NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership (MAP) All MAP Orientation Web Meeting 2022-2023

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for all Measure Applications Partnership (MAP) Workgroups, Advisory Groups, and Coordinating Committee members on October 27, 2022. The purpose of the meeting was to orient and prepare MAP members and other stakeholders for the upcoming 2022-2023 MAP Measures Under Consideration (MUC) review cycle. There were 221 attendees at this meeting, including MAP members, measure developers and stewards, NQF staff, government representatives, and members of the public.

Welcome, Introductions, and Review of Web Meeting Objectives

Jenna Williams-Bader, NQF Senior Director, welcomed participants to the orientation. Ms. Williams-Bader reviewed housekeeping reminders and the agenda (listed below).

- CMS Opening Remarks
- MAP Overview
- Review of MUC List
- CMS Program Changes
- Review of Rural Emergency Hospital Program
- Review of MAP Pre-Rulemaking Approach
- Review of Voting Process
- Use of Consent Calendar for the Coordinating Committee
- Role of the MAP Members, Measure Developers, and the Public in the 2022-2023 Pre-Rulemaking Process

Ms. Williams-Bader invited Dr. Dana Gelb Safran, NQF President and CEO, to provide opening remarks to the meeting participants.

Dr. Safran welcomed participants to the MAP 2022-2023 Orientation Meeting. Dr. Safran noted NQF's honor of its continued partnership with CMS and the different stakeholders that will participate in the MUC review for the upcoming pre-rulemaking cycle. Dr. Safran thanked returning MAP members and welcomed new members. Dr. Safran noted that the focus of the orientation is to prepare MAP members, measure developers, measure stewards, and the general public for the upcoming meetings in December and to orient these groups to the MAP processes, structure, and timeline. In addition, Dr. Safran highlighted the opportunity this MAP review cycle has to align with the 2022 CMS National Quality Strategy. In particular, Dr. Safran noted alignment with key areas and goals of advancing health equity, embedding quality into the care journey, embracing the digital age, and strengthening resilience in the healthcare system. Dr. Safran noted that NQF would produce a final recommendation spreadsheet containing final recommendations and the rationale for each MUC decision. NQF will publish this spreadsheet in late January. Dr. Safran concluded by thanking all MAP members, federal liaisons, and co-chairs for their time and effort, and gave a special "thank you" to CMS and program leads who joined the meeting.

Ms. Williams-Bader recognized the NQF team and CMS staff supporting MAP meeting activities. Ms. Williams-Bader then reviewed the meeting objectives:

- Review the role of MAP
- Review the MUC List processes
- Review CMS' 2022 MUC List needs and priorities
- Review the MAP pre-rulemaking approach

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) and Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG) at CMS, welcomed all meeting participants. As part of her opening remarks, Dr. Schreiber provided a presentation on the CMS National Quality Strategy.

Dr. Schreiber thanked NQF and CMS colleagues, the MAP co-chairs, and committee members. Dr. Schreiber highlighted that the purpose of MAP is to convene external content experts in quality and safety to provide recommendations to CMS on the use of new measures in the Medicare Fee for Service Value-Based programs. Dr. Schreiber clarified that while MAP does not generally comment on measures for Medicaid, Center for Medicare & Medicaid Innovation (CMMI) models and demonstrations, or the Marketplace Quality Rating System (QRS), MAP reviews most programs across CMS to ensure the measures used promote high-quality, safe care that is equitable for all individuals. Dr. Schreiber continued her presentation by reviewing the Department of Health & Human Services (HHS) Strategic Goals; CMS Strategic Pillars; CMS Cross-Cutting Initiatives; mission, vision, and Strategic Goals of the CMS National Quality Strategy; and the universal measure set and its selection criteria.

Before concluding the CMS opening remarks, Ms. Williams-Bader opened the floor for MAP stakeholders to ask questions. During this time, one question and one comment were raised:

- A MAP stakeholder asked if there had been any discussion of measure groupings so that measure users could understand how existing measures compare with the universal measure set. Dr. Schreiber stated that CMS groups related measures and employs the Cascade of Measures. The Cascade of Measures is a tool to help prioritize existing healthcare quality measures, align or reduce measures where there are too many, and identify measure areas for future development.
- A MAP stakeholder expressed appreciation for the universal measure set and stated that alignment across organizations and societies will be challenging. Dr. Schreiber expressed agreement.

MAP Overview

Ms. Williams-Bader provided an overview of MAP, explaining its statutory authority under the Patient Protection and Affordable Care Act of 2010. Ms. Williams-Bader stated that since 2011, NQF has convened MAP multistakeholder groups to provide input to the Secretary of HHS on the selection of quality and efficiency measures for public reporting, payment, and other programs. Ms. Williams-Bader noted that per the Consolidated Appropriations Act of 2021, MAP may also provide input on the removal of quality and efficiency measures. Ms. Williams-Bader noted that CMS funds the work of MAP.

Ms. Williams-Bader continued by reviewing the four key roles of MAP, the first to inform the selection of performance measures; second to provide input to HHS on the selection of measures; third to identify measure gaps for development, testing, and endorsement; and lastly to encourage measure alignment

across private and public programs, settings, levels of analysis, and populations. Ms. Williams-Bader highlighted the major components of the federal rulemaking process and reviewed how MAP works within the pre-rulemaking period. Ms. Williams-Bader emphasized that the input provided during the pre-rulemaking period facilitates a multistakeholder dialogue, allows for transparency and an open forum, and promotes the proposal of laws that are "closer to the mark."

The overview continued with a summary of the structure of MAP, which includes three Workgroups (Hospital, Clinician, and Post-Acute Care/Long-Term Care [PAC/LTC]) and two Advisory Groups (Rural Health and Health Equity), which the Coordinating Committee oversees. The Committee, Workgroups, and Advisory Groups are composed of voting organizational representatives, voting subject matter experts (SMEs), which include co-chairs, and non-voting federal government liaisons.

Ms. Williams-Bader continued by reviewing the charge of the Coordinating Committee, which is to: (1) provide input to HHS on the coordination of performance measurement strategies and Measure Set Review (MSR); (2) set the strategic direction for MAP and ensure alignment across MAP Advisory Groups and setting-specific Workgroups; and (3) provide final approval of the recommendations developed by setting-specific Workgroups.

Before continuing, Ms. Williams-Bader paused to address questions from MAP stakeholders. At this time, two questions were raised:

- A MAP stakeholder asked how SMEs are selected. Ms. Williams-Bader reviewed the nomination and selection process for SMEs.
- A MAP stakeholder asked if organizations are allowed to have representatives in multiple Workgroups. Ms. Williams-Bader stated that this is permitted; however, Ms. Williams-Bader noted that it is most often the case that an organization has a representative in a Workgroup and Advisory Group rather than all representatives in different Workgroups.

Ms. Williams-Bader continued by reviewing the charge of the Workgroups and the Advisory Groups. Additionally, Ms. Williams-Bader reviewed the federal programs for each of the Workgroups. Before concluding the discussion of the MAP overview, Ms. Williams-Bader opened the floor for stakeholders to ask questions. At this time, four questions were raised:

- A MAP stakeholder asked what mechanisms are in place for communication between the Workgroups and the Coordinating Committee. Ms. Williams-Bader responded that NQF uses the meeting summaries from the Workgroup meetings to communicate to the Coordinating Committee key discussion points and decisions made by the Workgroups. Ms. Williams-Bader stated that NQF welcomes feedback from MAP members on improving communication between the Coordinating Committee and the Workgroups.
- A MAP stakeholder asked if MAP members should also consider measure use when reviewing measures. Ms. Williams-Bader stated that NQF is in the process of incorporating measure use into the MSR process. Dr. Schreiber agreed that measure use should be addressed during the MSR and noted that there is no specific voting process for measure use.
- A MAP stakeholder asked how Advisory Group members who are also organizational representatives can best represent their respective organizations. Ms. Williams-Bader responded that it is the responsibility of individual organizations to advise their representatives. Ms. Williams-Bader also noted that NQF would provide further guidance on the role and expectations of MAP members in the future.
- A MAP stakeholder asked how members of the Rural Health Advisory Group should approach measures that may not be feasible in resource-limited settings such as those found in rural areas

but would otherwise receive support for rulemaking. Ms. Williams-Bader emphasized that the purpose of the two Advisory Groups is to identify the relevant gaps in measurement and provide input to address health equity and rural health issues. Ultimately, the issues raised by the Advisory Groups may impact the Coordinating Committee's final recommendation.

Creation of Measures Under Consideration (MUC) List

Susanne Young, NQF Manager, reviewed the statutory authority of the pre-rulemaking process. Ms. Young explained that HHS is required to establish a pre-rulemaking process in 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 CMS programs. This list of measures is known as the MUC List. Ms. Young noted that under the statute, CMS is to publish the MUC List by December 1st of each year and that the CBE will report the input of the multistakeholder groups by February 1st. Ms. Young highlighted that this process and input is one factor that HHS considers when evaluating measures. Ms. Young reviewed the 2022-2023 pre-rulemaking timeline, highlighting the approach CMS takes for selecting, reviewing, and finalizing the MUC List and how the MAP process fits within this timeline. She underscored that CMS is expected to publish the MUC List on December 1st, and the MAP review meetings will take place between December and January.

Ms. Young provided a high-level overview of the CMS 2022 Measures Under Consideration List Program-Specific Measure Needs and Priorities document. She encouraged MAP members, particularly Workgroup members, to pay close attention to this document as it provides a good reference point for measure discussion and review. Ms. Young walked through the structure of the Needs and Priorities document. Within the document, each of the federal programs includes (1) the program history and incentive structure, (2) an overview of the existing measures by measure type, (3) a breakdown of the number of measures for each Meaningful Measures 2.0 healthcare priority category, (4) high priority areas for future measure consideration, and (5) the measure requirements for the program. Ms. Young also noted that in addition to a breakdown of the 19 federal programs, the document also contains general pre-rulemaking information, CMS Meaningful Measures 1.0 accomplishments, Meaningful Measures 2.0 healthcare priorities, and future directions for quality measures.

Before concluding the discussion on the creation of the MUC List, NQF staff opened the floor for MAP stakeholders to ask any questions. At this time, MAP stakeholders raised three questions:

- A MAP stakeholder asked whether MAP participants would receive an email when the MUC List is released. Ms. Young confirmed that MAP members would be able to receive any news related to MAP, including the MUC List release, by subscribing to the MAP mailing list and alerts.
- A MAP stakeholder noted that in the needs and priorities example, the program listed had zero composite measures. The member inquired if some of the outcome measures within the program were composites. Ms. Young noted that NQF would need to look more closely at the measures under that program but can provide this information at a later time. However, Ms. Young highlighted that the NQF team would include that level of detail in the preliminary analysis in preparation for this year's review cycle.
- A MAP stakeholder asked if NQF could share an estimate on the number of measures under consideration for this cycle. Kim Rawlings, Task Order Contracting Officer Representation (COR), CCSQ, noted that while CMS cannot share this information at this time, NQF and CMS anticipate that most workgroups will have two-day review meetings this year due to the number of measures under consideration. This schedule differs from previous cycles when workgroups had one-day meetings.

CMS Program Changes

Tamyra Garcia, Deputy Director of the Quality Measurement and Value-Based Incentives Group (QMVIG) at CMS, provided an overview of the changes to the CMS Quality Payment Program (QPP). Ms. Garcia noted that all information presented during the presentation is currently in rulemaking, while CMS has finalized some rules for implementation. Ms. Garcia said MAP members can find all information in the Federal Register. Ms. Garcia explained that the purpose of the QPP is to incentivize high-value care by adjusting Medicare payment rates for clinicians. The QPP has two tracks that clinicians may choose from: (1) the Merit-based Incentive Payment System (MIPS) and (2) Advanced Alternative Payment Models (APMs). Ms. Garcia noted that her presentation would focus on updates to the MIPS program. Ms. Garcia said one notable change to MIPS in recent years is the transition to and implementation of the MIPS Value Pathways (MVPs). This transition aims to move from siloed activities towards a more aligned measure set that is relevant to clinical practice, meaningful to patient care, promotes value, and incorporates improvement activities. Ms. Garcia explained that CMS designed this approach using feedback from providers who reported the traditional MIPS structure was too complex, with too many choices and limited alignment with their relevant specialties. Ms. Garcia also explained that the traditional program made it challenging to translate information to its compare site in a way patients could understand.

Ms. Garcia explained that for 2023, CMS's proposal focuses on ensuring more meaningful clinician participation. For this year, CMS opted to introduce two policies: (1) calculating administrative claim measures at the affiliated group's taxpayer identification number (TIN) level when reporting as subgroups and (2) introducing five new MVPs and revising seven previously established MVPs. Ms. Garcia noted the goal is to ensure that each MVP includes complementary measures and activities and make the implementation reasonable and feasible. In addition, Ms. Garcia said the new rules focus on building on patient outcomes and patient-centeredness.

Ms. Garcia reviewed the finalized changes to the Hospital Inpatient Quality Reporting (IQR) program. Ms. Garcia said this year's policies expanded the measure set and further established commitment to health equity digital measurement and maternal care. Ms. Garcia provided a brief overview of the measures adopted, which include ten new measures: three health equity-related measures, four electronic clinical quality measures (eCQMs), one patient-reported outcome measure, and two claims-based measures. In addition, Ms. Garcia shared that CMS established a "birthing friendly" hospital designation, which seeks to capture the quality and safety of maternity care. Ms. Garcia said CMS will display this designation on their Care Compare website.

Ms. Garcia proceeded to share an update for the Skilled Nursing Facility Value-based Purchasing Program (SNF VBP). Ms. Garcia noted that recent legislation in 2021 expanded this program and authorized CMS to add nine additional measures for a total of ten measures. These new measures may focus on functional status, patient safety, care coordination, and patient experience. Ms. Garcia shared that CMS is focused this year on expanding the program via measures and determining the essential program requirements (e.g., minimal case requirements, exclusion criteria, and what constitutes low-value facilities). Ms. Garcia said CMS released several requests for information (RFIs) to inform future expansion policies and measures. Ms. Garcia concluded the presentation by providing additional details on CMS's phased approach to expanding the program.

Ms. Williams-Bader noted that due to time constraints, NQF and CMS would answer questions through the chat. Three questions and one comment were raised.

- A MAP stakeholder inquired if two workgroups could review a measure if the topic has implications for two distinct groups. Ms. Williams-Bader responded that if a measure is submitted for programs in multiple settings, it would be reviewed by all the relevant workgroups.
- A MAP Stakeholder commented that the Birthing Friendly designation is timely and important for quality and safety.
- A MAP stakeholder asked whether the MAP Clinician Workgroup and MAP Coordinating Committee will review the measures within the MVP or whether the proposed rule is the primary method to gather stakeholder feedback. Ms. Garcia responded that MAP does not review the MVPs; however, CMS does hold a call for candidate MVPs similar to the Call for Measures and has public webinars for feedback to inform MVP proposals.
- A MAP stakeholder inquired if all measures within an MVP are required to be reported on by groups. Ms. Garcia responded that groups could select four of the available quality measures to satisfy the MVP quality reporting requirements.

Various MAP stakeholders raised additional questions in the chat that required further research by CMS and which CMS answered post-orientation meeting. Three questions were raised and answered.

- A MAP stakeholder asked about the definition of an episodic neurological condition. CMS personnel stated that episodic neurological conditions include several common conditions, such as weakness, stiffness, paralysis, arrythmias, pain, ataxia, migraines, involuntary movements, and seizures. CMS personnel clarified that in most cases, neurological conditions cause discrete, episodic impairment whereas neurological diseases are characterized by progressive deterioration.
- A MAP stakeholder asked if vendors need to build all four Hospital IQR eCQMs. CMS personnel stated that CMS requires hospitals to use electronic health records (EHRs), which are certified to all available eCQMs in the measure set used in the Hospital IQR Program (84 FR 42505 through 42506). CMS personnel also clarified that specific to the calendar year (CY) 2023 reporting period, hospitals are required to use technology certified to the 2015 Edition Cures Update for all available eCQMs.
- A MAP stakeholder asked when the SNF VBP will transition to the Potentially Preventable Readmission Measure instead of the SNF 30-Day All-Cause Readmission Measure (SNFRM). CMS personnel stated that CMS' work on the transition to the Potentially Preventable Readmission Measure from the SNFRM is ongoing and that CMS plans to address this in future rulemaking.

Review of Rural Emergency Hospital Program

Dr. Anita Bhatia, Program Lead, and Melissa Hager, Measure Lead for the Rural Emergency Hospital Quality Reporting (REHQR) program, Division of Quality Measurement and Value-Based Incentives and Quality Reporting for the CCSQ, provided a presentation on the upcoming Rural Health Emergency (REH) Program. Dr. Bhatia began the presentation by highlighting the program's provider type and care settings. Under the statute, REH hospitals are a new provider type that will arise from the conversion of small existing rural hospitals and existing critical access hospitals (CAH). Dr. Bhatia noted that at this time, there are currently no rural emergency hospitals, nor does CMS know how many will convert, or the timeline for the conversion. Dr. Bhatia did specify that individual states and jurisdictions must have licensing requirements for the conversion, which are underway. Dr. Bhatia clarified that under the program, an REH must provide emergency services and observation care but can also provide outpatient and skilled nursing facility (SNF) services and that services must not exceed an annual per-patient

average of 24 hours. Dr. Bhatia noted that these parameters are subject to rulemaking, but payment for these services will begin on January 1st, 2023.

Dr. Bhatia continued the presentation by highlighting the specific requirements REH must follow but noted that these requirements and conditions of participation also apply to other quality reporting programs. Dr. Bhatia added that REH provisions do not include statutory language linking reporting to a payment structure as REHs are smaller in size and limited in resources. The program's goals are to limit the burden on REHs and incentivize reporting. Dr. Bhatia shared that as part of the program implementation, CMS released an RFI last year which provided key insights on topics and measures for the program.

Ms. Hager reviewed the measures CMS requested feedback on as part of the RFI. These measures included selected Hospital Outpatient Quality Reporting (OQR) program measures, Medicare Beneficiary Quality Improvement Project (MBQIP) measures, and other current, claims-based hospital OQR quality measures. Ms. Hager disclosed that CMS included four measures considered for REH in the 2022-2023 MUC List. These measures included:

- OP-10: Abdomen Computed Tomography (CT)—Use of Contrast Material (process measure)
- OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients (process measure)
- OP-32: Facility 7-Day Risk – Standardized Hospital Visit Rate After Outpatient Colonoscopy (outcome measure)
- OP-36: 7-day Risk Standardized Hospital Visits Within 7-Days After Hospital Outpatient Surgery (outcome measure)

Ms. Hager noted that in addition to these quality measures, CMS might add measures in future rulemaking. Dr. Bhatia clarified that the MBQIP measure is used within the Health Services Advisory Group (HRSA) program and that while this is the first program of its type, REHs are familiar with quality reporting. Dr. Bhatia concluded the presentation by noting that more details on the request for comments will be available on November 1st, 2022. Before ending the discussion, NQF staff opened the floor for MAP stakeholders to ask questions.

- A MAP stakeholder asked whether the REH quality measures might be associated with the Community Health Access and Rural Transformation (CHART) Model from the CMS Innovation Center. Ms. Garcia noted that this is a new provider type, and CMS is collaborating across the board to ensure alignment. However, they will review the program and follow up with the MAP stakeholder.
- A MAP stakeholder asked if the SNF services include short-term and long-term residents, given the diverse types of patients seeking SNF services. The MAP stakeholder also inquired if SNF measures fall within the Hospital Workgroup or Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup. Dr. Bhatia noted that it is dependent upon the services provided. She clarified that the REH program is unique as CMS usually develops programs for a set of providers already in place. In contrast, CMS developed the REH program without knowing who the provider type is. Dr. Bhatia explained that it is therefore all dependent upon the finalization of the policies. Regarding measure review, Ms. Williams-Bader noted that it is measure dependent. Ms. Williams-Bader explained that if the MUCs seem more hospital-based, the MAP Hospital Workgroup will review them, but the PAC/LTC Workgroup will review PAC/LTC measures. Ms. Williams-Bader also clarified that both advisory groups would review all measures, unlike workgroups that review specific measures that fall under their purview.

- A MAP stakeholder noted that under the alignment of programs, they hope SNF service expectations within REH align with broader SNF expectations.
- A MAP stakeholder asked for clarification on whether the 24-hour service parameter of the REH program is under, longer than, or within 24 hours. Dr. Bhatia noted that the language states "an average of 24 hours"; however, this is subject to rulemaking. Dr. Bhatia encouraged the MAP stakeholder to review the proposals, which will be published soon.

MAP Pre-Rulemaking Approach – Measure Selection Criteria

Ms. Williams-Bader provided an overview of the MAP measure selection criteria (MSC) and reviewed the seven criteria and sub-criteria. MAP uses the MSC to evaluate the strengths and weaknesses of a program measure set and how adding an individual measure would contribute to the set. Ms. Williams-Bader noted that the criteria are not absolute rules but provide general guidance and serve as the basis of the preliminary analysis algorithm. The seven criteria include:

1. NQF-endorsed measures are required for program set measures, 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.
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.
3. Program measure set is responsive to specific program goals and requirements, including all statutory requirements.
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.
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.
6. Program measure set supports healthcare equity, helps identify gaps and disparities in care, and promotes access, culturally sensitive, and unbiased care for all.
7. Program measure set is aligned across programs and settings as appropriate and possible.

Before concluding the discussion on the MSC, NQF staff opened the floor for MAP stakeholders to ask questions. At this time, three questions and two comments were raised:

- A MAP stakeholder inquired about the cost of incorporating eCQMs into the electronic medical record. Ms. Williams-Bader responded that NQF could not comment on this matter and invited MAP stakeholders to share their perspectives. One MAP stakeholder stated that there are often direct and indirect costs associated with implementing eCQMs. Another MAP stakeholder agreed with the previous member's assessment.
- A MAP stakeholder asked whether MAP members should consider unintended negative consequences to hospitals when evaluating measures. Ms. Williams-Bader responded that potential negative unintended consequences at the provider level might be considered by MAP, particularly when evaluating a measure's feasibility.
- A MAP member asked whether MAP members should consider the measure set when evaluating individual measures, particularly when apparent measure gaps are present. Ms. Williams-Bader stated that MAP members are encouraged to discuss measurement gaps as time permits.

Review of MAP Pre-Rulemaking Approach

Ms. Williams-Bader reviewed the four decision categories for the 2022-2023 MAP pre-rulemaking cycle, which MAP members should keep in mind when reviewing measures:

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

Ms. Williams-Bader highlighted the key differences between each decision category which centered around how well the MUC met the evaluation criteria. Ms. Williams-Bader noted that MAP Workgroups must reach a decision about every MUC and that one or more statements should accompany each decision on why the Workgroup came to that decision. Ms. Williams-Bader also highlighted that the decision categories are standardized for consistency.

Following the decision criteria, Ms. Williams-Bader provided an overview of the preliminary analysis (PA) algorithm, which provides MAP members with a brief profile of each measure and serves as a starting point for MAP discussion during the December virtual Review Meetings. Ms. Williams-Bader noted that measure developers submit a multitude of information to CMS. As a result, NQF staff will use the algorithm to evaluate each MUC. Ms. Williams-Bader said MAP members will receive the preliminary analyses and the meeting materials before the review meetings in December. Ms. Williams-Bader pointed out that the Coordinating Committee has approved the algorithm and that NQF has refined the algorithm over the years in collaboration with the Coordinating Committee. Ms. Williams-Bader reviewed the seven assessments the Workgroups use to derive one of the four decision categories. The seven assessments include:

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 settings (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.

Before concluding the discussion of the MAP pre-rulemaking approach, NQF staff opened the floor for MAP stakeholders to ask any questions. At this time, four questions were raised:

- A MAP stakeholder asked for clarification regarding the timeline of when NQF staff completes the PAs for each measure. Ms. Rawlings responded that the NQF team relies on CMS program leads and measure leads to review the PAs, given the short turnaround time. Ms. Rawlings also noted that stewards and developers can provide public comment on the PAs once available.
- A MAP stakeholder asked if measure developers can review the PAs before their dissemination to Workgroup members. Ms. Williams-Bader responded that there is no opportunity for measure developers to review the PAs due to time constraints. However, measure developers are encouraged to review the PAs posted on the NQF website and contact NQF with questions

or concerns. Additionally, measure developers are encouraged to attend the public Review Meetings.

- A MAP stakeholder asked if PAs are made available prior to the Workgroup meetings. Ms. Williams-Bader responded that NQF could only provide information on specific measures after the release of the MUC List by December 1st. NQF aims to disseminate meeting materials, including the PAs, five business days in advance of each Review Meeting. Ms. Williams-Bader emphasized that meeting scheduling depends on the date on which CMS releases the MUC List.
- A MAP stakeholder inquired if measures are modified as a result of feedback from end users once they are implemented. Ms. Williams-Bader clarified that during the MSR process, MAP reviews and considers the potential removal of measures; however, during the pre-rulemaking process, MAP is mainly centered on reviewing measures that are being introduced to a program or measures that have been substantially modified.
- A MAP stakeholder asked if measure developers can re-submit measures that receive conditional support for rulemaking or are not supported for rulemaking with potential for mitigation. Ms. Williams-Bader emphasized that MAP provides recommendations; however, HHS and CMS are under no obligation to follow MAP recommendations. The authority to select measures for rulemaking and determine which measures should repeat the MUC cycle lies with CMS and the Secretary of HHS. Ms. Williams-Bader noted that measures that receive the previously specified decision categories are not required to repeat the MUC cycle.

Review of Voting Process

Gus Zimmerman, NQF Analyst, reviewed the NQF voting procedure, voting key terms, and principles. Mr. Zimmerman highlighted that quorum is defined as 66 percent of the Workgroup and Committee voting members present virtually for live voting. Quorum must be established prior to voting. Mr. Zimmerman emphasized that organizational members who are unable to attend a meeting should work with their organization to identify a substitute to attend the meeting and notify NQF staff of the arrangement. Mr. Zimmerman reviewed that if MAP does not establish a quorum during a meeting, then 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.

Mr. Zimmerman noted that NQF staff will provide an overview of the process for establishing consensus at the start of each meeting, and voting will begin after introductory presentations and relevant context. Mr. Zimmerman said each MAP participant will receive a copy of the detailed preliminary analysis and staff decisions (e.g., support, do not support, or conditional support) and rationale to support how staff reached that conclusion. Mr. Zimmerman explained if votes do not reach a consensus, the preliminary analysis decision will stand for the Coordinating Committee's consideration.

Before concluding the discussion on the voting process, NQF staff opened the floor for MAP stakeholders to ask any questions. At this time, three questions were raised:

- A MAP stakeholder asked if public comments would occur prior to voting. Ms. Williams-Bader stated that there are multiple opportunities for public comment. There are two opportunities for members of the public to submit written comments. The first will occur following the release of the MUC List, and the comments will be made available for the Workgroup meetings. The second written comment period will allow members of the public to provide feedback on the Workgroups' draft recommendations. NQF will provide a written summary of these comments to the Coordinating Committee prior to voting. Lastly, members of the public may also provide comments during Workgroup meetings.

- A MAP stakeholder asked how voting would take place during the Review Meetings. Mr. Zimmerman responded that NQF would provide a polling link during the meeting to allow each member to vote confidentially.
- A MAP stakeholder asked how early MAP members should expect to receive meeting materials. Ms. Williams-Bader responded that NQF aims to disseminate meeting materials five days before the meeting. Various MAP stakeholders expressed the need for a list of meeting dates. Ms. Williams-Bader shared that this would become available once NQF finalizes the meeting dates.

Use of Consent Calendar for the Coordinating Committee

Ms. Williams-Bader provided a high-level overview of the consent calendar, which the Coordinating Committee will use during their Review Meeting. The use of consent became part of the last MAP cycle and was formalized in a written format for the 2022 MSR earlier this year. Ms. Williams-Bader explained that the purpose of the consent calendar is to focus the Coordinating Committee discussion on measures that elicit strong differences of opinion among Workgroup members. Ms. Williams-Bader proceeded to provide a summary of the criteria for a measure to be added to a consent calendar. Ms. Williams-Bader did note that NQF is still finalizing the process and timeline for this year's review, but the intent is to use it for the Coordinating Committee review.

Before concluding the discussion of the consent calendar, NQF staff opened the floor for MAP stakeholders to ask any questions. No questions were raised.

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

Joelencia LeFlore, NQF Analyst, reviewed the role of MAP members, measure developers, and the public during the 2022-2023 pre-rulemaking process. Ms. LeFlore emphasized that prior to meetings, MAP members should review meeting materials and confirm a substitute from their organization if unable to attend. Ms. LeFlore noted if an organization elects to send a substitute, the representative must notify NQF in advance of the meeting and complete the disclosure of interest (DOI). Ms. LeFlore stated that members should be prepared to participate in online voting after the meeting if needed.

Ms. LeFlore said the role of measure developers is to attend the Advisory Group, Workgroup, and Coordinating Committee meetings. During each Review Meeting, measure developers should be prepared to provide clarity statements in response to questions and participate in opportunities for public comment. Ms. LeFlore noted that measure developers should contact NQF regarding any questions or concerns.

Ms. LeFlore said the role of the public is to participate in any public commenting opportunities, including when the MUC List is published or by attending the Review Meetings. Verbal public comments should be limited to two minutes. Ms. LeFlore noted after the final Workgroup Review Meeting, the public may comment on the preliminary recommendations spreadsheet.

Ms. Williams-Bader emphasized the importance of quorum and encouraged organizational members to consider sending a substitute when unable to attend. Ms. Williams-Bader noted if an organization elects to send a substitute, NQF should be notified in advance so that the substitute can complete a DOI in order to vote during the meeting. Substitutes who have yet to complete a DOI prior to the meeting will not be able to vote.

Before concluding the discussion on the role of MAP members, measure developers, and the public, NQF staff opened the floor for MAP stakeholders to ask any questions. At this time, five questions were raised:

- A MAP stakeholder requested that lead discussants be given meeting materials at least one week in advance in order to prepare. Ms. LeFlore responded that NQF aims to send lead discussants meeting materials five days in advance.
- A MAP stakeholder inquired about what knowledge MAP members should bring to the MUC cycle. Ms. Williams-Bader reiterated that the role of MAP is to consider whether the MUCs are appropriate for their respective programs. Ms. Williams-Bader stated that although scientific knowledge is welcome to consider aspects such as reliability and validity, the primary role of MAP is to consider the fit of each measure within the program and the implications of the measure.
- A MAP stakeholder asked how often a substitute must complete a DOI. Ms. LeFlore responded that so long as their disclosures do not change, a substitute should complete a DOI once per MUC cycle.
- A MAP stakeholder asked when a schedule of meetings will be made available. Ms. LeFlore stated that the schedule of meetings would be made available soon and invited MAP members to subscribe to the MAP mailing list and alerts to receive the latest information.
- A MAP stakeholder asked where the meetings would take place. Ms. LeFlore responded that meetings would be held virtually via Zoom.

Public Comment

Ms. Williams-Bader opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Ms. Young presented the next steps, including an overview of the MAP timeline. Ms. Young reviewed CMS will release the MUC List by December 1st, 2022, and a public comment period will follow. NQF will hold a second public comment period in January. NQF will host two-day Workgroup and Advisory Group web meetings in December. The Coordinating Committee Review Meeting will be held in late January to finalize recommendations. The deadline to submit final recommendations to HHS is February 1st, 2023. Lastly, Ms. Young directed MAP stakeholders to the relevant resources and contact information for MAP Workgroups, Advisory Groups, and Coordinating Committee.

Before concluding the discussion of the next steps, NQF staff opened the floor for MAP stakeholders to ask any questions. During this time, three questions were raised:

- A MAP stakeholder asked whether comments submitted during the first public commenting period need to be re-submitted during the second public commenting period. Ms. Young responded that the Coordinating Committee will see all public comments submitted during each period and that there is no need to re-submit the same comment in each period.
- A MAP stakeholder asked when public comments should be submitted for the first public comment period. The member noted that the MUC List is to be published by December 1st, and the Advisory Group meetings will be held the week of December 5th. Ms. Young responded that while the non-voting Advisory Groups will not receive public comments, all Workgroups (which are composed of voting members) will receive public comments.
- A MAP stakeholder asked for clarification regarding the duration of Workgroup meetings. Ms. LeFlore responded that NQF typically holds the Workgroup meetings from 10 AM to 6 PM ET.

Ms. Williams-Bader added that the number of measures would likely necessitate two-day Workgroup meetings.

Ms. Williams-Bader expressed excitement for the upcoming MUC cycle and appreciation for MAP members. Ms. Williams-Bader stated that the presentation slides are available on the NQF website. Ms. Williams-Bader closed the meeting.