Meeting Summary

Full Collaborative

The National Quality Forum (NQF) convened a full Collaborative meeting for the CQMC on November 17, 2021 to review the Accountable Care Organization (ACO)/Primary Care Medical Home PCMH)/Primary Care (PC), Orthopedics, Gastroenterology, Neurology, and HIV and Hepatitis C core Sets.

Welcome and Roll Call

NQF staff welcomed participants to the meeting and acknowledged the co-chairs of the ACO/PCMH/PC, Orthopedics, Gastroenterology, Neurology, and HIV and Hepatitis C Workgroups. The full Collaborative was advised that co-chairs would offer opening remarks before presenting their respective workgroup activities. NQF staff reviewed the antitrust statement and acknowledged that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff shared that in the interest of time, attendance would be retrieved from the list generated by the webinar platform The meeting objectives were highlighted as follows:

- Update on CQMC Activities to Date
- Review of the Full Collaborative Voting Process
- Discussion of the ACO/PCMH/PC, Orthopedics, Gastroenterology, Neurology, and HIV and Hepatitis C Core Sets Ad Hoc Maintenance Updates
- Update on the CQMC Measure Selection Principles

Update on CQMC Activities

AHIP staff shared the CQMC achievements for 2021, including ad hoc maintenance for the existing workgroup core sets (i.e., ACO/PCMH/PC, Behavioral Health, Cardiology, Gastroenterology, HIV/Hepatitis C, Neurology, Obstetrics/Gynecology, Orthopedics, and Pediatrics), updates to the Implementation Guide, creation of a new Cross-Cutting Workgroup to select and prioritize cross-cutting measures (e.g., measures that address essential aspects of quality and apply broadly across different conditions, diseases, and/or specialties), and creation of new Digital Measurement Workgroup to develop a Guide that will define digital measurement, differentiate between digital measures and eCQMs, and propose potential solutions to barriers to advancing digital measurement. AHIP noted that the CQMC hosted three speaker series presentation that focused on diagnostic quality, measurement-based care, and COVID-19 vaccination measures. Speaker series presentations will continue in 2022.

AHIP shared that before the end of the year the Medical Oncology Workgroup will convene to perform its core set ad hoc maintenance and the Measure Model Alignment Workgroup will convene

and create a recommendations report that will provide guidance on aligning aspects of measurement models (e.g., how data is captured in the EHR, how measures are reported, use of registries, information transfer to accreditation agencies and payers through dashboards) beyond the individual measures themselves.

AHIP staff noted that next year all core sets will undergo full maintenance and Workgroups will continue working on digital measurement and core set implementation. The CQMC will convene a new Health Equity Workgroup to provide input on a Health Equity Measures Report, which will prioritize equity measures relevant to the CQMC. The report will include current core measures that are disparities sensitive, outline additional health equity measures, and provide recommendations on how the CQMC should promote health equity through its core measure sets.

Full Collaborative Review and Voting Process

During core set maintenance, Workgroups conduct initial reviews and vote on measures brought forth by NQF staff and workgroup members; workgroup voting results are then presented to the Steering Committee before proceeding to the full Collaborative. During workgroup meetings, members conduct a verbal consensus to decide which measures to include on the voting list. After Steering Committee approval, the full Collaborative convenes to review the workgroups' recommended core set updates. NQF shared that during full Collaborative review meetings all CQMC members can hear from the respective workgroup co-chairs about their measure discussions and recommended core set updates. The co-chairs from the respective workgroups will highlight key points from the discussion for each of the measures; voting and non-voting participants will have an opportunity to comment on the measures. To avoid duplication of efforts, the full Collaborative should rely on the recommendations of the workgroups unless there is significant concern with the measures being proposed.

Full Collaborative quorum is defined as representation from at least 20 percent of the health plan members, at least 20 percent of the provider members, and at least 20 percent of members from the remaining voting categories (i.e., consumers, purchasers, regional collaboratives). For a measure to pass, CQMC defines a supermajority as 60 percent of Voting Participants casting a vote affirmatively AND at least one affirmative vote cast by a representative from each Voting Participant category.

ACO/PCMH/PC Core Set Workgroup Recommendations

NQF staff introduced Dr. Amy Mullins as the provider co-chair and Dr. Lisa Lacarrubba as the new payer co-chair. The co-chairs introduced the Workgroup's updated core set and recognized the Workgroup members for their contributions during the 2021 ad hoc maintenance year. A co-chair noted that the Workgroup members recommended three changes: the removal of two measures and the addition of one measure. The Steering Committee recommended that another measure, #3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM), should not move to full Collaborative voting at this time, but should be discussed further by the Workgroup during 2022 maintenance.

#0057: Comprehensive Diabetes Care: Hemoglobin A1c Testing

A co-chair shared that this measure is recommended for removal because it is being retired and is a process measure while an outcome measure focused on A1C poor control is currently in the core set. This measure is no longer used in any CMS programs, not included in any other CQMC core sets, and proposed to be retired from Health Effectiveness Data and Information Set (HEDIS) in 2022. Collaborative members did not have comments or questions.

#0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy and N/A: Kidney Health Evaluation for Patients with Diabetes

A co-chair shared that this HEDIS measure is being replaced by another measure in 2022 and will no longer be maintained. Health plan members of the Workgroup reported that the measure has high performance across health plans. The measure will be replaced by the measure #N/A: Kidney Health Evaluation for Patients with Diabetes. The Workgroup voted to remove #0062 and replace it with #N/A: Kidney Health Evaluation for Patients with Diabetes since it is more specific and evidence-based. A member asked how the measure was determined to be "topped out". The co-chair explained that health plans were no longer collecting the measure since it was high performing and did not have room for improvement. A member asked if there was a set period in which performance had to remain high for a measure to be retired. A co-chair mentioned that performance for this measure has been high for years. A full Collaborative member who is the measure steward clarified that performance for #0062 had very little variation and the new measure (N/A: Kidney Health Evaluation for Patients with Diabetes) will be more aligned with clinical guidelines and evidence. A member asked if the measure excluded testing for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs). A co-chair explained that there is not an exclusion for ACE/ARB therapy since these individuals would benefit from annual measurement of glomerular filtration rates (GFRs). This metric should be assessed annually for everyone diagnosed with diabetes to detect and monitor renal disease.

#3568: Person-Centered Primary Care Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

The Steering Committee chair shared that there were some concerns with moving this measure forward to full Collaborative voting since this was a new measure and several Workgroup members requested additional meeting time for discussion. Some members had outstanding questions related to risk-adjustment and the evidence linking measure results to improved health outcomes. This measure will not move forward to full Collaborative voting at this time but will be revisited for continued Workgroup discussion during the upcoming maintenance cycle in 2022.

A full Collaborative member who is also a member of the Workgroup shared that the review process would be strengthened if the CQMC sought public review and comment on core set decisions. This type of feedback would allow certain member categories like patient and consumer advocates to have more equal influence. The member expressed that meaningful measures and PRO-PMs are important to patients and it is important to have patient advocate perspectives represented in CQMC decisions. The Steering Committee chair responded that the Steering Committee was not making a

statement or decision based on the merits of the measure but toto allow a thorough discussion of the measure during maintenance in the upcoming year. The full Collaborative was also reminded that while the core sets do not go through public comments, many CQMC white papers and reports do have public commenting. The core sets also include notes to provide additional details about how the measures should be used and Workgroup recommendations about particular measures.

Additional Measures Considered by the Workgroup

NQF staff noted that there were several additional measures discussed by the Workgroup.

- 0418/0481e: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- 0421/0421e: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- N/A: Non-Recommended Cervical Cancer Screening in Adolescent Female (MIPS ID 443)
- 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy

Measures #0418/0418e, #0421/0421e, and #N/A: Non-Recommended Cervical Cancer Screening in Adolescent Females (MIPS ID 443) will remain in the core set based on Workgroup consensus.

The Workgroup decided not to add measure #3541 based on the consensus during the meeting. The Workgroup agreed monitoring related to opioid therapy is important, but some Workgroup members were concerned about potential unintended consequences of the measure and that it is specified at the health plan level. The Workgroup wanted to discuss the measure again in the future.

Key Topics

The ACO/PCMH/PC Workgroup voted to remove 2 measures and add 1 measure during ad hoc maintenance. A co-chair also highlighted that the Workgroup discussed on the possibility of creating separate ACO and Primary Care Workgroups in the future based on how value-based models are evolving.

NQF staff shared that next year the Workgroup and core set will remain as a single group, but the CQMC may consider the potential for separate groups in the future. NQF staff shared that the Workgroup discussed how changes to the Medicare Shared Savings Program (MSSP) measure set relate to the CQMC core set and how to achieve the greatest alignment of measures across programs related to ACO quality performance.

Orthopedics Core Set Workgroup Recommendations

NQF staff noted that both Orthopedic co-chairs Dr. Robin Neil Kamal, (provider co-chair) and Dr. John Zetzche, (payer co-chair) had prior commitments and were unable to attend the meeting. NQF staff presented the Workgroup voting results for the Orthopedics core set measures. Workgroup members discussed the potential removal of one measure and addition of five measures during ad hoc maintenance.

#3470: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedure

NQF staff shared that this measure was newly endorsed in the NQF Consensus Development Process (CDP) fall 2018 cycle by the All-Cause Admission and Readmissions Standing Committee. The measure examines the facility-level risk-standardized rate of acute, unplanned hospital visits within seven days of an orthopedic procedure performed at an ambulatory surgical center among Medicare fee-for-service (FFS) patients aged 65-years and older. The Workgroup members considered addition of this measure since it addressed two previously identified gap areas (i.e., outcome measures and ambulatory setting measures). A few Workgroup members asked for clarification on exclusions and time periods specified in the measure. The measure developer shared that there are no exclusions, and the seven-day timeframe serves as a proxy for discharge failures and surgery complications. A Workgroup member raised concern that that the measure was tested with Medicare FFS patients 65-years and older but had not been tested with privately insured populations. The Workgroup voted to add this measure to the core set.

#3493: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups AND #1550: Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

NQF staff shared that measure #3493 was endorsed during the NQF CDP spring 2019 cycle by the Surgery Standing Committee. Workgroup members considered the addition of measure #3493 because it addresses the outcome measures gap area. It was noted that measure #3493 is a re-specified version of #1550 (currently in the core set). Both measures calculate a risk-standardized rate of complications up to 90 days post admission for elective primary THA and TKA in Medicare FFS beneficiaries 65-years and older. The measures are nearly identical but measure #3493 is specified at the clinician level and #1550 is specified at the facility level. NQF staff shared that measure #3493 is planned to be used in future programs in the near future. The Workgroup voted to add #3493 to the core set and to keep #1550 in the core set, noting that including both measures promote alignment across levels of analysis.

#3559: Hospital-Level, Risk-Standardized Improvement Rate in Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA) AND #2653: Functional Status After Primary Total Knee Replacement

NQF staff shared that measure #3559 was endorsed in the NQF CDP spring 2020 cycle by the Patient Experience and Function Standing Committee. Measure #3559 is a hospital-level patient reported outcome-based performance measure (PRO-PM) that calculates risk-standardized improvement rate following elective primary THA/TKA for Medicare FFS patients 65-years and older. Workgroup members considered addition of measure #3559 as it addresses the gap area of outcome measures. Workgroup members conducted a comparison of measure #3559 and measure#2653, which is already in the core set. There are importance differences between the measures. Measure#3559 includes hip replacement in addition to knee replacement and focuses on improvement over time.

The measures are also specific at different levels of analysis. The Workgroup voted to add #3559 to the core set and keep #2653 in the core set.

#3461: Functional Status Change for Patients with Neck Impairments AND #0425: Functional Status Change for Patients with Low Back Impairment

NQF staff shared that measures #3461 and #0425 were discussed together because they are structured similarly and stewarded by the same organization (i.e., Focus on Therapeutic Outcomes). Measure #3461 was endorsed during the NQF CDP spring 2019 cycle by the Patient Experience and Function Standing Committee. The measure is a PRO-PM, measuring risk-adjusted change in functional status for patients 14 years and older with neck impairments, using the Neck Functional Status PROM tool. Measure #0425 is a PRO-PM measuring risk-adjusted change in functional status for patients 14-years and older with low back impairments, which is assessed using the Low Back Functional Status PROM tool. The Workgroup members considered both measures for addition since they address the gap area of spine and back care and are PRO-PMs.

The Workgroup discussed that measure #3461 was tested mostly among physical therapists but included some orthopedic surgeons. The measure's risk adjustment model includes surgical status, which allows the metric to be used for both surgical and non-surgical patients. The Workgroup members voted to add both measures to the core set.

Additional Measures Considered by the Workgroup

NQF staff noted that there were other measures that were discussed by the Workgroup but that did not move forward to the Orthopedics voting list based on consensus during the meeting. These measures included:

- N/A: Unplanned Reoperation Within the 30-Day Postoperative Period (MIPS 355). This measure is currently in the core set but was brought forth for potential removal due to its high performance in MIPS based on registry data. Workgroup members noted that the measure remains important and is still active in CMS programs. The Workgroup reached consensus during the meeting that the measure should remain in the core set.
- #3474: Hospital-level, risk-standardized payment associated with a 90-day episode of care for elective primary total hip and/or total knee arthroplasty (THA/TKA) (Resource Use Measure) and #3512: Knee Arthroplasty (Resource Use Measure). NQF shared that these two cost and resource use measures were recently NQF endorsed. The CQMC does not currently include cost and resource use measures within its core sets because cost considerations are considered components of the value-based models in which the CQMC core set measures are used.

Key Topics

The current Orthopedics core set includes 15 measures; the Workgroup recommended to add 5 outcome measures during ad hoc maintenance.

The Workgroup will continue to follow progress on the following Minnesota Community Measurement (MNCM) measures:

- Leg Pain After Lumbar Fusion (MIPS ID 473)
- Leg Pain After Lumbar Discectomy/Laminotomy (MIPS ID 461)
- Back Pain After Lumbar Fusion (MIPS ID 460)
- Back Pain After Lumbar Discectomy/Laminectomy (MIPS ID 459)

These pain assessment measures currently use the visual analog pain scale. Discussions are underway to incorporate numeric scales to allow data collection during virtual visits.

Gastroenterology Core Set Workgroup Recommendations

NQF noted that the workgroup did not recommend any core set updates during ad hoc maintenance. The workgroup t convened to discuss measurement gaps and other core set considerations for future maintenance cycles.

The new Gastroenterology co-chairs, Dr. Ken Freedman (payer co-chair) and Dr. David Leiman (provider co-chair) introduced themselves to the full Collaborative. NQF staff shared a list of the identified gap areas as follows:

- Non-alcoholic fatty liver disease
- Quality of colonoscopy, including post-colonoscopy complications
- Patient safety and adverse events related to colonoscopy
- Pancreatitis
- Medication management and adherence
- Gastroesophageal reflux disease (GERD)
- Cirrhosis
- Additional areas of outpatient measure development by the American Gastroenterological Association (Hepatitis C sustained virological response, Barrett's esophagus, inflammatory bowel disease)
- Measures reflecting diversity of gastroenterological conditions, measures spanning the care continuum, patient-reported outcomes, resource utilization measures, and measures that capture disparities

NQF staff shared that before and after creating the core set Workgroup members determine which important and meaningful topic areas or conditions should be covered in the core sets. Gap areas are identified if no existing measures exist related to the topic area or existing measures to not meet the CQMC selection principles. NQF staff shared that identifying gap areas help inform the environmental scan of measures and how Workgroups prioritize measure for core set inclusion, so the cores sets become more innovative and comprehensive over time.

A co-chair confirmed that the identified measurement gaps for Gastroenterology are reflective of the field. The co-chair shared that their specialty organization is interested in the development of measures for fatty liver disease, metabolic liver disease, GERD, and pancreatitis. The co-chair shared

that their organization has recently developed measures related to acute pancreatitis and hospitalized patients with pancreatitis. The co-chair stated that these measures are relatively innovative as they are not restricted to gastroenterologist but can potentially be applicable to internal medicine, surgeons, etc.

A co-chair noted that there are several areas in gastroenterology that would be useful to assess quality and drive improvement across the care of continuum including episode of care, treatment, and confirmation for Hepatitis C; management of *H. pylori* as an infectious disease; and resource utilization due to procedural aspects of gastroenterology. The co-chair also highlighted the potential to stratify measures to further understand and help address quality gaps.

Another co-chair shared that their organization has recently been focusing on non-alcoholic fatty liver disease (NAFLD) as the knowledge surrounding the condition has increased in recent years, with the expectation that additional therapies will be approved in the near future. The co-chair noted the importance of managing NAFLD, including the use of available medications and bariatric surgery to minimize or reversing disease progression. The co-chair also noted t the optimal use of biologic therapy and the role of drug monitoring for inflammatory bowel disease as additional areas for quality measurement. Lastly, the co-chair shared that there is interest in measuring disparities and their reduction within the field of gastroenterology (e.g., disparities in access to treatment or types of treatments based on gender, race, ethnicity, geography).

A co-chair shared that the measure scan resulted in one measure for potential consideration: N/A: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma. This measure was developed through collaboration by the American Gastroenterological Association (AGA) and the College of American Pathologists (CAP). This process measure assesses the percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal, or small bowel carcinoma, biopsy, or resection containing impression, conclusion, or recommendation of testing for MMR or MSI. The measure is specified at the individual clinician or clinician group/practice level of analysis, and it applies to both the inpatient and outpatient care setting. The rationale for the measure is that MMR/MSI testing can guide treatment decisions and identify patients with Lynch syndrome. The measure applies to the management of tumors in gastroenterology, pathology, and oncology specialties The co-chair shared that the Workgroup decided to continue discussing this measure during the 2022 maintenance cycle to allow for additional time to follow up about potential updates to the measure and allow additional groups to provide feedback on the measure.

A co-chair shared general barriers discussed by the Workgroup as follows:

- Limited by available measures – many measures of interest are still being developed and tested,
- Limited by data availability and infrastructure limitations,
- Electronic Clinical Quality Measures (eCQMs) are preferred where possible, but specialty-specific eCQMs are more rare than general eCQMs, and
- Smaller practices may be unable to pay for tools to use eCQMs.

The co-chair shared that the Workgroup discussed the following potential solutions:

- Provide guidance and testing resources for measure developers, and
- Track results from core set adoption to understand areas that still need to be targeted for improvement.

The co-chair noted that the biggest limitation is the availability of measures and testing of new measures but recognized that this is not necessarily unique to Gastroenterology. The co-chair shared that the Workgroup will continue monitoring measures as they are developed and tested. Another co-chair noted that the Workgroup expressed preference for measures that can be collected electronically (e.g., medical records extraction or claims) and recommended testing measures under development through partnerships with large group practices.

Neurology Core Set Workgroup Recommendations

NQF staff introduced Dr. Anup Patel (provider co-chair) and noted that Dr. John Smith (payer co-chair) had a conflict and sent his regrets. The co-chair noted that the Neurology core set was developed in 2020 and that there were no changes recommended during 2021 ad hoc maintenance.
The co-chair shared that the Workgroup identified the following gap areas:

- Pain assessment,
- Opioid use and misuse,
- Quality of life assessments,
- Pediatric medication reconciliation,
- Transitions of care (e.g., transitions from pediatric to adult neurology care),
- Outcome measures, and
- Social determinants of health.

The co-chair shared that the Neurology specialty recognizes the need for outcome measures related to quality of life (e.g., to maintain or improve) and that there is an outcome measure for epilepsy that is currently under development. The co-chair noted that there were some measures that exist on medication reconciliation, but not for pediatric medication reconciliation. Also, noted as a gap was measurement related to social determinates of health (SDOH), especially examining existing data registry and other data sources to determine areas for improvement. The co-chair noted that the American Academy of Neurology (he is the vice chair of the quality committee) has ongoing work in measure development in the disease areas of ALS, back pain, child neurology, dementia, epilepsy, multiple sclerosis, Parkinson's, and transitions of care.

The Workgroup identified barriers with potential solutions in the Neurology core set. Barriers include:

- Unclear if telehealth visits are included in measure calculations, and
- Difficult for smaller specialties to use eCQMs because of less Electronic Health Records (EHR) system standardization.

The Workgroup identified possible solutions:

- Encourage developers to include telehealth codes in the visit types specified measures (e.g., per the need highlighted by the COVID-19 pandemic where consultation moved to telehealth),
- Communicate the results to CQMC stakeholders for implementation purposes, and
- Examine opportunities for implementation and analyze quality for different groups that have the potential of experiencing disparities in care.

NQF staff noted that the Workgroup is expected to review several AAN measures during the 2022 maintenance cycle. Several measures experienced a delay in testing due to the COVID-19 pandemic.

HIV/Hepatitis C Workgroup Recommendations

NQF staff introduced Dr. Andrea Weddle (provider co-chair) and Dr. Michael Horberg (payer co-chair) who offered brief introductory remarks. It was noted that like the Neurology Workgroup, there were no new measures identified for removal or addition to the HIV/Hepatitis C core set during ad hoc maintenance.

A co-chair shared highlights of the Workgroup discussion on the gap areas.

- HIV
    - Pre-exposure prophylaxis (PrEP) use in high-risk individuals,
    - HIV screening for patients with known and newly diagnosed sexually transmitted infections (STIs), and obstetric patients, and
    - Early treatment and suppression, follow-up, adherence to antiretrovirals.
- Hepatitis C
    - Sustained Virological Response (SVR) and testing of viral load 12 weeks post-end treatment, and prevention of future negative outcomes related to Hepatitis C (e.g., liver failure, cirrhosis, and cancer),
    - Other measures reflecting increased ability to treat Hepatitis C,
    - Hepatitis C screening for patients who are active injection drug users, and
    - Hepatitis C screening follow-up.

A co-chair reviewed the core set future goals for next year, including barriers and potential solutions to core set impact and adoption. The Workgroup identified the following barriers:

- Limited by available measures – e.g., no quality-of-life measure which has been identified as a top priority for people living with HIV, and
- Difficult to develop a general set of measures for all core sets since each condition is unique.

Potential solutions identified by the Workgroup include:

- Consider the following cross-cutting topics: quality of life, social determinants of health, ability to provide for self and family, ability to participate in daily activities, and

- Stratify existing measures.

The co-chair emphasized the importance of having the Health Resources and Services Administration (HRSA) HIV/AIDS bureau as active participants of the Workgroup, as it oversees the Ryan White HIV/AIDS programs and quality indicators. HRSA was also reported to be working on examining the quality of life of people living with HIV, Ending the HIV Epidemic Initiative in the U.S., and updating the National HIV/AIDS strategy, which is expected to generate the need for a measure for quality-of-life. A co-chair also noted that the Workgroup recommended that in the future they should consider including measures on cross-cutting topics related to quality of life and SDOH factors (e.g., food, housing stability, economic stability, and the ability to maintain an active life that includes engaging in social activities). The co-chair noted that in the upcoming year the Workgroup will consider adding a proxy quality of life measure to the HIV/Hepatitis C core set.

Measure Selection Principles Update

NQF staff shared that they are updating the CQMC Principles for Core Set Measure Selection. The principles describe the characteristics that individual measures should have to be included in the core sets, as well as the values and concepts that core sets should promote. The principles were last updated in 2018 and are being refined to ensure they remain relevant over time. NQF staff shared that a Google document was sent to the full Collaborative with a request for feedback on potential updates to the measure selection principles. NQF requested members reach out via email if they were having any challenges accessing the document or would still like to provide input. The updated principles will be shared in the coming months after changes are approved by the CQMC Steering Committee.

Next Steps

NQF staff shared that the full Collaborative's discussion will be summarized and shared with Collaborative members in the form of a meeting summary which will be posted on the CQMC SharePoint. It was noted that a voting survey and meeting summary will be sent to all voting members of the full Collaborative; the voting survey will be open for four weeks before being tallied and finalized. NQF thanked the co-chairs, partners at CMS and AHIP, and full Collaborative members for participating in the meeting. NQF staff also provided closing remarks and thanked the full Collaborative for their participation.