA, or CDC's other billions of dollars being poured into getting this done.

But all of those funds are limited to a year or year

and a half use, and I fear we will do a lot of things that are not going to be sustained.

There's not going to be a lot of system sustainability packed into those funds being used. So, if we can somehow align a ongoing measurement, that is reflective of overall infection control performance in the long-term care setting, would to me, is a gap.

And there are some parallel things that indirectly measure that. But if we could have something that entails an overall infection control performance of a facility.

Co-Chair Merkelz: Thank you, Raj. We'll have that -- you know, we'll log that in under the long-term care quality reporting gap, as well. Why don't we close out the SNF quality reporting gaps? And I'll go over to Nicole.

Member Fallon: Thanks, Kurt. I want to go over what a couple of other --

(Simultaneous speaking.)

Member Mahajan: And include that for SNF as well.

Member Fallon: Sorry.

Co-Chair Merkelz: Yes, go ahead, Nicole.

Member Fallon: Just wanted to build on a couple of other comments, and then make just a general observation. And I'll start with that.

When we think about SNF quality reporting, at least my sense has been is that we're more focused on the short stay because it's tied to Medicare, and Medicare payment.

So, I think it's important when we think about measures, to make sure we know the population we're talking about. And, Kurt, you kind of alluded to

this a little bit.

There are measures that are appropriate for folks that are in a custodial care, kind of long stay situation versus short stay. And I think one of the flaws with the way CMS looks at things right now, is it's about this hundred days, and being there for -- being in a nursing home for a hundred days doesn't delineate whether you're there for rehabilitation, or whether you're there for just kind of ongoing support.

And the outcomes that we seek, are a little bit different for those two populations. And so I think we want to be really careful as we think about measures, that we're comparing the same population.

So, that was one comment.

The other thing I wanted to add from a measure perspective, and one that our members brought up when we had this conversation.

They feel like they had pretty strong consensus, that pain management would be a good measure to look at.

However, with the caveat that the current MDS questions are still a little subjective, and that there's some better tools out there to kind of gauge that, and get kind of consistent responses from folks.

Again, that goes back to you know, looking at the individual when you're assessing pain.

So, somebody who's been on strong pain medications for a lot of years, you need to look at pain management a little bit differently than for somebody that normally isn't on a pain medication.

But nonetheless, they felt like pain management was a really important one, that maybe we should look at.

So, I thought I'd throw that out.

Co-Chair Merkelz: Thank you so much, Nicole. I agree. I just already have my mind going on thinking of so many factors going with the pain management aspect.

And, certainly with this population, you know, looking at how adjuvants are used, and other alternative therapies can be, and should be used in long-term care as well.

Certainly don't want to drive more pain medications in this population.

But no, I think your point is well, is well stated.

Matt, why don't we go put up the long-term care quality reporting measure information?

Dr. Pickering: Yes, Kurt, I think we'll maybe switch to the Value Based Purchasing first.

Co-Chair Merkelz: Oh, yes.

Dr. Pickering: I think there's some more discussion around that.

But I did want to, also want to mention that we do have the public comment at the end of all of this today. It was scheduled for 5:35.

We're going to push that back to 5:45 p.m. Eastern, for the public comment so we have more discussion time.

If we're not able to get through all of the programs today for gaps, if you have any input you'd like to share, please drop that into the chat so that we can keep the conversation moving.

We will capture the chat as well, and include that in the meeting summary, and recommendations.

So, please just feel free to drop your recommendations on gaps to all the programs,

especially the ones we don't get to today, in the chat.

So, Kurt, back to you.

There's the SNF VBP. You can see there's a series of questions listed here. One about just general gaps, but also what measures would you prioritize to include, as well as the aspects of those measures you would see to be most important.

Because this is the expansion of this program. So, there's currently that one measure in the program.

We voted on some, a couple other measures with the conditional support and support, but are there others to think about?

Go ahead, Kurt, sorry.

Co-Chair Merkelz: No, and to the workgroup, what are those, what are those other considerations under the value based payment program?

Member Andersen: This is Dan, and I think we heard earlier today that exploring the RN staffing might be a good idea.

Co-Chair Lamb: I guess I would challenge us, Kurt, that you know, now that the door is open for potentially nine new measures, what's important?

If we could choose what is important to consumers, to the providers, to the beleaguered healthcare folks, what needs to be in that 10 measure set? And if we can only choose those things, what should be there?

(Pause.)

Dr. Pickering: Any thoughts from the workgroup?

(Pause.)

Co-Chair Lamb: I'll put out a straw person, which is a balance. You know, NQF has really moved away from structural measures, and moved much heavily

into process and outcome.

And today we supported a structure measure, which is you know, my last couple of years at, at NQF, those have virtually disappeared.

And so kind of a balance in looking at structure, process, outcome, safety, as well, you know, and particularly as Raj was saying, with infection rates. That's going to be absolutely critical with what we're going through.

And there needs to be a balance with the patient experience. I would like to see a balance menu that people know that, that there is in the value based purchasing, they're going to be rewarded for looking at this more comprehensive thinking about these programs.

So, challenge it. Go for it.

Dr. Schreiber: So, can I just thank you for that one? I like structural measures, actually. I think they have a role.

I think they have a role in organizations' providers committing to certain things.

I think they have a role from CMS's point of view, in signaling things that are important. And so I just want to say thank you.

And I think your comment about a balance, sort of this holistic view, or you know, balance of measures, as well as what we measure, is really important.

So, thank you.

Dr. Pickering: And I see Cheryl, you have your hand raised?

Member Phillips: Yes, I was just going to echo support for the balance.

We know that when we just focus on safety, and safety is critically important, we then create and we've all heard the expression, the surplus of safety.

We can make people's lives very safe and very miserable. And that's not the goal of quality measurement in any post-acute and long-term care setting.

So, the balance incorporating the person's goals and experience, is critical.

Dr. Pickering: Great, thank you. And thank you for those workgroup members adding comments in the chat. It looks like some saying everything about the QRP program would apply to VBP.

Some transition measures would be important for continuity; prioritize those that are AQF endorsed, and those that SNF can actually make an impact on.

Some agreement with some previous comments, as well. And then yes, Gerri, a comment about cross-walk, what's measured across PAC/LTC programs.

We're doing a good job on those safety measures across programs, which ones are missing and which programs?

So, that's something that, and we'd require further discussion, and maybe some work to create that cross-walk on the NQF side.

(Pause.)

Dr. Pickering: If there's no other comments on the SNF VBP --

Dr. Schreiber: Actually, Matt, can I ask another question?

Dr. Pickering: Sure, go ahead.

Dr. Schreiber: Since someone raised the cross-walk.

Cross-walks certainly across post-acute care, but do you think there are opportunities for cross from post-acute care to hospital to home, for example? Because we don't always, you know, take those measures across the entire continuum.

Dr. Pickering: So, Gerri, you had made that comment. I see you nodding your head, looks like in agreement with that, that approach.

Co-Chair Lamb: Yes, definitely. In fact, you know I was sitting here when we were talking about one of the measures we were reviewing.

I was wondering what happened in the hospital committee, and what their discussions were of some of the things related to risk adjusters, and burden, and so forth.

There are so many commonalities. And it's easy to get siloed. And so I'd like to see more interplay between the MAPS.

Member Mahajan: This is Raj, and I just wanted to, Michelle, I think you might have seen the work that the interoperability folks are doing on specific use cases around, they worked on functional status, and cognitive status, and now working on advance directives, et cetera. Speech, where they have used both ways.

The information transferred not only from hospital to SNF, but SNF to home health, or SNF back to a hospital. And that is the FHIR, you know, past year project. And so just kind of working hand-in-hand with that. A lot of it does boil down to is information available to in real-time at both places, and is it interoperable. And I think they made some, some very significant strides in, to make that happen.

So, definitely a -- to me, it's always been the Achilles heel, and there is some movement of the needle in that. So, if we can, you know, again, have different

programs not be in, and we're talking about silos within the care setting, but also there are some silos within the federal, you know, programs as well.

So, if we can talk to our folks over there, it'll be helpful. I think there might be some, some resources to tap into.

Dr. Schreiber: Thank you for those comments. You're speaking to the right person. It's one of my favorite topics.

Co-Chair Merkelz: Well, there's certainly a lot of good discussion here, and what's taking place in the chat as well.

I think having those linkages are so important. We have the care silos and you know, Pamela talking about having some standardized approach so, for patients, and looking out for linkages, including around standardized functional measurements on individuals.

And something I commented several times to this workgroup, is around medication reconciliation.

We know that it's a best practice, but we don't have, there's no standard to how a medication reconciliation is actually completed, and what actually entails a good delivery of a medication reconciliation plan.

And such incredible opportunities to impact, and safety, and outcomes, and falls, and utilization of care, and adverse events, and decreasing return to hospitals.

And just so much can be, come from a unified approach to something that I consider so simple within medication reconciliation.

So, would love to see something like that take place across all the organizations.

Dr. Pickering: Alan, I see your hand is raised.

Dr. Levitt: Well, since Kurt brought up medication reconciliation, I just did have a medication question overall.

So, what are the thoughts on medication measures? Either if SNF setting anti-psychotic use, anti-depressant use, anti-anxiety use, global medication measure? Anybody have thoughts on those being incorporated in such a program?

(Pause.)

Co-Chair Lamb: Alan, I have mixed feelings about that. You know, my experience is we tend to medicalize that. And so I'm wondering how can we look at medication management through the lens of the patient and consumer?

Not the provider in terms of are you following guidelines, and are you doing this. Is, how's it working for you? Are you getting relief? Are you getting symptom management? What do you want to see? Kind of the discussion we were having earlier.

So, if I had my druthers, I'd put more energy into the patient side of things, than one more measure. And I'll just say, you know, we talk about functional status.

I co-chair the PEF, which you know the patient experience and function, and we have a gazillion measures on every joint of the body.

We don't have a lot in terms of the patient experience of functionality. And so I'd really like to switch that gear for a little bit.

So, I don't know how others feel about that.

Dr. Pickering: Alice, you had --

(Simultaneous speaking.)

Dr. Levitt: Would you mean switch --

Dr. Pickering: -- your hand raised? Oh, sorry, Alan, go ahead.

Dr. Levitt: No, I just, no, that's fine. Keep going.

Dr. Pickering: I was just going to recognize Alice. You have your hand raised?

Member Bell: Thank you, I was just going to agree with Gerri again.

I think, and it kind of goes back to a little bit of that concept of efficiency of movement.

And sometimes people need to do things not exactly the way we may think they should do them, but in a way that works for them.

And so I agree function needs to be considered in the context of the individual, the environment in which they're going to need to function, and how they do it most efficiently, effectively, in a way that is ultimately sustainable for them.

And then just going back to medication, I think the other thing is that's a huge, hugely important transitional measure.

Because what happens to people when they get home in terms of even the best laid plans for how they're going to manage, is often nightmarish.

They have three different lists, from three different settings that they might have been in. Their reconciliation remains a challenge and a problem. And it can have a huge impact on function, ultimately.

Dr. Pickering: David, you have your hand raised?

Member Andrews: Yes, I just, I agree completely. I see no surprise that we should put more focus on the

patient, and the patient's experience and reaction to things.

In regard to medication, I have some concern because as a country, we take so many more medications than most anyplace else, and the payoff of those medications is often questionable.

We also have a population that's relentlessly assaulted with suggestions that their life would be so much better if they had another medication.

So, I think we have to be careful that we don't rely on the patient's desire for, and use of more medications, but can sort of modulate that some with the actual efficacy of the medications.

The pain medication issue, which everybody knows about, is an example of where we went way overboard a long way.

Co-Chair Merkelz: I see as almost multiple tiered though. It's not just medication reconciliation, or medication management.

To me, it's a huge component of the medication reconciliation process, that I really think can get into the concepts of does the patient understand the reasons why they take the medication.

And do they know how to respond to variances, and what they're supposed to be monitoring as far as their medications?

So, I think there's a real opportunity to extend into the patient realm, when we look at these type of measures, and trying to get patient understandings, patient experience, as part of it.

And Gerri also pointed out the NQF action team on person centered medication safety, recently put out some recommendations that also spoke to what I just said, as well.

Dr. Pickering: And then Nicole had a comment about medication that it's challenging.

Patients come with a prescription for certain meds, and it's hard to reduce them when the person is in a short stay versus long stay, because it requires time to assess the person over time.

And I recognize it's getting close to 5:35, so for those members of the public that may be dialing on, we're going to push the public comment back to 5:45.

So, we have about 10 more minutes for some gap discussion.

Alan, you asked a question about medications and/or medication measures, medication use quality measures. Do you have any other follow-up questions for the workgroup related to that?

Dr. Levitt: No. I mean I think it a general comment, and I guess my follow up question on that is, a lot of times we talk about these things as how you operationalize it, you know.

What data source I was going to, I have pick your brains in terms of well, what data source could we use to do something like that.

It's probably too much for the discussion here, but it's something to think about in the chats and everything else.

It's not just well, you know, what topics are great, how could we really operationalize and do it to what data sources, to make, actually make it a meaningful measure that we could bring back here one day?

I won't, but somebody will.

Dr. Pickering: Yes, Alan, you're already at the beach, I don't know.

Dr. Levitt: Yes, I'm already.

Dr. Pickering: So, to Alan's question, a data source is to do some medication use measures. Any initial thoughts on that?

Member Andersen: This is Dan Andersen, I'd kick it up. I would suggest for medication measures, we would use a hybrid approach, including both the MDS and part-D claims.

And I would throw out there that one important area for medication measures, would be looking at kind of like the, for lack of a better terms, psychoactive medications. Anti-psychotics or what have you. Basically, medications that might be used to control behavior when you're trying to work with a resident. You might have to, you know, dementia or some other thing that's causing quote unquote, behavior issues.

I would say that's an important thing to look at.

(Pause.)

Member Andersen: And I mentioned the use of a hybrid approach because I think it's abundantly clear that you know, the MDS I think is a good tool, but it can also be a blunt instrument. And, you know, there's a lot of suggestions that those measures, especially on drugs, are easy to gain.

So, we have to have some kind of a separate data source to do a little bit of cross checking. Especially for the, you know, some of the exclusions.

Member Mahajan: And I would -- and the anti-psychotics have been, in some shape or form, around for almost 10 years. And definitely we can elevate them to these programs.

But I think with the stewardship and antibiotic use, with everything around safety, there are some, some very strong measures that are out there now.

I would definitely support something around

antibiotic use, and stewardship that is related. And some of those things have, CDC has been working for a while in the post-acute setting with some of the vendors, and so, I think it's very important we consider that.

Dr. Schreiber: So, I hope you guys don't mind if I ask a question, just a little bit different. Where do you think measures should be in terms of being digital? What do you think the capabilities of the electronic medical records really are, and are going to be, in post-acute care?

Because CMS has made the commitment obviously, to digital measures. And a lot of the data and data places, standardized data elements are all going to revolve around electronic medical records being part of health information exchanges.

And that is it reasonable to start asking questions about the use of the electronic medical record transitioning to digital measures, or ensuring that we're sharing data in even a more robust way?

I think of medication management, for example, is a prime example.

Member Mahajan: This is Raj, and I would say that the work that, at least on the antibiotic use measure, it had its own challenges. And I know once the pandemic hit, everybody had other fires to deal with.

But I think the response from the group that CDC had, had gotten together with the major IRF vendors in the post-acute, which really has boiled down to maybe four or five, and most with just three.

I think everybody was cooperating, and there was some progress made pre-pandemic. And I personally, have worked on this where could you actually go after MADRAC and have hospitals then, and post-acute have some standard, and work on MADRAC.

So, answer is yes, I think yes, we are you know, away from the ideal situation. But if we don't start and have that incentive baked in, or characteristics baked in, we would not see the vendors cooperate. And they won't cooperate because their customers are not asking for it.

So, I think capabilities are there, but there hasn't been the ROI, or the business case on it.

Dr. Pickering: And I see David Andrews has his hand up. David?

Member Andrews: Yes, I think that the digital is inevitable, and digital has wonderful advantages. But by comparison with my experience as a teacher where I had digital evaluations of my teaching, after a while they became mostly meaningless, repetitive, and not very useful. And by far the most useful information I got for improvement was narrative comments.

So, I think that having digital system is fine. It's ideal if you can have a hybrid system where there's some sort of opportunity for narrative comments, that can be utilized more in improvement than the digital comments often can.

Dr. Pickering: Any other responses to the digital measures question?

(Pause.)

Dr. Pickering: Okay. And Dr. Schreiber, or Alan, any follow-up? Maybe one last question, if you have it?

Dr. Schreiber: I'll leave that for Alan.

Dr. Levitt: No, I think we're fine. We can keep going, so that way we can meet Michelle's goal of ending a little early.

Dr. Schreiber: Yes, remember the challenge, Matt.

Dr. Pickering: Yes, that's right, that's right. We could have ended a lot earlier. Well, thank you all --

(Simultaneous speaking.)

Dr. Levitt: And I apologize to those programs and to those settings we didn't have a chance to get to this year.

Please send your comments either through the chat as Matt said, so that we can incorporate it in the report.

Dr. Pickering: Yes, thank you as well. I'll emphasize that as Alan mentioned. Any gaps, any thoughts on gaps for the programs we weren't able to get to? So, that's the long-term care, the ERP program, the home health, hospice.

Please indicate which program, and your thoughts in the chat. As I mentioned, that chat will reflect that within the summary of the meeting today, as well as within the recommendations of the final report.

So, we appreciate any additional thoughts you have for gaps across those programs, that will be helpful for CMS moving forward.

At this point, we have a time for the opportunity for public comment, and so I appreciate folks being patient as we get through a little bit of that discussion around the gaps.

So, if you are a member of the public, and you'd like to comment on all of the day's proceedings today, and would like to share that with the workgroup, now is the opportunity to do so.

So, please use the raised hand feature, if you have that available to you. We will recognize you in order as we see them. Of you can use the chat function, and we will draw attention to that, as well.

Or if you're sort of dialing in and unable to use the

raised hand feature, or the chat feature, please go ahead and take yourself off mute, and make your comments known.

So, we'll pause for a little bit of time for public comment.

(Pause.)

Dr. Pickering: Once again, this is opportunity for the public to make any comments for the workgroup, on the entirety of the day's proceedings. You can use the raised hand feature, the chat box, or take yourself off mute. So, opportunity for public comment.

(Pause.)

Dr. Pickering: One last call.

(Pause.)

Dr. Pickering: Okay, seeing no hands raised, nothing in the chat, we will go ahead and move to the last item on our agenda, which is the summary of the day, next steps.

I'll turn to my colleague, Becky Payne. Becky?

Summary of the Day and Next Steps

Ms. Payne: Thanks, Matt, and thanks everyone for sticking with us towards the end here. We know it's been a long day.

If we can jump to the next slide. So, we are just about at the end of our MAP process for this year, which I know feels like it just started. This is our final workgroup meeting, but we will have the MAP coordinating committee meeting in January of next year.

We can move to the next slide. So, we do have the date for that meeting here. It will be January 19, and as always, all of our MAP members are welcome to

attend the other meetings as members of the public, to comment at that time.

And we will also have a second public comment period opening up on December 30 through January 13. And all of this will be reflected in our final report that will be published on February 1.

If we can jump one more slide.

So, again, thank you all so much for your participation today. Your input is absolutely critical to this process.

We welcome you to contact us at any time with additional questions, concerns, thoughts on how we can improve this process for next year. We always appreciate it.

And so I will go ahead and turn it to Gerri and Kurt, if you want to offer some closing remarks for today.

Co-Chair Merkelz: I'll pass off to Gerri in just a second. I'll just say the only thing better than a successful meeting, is ending a successful meeting early.

So with that, it was a very beneficial day, lots of great discussion, and I'll let Gerri say this in closing remarks.

(Pause.)

Co-Chair Merkelz: Gerri, are you there?

Dr. Levitt: You have to unmute, Gerri.

Co-Chair Merkelz: Unmute.

Co-Chair Lamb: Darn, I wasted a whole minute there. So, I am not going to summarize. Just thank you to everyone for a really wonderful discussion.

To our workgroup members, to CMS, to the measure developers who were fabulous today. And certainly

to our NQF team for a totally new team, yay, you. You did absolutely phenomenal.

And I would like to end with a very fond goodbye to Alan. Alan, we're going to miss you. You have been just such a wonderful part of this work, and I know I'm speaking for all of us when we wish you just the best. And have a wonderful retirement.

Dr. Levitt: Thank you, very much from the bottom of my post-acute care heart. My heart's always been, and always will be, in post-acute care and all of this work.

Thank you all; thank the committee, thank the Chairs. Thank my entire CMS team.

You gave me the ideal send off today. The discussion, everything we did. The comments, you know, we're not here to all agree. We come from all different, you know, we all have the same goal. I think I've said that before, we all have the same goal here. We're looking at it differently; we all need to continue to work together.

Please, the best honor you can give me is to continue this type of discussion, you know, onward and onward, as we continue to move everything forward. Thank you very much.

Dr. Pickering: And thank you as well. And, Michelle, I'm just going to say thank you's may not be included in the final countdown here. So, we technically are about 14 minutes early, or I'm just saying thank you's are kind of like after a meeting ends.

Dr. Schreiber: I'll give you that, Matt. No, you're

right.

(Laughter.)

Ms. Elliott: Clinician record still stands.

Dr. Pickering: Well, I will say thank you as well to this workgroup, for all of your time today. It was a long day, we got through all the measures, so thank you very much. Getting into some gap discussions for your time.

Thank you so much to our Co-Chairs, Gerri and Kurt, for all of your time in advance of this meeting, and prepping with this new team, at NQF, and for your leadership and guidance throughout the day, as well as leading up to this meeting.

And thank you to our CMS colleagues. Your partnership as well for this, we very much find value in your participation on these meetings, as well as the measure developers. It's a lot to submit these measures for the Measures Under Consideration, and we recognize your participation and thank you for that.

Finally, to the members of the public, thank you for your input. And also thank you so much to the NQF staff for a series of MAP meetings this week and last week.

I hope you all can pat yourselves on the back as this is all said and done for these meetings. And looking forward to MAP coordinating committee in January.

Adjourn*

With that, I thank you and wish you happy holidays, and we will see you next time. And take care.

(Whereupon, the above-entitled matter went off the record at 5:50 p.m.)