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  - Please raise your hand and unmute yourself when called on
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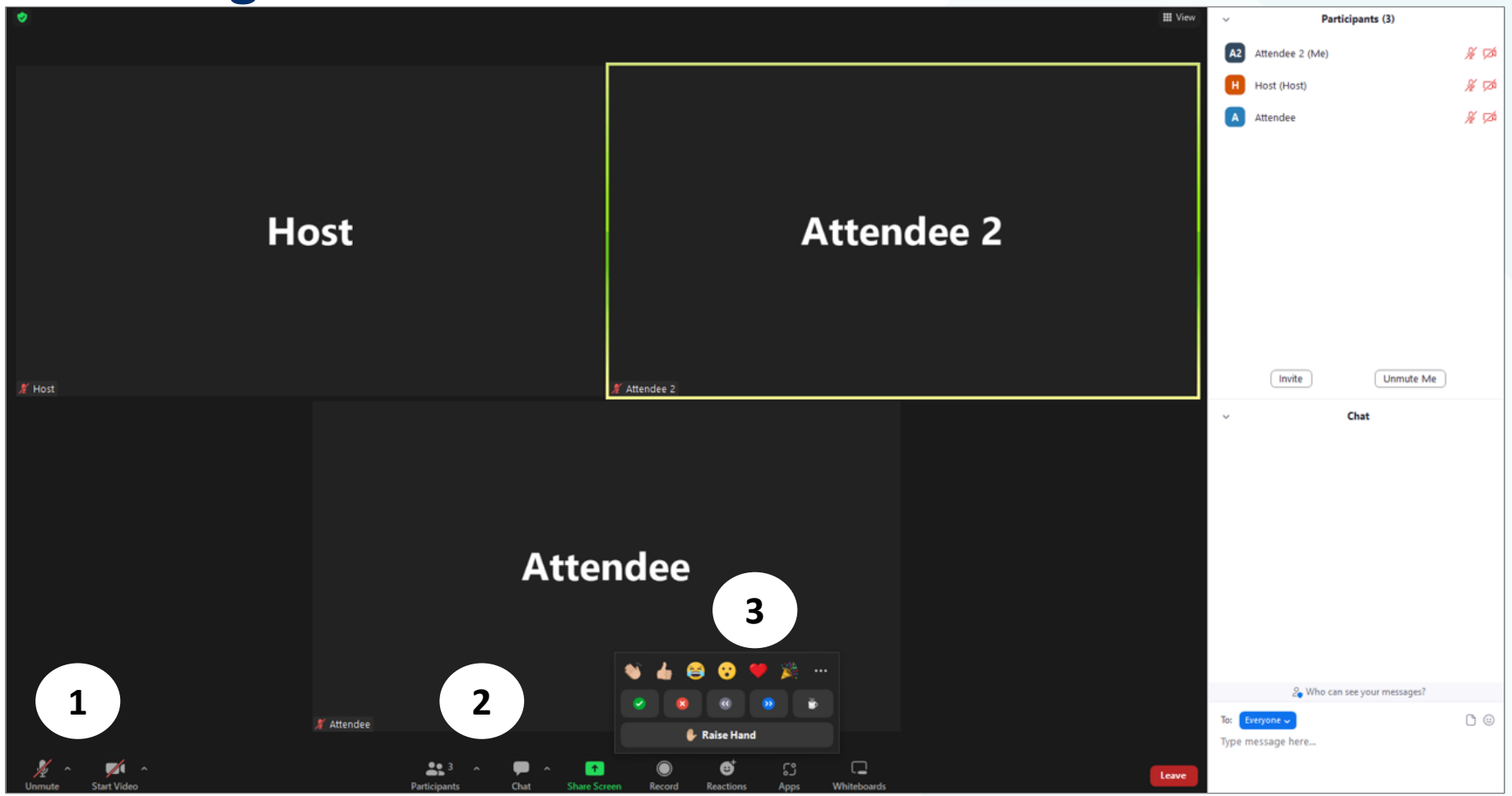
Using the Zoom Platform



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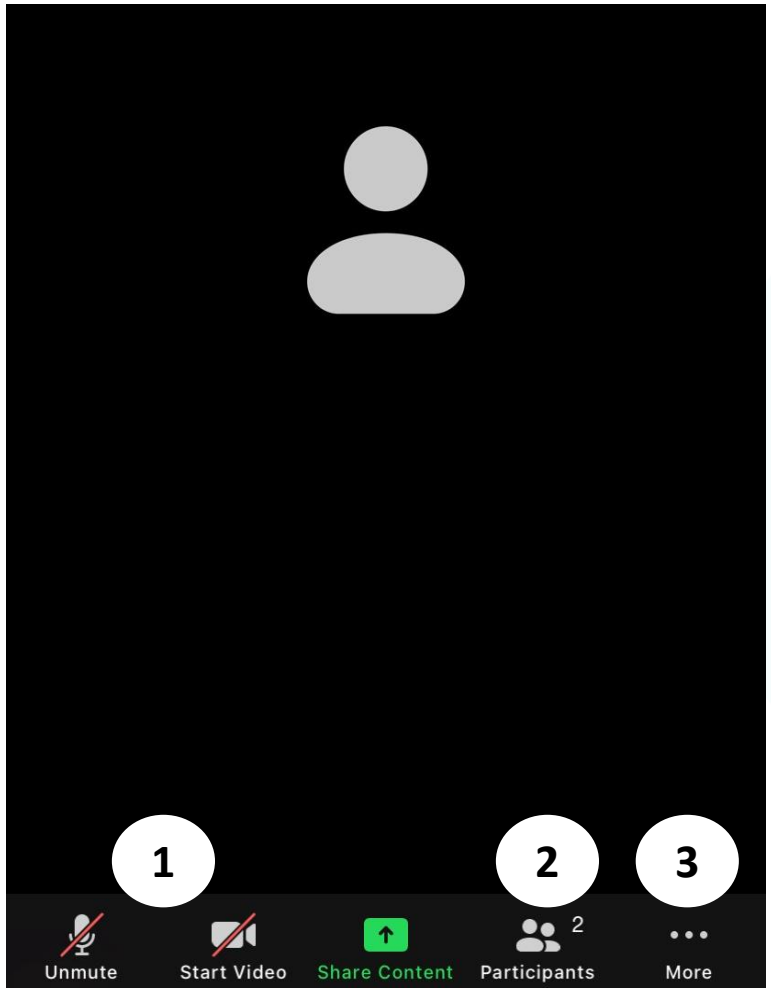

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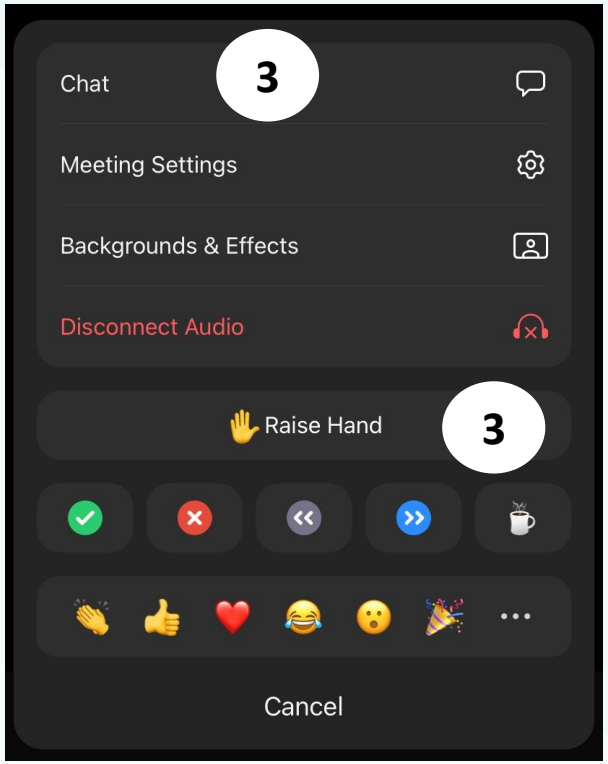

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https://www.qualityforum.org

Measure Applications Partnership (MAP)

All MAP Orientation and Pre-Rulemaking Process Web Meeting

October 27, 2022

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003, Option Year 4

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Agenda

- Welcome, Introductions and Review of Meeting Objectives
- Centers for Medicare & Medicaid Services (CMS) Opening Remarks
- MAP Overview
- Creation of Measures Under Consideration (MUC) List
- CMS Program Changes
- Review of Rural Emergency Hospital Program
- Break
- MAP Pre-Rulemaking Approach – Measure Selection Criteria

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Agenda (continued)

- Decision Categories and Preliminary Analysis Algorithm
- Voting Process
- Use of Consent Calendar for the Coordinating Committee Meeting
- Roles of MAP Members, Measure Developers and the Public in the 2022-2023 Pre-Rulemaking Process
- Opportunity for Public Comment
- Next Steps
- Adjourn

Welcome

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Opening Remarks

Dana Gelb Safran, Sc.D.

President and CEO, National Quality Forum (NQF)

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National Quality Forum MAP Staff

- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Senior Managing Director
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
- **Udara Perera, DrPHc, MPH,** Director
- **Tamara Funk, MPH,** Director
- **Ashlan Ruth, BS IE,** Project Manager
- **Ivory Harding, MS,** Manager
- **Susanne Young, MPH,** Manager

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National Quality Forum MAP Staff (continued)

- **Gus Zimmerman, MPP,** Analyst
- **Joelencia LeFlore,** Analyst
- **Magdelana Stinnett,** Analyst
- **Madeline Henry,** Associate
- **Bobby Burchard,** Associate

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CMS Staff

- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), CCSQ, CMS

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Meeting Objectives

1. Review the role of MAP and implementation results
2. Review the Measures Under Consideration (MUC) List process
3. Review CMS' 2022 MUC List needs and priorities
4. Review the MAP pre-rulemaking approach

CMS Opening Remarks

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Opening Remarks

Michelle Schreiber, MD

Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS) and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG)

Advancing Excellence:
CMS National Quality Strategy

Linking to multiple HHS, CMS and national initiatives to promote best health and wellness for all individuals.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HHS Strategic Goals

1. Protect and Strengthen Equitable Access to High Quality and Affordable Healthcare
2. Safeguard and Improve National and Global Health Conditions and Outcomes
3. Strengthen Social Well-being, Equity, and Economic Resilience
4. Restore Trust and Accelerate Advancements in Science and Research for All
5. Advance Strategic Management to Build Trust, Transparency, and Accountability

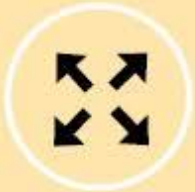
CMS Strategic Pillars

ADVANCE EQUITY

Advance health equity by addressing the health disparities that underlie our health system

EXPAND ACCESS

Build on the Affordable Care Act and expand access to quality, affordable health coverage and care



ENGAGE PARTNERS

Engage our partners and the communities we serve throughout the policymaking and implementation process

DRIVE INNOVATION

Drive Innovation to tackle our health system challenges and promote value-based, person-centered care

PROTECT PROGRAMS

Protect our programs' sustainability for future generations by serving as a responsible steward of public funds

FOSTER EXCELLENCE

Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS's operations

CMS Cross-Cutting Initiatives

- Integrating the 3M's (Medicare, Medicaid & CHIP, Marketplace)
- Elevating Stakeholder Voices Through Active Engagement
- Behavioral Health
- Drug Price Affordability
- Maternity Care
- Benefit Expansion
- Rural Health
- Preparing the Health Care System for Post-Pandemic World
- Coverage Transition (COVID-19/ PHE Unwinding)
- **National Quality Strategy**
- Safety and Quality of Care in Nursing Homes
- Data to Drive Decision Making
- Future of Work @ CMS

CMS National Quality Strategy: Mission & Vision

Mission

Achieve optimal health and well-being for all individuals.

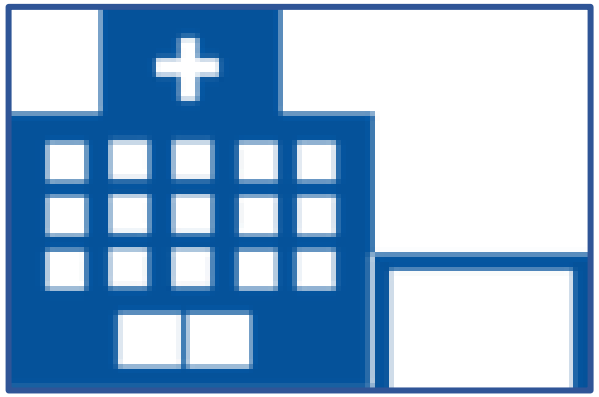
Vision

CMS is a trusted partner, shaping a resilient, high-value American health care system that delivers highest-quality, safest, and equitable care for all.

Advancing Excellence: CMS National Quality Strategy

To achieve optimal health and well-being for all persons, CMS will:

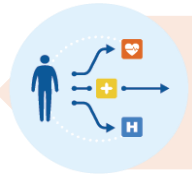
Enable the safest, most effective care for every individual



Ensure a responsive and resilient healthcare system

CMS National Quality Strategic Goals

Ensure best, safest, most effective care for all individuals



Improve quality & health outcomes across the care journey

Advance Health Equity & whole-person care

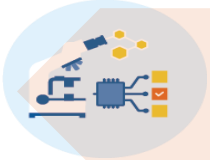
Target zero preventable harm

Engage individuals and communities as partners in their care

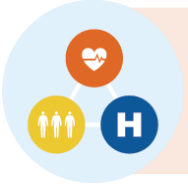
Enable a responsive, equitable, and resilient healthcare system

Enable a responsive and resilient healthcare system to improve quality

Accelerate and Support the Digital Transition of Health Care



Promote innovation in science, analytics & technology



Align and coordinate quality across programs and care settings

Universal Measure Set: Purpose

- Having a national measure set for clinicians, plans, and ambulatory care would:
  - Align measures and programs across CMS
  - Reduce provider burden by streamlining and aligning measures used in programs
  - Focus provider attention
  - Allow for consistent stratification of core measures to promote equity
  - Prioritized measures for robust, all CMS payer reporting and transition to interoperable digital data metrics
  - Allow for cross comparisons
- Other universal sets will include aligned measure sets for the pediatric population, and additional universal add-ons for specific practice settings (i.e. hospital type facilities, post acute care)

Universal Measure Set: Selection Criteria

- The measure is of a high national impact
- The measure can be benchmarked nationally and globally
- The measure is applicable to multiple populations and settings
- The measure is appropriate for stratification to identify disparity gaps
- The measure has scientific acceptability
- The measure is feasible and computable (or capable of becoming digital)
- The measure has no unintended consequences

These measures will be use across CMS quality programs and prioritized for stratification and digitization. CMMI retains the role to test new and innovative measures.

Next Steps

The National Quality Strategy represents a newly envisioned, unified approach to achieving the highest quality outcomes for all individuals.

We need your input to succeed.

The success of this Strategy relies on coordination, innovative thinking & collaboration across all entities. Input from stakeholders like you is critical to help us create a simplified national picture of quality measurement that's meaningful to individuals, providers & payers.

Send feedback to QualityStrategy@cms.hhs.gov

Resources

- HHS Strategic Plan FY 2022 – 2026: https://www.hhs.gov/about/strategic-plan/2022-2026/index.html
- CMS National Quality Strategy: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy
- CMS National Quality Strategy (blog): https://www.cms.gov/blog/cms-national-quality-strategy-person-centered-approach-improving-quality
- CMS Framework for Health Equity 2022 – 2032: https://www.cms.gov/files/document/cms-framework-health-equity.pdf

MAP Overview

Measure Applications Partnership (MAP) [2]

Statutory Requirement

- The Patient Protection and Affordable Care Act (ACA) of 2010 requires the U.S. Department of Health and Human Services (HHS) to contract with a consensus-based entity (i.e., NQF) to **"convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures and efficiency measures" for public reporting, payment, and other programs** (ACA Section 3014).
- The Social Security Act (SSA) establishes a pre-rulemaking process by which a multistakeholder group provides input into the selection of quality measures (SSA Section 1890A).
- The Consolidated Appropriations Act (2021) gave the consensus-based entity the opportunity to provide input on the **removal of quality and efficiency measures.**
- This work is funded by the Centers for Medicare & Medicaid Services (CMS).

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The Role of MAP

- Inform the selection of performance measures to achieve:
  - Improvement
  - Transparency
  - Value for all
- Provide input to HHS on the selection of measures for:
  - Public reporting
  - Performance-based payment
  - Other federal programs
- Identify measure gaps for development, testing, and endorsement
- Encourage measurement alignment across public and private programs, settings, levels of analysis, and populations to:
  - Promote coordination of care delivery
  - Reduce data collection burden

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Rulemaking

Rulemaking refers to the process that government agencies—such as the Centers for Medicare & Medicaid Services (CMS)—use to create regulations.

https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf

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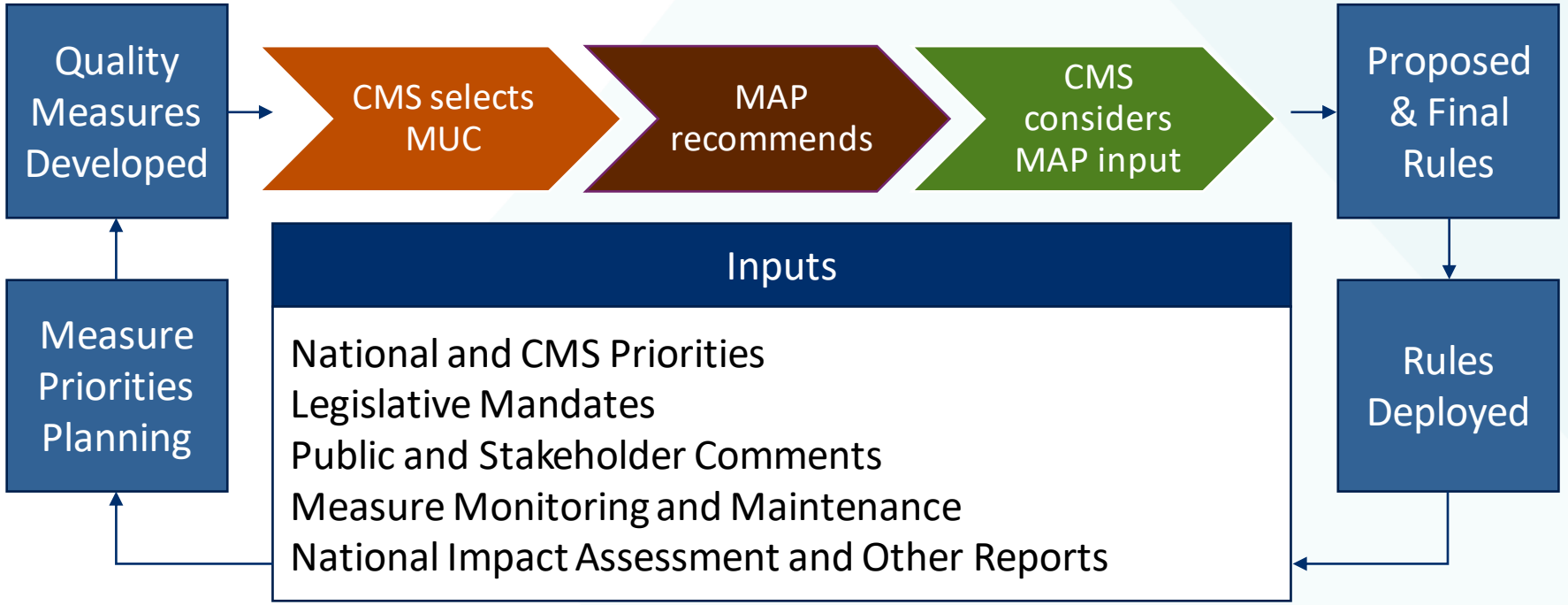
Pre-Rulemaking



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rulemaking

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Value of Pre-Rulemaking Input

- Facilitates multistakeholder dialogue that includes HHS representatives
- Allows for a consensus-building process among stakeholders in a transparent and open forum
- Proposed laws are “closer to the mark” because the main provisions related to performance measurement have already been vetted by the affected stakeholders

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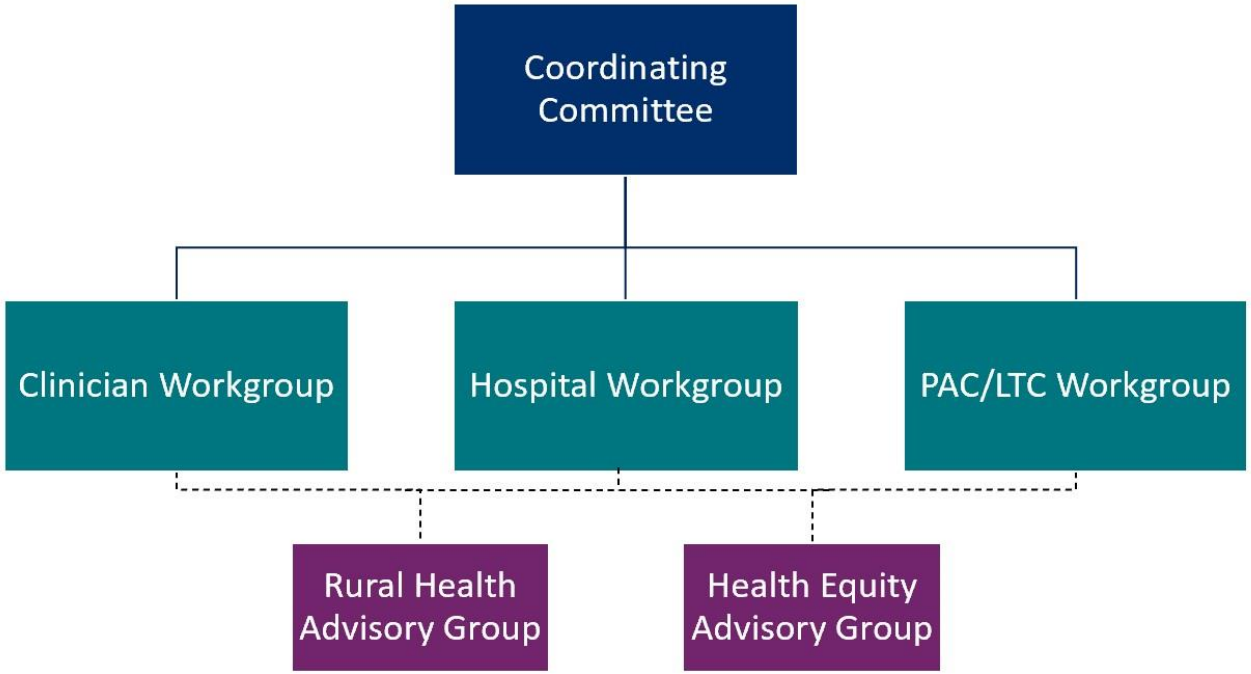
MAP Structure



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MAP Members

Organizational

- Constitute the majority of MAP members
- Include those who are interested in or affected by the use of measures
- Organizations designate representatives

Subject Matter Experts

- Serve as individual representatives bringing topic-specific knowledge to MAP deliberations
- Co-chairs of MAP's Coordinating Committee, Workgroups, and Advisory Groups are SMEs

Federal Liaisons

- Serve as ex-officio, nonvoting members representing a federal agency

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MAP Coordinating Committee Charge

- Provide input to HHS on the coordination of performance measurement strategies and measure set review across public sector programs, across settings of care, and across public and private payers
- Set the strategic direction for MAP and ensure alignment among MAP Advisory Groups and setting-specific Workgroups
  - Clinician Workgroup
  - Hospital Workgroup
  - Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup
  - Rural Health Advisory Group
  - Health Equity Advisory Group
- Provide final approval of the recommendations developed by setting-specific Workgroups

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MAP Workgroup Charge

- Provide annual pre-rulemaking input on Measures Under Consideration (MUCs), assess their fit within federal programs, and provide recommendations to HHS
- Ensure the alignment of measures and data sources to reduce duplication and burden while emphasizing alignment be balanced with consideration of patient needs across settings
- Standardize measure concepts across setting-specific programs to promote common goals and implement standardized data elements

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MAP Clinician Workgroup Programs

Merit-based Incentive Payment System (MIPS) Program

Medicare Shared Savings Program (Shared Savings Program)

Medicare Part C and D Star Ratings

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MAP Hospital Workgroup Programs

- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting (HIQR) Program
- Hospital Outpatient Quality Reporting (HOQR) Program
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
- Rural Emergency Hospital (REH) Program (New in 2023)

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MAP PAC/LTC Workgroup Programs

- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (HQRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

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MAP Rural Health Advisory Group Charge

- To provide input on measurement issues to MAP Workgroups and Coordinating Committee during the pre-rulemaking process and to provide rural perspectives on the selection of quality measures in MAP
- Identify rural-relevant gaps in measurement
- To provide input to help address priority rural health issues, including the challenge of low case-volume and access

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MAP Health Equity Advisory Group Charge

- Provide input to the MAP Workgroups and Coordinating Committee during the pre-rulemaking process on measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Identify health disparity gaps in measurement
- Provide input to reduce health differences closely linked with social, economic, or environmental disadvantages

Questions? (1)

Creation of Measures Under Consideration (MUC) List

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Statutory Authority: Pre-Rulemaking Process

- Under section 1890A of the Act and ACA 3014, HHS is required to establish a pre-rulemaking process under which a consensus-based entity (CBE) would convene multistakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain CMS programs.
- The list of quality and efficiency measures HHS is considering for selection is to be publicly published **no later than December 1** of each year. No later than **February 1** of each year, the CBE is to report the input of the multistakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures.

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2022-2023 Pre-Rulemaking Timeline

January	• Candidate measure submission period opens
March	• CMS posts Needs and Priorities document
March-April	• MUC stakeholder education and outreach
May	• Candidate measure submission period closes
July-August	• CMS programs review candidate measures
September-November	• CMS and HHS review draft MUC List
December	• MUC List release
December-January	• MAP Review Meetings
February	• MAP publishes recommendations

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CMS' 2022 MUC Needs and Priorities Document

Hospital Outpatient Quality Reporting Program

Program History and Structure:

- Established by Section 109 of the Tax Relief and Health Care Act (TRHCA) of 2006
- The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care
- Pay-for-Reporting Program
- Facilities receive a two-percentage point (2%) reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- Data publicly reported on the CMS *Hospital Compare* website

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	5
Intermediate Outcome	0
Outcome	3
Patient Reported Outcome-Based Performance Measure (PRO-PM)	2
Process	4
Structure	1
Total	**15**

Meaningful Measures 2.0 Healthcare Priorities	Number of Measures
Person-centered Care	2
Equity	0
Safety	4
Affordability and Efficiency	8
Chronic Conditions	1
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**15**

CMS Program Measure Needs and Priorities: March 2022 27

https://www.cms.gov/files/document/2022-muc-list-program-specific-measure-needs-and-priorities.pdf

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CMS' 2022 MUC Needs and Priorities Document (continued)

High Priority Areas for Future Measure Consideration:

As care moves more toward the ambulatory side, it is important to ensure that procedu
clinical care in hospital settings are of equal high quality and that consumers can compa
across facilities, including ASCs.

- **Equity**
- **Person-Centered Care**
- **Behavioral Health**
- **PRO-PM**
- **Outcome eCQMs**

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Outpatient Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must address a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration
2. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
3. Measure must be fully developed, tested, and validated in the hospital outpatient setting
4. Measure must promote alignment across HHS and CMS programs
5. Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to
    a. The level of burden associated with validating measure data, both for CMS and for the end user
    b. Whether the identified CMS system for data collection is prepared to accommodate the proposed measure(s) and timeline for collection
    c. The availability and practicability of measure specifications, e.g., measure specifications in the public domain
    d. The level of burden the data collection system or methodology poses for an end user
6. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

https://www.cms.gov/files/document/2022-muc-list-program-specific-measure-needs-and-priorities.pdf

Questions? (2)

CMS Program Changes

Quality Payment
PROGRAM

MIPS VALUE PATHWAYS (MVPS) UPDATE

OCTOBER 2022

Quality Payment Program

Overview

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you participate in an Advanced APM* and achieve Qualifying APM Participant (QP) status, you will be excluded from the MIPS reporting requirements and payment adjustments.

*Note: If you participate in an Advanced APM and don't achieve QP or Partial QP status, you will be subject to a performance-based payment adjustment through MIPS unless you are otherwise excluded.

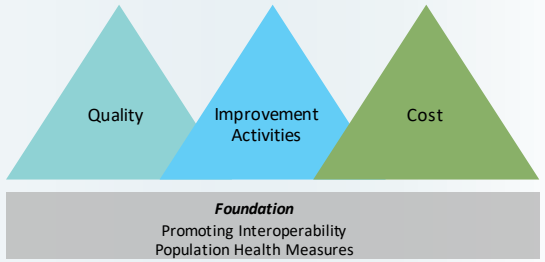
MIPS Value Pathways

Structure of Traditional MIPS	MIPS Value Pathways Framework	Future State of MIPS
• Many Choices • Not Meaningfully Aligned • Higher Reporting Burden	• Cohesive • Lower Reporting Burden • Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority	• Simplified • Increased Voice of the Patient • Increased CMS Provided Data • Facilitates Movement to Alternative Payment Models (APMs)

Building Pathways Framework

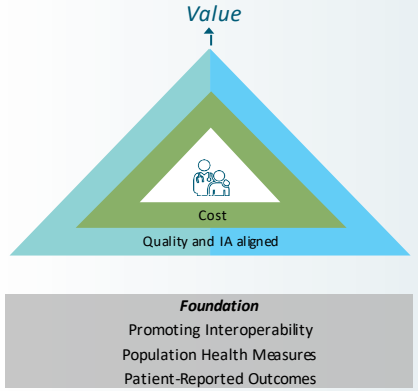
MIPS Pathways
Clinicians report on fewer measures and activities based on specialty and/or outcome within a MIPS Value Pathway

Moving to Value

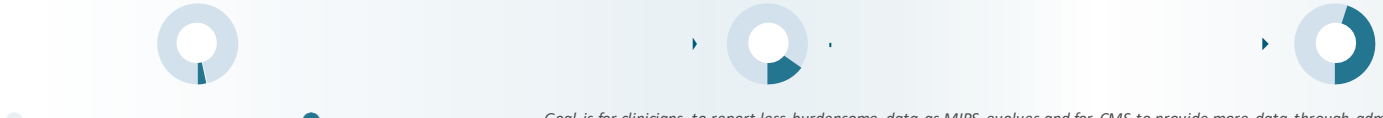


Fully Implemented Pathways

Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.



Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

2023 Policy Highlights

Key MVP Policies from the 2023 Proposed Rule

- In July, CMS issued our proposed policies for QPP via the **2023 Medicare Physician Fee Schedule (PFS) Proposed Rule**.
- We recognize the challenges faced by many across the country over the past 2 years. As we look to the future of QPP, **CMS remains committed to promoting more meaningful participation for clinicians, ensuring the policies continue to drive us toward value and improved health outcomes for patients.**

MVPs

- We're focusing our proposals on continuing to **develop new MVPs and refining the subgroup participation option**.
  - Introducing **5** new MVPs and proposed revising **7** previously established MVPs for reporting, beginning with the 2023 performance year.
  - Calculating administrative claims measures at the affiliated group Taxpayer Identification Number (TIN) level when reporting as subgroups.

MIPS Value Pathways (MVPs) Proposals

MVP Candidates

CMS is proposing **5 new MVPs** and revising the **7 previously established MVPs** that would be available beginning with the 2023 performance year:

Proposed MVPs
Advancing Cancer Care MVP
Optimal Care for Kidney Health MVP
Optimal Care for Patients with Episodic Neurological Conditions MVP
Supportive Care for Neurodegenerative Conditions MVP
Promoting Wellness MVP

Previously Established MVPs
Advancing Rheumatology Patient Care MVP
Coordinating Stroke Care To Promote Prevention and Cultivate Positive Outcomes MVP
Advancing Care for Heart Disease MVP
Optimizing Chronic Disease Management MVP
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP
Improving Care for Lower Extremity Joint Repair MVP
Patient Safety and Support of Positive Experiences with Anesthesia MVP

For more information, visit the Explore MVPs webpage

Overview of Hospital IQR Program Finalized Changes

- Adoption of 10 new measures
- Refinement of two currently adopted measures
- Establishment of a publicly-reported “Birthing Friendly” hospital designation to capture the quality and safety of maternity care
  - This designation would be awarded to hospitals based on their attestation to the Maternal Morbidity Structural Measure and will begin being reported in Fall 2023

Ten New Hospital IQR Program Measures

Measure Name	Finalized Start of Data Collection
Hospital Commitment to Health Equity	Calendar Year (CY) 23 Reporting Period
Screening for Social Drivers of Health	Voluntary CY 23 Reporting; Mandatory CY 24 Reporting
Screen Positive Rate for Social Drivers of Health	Voluntary CY 23 Reporting; Mandatory CY 24 Reporting
Cesarean Birth eCQM	Added to the eCQM list from which hospitals can self-select to report in CY 23; mandatory reporting for all hospitals beginning with CY 24
Severe Obstetric Complications eCQM	Added to the eCQM list from which hospitals can self-select to report in CY 23; mandatory reporting for all hospitals beginning with CY 24
Hospital Harm- Opioid-Related Adverse Events eCQM	Added to the eCQM list from which hospitals can self-select to report in CY 24
Global Malnutrition Composite Score eCQM	Added to the eCQM list from which hospitals can self-select to report in CY 24
Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) PRO-PM	Two voluntary reporting periods followed by a mandatory period which runs from July 1, 2025 – June 30, 2026
Medicare Spending Per Beneficiary (MSPB)	Claims beginning with FY 2024 payment determinations
Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA	Claims with admissions dates from April 1, 2019 – March 31, 2022 (excluding claims covered by the COVID-19 related Extraordinary Circumstance Exception [ECE])

Updates of the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program Expansion in the FY 2023 Final Rule

- The Program will add 3 new measures to the FY 2026/FY 2027 program years which includes the SNF HAI, Discharge to Community and the Total Nurse Staffing Measure.

- Finalized rule include adjustments to the payment methodology that addressed the change of the program from 1 measure to multiple. The changes included:
  - Minimum Case and Minimum Measure requirements
  - Changes to the scoring methodology for how each measures points are determined and aggregated up to calculate the Total Performance Score
  - New exclusion policy and removal of the Low Volume protocol

- Also included a Request For Information on the inclusion of the Nursing Turnover measure, COVID 19 Vaccine Measure for staff, considerations for the adjustments of the scoring methodology for Health Equity, Validation of measures and changing the exchange function of the payment methodology

Expansion Measures Performance Period and Baseline Periods

Short Name	Measure Name	First Applicable Program Year Impacting Payments	First Baseline Period	First Performance Period
SNF HAI	Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization measure	FY 2026	FY 2022 *October 1, 2021 – September 30, 2022*	FY 2024 *October 1, 2023 - September 30, 2024*
PBJ	Total Nursing Hours per Resident Day measure	FY 2026	FY 2022 *October 1, 2021 – September 30, 2022*	FY 2024 *October 1, 2023 - September 30, 2024*
DTC	Discharge to Community – Post Acute Care Measure for Skilled Nursing Facilities	FY 2027	FY 2021 & FY 2022 *October 1, 2020 – September 30, 2022*	FY 2024 & FY 2025 *October 1, 2023 – September 30, 2025*

Finalized Measure-Related Proposals for the FY 2026 and FY 2027 Program

Short Name	Measure Name	SNF VBP Fiscal Year (FY)				
		FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Claims-Based Outcome Measures						
SNFRM	Skilled Nursing Facility 30-Day All-Cause Readmission measure	✓	✓	✓	✓	✓
SNF HAI	Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization measure	n/a	n/a	n/a	✓	✓
DTC	Discharge to Community – Post Acute Care Measure for Skilled Nursing Facilities	n/a	n/a	n/a	n/a	✓
Payroll Based Journal Structural Measure						
PBJ	Total Nursing Hours per Resident Day measure	n/a	n/a	n/a	✓	✓

Questions? (3)

Review of Rural Emergency Hospital Program

CMS Logo

Rural Emergency Hospitals
Presented by

Anita Bhatia, PhD

Program Lead, Rural Emergency Hospital Quality Reporting (REHQR) Program

Division of Value-Based Incentives and Quality Reporting

Center for Clinical Standards & Quality

Melissa Hager, RN

Measure Lead, Rural Emergency Hospital Quality Reporting (REHQR) Program

Division of Quality Measurement

Center for Clinical Standards & Quality

Background

Consolidated Appropriations Act, 2021 (CAA) (Section 125, pg. 1779) establishes a new provider type – Rural Emergency Hospitals (REHs)

Rural Emergency Hospitals

- Must convert from a facility which was either a rural subsection (d) hospital with not more than 50 beds or a Critical Access Hospital (CAH) on the date of enactment of the CAA, 2021 (December 27, 2020)
- Must provide emergency services and observation care
- May provide other outpatient services as specified by the Secretary through rulemaking
- Services must do not exceed an annual per patient average of 24 hours

Rural Emergency Hospitals
(cont'd.)

- Permitted to provide Skilled Nursing Facility (SNF) services in a distinct part licensed as a SNF to furnish post-hospital extended care services
- Eligible for payment for items and services furnished on or after January 1, 2023
  - Individual REH services are paid at the OPPS rate plus a 5 percent additional payment that is not subject to a copayment
- Provided an additional monthly facility payment

Health and Safety Standards/CoPs

The CAA requires the following:

- REH's emergency department must be staffed 24/7
- REHs must meet the applicable CAH staffing and staffing responsibilities requirements under 42 CFR 485.631

Health and Safety Standards/CoPs

(cont'd.)

The CAA requires the following:

- REHs must have a transfer agreement with a level I or level II trauma center
- REHs must meet the CAH emergency services requirements at 42 CFR 485.618 and the applicable hospital emergency department requirements
- REHs are subject to the EMTALA requirements under section 1867 of the Social Security Act

Quality Measures and Quality Reporting

Promote higher quality, more efficient health care for Medicare beneficiaries through measurement.

The CAA requires the following, beginning with 2023 (on or after 1/1/2023):

- REHs shall submit data on quality measures
- Measures selected for the REHQR Program are at the Secretary's discretion
- Quality measure data shall be made publicly available on a CMS website
- The REH provision does NOT specifically include statutory language linking reporting to a payment structure

Request for Information (RFI)

- Published in the CY 2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Proposed Rule on July 26, 2022 (87 FR 44502)
- Target areas in the RFI included: health equity, measures recommended by the National Advisory Committee on Rural Health and Human Services, and other potential measure topics for consideration, including mental and behavioral health, maternal health, telehealth, and emergency services

Quality Measures

RFI requested feedback on the following:

Selected Hospital OQR Program Measures:

- OP–2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- OP–3: Median Time To Transfer to Another Facility for Acute Coronary Intervention
- OP–4: Aspirin on Arrival
- OP–18: Median Time From ED Arrival to ED Departure for Discharged ED Patients
- OP–20: Door to Diagnostic Evaluation by a Qualified Medical Professional
- OP–22: Left Without Being Seen

Medicare Beneficiary Quality Improvement Project (MBQIP) Measure:

- The Emergency Department Transfer Communications (EDTC)

Other Current, Claims-Based Hospital OQR Quality Measures

- OP-10: Abdomen Computed Tomography (CT)—Use of Contrast Material
- OP-32: Facility 7-Day Risk- Standardized Hospital Visit Rate After Outpatient Colonoscopy

Stay Tuned

More details will be forthcoming in the CY 2023 OPPS/ASC final rule!

Questions? (4)

Break

MAP Pre-Rulemaking Approach – Measure Selection Criteria

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MAP Measure Selection Criteria (MSC)

- Identify characteristics that are associated with ideal measure sets for public reporting and payment programs
- Provide general guidance and complement program-specific statutory and regulatory requirements
- Focus should be on the selection of high-quality measures that address CMS' Meaning Measures Initiative and CMS' National Quality Strategy
- Reference for:
  - evaluating the relative strengths and weaknesses of a program measure set
  - how the addition of an individual measure would contribute to the set
- MAP uses the MSC to guide its recommendations; MSC are the basis of the preliminary analysis algorithm

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MAP Measure Selection Criterion 1:

NQF-endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective. Measures are based on scientific evidence and meet requirements for validity, feasibility, reliability and use.

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

- **Subcriterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need.
- **Subcriterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs.
- **Subcriterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs.

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MAP Measure Selection Criterion 2:

Program measure set uses impactful measures which significantly advance healthcare outcomes for high priority areas in which there is a demonstrated performance gap or variation.

Demonstrated by a program measure set that promotes improvement in key national healthcare priorities such as CMS's Meaningful Measures Framework, emerging public health concerns and ensuring that the set addresses key improvement priorities for all providers.

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MAP Measure Selection Criterion 3:

Program measure set is responsive to specific program goals and requirements, including all statutory requirements.

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

- **Subcriterion 3.1** Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s).
- **Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers.
- **Subcriterion 3.3*** Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness.
- **Subcriterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.
- **Subcriterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available.

**For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period*

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MAP Measure Selection Criterion 4:

Program measure set may include a mix of measure types; however, highest priority is given to measures which are digital, or patient-centered/patient-reported outcomes, and/or support equity. Process measures must have a direct and proven relationship to improved outcomes in a high impact area where there are no outcome/intermediate outcome measures.

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

- **Subcriterion 4.1** In general, preference should be given to measure types that address specific program needs.
- **Subcriterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes.
- **Subcriterion 4.3** Payment program measure sets should include outcome measures and cost measures to capture value.

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MAP Measure Selection Criterion 5:

Program measure set enables measurement of person- and family-centered care and services AND are meaningful to patients and useful in making best care choices.

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration.

- **Subcriterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination.
- **Subcriterion 5.2** Measure set addresses shared decision making, such as for care and service planning and establishing advance directives.
- **Subcriterion 5.3** Measure set enables assessment of the person's care and services across providers, settings, and time.

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MAP Measure Selection Criterion 6:

Program measure set supports healthcare equity, helps identify gaps and disparities in care, and promotes access, culturally sensitive, and unbiased care for all.

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

- **Subcriterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services).
- **Subcriterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack) and that facilitate stratification of results to better understand differences among vulnerable populations.

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MAP Measure Selection Criterion 7:

Program measure set is aligned across programs and settings as appropriate and possible.

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

- **Subcriterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals).
- **Subcriterion 7.2** Program measure set places strong emphasis on measures that promote alignment and can be used across multiple programs or applications.

Questions? (5)

MAP Decision Categories

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2022-2023 MUC Decision Categories

- Support for Rulemaking
- Conditional Support for Rulemaking
- Do Not Support for Rulemaking with Potential for Mitigation
- Do Not Support for Rulemaking

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2022-2023 MUC Decision Categories (continued 1)

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation of the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP preliminary analysis algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.

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2022-2023 MUC Decision Categories (continued 2)

Decision Category	Definition	Evaluation Criteria
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such a modification would be considered a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

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MUC Decision Categories

- MAP Workgroups must reach a decision about every measure under consideration
- Decision categories are standardized for consistency
- Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached

Preliminary Analysis Algorithm

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Preliminary Analysis of Measures Under Consideration

- The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions.
- Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure.
- To facilitate MAP's discussions, NQF staff will conduct a preliminary analysis of each measure under consideration.
- The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration.
- This algorithm was approved by the MAP Coordinating Committee to evaluate each measure.

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MAP Preliminary Analysis Algorithm

1. The measure addresses a critical quality objective not adequately addressed by the measures in the program set.
2. The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.
3. The measure addresses a quality challenge.
4. The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.
5. The measure can be feasibly reported.
6. The measure is applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).
7. If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.

MAP Preliminary Analysis Algorithm –continued 1

Assessment 1: The measure addresses a critical quality objective not adequately addressed by the measures in the program set.

- **Definition:**
  - The measure addresses key healthcare improvement priorities; or
  - the measure is responsive to specific program goals and statutory or regulatory requirements; or
  - the measure can distinguish differences in quality, is meaningful to patients/consumers and providers, and/or addresses a high-impact area or health condition.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a “do not support for rulemaking.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm – continued 2

Assessment 2: The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.

- **Definition:**
  - For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s).
  - For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a "do not support for rulemaking."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm –continued 3

Assessment 3: The measure addresses a quality challenge.

- **Definition:**
  - The measure addresses a serious reportable event (i.e., a safety event that should never happen); or
  - the measure addresses unwarranted or significant variation or a gap in care that is evidence of a quality challenge.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a “do not support for rulemaking.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm –continued 4

Assessment 4: The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.

- **Definition:**
  - The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or
  - the measure captures a broad population; or
  - the measure contributes to alignment between measures in a particular program set (e.g., the measure could be used across programs); or
  - the value to patients/consumers outweighs any burden of implementation.
- **Result:**
  - Yes: The review can continue.
  - No: The highest rating can be “do not support for rulemaking with potential for mitigation.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm – continued 5

Assessment 5: The measure can be feasibly reported.

- **Definition:**
  - The measure can be operationalized (e.g., the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care).
- **Result:**
  - Yes: The review can continue.
  - No: The highest rating can be "do not support for rulemaking with potential for mitigation."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm –continued 6

Assessment 6: The measure is applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).

- **Definition:**
  - The measure is NQF-endorsed; or
  - the measure is fully developed and full specifications are provided; and
  - measure specifications are provided for the level of analysis, program, and/or setting(s) for which it is being considered.
- **Result:**
  - Yes: The measure could be supported or conditionally supported.
  - No: The highest rating can be "conditional support for rulemaking."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

MAP Preliminary Analysis Algorithm – continued 7

Assessment 7: If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.

- **Definition:**
  - Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or
  - feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and
  - feedback is supported by empirical evidence.
- **Outcome:**
  - If no implementation issues have been identified: Measure can be supported or conditionally supported.
  - If implementation issues are identified: The highest rating can be "conditional support for rulemaking." MAP can also choose to not support the measure, with or without the potential for mitigation. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

Questions? (6)

Review of Voting Process

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Key Voting Principles

- **Quorum** is defined as **66 percent** of the voting members of the Workgroup and Committee present virtually for live voting to take place.
  - Quorum must be established prior to voting. The process to establish quorum is constituted of (1) taking roll call and (2) determining if a quorum is present. At this time, only if a member of the Committee questions the presence of a quorum is it necessary to reassess the presence of the quorum.
- If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.
- MAP has established a **consensus** threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60 percent of the quorum figure voting positively.
  - Abstentions do not count in the denominator.
- Every measure under consideration will receive a decision.

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Key Voting Principles (continued)

- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the co-chairs to give context to each programmatic discussion, voting will begin.
- The Review Meeting agenda will organize content as follows:
  - Measures under consideration will be divided into a series of related groups for the purposes of discussion and voting.
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
  - MAP participants will receive a copy of the detailed preliminary analysis and staff decisions (i.e., support, do not support, or conditional support) and rationale to support how that conclusion was reached.

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Voting Procedure

- **Step 1.** Staff will review the preliminary analysis for each measure under consideration (MUC) using the MAP selection criteria and programmatic objectives.

- **Step 2.** The co-chairs will ask for clarifying questions from the Workgroup. The co-chairs will compile all Workgroup questions.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to clarifying questions on the preliminary analysis.

Voting Procedure (continued 1)

- **Step 3.** Voting on acceptance of the preliminary analysis decision
  - After clarifying questions have been resolved, the co-chairs will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the Workgroup recommendation. If less than 60% of the Workgroup votes to accept the preliminary analysis assessment, discussion will open on the measure.
  - Note: These voting steps may change based on feedback from prior MUC cycles.

Voting Procedure (continued 2)

- **Step 4.** Discussion and voting on the MUC
  - Lead discussants will review and present their findings.
  - The co-chairs will then open for 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 by others in the interest of time.
  - After the discussion, the co-chairs will open the MUC for a vote.
    - NQF staff will summarize the major themes of the Workgroup's discussion.
    - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
    - If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.

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Voting Procedure (continued 3)

- **Step 5:** Tallying the votes
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.

Questions? (7)

Use of Consent Calendar for the Coordinating Committee

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Consent Calendar Principles

- The purpose is to focus the Coordinating Committee discussion on measures that elicited strong differences of opinion among Workgroup members, measures that did not reach consensus, and measures for which new information emerged during public comment.
- To be added to the consent calendar, a measure must meet all of the following criteria:
  - 80% or greater of voting Workgroup members vote for the same decision category
  - No process concern(s) identified that may have affected the recommendation of a measure
  - No new information is received through public comment that was not available or discussed during the Workgroup's measure review meeting, which is conflicting to the Workgroup's recommendation(s)
  - The measure was not pulled for discussion by the Coordinating Committee
  - No additional concerns identified that require Coordinating Committee discussion

Questions? (8)

Role of MAP Members, Measure Developers and the Public in the 2022-2023 Pre-Rulemaking Process

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Role of MAP Members

- Prior to relevant Review Meeting:
  - Confirm substitutes (organization representatives) and complete disclosures of interest (DOIs)
  - Review meeting materials
    - Agenda
    - Slide deck
    - Lead discussant list
    - Preliminary analyses
- Attend relevant Review Meeting or send substitute (if an organizational representative)
- After Review Meeting:
  - Participate in online voting, if needed

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Role of Measure Developers

- Attend Advisory Group, Workgroup and Coordinating Committee Review Meetings
- During each Review Meeting:
  - Provide clarity statements at appointed times
  - Participate in opportunities for public comment

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Role of the Public

- Participate in public commenting on the MUC List
- During each Review Meeting:
  - Participate in opportunities for public comment
  - Please limit comments to two minutes
- After final Workgroup Review Meeting:
  - Participate in public commenting on the preliminary recommendations spreadsheet

Questions? (9)

Opportunity for Public Comment

MAP Next Steps

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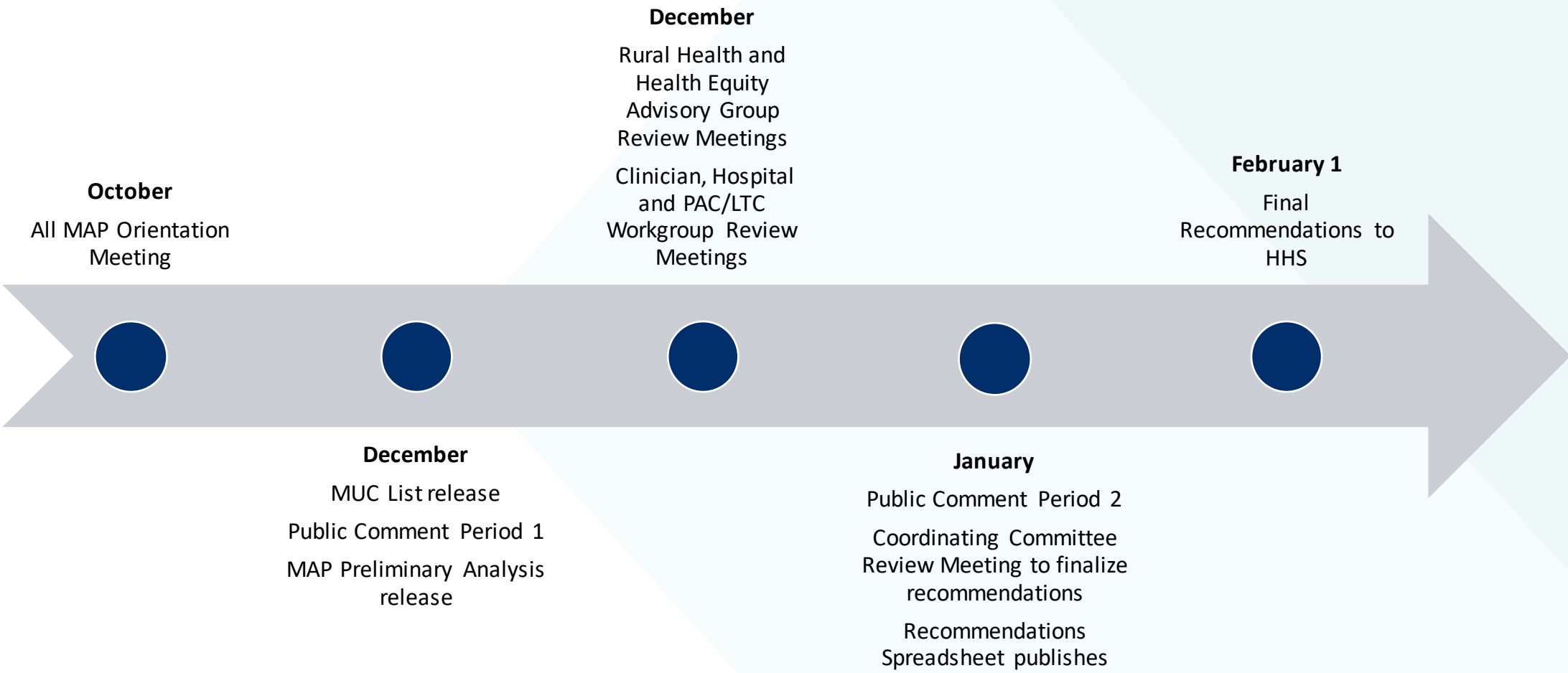
Timeline of MAP MUC Activities



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MAP Resources

- CMS' 2022 MUC List Needs and Priorities Document
  - 2022 Needs and Priorities (PDF)
- CMS' Pre-Rulemaking Overview
  - CMS Pre-Rulemaking Webpage
- MAP Member Guidebook
  - Member Guidebook (PDF)

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MAP Contact Information

- Coordinating Committee project page: Coordinating Committee webpage
  - Email: MAPcoordinatingcommittee@qualityforum.org
- Clinician Workgroup project page: Clinician Workgroup webpage
  - Email: MAPClinician@qualityforum.org
- Hospital Workgroup project page: Hospital Workgroup webpage
  - Email: MAPHospital@qualityforum.org
- PAC/LTC Workgroup project page: PAC/LTC Workgroup webpage
  - Email: MAPPAC-LTC@qualityforum.org
- Rural Health Advisory Group project page: Rural Health Advisory Group webpage
  - Email: MAPRural@qualityforum.org
- Health Equity Advisory Group project page: Health Equity Advisory Group webpage
  - Email: MAPHealthEquity@qualityforum.org

THANK YOU.

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Appendix

MAP Membership

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Coordinating Committee Membership

Committee Co-Chairs: Chip Kahn, MPH; Misty Roberts, MSN

Organizational Members (Voting)

- American Academy of Hospice and Palliative Medicine
- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- American Medical Association
- American Nurses Association
- America's Health Insurance Plans
- AmeriHealth Caritas
- Blue Cross Blue Shield Association
- Civitas Networks for Health
- Covered California
- HCA Healthcare
- Johnson & Johnson Health Care Systems, Inc.
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- Outcare
- Patient & Family Centered Care Partners, Inc.
- Patients for Patient Safety US (PFPS US)
- Purchaser Business Group on Health

Coordinating Committee Membership (continued)

Individual Subject Matter Experts (Voting)

- Nishant Anand, MD, FACEP
- Dan Culica, MD, PhD
- Janice Tufte
- Lindsey Wisham, MPA

Federal Government Liaisons (Non-Voting)

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Office of National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)

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Clinician Workgroup Membership

Workgroup Co-Chairs: Rob Fields, MD; Lisa Hines, PharmD, CPHQ

Organizational Members (Voting)

- American Association of Nurse Practitioners
- American College of Cardiology
- American College of Radiology
- American Physical Therapy Association
- Blue Cross Blue Shield of Massachusetts
- Consumer's Checkbook
- Dr. Traci's House
- Emergency Department Practice Management Association (EDPMA)
- Genentech, Inc.
- HealthPartners, Inc.
- Intermountain Healthcare
- Invitae Corporation
- Magellan Health, Inc.
- OCHIN, Inc.
- Patient Safety Action Network
- Purchaser Business Group on Health
- St. Louis Area Business Health Coalition
- Texas Health Resources

Clinician Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Zeeshan Butt, PhD
- Kendra Gustafson, MPA, BSN, RN, CPXP, CPPS
- Amy Nguyen Howell, MD, MBA, FAAFP
- Henry Lin, MD, FACS

Federal Government Liaisons (Non-Voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Veterans Health Administration (VHA)

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Hospital Workgroup Membership

Workgroup Co-Chairs: Akin Demehin, MPH; R. Sean Morrison, MD

Organizational Members (Voting)

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- Cigna Healthcare
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association
- Kidney Care Partners
- Medtronic
- Mothers Against Medical Error
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey Associates
- Project Patient Care
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

Hospital Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Richard Gelb, MA
- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB
- Jennifer Wills, RD, MPPA

Federal Government Liaisons (Non-Voting)

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Veterans Health Administration (VHA)

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PAC/LTC Workgroup Membership

Workgroup Group Co-Chairs: Kurt Merkelz, MD, CMD; Mary Ellen DeBardeleben, MBA, MPH, CJCP

Organizational Members (Voting)

- AARP
- Academy of Nutrition and Dietetics
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Physical Medicine and Rehabilitation (AAPM&R)
- American Geriatrics Society
- American Medical Rehabilitation Providers Association
- American Occupational Therapy Association
- ATW Health Solutions
- LeadingAge
- National Hospice and Palliative Care Organization
- National Partnership for Healthcare and Hospice Innovation
- National Pressure Injury Advisory Panel
- National Transitions of Care Coalition
- Service Employees International Union
- SNP Alliance
- Society for Healthcare Epidemiology of America
- The SCAN Foundation

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PAC/LTC Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Gregory Alexander, PhD, RN, FAAN
- Dan Andersen, PhD
- Terrie Black, DNP, MBA, CRRN, FAHA, FAAN
- Gerri Lamb, PhD, RN, FAAN
- Paul Mulhausen, MD, MHS

Federal Government Liaisons (Non-Voting)

- Centers for Medicare & Medicaid Services (CMS)
- Office of National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)

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Health Equity Advisory Group Membership

Advisory Group Co-Chairs: Rebekah Angove, PhD; Laurie Zephyrin MD, MPH, MBA

Organizational Members (Voting)

- Aetna
- American Medical Association
- American Nurses Association
- American Society of Health-System Pharmacists
- America's Essential Hospitals
- Beth Israel Lahey Health
- Fenway Health
- Merative
- Kentuckiana Health Collaborative
- National Committee for Quality Assurance (NCQA)
- National Health Law Program
- Patient Safety Action Network
- Planned Parenthood Federation of America (PPFA)
- The SCAN Foundation
- Vizient Inc.

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Health Equity Advisory Group Membership (continued)

Individual Subject Matter Experts (Voting)

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

Federal Government Liaisons (Non-Voting)

- Centers for Medicare & Medicaid Services (CMS)
- Health Resources & Services Administration (HRSA)
- Office of National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)

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Rural Health Advisory Group Membership

Advisory Group Co-Chairs: Kimberly Rask, MD, PhD, FACP; Keith Mueller, PhD

Organizational Members (Voting)

- American Academy of Family Physicians (AAFP)
- American Academy of PAs (AAPA)
- American Heart Association
- American Society of Health-System Pharmacists
- IBM Consulting
- LifePoint Health
- Michigan Center for Rural Health
- Minnesota Community Measurement
- National Rural Health Association
- Trauma Center Association of America
- UnitedHealth Group

Rural Health Advisory Group Membership (continued)

Individual Subject Matter Experts (Voting)

- Rosie Bartel
- William Cundiff, JD, MBA, CHC
- Rev. Bruce Hanson
- Cody Mullen, PhD
- Traci Sellers-Pullen, RN, MSOL, CCM
- Jessica Schumacher, PhD, MS

Federal Government Liaisons (Non-Voting)

- Centers for Medicare & Medicaid Services (CMS)
- Federal Office of Rural Health Policy, HRSA
- Indian Health Service, DHHS
- Veterans Health Administration (VHA)