NATIONAL QUALITY FORUM
Driving measurable health improvements together

Measure Applications Partnership (MAP) Clinician Workgroup: 2022 Measure Summary Sheets

June 6, 2022

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00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00254-C-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
Numerator	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care
Numerator Exclusions	N/A
Denominator	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed
Denominator Exclusions	N/A
Denominator Exceptions	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician or other qualified health care professional managing the ongoing care of the patient with diabetes
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document

Field Label	Field Description
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare
Measure Steward	American Academy of Ophthalmology
Data Reporting Begin Date	Merit-Based Incentive Payment System Program 2018-01-01; Doctors & Clinicians Compare 2018-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • This measures information exchange, not necessarily care coordination and a primary care clinician or endocrinologist may not be able to influence this outcome from a patient vision standpoint. • Has to be performed by a specialist, should be covered under the specialty referral communication measure. Requires significant efforts to track down the records and meet this requirement. High burden and high cost, strong performance could indicate better resourced organization rather than higher standard of care.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	0089

Field Label	Field Description
History of CBE Endorsement	The NQF Primary Care and Chronic Illness Committee reviewed the measure for endorsement maintenance in 2019. The Standing Committee did not vote on the recommendation for endorsement because the measure did not pass the validity criterion—a must-pass criterion. In addition, the measure did not reach consensus on the evidence and reliability criteria. For importance to measure and report, votes were: 0 High, 1 Moderate, 2 Low, and 13 Insufficient. For reliability, votes were: 1 High, 7 Moderate, 6 Low, and 1 Insufficient. For validity, votes were: 0 High, 5 Moderate, 11 Low, and 0 Insufficient. Rationale: • Committee members noted there is no evidence indicating communication between physicians performing the dilated macular or fundus exam and those treating the diabetes will lead to improved health outcomes for the patient. • Some Committee members did not see value in a performance measure addressing this measure focus, in addition to their concern about the evidence. However, some Committee members had a different opinion, and saw value in the measure as a potential driver of improved outcomes. The developer noted that care coordination measures are an important gap in the measurement field. • More than 60 percent of the Committee members voted Insufficient on evidence. The Committee was able to vote on evidence with exception; however, the Committee did not reach consensus on evidence with exception. • The Committee did not reach consensus on the reliability of the measure. Since testing on the measure was not at the clinician: individual level of analysis, this measure was evaluated at the clinician: group/practice level of analysis only. In addition, the developer specified the measure for outpatient, post-acute care, and domiciliary settings, but these analyses were not conducted separately. A few Committee members with an ophthalmology background noted that a very small percentage of ophthalmologists reporting on this measure would be from the domiciliary setting and would be predominantly reporting at the outpatient setting. • The Committee noted that the empirical validity results using Pearson's correlation coefficients to compare performance of 0089 with PQRS #117 *Diabetes: Eye Exam* were weak at the claims and registry levels (0.11 and 0.16). However, one Committee member believed the correlation coefficients would be stronger except that the providers reporting the two measures may be taking care of different types of patients.

Field Label	Field Description
History of CBE Endorsement	During the Post-Comment Meeting, the Committee was asked by the developer and other stakeholders to reconsider this measure and its e-Measure companion. The developer's rationale for reconsideration was as follows: (1) Committee members with ophthalmology and endocrinology backgrounds supported the measure; (2) the measure could pass under the exception to evidence criterion, where gap in care can substitute for empirical evidence; (3) while there was limited data available for the empirical validity correlation analysis, and despite weak correlation results of 0089, it was still positive and the measure also had strong face validity; (4) the Committee had expressed a preference for a general measure on care coordination, but no general measure currently exists; (5) and there was a lack of Committee quorum on the call for the discussion of 0089e. During the post-comment call, the developer emphasized that the measures address a CMS priority area of effective communication and coordination. One Committee member was supportive of the measures, as care coordination between the primary care practitioner and/or endocrinologist with the ophthalmologist is important. The Committee member noted that all providers caring for the patient need to know the level of diabetic retinopathy and dates of evaluation by the ophthalmologist. He also indicated that obtaining evidence on these measures would be extremely challenging. Another Committee member noted that it would be more beneficial for the primary care practitioner to receive a note from the ophthalmologist or a copy of the ophthalmologist office visit note. Some Committee members reiterated the discussion from the measure evaluation web meetings in July 2019: There is no evidence indicating that communication will lead to improved health outcomes for the patient. In addition, the level of retinopathy or knowing the outcome of the diabetic retinopathy evaluation will not change the endocrinologist's or primary care practitioner's treatment of the diabetic patient. One Committee member noted unintended consequences as the lack of interoperability of the current systems allows clinicians other than the treating practitioner to receive the ophthalmologist reports. Finally, one Committee member stressed that the measures did not pass multiple NQF criteria and should not be recommended for endorsement. NQF noted that five organizations submitted supportive comments to re-endorse the two measures during the commenting period. The Committee voted on whether they would like to re-consider measures 0089 and 0089e, and by a vote of 3-Yes, 11-No, they elected not to reconsider measures 0089 and 0089e. Both measures were not recommended for NQF re-endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2013-2014 Recommendation: Physician Compare: Do Not Support; Value-Based Payment Modifier: Do Not Support
Rationale for MAP Recommendation	This measure has not reviewed by MAP for the Merit-based Incentive Payment System.

Section 4: Performance and Reporting Data

Year	Total number of measure reporters (group)	Measure reporting rate	Total number of measure reporters (individuals)	Measure reporting rate (individuals)
2018	147	0.20%	466	0.04%
2019	153	0.20%	447	0.04%
2020	123	0.16%	381	0.03%

- 2018: Total number of reporters for all measures: groups – 72,839; individuals – 1,049,233
- 2019: Total number of reporters for all measures: groups – 75,979; individuals – 1,133,482
- 2020: Total number of reporters for all measures: groups – 75,704; individuals – 1,150,636

Year	Mean performance (registry submission groups)	Mean performance (registry individuals)
2018	78.95	86.90
2019	85.91	90.63
2020	83.28	87.23

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data used in the measure are generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry). All data elements are in defined fields in electronic clinical data (e.g., clinical registry, nursing home MDS, home health OASIS). The measure developer did not identify an areas of concern or make any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.
Source and Date of Feasibility Data	CBE Measure Submission, 5/11/2021

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	05796-E-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Section 7: Negative Unintended Consequences

At this time, NQF does not have information about potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF does not have any additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 1
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program – 0

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member noted the measure is valuable because of the substantially higher prevalence of diabetes in the African American and Hispanic populations and disparities in the diabetes quality measures in general.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) there needs to be a look at the evidence to see if there are processes with clearer links to outcomes, and 2) coordination with the American Diabetes Association on their work to improve the evidence base. Workgroup members included those conditions to ensure the measure improves patient outcomes and incorporates the latest ongoing work to improve the evidence base for the measure.

Public Comments

MarsdenAdvisors

Do you support retaining this measure in the program? Yes

MarsdenAdvisors opposes the MAP recommending removal of Measure 19. This measure has seen year-over-year improvement and is still important for improving and driving coordinated care. According to the Agency for Healthcare Research and Quality (AHRQ), care coordination is vital to achieve safer, more effective, and more cost-efficient care. By removing this measure, CMS would remove the structure and incentive for clinicians and practices to monitor this important metric.

In addition, for the retina subspecialty, there are currently only six benchmarked MIPS quality and QCDR measures. Two of the few available retina measures are being considered by the MAP for recommended removal. This would leave clinicians in the retina subspecialty to try to find and report on measures completely unrelated to their clinical practice, rather than using meaningful measures that truly evaluate the care they provide.

Covenant Physician Partners

Do you support retaining this measure in the program? Yes

This measure continues to be a good indication of communication between providers.

American Academy of Ophthalmology

Do you support retaining this measure in the program? Yes

As the leading society in ophthalmology with 27,000 members, the American Academy of Ophthalmology understands the need for quality measures that are clinically relevant and improve patient outcomes. We are providing support for the following criteria that were utilized by the MSR process and rebut the proposed removal of the measure. We strongly support the maintenance of this measure for the MIPS program to continue to meet the goal of quality improvement for Medicare beneficiaries:

1 - Measure does not contribute to the overall goals and objectives of the program

The patient care objectives of the Quality Payment Program are as follows (https://qpp.cms.gov/about/qpp-overview): to improve beneficiary population health; to improve the care received by Medicare beneficiaries, to lower costs to the Medicare program through improvement of care and health, to advance the use of healthcare information between allied providers and patients, to educate, engage and empower patients as members of their care team. This measure directly contributes to these overall objectives and is categorized by CMS as aligned with this domain of the National Quality Strategy to address the most common health concerns that Americans face: Communication and Care Coordination, and as aligned with this Meaningful Measure Area: Transfer of Health Information and Interoperability. Furthermore, this measure is important to the overall goal of CMS for health equity, announced by CMS on April 20, 2022, that health equity is the first "pillar" of its strategic vision. Black and Hispanic/Latinx individuals have significantly related higher rates of diabetes-related complications, including blindness, than White individuals in the US, and lower socioeconomic status predicts higher complication rates. This quality measure contributes to the advancement of health equity by focusing attention on the care coordination of all patients with diabetes and reinforcing the need for glucose control across all populations.

2 - Measure is duplicative of other measures within the same program

There are no other measures within MIPS that are duplicative.

4 - Performance or improvement on the measure does not result in better patient outcomes

Performance or improvement on the measure does result in better patient outcomes, because this enhances communication and care coordination, which is an important contributor to better patient outcomes.

5 - Measure does not reflect current evidence

This is a coordination of care measure among different care providers and does reflect the current evidence and thinking regarding the optimal patient management for improving the outcome of patients. In fact, the American Diabetes Association is leading an initiative to address this gap in performance and improve the communication and transfer of relevant information between endocrinologists, internists and family physicians, and ophthalmologists and optometrists, based on research activities conducted by the ADA.

6 - Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the electronic Clinical Quality Measure (reflecting 2020 performance year performance), the measure is marked as Yes for topped out. However, we would urge that there be consideration that 2020, 2021

and probably 2022, we have been in the midst of the COVID-19 pandemic, a large number of clinicians have opted out of MIPS reporting, and participation and performance rates may have been affected by the pandemic and we need additional time for consideration of measure performance, particularly for the small practices without EHRs.

7 - Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the Clinical Quality Measure (reflecting 2020 performance year performance), the measure is marked as Yes for topped out. However, we would urge that there be consideration that for 2020, 2021 and probably for the 2022 performance year, we have been in the midst of the COVID-19 pandemic. A large number of clinicians have opted out of MIPS reporting, participation and performance rates may have been affected by the pandemic, and we need additional time for consideration of measure performance, particularly for the small practices without EHRs which may be practicing in rural, inner-city, and underserved areas of the country.

8 - Measure leads to a high level of reporting burden for reporting entities

This does not impose a high level of reporting burden because the majority of ophthalmologists are on EHR and on the IRIS Registry and can report this measure via automated data extraction from their EHR.

9 - Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure

CMS does not publish the number of entities reporting each measure in the MIPS program, so this is difficult to ascertain. However, this appears to be a measure reported by a significant number of participants, including entities with low volumes. For the 2021 MIPS reporting year, 104 entities reported QPP19 through the IRIS Registry, including entities with a low volume of patients eligible for this measure. However, we would urge that there be consideration that for 2020, 2021 and probably for the 2022 performance year, we have been in the midst of the COVID-19 pandemic. A large number of clinicians have opted out of MIPS reporting, participation and performance rates may have been affected by the pandemic, and we need additional time for consideration of measure performance, particularly for the small practices without EHRs which may be practicing in rural, inner-city, and underserved areas of the country.

10 - Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

There are no negative unintended consequences of this measure, including potential negative impacts to the rural population or possible contribution to health disparities, because the lack of communications will only lead to a negative impact on performance, and not a positive impact on performance.

It seems as though the only criteria not met is #3, Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement. The stipulation that measures are approved by a consensus-based entity was never a criterion for approval into the MIPS program and many CMS measures were included in the MIPS program without consensus-based entity approval. Consensus-based entity approval required costly requirements for testing and validation, which is why it is onerous for specialty societies to apply for and maintain our NQF approval. Societies also incur high costs to maintain NQF membership. It is disingenuous to impose this requirement 7 years after quality measures have been accepted and used in

the MIPS program without having had to meet this requirement. This imposes a high and costly burden on measure stewards to maintain existing quality measures, in addition to the testing requirement burden that is now enforced on all QCDR measures. These costly unfunded mandates take funding away from specialty societies to develop quality measures.

Should you have any questions or want a further discussion, please contact Brandy M. Keys, MPH, AAO Director of Health Policy at bkeys@aao.org or 202-737-6662.

Public Comments Post-Workgroup Meeting

Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)

VIA ELECTRONIC MAIL

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Group Director for the Quality Measurement and Value-Based Incentives Group
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Re: Feedback Regarding the Measure Set Review Process

Dear Dr. Schreiber:

The undersigned members of the Physician Clinical Registry Coalition ("Coalition") write to express our serious concerns regarding the Centers for Medicare and Medicaid Services' ("CMS") Measure Set Review ("MSR") process. The Coalition is a group of medical society- and board-sponsored clinical data registries that collect and analyze clinical outcomes data to identify best practices and improve patient care, and that support clinicians with Merit-Based Incentive Payment System ("MIPS") reporting requirements. We are committed to advocating for policies that encourage and enable the development of clinical data registries and enhance their ability to improve quality of care through the analysis and reporting of clinical outcomes. Most of the members of the Coalition are measure stewards, meet the definition of clinician-led clinical data registry under the 21st Century Cures Act, and have been approved as Qualified Clinical Data Registries under the MIPS program.

The Consolidated Appropriations Act of 2021 ("CAA") authorized the National Quality Forum ("NQF") to provide feedback to CMS on quality and efficiency measures that could be considered for removal. Consolidated Appropriations Act, H.R. 133, 116th Cong., tit. 1A § 102(c)(4) (2020) (codified at 42 U.S.C. § 1395aaa(b)(4)). This process is referred to as the MSR process. During a presentation on April 21, 2022, NQF stated that the CAA "presents an opportunity for CMS to [r]eceive additional stakeholder feedback on potential measure removal in their quality programs [and i]ncrease transparency about measures being considered for removal."

The current MSR process, however, does not accomplish these goals. The MSR process, in its current form, does not provide adequate opportunity for feedback from the public, including measure stewards. Stakeholders were provided only five business days to submit comments on the measures considered for removal. Moreover, during the public comment period, stakeholders were provided insufficient

information to provide meaningful feedback on the selected measures. The rationale for removing each measure was not provided until after the conclusion of the public comment period. This lack of information, coupled with the inadequate timeframe to submit public comments, undercuts the purpose of the MSR process and call into question whether the Measure Applications Partnership ("MAP") Advisory Groups, Workgroups, and Coordinating Committee are provided adequate information to holistically review the quality measures and render appropriate recommendations. Feedback from specialty societies is crucial to help ensure that specialty-specific measures are not inappropriately removed when the specialty has a limited measure set. Removal of these measures may create scoring inequities and jeopardize the ability of clinicians to participate in a program.

Therefore, the Coalition urges CMS to consider the flaws in the 2022 MSR process that have been identified in this letter when evaluating the NQF recommendations and require NQF to fix those flaws. In addition, we recommend that NQF provide detailed summaries of the MAP Workgroup's discussions and concerns.

Determining the meaningfulness of quality measures under the current MSR process is not in the public's best interest. Measure stewards should be considered valuable stakeholders in the review progress. Medical specialty organizations make great investments in measure development that support CMS programs. Measure stewards are granted approval of their measures on an annual basis. Measure stewards support and explain their MIPS measures, both electronic and nonelectronic, to CMS and its contractors during the review cycles. Measure stewards also support QCDR measures through the Self-Nomination process with validity and reliability testing. In addition, measure stewards must comply with requirements for measure update and maintenance activities that are overseen by CMS and its contractors. Further, these measures are already subject to removal by CMS if they are topped-out or lack benchmarks.

Many measures selected for removal cover the breadth and scope of medical care and provide benchmarks and metrics that cover diagnoses and procedures of interest.

Clinicians have differing practice styles and patient populations. To pigeonhole them into fewer measures that do not align with or are peripheral to their practice patterns can distort their performance profiles. Reducing the number of meaningful quality measures, particularly measures that serve specific medical specialties or measures that are reported by thousands of clinicians, marginalizes the very clinicians who champion quality improvement and shoulder the responsibility of quality reporting.

Inadequate Timeframe for Public Feedback

Measure stewards were not consulted nor informed about the MSR process until the public comment period for the MSR proposal was announced on May 18, 2022. We hope that in future cycles, NQF will provide advance notice to measure stewards that their measures were selected for review.

Additionally, as stated above, stakeholders were given only five business days to provide feedback. Most medical specialty associations that develop and steward quality measures have robust public comment process with provider-led committees that provide insight on a continual basis regarding quality program policies. To complete a review process in such a short period of time lacks feasibility and respect for the clinical community. A five-business-day comment period is unreasonable, particularly compared to the comment period required under the Administrative Procedure Act and the Medicare statute, and it creates a significant burden on measure stewards.

Moreover, during the Rural Health Advisory Group MSR Meeting, only ten minutes were allotted for public comments on the seven measures up for review, leaving just 1.5 minutes for each measure. NQF

was asked about the lack of opportunities for public and measure steward feedback and claimed that it did not have time to ask for input due to other MAP review processes that must happen before the end of this year, and that the bulk of the meeting time was reserved for discussion among the NQF workgroup members, and not for measure stewards. Call participants were told that this is the "first year" of the process, and that stakeholders can provide input on the process to make it better for next year. However, this assurance offers no recourse to stewards with measures recommended for removal in the current MSR cycle.

Lack of Transparency

Transparency is essential to the integrity of any decision-making process. The Coalition urges NQF to provide greater transparency in the MSR process. Under the current process, NQF provided a survey for MAP Workgroup and Advisory Group members to nominate measures in selected federal programs for removal. However, the specific survey questions and accompanying spreadsheet used by such members to aid in measure nomination were not made publicly available, and the public had no opportunity to comment. It is unclear what type of metrics or benchmarks were provided to MAP members, if any, which raises concerns as to whether survey respondents had insufficient and only cursory information on which to make their decisions. Furthermore, the survey methodology and response rates have not been shared with the public. The measures discussed to date have had as few as three survey responses supporting their removal according to the NQF presentations.

In addition, NQF did not provide the rationale for removing each measure prior to the conclusion of the public comment period on May 25, 2022. Although the MAP Clinician Workgroup Summary Sheets, the MAP Hospital Workgroup Summary Sheets, and the MAP PAC-LTC Workgroup Summary Sheets (collectively, the "Summary Sheets") describe the rationale for removal consideration and the votes for removal consideration, NQF did not post the Summary Sheets until June 6, 2022—almost two weeks after the end of the public comment period. The Summary Sheets provided material information that should have been provided to stakeholders prior to commencement of the public comment period. Because material information was not provided to the public prior to the comment period, stakeholders were unable to provide complete, meaningful comments.

Lastly, NQF needs to implement sufficient safeguard to ensure that all public comments are considered. It has come to our attention that the Summary Sheets, which describes the public comments, left off some stakeholder feedback submitted during the comment period.

Therefore, the Coalition urges **CMS to consider the flaws in the 2022 MSR process that have been identified in this letter when evaluating the NQF recommendations and instruct NQF to revise the MSR process to address the aforementioned concerns. Additionally, we recommend that NQF provide detailed summaries of the MAP Workgroup's discussions and concerns.**

We appreciate your consideration of our feedback. If you have any questions, please contact Rob Portman or Leela Baggett at Powers Pyles Sutter & Verville, PC (Rob.Portman@PowersLaw.com or Leela.Baggett@PowersLaw.com).

Respectfully submitted,

American Academy of Dermatology
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons

American College of Emergency Physicians
American College of Gastroenterology
American College of Radiology
American College of Rheumatology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Urological Association
Congress of Neurological Surgeons
Society of Interventional Radiology
Society of NeuroInterventional Surgery
The Society of Thoracic Surgeons

05796-E-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (eCQM)

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	05796-E-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
Numerator	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care
Numerator Exclusions	N/A
Denominator	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed
Denominator Exclusions	N/A
Denominator Exceptions	Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes. Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Field Label	Field Description
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare
Measure Steward	American Academy of Ophthalmology
Data Reporting Begin Date	Merit-Based Incentive Payment System Program 2018-01-01; Doctors & Clinicians Compare 2018-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • This measures information exchange, not necessarily care coordination and a primary care clinician or endocrinologist may not be able to influence this outcome from a patient vision standpoint. • Has to be performed by a specialist, should be covered under the specialty referral communication measure. Requires significant efforts to track down the records and meet this requirement. High burden and high cost, strong performance could indicate better resourced organization rather than higher standard of care.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed

Field Label	Field Description
Consensus-Based Entity Number	0089e
History of CBE Endorsement	The NQF Primary Care and Chronic Illness Committee reviewed the measure for endorsement maintenance in 2019. The measure did not pass the evidence and validity criteria—both of which are must-pass. In addition, the Committee did not reach consensus on the reliability criterion. For importance to measure and report, votes were: 0 High, 3 Moderate, 3 Low, and 8 Insufficient. For reliability, votes were: 1 High, 7 Moderate, 4 Low, and 2 Insufficient. For validity, votes were: 0 High, 4 Moderate, 9 Low, and 1 Insufficient. Rationale: • Committee members did not re-discuss the evidence criterion as it was identical to the evidence measure 0089, for which it was previously noted that there is no evidence indicating communication between physicians performing the dilated macular or fundus exam and those treating the diabetes will lead to improved health outcomes for the patient. • Also recapped from the evidence discussion for measure 0089, some Committee members did not see value in a performance measure addressing this measure focus, in addition to their concern about the evidence. However, some Committee members had a different opinion, and saw value in the measure as a potential driver of improved outcomes. The developer previously noted that care coordination measures are an important gap in the measurement field. • The Committee noted that the empirical validity result using Pearson's correlation coefficients to compare performance of 0089 with PQRS #117 *Diabetes: Eye Exam* was weak at the EHR level (0.08). There was a moderate correlation (0.59) with the measure, *Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*. During the Post-Comment Meeting, the Committee was asked by the developer and other stakeholders to reconsider this measure and its e-Measure companion. The Committee voted on whether they would like to re-consider measures 0089 and 0089e, and by a vote of 3-Yes, 11-No, they elected not to reconsider measures 0089 and 0089e. The Standing Committee did not recommend this measure for continued endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

Year	Total number of measure reporters (group)	Measure reporting rate	Total number of measure reporters (individuals)	Measure reporting rate (individuals)
2018	1,808	2.48%	1,734	0.17%
2019	1,625	2.14%	1,328	0.12%
2020	1,254	1.66%	930	0.08%

- 2018: Total number of reporters for all measures: groups – 72,839; individuals – 1,049,233
- 2019: Total number of reporters for all measures: groups – 75,979; individuals – 1,133,482
- 2020: Total number of reporters for all measures: groups – 75,704; individuals – 1,150,636

Year	Mean performance (EHR submission groups)	Mean performance (EHR submission individuals)
2018	74.40	79.42
2019	72.79	74.29
2020	71.27	71.69

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data used in the measure are generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score). All data elements are in defined fields in electronic health records (EHRs). The measure developer did not identify areas of concern or make any modifications as a result of testing and operational use of the measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.
Source and Date of Feasibility Data	CBE Measure Submission, 5/11/2021

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Section 7: Negative Unintended Consequences

At this time, NQF does not have information about potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF does not have any additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 2
- No (Do Not Support Retaining in Proposed Program) – 6
- Unsure of Retaining in Proposed Program – 0

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns, although one member noted the lack of endorsement influenced their vote supporting removal and the standards for measures should be high given small volume challenges in rural populations. The member also noted that since these measures are voluntarily reported in MIPS, the balance of burden and benefits for the measure would be more manageable than in other settings. Another advisory group member shared a stronger preference for outcome measures than for intermediate outcome measures that reflect standard of care or processes and reiterated the preference for endorsed measures.

MAP Health Equity:

Comments were carried forward from the non-eCQM version of the measure. An advisory group member noted the measure is valuable because of the substantially higher prevalence of diabetes in the African American and Hispanic populations and disparities in the diabetes quality measures in general.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) there needs to be a look at the evidence to see if there are processes with clearer links to outcomes, and 2) coordination with the American Diabetes Association on their work to improve the evidence base. Workgroup members included those conditions to ensure the measure improved patient outcomes and incorporated the latest work ongoing to improve the evidence base of the measure.

Public Comments

MarsdenAdvisors

Do you support retaining this measure in the program? Yes

MarsdenAdvisors opposes the MAP recommending removal of Measure 19. This measure has seen year-over-year improvement and is still important for improving and driving coordinated care. According to the Agency for Healthcare Research and Quality (AHRQ), care coordination is vital to achieve safer, more effective, and more cost-efficient care.

NQF's EHR Care Coordination Committee wrote and emphasized the following statement in its Environmental Scan Report last year:

"Measurement using EHRs in this area is critical, as measurement will drive quality improvement efforts to enhance care communication and care coordination, two processes that are essential to achieving the Quadruple Aim of enhancing the patient experience, improving population health, improving the work life of healthcare providers, and reducing costs."

By removing this measure, CMS would remove the structure and incentive for clinicians and practices to monitor this important metric.

In addition, for the retina subspecialty, there are currently only six benchmarked MIPS quality and QCDR measures, only four of which are available as eCQMs. Two of the few available retina measures are being considered by the MAP for recommended removal. This would leave clinicians in the retina subspecialty to try to find and report on measures completely unrelated to their clinical practice, rather than using meaningful measures that truly evaluate the care they provide.

American Society of Retina Specialists

Do you support retaining this measure in the program? Yes

"ASRS opposes removing this measure from the MIPS program. This measure, by facilitating care coordination between retina specialists and other practitioners, meets one of the key goals of the MIPS program. MIPS measures that continue to encourage communication between the ophthalmologist and primary care provider remain important. Retina specialists currently check with the patient during their examination to confirm they are sending the report to the correct primary care practitioner, since primary care physicians do change for some patients over the course of a year. Removing this would no longer encourage retina specialists to identify the correct primary care provider or to send a report to them. Primary care providers want these reports from the eye care providers as their quality of care is measured by asking patients if they had their diabetic eye exam and acknowledging receipt of these reports in some practices. (Holley & Lee, Investigative Ophthalmology & Visual Science, April 2010, Vol.51, 1866-187).

This measure is so important, in fact, that ASRS, along with other ophthalmology, optometric, and primary care organizations, is currently participating in a workgroup convened by the American Diabetes Association to develop a template for the communications retina specialists send back to primary care physicians that ensures the clinical information is presented in the most appropriate and understandable format.

The continued high performance on this measure by retina specialists and other eye care professionals indicates that the appropriate care that leads to better outcomes is being provided. This measure should stay in the program so that MIPS clinicians can continue to receive credit for providing this high-quality care. "

American Academy of Ophthalmology

Do you support retaining this measure in the program? Yes

As the leading society in ophthalmology with 27,000 members, the American Academy of Ophthalmology understands the need for quality measures that are clinically relevant and improve patient outcomes. We are providing support for the following criteria that were utilized by the MSR process and rebut the proposed removal of the measure. We strongly support the maintenance of this measure for the MIPS program to continue to meet the goal of quality improvement for Medicare beneficiaries:
1. Measure does not contribute to the overall goals and objectives of the program

The patient care objectives of the Quality Payment Program are as follows (https://qpp.cms.gov/about/qpp-overview): to improve beneficiary population health; to improve the care received by Medicare beneficiaries, to lower costs to the Medicare program through improvement of care and health, to advance the use of healthcare information between allied providers and patients,

to educate, engage and empower patients as members of their care team. This measure directly contributes to these overall objectives and is categorized by CMS as aligned with this domain of the National Quality Strategy to address the most common health concerns that Americans face: Communication and Care Coordination, and as aligned with this Meaningful Measure Area: Transfer of Health Information and Interoperability. Furthermore, this measure is important to the overall goal of CMS for health equity, announced by CMS on April 20, 2022, that health equity is the first "pillar" of its strategic vision. Black and Hispanic/Latinx individuals have significantly related higher rates of diabetes-related complications, including blindness, than White individuals in the US, and lower socioeconomic status predicts higher complication rates. This quality measure contributes to the advancement of health equity by focusing attention on the care coordination of all patients with diabetes and reinforcing the need for glucose control across all populations.

2. Measure is duplicative of other measures within the same program

There are no other measures within MIPS that are duplicative.

4. Performance or improvement on the measure does not result in better patient outcomes

Performance or improvement on the measure does result in better patient outcomes, because this enhances communication and care coordination, which is an important contributor to better patient outcomes.

5. Measure does not reflect current evidence

This is a coordination of care measure among different care providers and does reflect the current evidence and thinking regarding the optimal patient management for improving the outcome of patients. In fact, the American Diabetes Association is leading an initiative to address this gap in performance and improve the communication and transfer of relevant information between endocrinologists, internists and family physicians, and ophthalmologists and optometrists, based on research activities conducted by the ADA.

6. Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the electronic Clinical Quality Measure, the measure is marked as NO for topped out, so the performance is not uniformly high and does have variation in performance overall and by subpopulation, per CMS.

7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the electronic Clinical Quality Measures, there is a substantial differentiation between high and low performers with a demonstrated variation in performance overall, with a mean performance rate of 69.24%, and a range from the 3rd decile of 54.33% to >= 97.88% for the 10th decile.

8. Measure leads to a high level of reporting burden for reporting entities

This does not impose a high level of reporting burden because the majority of ophthalmologists are on EHR and on the IRIS Registry and can report this measure via automated data extraction from their EHR.

9. Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure

CMS does not publish the number of entities reporting each measure in the MIPS program, so this is difficult to ascertain. However, this appears to be a measure reported by a significant number of participants, including entities with low volumes. For the 2021 MIPS reporting year, 1,557 entities reported eCQM142v9 through the IRIS Registry, including entities with low volume of patients eligible for this measure.

10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

There are no negative unintended consequences of this measure, including potential negative impacts to the rural population or possible contribution to health disparities, because the lack of communications will only lead to a negative impact on performance, and not a positive impact on performance.

It seems as though the only criteria not met is #3, Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement. The stipulation that measures are approved by a consensus-based entity was never a criterion for approval into the MIPS program and many CMS measures were included in the MIPS program without consensus-based entity approval. Consensus-based entity approval required costly requirements for testing and validation, which is why it is onerous for specialty societies to apply for and maintain our NQF approval. Societies also incur high costs to maintain NQF membership. It is disingenuous to impose this requirement 7 years after quality measures have been accepted and used in the MIPS program without having had to meet this requirement. This imposes a high and costly burden on measure stewards to maintain existing quality measures, in addition to the testing requirement burden that is now enforced on all QCDR measures. These costly unfunded mandates take funding away from specialty societies to develop quality measures.

Should you have any questions or want a further discussion, please contact Brandy M. Keys, MPH, AAO Director of Health Policy at bkeys@aao.org or 202-737-6662.

Public Comments Post- Workgroup Meeting

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

00641-C-MIPS Functional Outcome Assessment

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00641-C-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.
Numerator	Visits where patient has documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies.
Numerator Exclusions	N/A
Denominator	All visits for patients aged 18 years and older
Denominator Exclusions	N/A
Denominator Exceptions	Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare
Measure Steward	Centers for Medicare & Medicaid Services

Field Label	Field Description
Data Reporting Begin Date	Merit-Based Incentive Payment System Program 2018-01-01; Doctors & Clinicians Compare 2018-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 4
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • This measure is so broadly inclusive that it is unclear how it will lead to better patient outcomes. Becomes a check box assessment rather than thoughtful practice. • Measure denominator of all adults age 18 and older at with assessment during every visit with standardized tool makes this measure more burdensome than it could be with a more focused denominator

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	2624
History of CBE Endorsement	Endorsement was removed for this measure in November 2021. The developer chose not to re-submit the measure for maintenance of endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

Year	Total number of measure reporters (group)	Measure reporting rate	Total number of measure reporters (individuals)	Measure reporting rate (individuals)
2018	Not available	Not available	104	0.01%
2019	539	0.71%	422	0.04%
2020	614	0.81%	451	0.04%

- 2018: Total number of reporters for all measures: groups – 72,839; individuals – 1,049,233
- 2019: Total number of reporters for all measures: groups – 75,979; individuals – 1,133,482
- 2020: Total number of reporters for all measures: groups – 75,704; individuals – 1,150,636

Year	Mean performance (registry submission groups)	Mean performance (registry individuals)
2018	Not available	39.85
2019	96.12	90.55
2020	93.57	93.88

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	CBE Measure Submission, 2020: Data used in the measure are generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score). No data elements are in defined fields in electronic sources. At the time of this submission, this measure is not currently being considered as eMeasure. The results of the testing of these claims demonstrated an opportunity to improve the specificity for the 2013 measure claims and registry specification. Modifications were made to the guidance section of the specification to include documentation of the actual Standardized Functional Outcome Assessment Tool used when performing a functional outcome assessment. During its 2016 review of the measure, NQF's Person- and Family-Centered Care Committee members raised concerns around feasibility, noting both that the measure is abstracted from administrative claims and paper medical records, and that only 3.6% of eligible providers reported on it despite its use in the Physician Quality Reporting System, possibly indicating feasibility issues.
Source and Date of Feasibility Data	CBE Measure Submission, 11/9/2020 NQF-Endorsed Measures for Person- and Family-Centered Care Phase 2, 3/31/2016

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	01248-C-MIPS Functional Status Change for Patients with Knee Impairments

Section 7: Negative Unintended Consequences

During its 2016 review of the measure, NQF's Person- and Family-Centered Care Committee members were concerned that the measure can be gamed as the documentation of a care plan would fulfill the measure, but would not ensure that the patient received the right care. The developers noted that linking the care plan and the collection of outcomes data would naturally be linked for providers.

Section 8: Additional Information

At this time, NQF does not have any additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program – 2

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member noted that there may be equity concerns relating to recovery from strokes and other significant events. Another advisory group member noted more insight regarding the absence of functional outcome assessments in certain populations by stratification would be helpful to fully assess the measure.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted that the measure was appropriate for specialties like physical therapists who regularly use functional assessments in their practice and the optional reporting nature of the MIPS program ensures that clinicians who do not use functional assessments do not have to report the measure.

Public Comments

The American Academy of Physical Medicine and Rehabilitation
Do you support retaining this measure in the program? Yes

Until NQF provides rationale for why they are recommending removal of any measure, we cannot properly respond and comment.

Carilion Clinic
Do you support retaining this measure in the program? Yes, under certain conditions

The definition seems vague. Would eliminate unless you can target this to conditions that have easily assessable functional outcomes (like pain management).

Public Comments Post-Workgroup Meeting

American Occupational Therapy Association

Do you support retaining this measure in the program? Yes

The American Occupational Therapy Association (AOTA) supports this measure, as it is an important measure for occupational therapy practitioners reporting in the MIPS program, and ensures that client function is being addressed. AOTA also recommends adding occupational therapy as a specialty along with physical therapy to the MAP rationale, as function is a focus of occupational therapy evaluation and assessment.

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

01101-C-MIPS Barrett's Esophagus

Section 1: Brief Measure Information 1: Brief Measure Information

Field Label	Field Description
CMIT Number	01101-C-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia.
Numerator	Esophageal biopsy report documents the presence of Barrett's mucosa and includes a statement about dysplasia
Numerator Exclusions	N/A
Denominator	All surgical pathology esophageal biopsy reports for Barrett's Esophagus.
Denominator Exclusions	Specimen site other than anatomic location of esophagus: G8797
Denominator Exceptions	Documentation of medical reason(s) for not submitting the histological finding of Barrett's mucosa (e.g., malignant neoplasm or absence of intestinal metaplasia) (3126F with 1P)
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare
Measure Steward	College of American Pathologists
Data Reporting Begin Date	Merit-Based Incentive Payment System Program: 2018-01-01; Doctors & Clinicians Compare: 2018-01-01

Field Label	Field Description
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 4
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 9. Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure Notes from survey respondents: • CMS has acknowledged this measure is topped out • Measure construct appears to be measuring a standard of care. Does the rate diagnosing this condition indicate good or poor performance • Does this encourage excessive endoscopy in gerd?

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsement Removed
Consensus-Based Entity Number	1854
History of CBE Endorsement	2012: Initial Endorsement 2019: Endorsement Removed; measure steward elected not to resubmit for endorsement

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2012-2013 Recommendation: Recommendation: Physician Quality Reporting System: Submit for NQF endorsement Date reviewed: 2013-2014 Recommendation: Physician Compare: Do Not Support; Value-Based Payment Modifier: Do Not Support
Rationale for MAP Recommendation	This measure has not been reviewed by MAP for Merit-Based Incentive Payment System.

Section 4: Performance and Reporting Data

Year	Total number of measure reporters (group)	Measure reporting rate	Total number of measure reporters (individuals)	Measure reporting rate (individuals)
2018	307	0.42%	33	0.003%
2019	345	0.45%	33	0.003%
2020	313	0.41%	Not available	Not available

- 2018: Total number of reporters for all measures: groups – 72,839; individuals – 1,049,233
- 2019: Total number of reporters for all measures: groups – 75,979; individuals – 1,133,482
- 2020: Total number of reporters for all measures: groups – 75,704; individuals – 1,150,636

Year	Mean performance (registry submission groups)	Mean performance (registry individuals)
2018	99.01	96.61
2019	99.28	99.58
2020	99.00	Not available

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	Data used in the measure are generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), and abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry). Some data elements are in defined fields in electronic sources. The measure developer worked with SNOMED Terminology Solutions staff to determine how to electronically specify this measure. Difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues to be determined; testing is in the planning phase.
Source and Date of Feasibility Data	CBE Measure Submission, 9/5/2019

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

NQF does not have information on potential negative unintended consequences associated with this measure at this time.

Section 8: Additional Information

NQF does not have any additional information for this measure at this time.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 3
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member stated difficulty understanding equity implications because the measure appeared topped out at 99%, indicating the majority of reports contain the dysplasia statement. The member noted there may be health equity concerns with the screening aspects. Another member did not support retainment in the program because they were uncertain of the benefit of the measure and if the measure was stratified, whether the data would showcase high rates of patients with diverse backgrounds. Additionally, another advisory group member restated the health equity perspective is hard to determine due to the topped-out status of the measure, and the data not being stratified.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Removal

Workgroup Rationale

MAP supported removing the measure from the program on the condition that a replacement measure entered the program. Workgroup members noted the small number of pathology measures in the MIPS program and how removing the measure could create a gap. Workgroup members noted that the measure is topped out with no role for continuous improvement.

Public Comments

College of American Pathologists

Do you support retaining this measure in the program? Yes

Does the measure contribute to the overall goals and objectives of the program?

Yes: MIPS is designed to measure and improve care provided by clinicians serving Medicare beneficiaries. A significant majority of medical decisions are made based on data generated by pathology and laboratory medicine. It is therefore important that pathologists be evaluated across the breadth of practice to ensure they are providing timely, accurate, and complete information to partner clinicians and patients. However, pathology has proven to be a difficult specialty to identify and construct MIPS measures for, given the unique payment structure of laboratory medicine (many common tests are not reimbursed by Medicare) and the attribution issues inherent in laboratory-based care. Therefore measures such as QID 249 are critical to ensuring that the MIPS program is fulfilling its intent.

Furthermore, with the advent of the Cures Act, pathology reports are more readily available to patients. Thus the completeness of reports is even more important to reduce patient anxiety and promote meaningful discussions between patients and their clinicians. Maintaining a robust set of publicly available, low burden, quality measures for pathology is critical.

Does the measure result in better patient outcomes?

Yes: since Barrett's esophagus is a precursor to esophageal cancer, early detection and grading of Barrett's is important to reduce subsequent disease burden. Dysplasia is the best histologic marker for cancer risk, driving treatment decisions and outcomes. Grading of dysplasia is critical to medical decision making: the American College of Gastroenterology (ACG) recommends that endoscopic surveillance be performed in patients with Barrett's esophagus at intervals dictated by the degree of dysplasia noted on previous biopsies (Shaheen, N et al 2022). In fact, Barrett's esophagus with high-grade dysplasia is an actionable diagnosis while low-grade is often not. Therefore appropriate grading is essential to proper treatment and outcomes such as avoidance of esophageal carcinoma.

Does the measure reflect the current evidence?

The guideline cited in the original version of the measure (Wani, S et al 2016) has since been retired. However, a new guideline regarding the diagnosis and management of Barrett's esophagus was recently published by the ACG in March 2022 (Shaheen, N et al 2022). This measure is consistent with the recommendations in that guideline.

Is there a high level of reporting burden for reporting entities?

No: in fact, this measure is critical for small practices with limited resources because it has a low reporting burden. QID 249 can be reported via claims for the MIPS program, an option only available to small practices but one which has very little burden. The same is not true of all pathology measures in MIPS; for example QID 440 has a higher reporting burden because it must be reported via a registry not through claims.

Even for larger practices who cannot report MIPS through claims, the burden for this measure is low. Pathologists who use the CAP's Pathologists Quality Registry can have this measure automatically extracted from their pathology report or can work with their billing/practice management company to send the relevant G codes to the Registry. Therefore the measure is among the lowest burden options for many practices

Does the measure have negative unintended consequences?

No; there is no evidence that statements about dyplasia and grade lead to any unintended consequences such as overtreatment or overuse. Barrett's is not a malignancy treated with radiation or chemotherapy, which could have significant side effects. Furthermore, the recent ACG guideline (Shaheen, N et al 2022) is explicit about what treatments are appropriate and inappropriate for certain populations based on grading of dysplasia. Therefore this measure could actually help avoid unnecessary treatment by promoting appropriate grading.

There is no evidence this measure has a disparate impact on rural populations. Access to endoscopy in rural areas may be limited, similar to other forms of specialty care in rural areas, but that is not within the control of this measure. The quality action indicated by this measure does not require sophisticated equipment or techniques so in fact it would be accessible to pathologists with limited resources in rural areas. As noted above, this measure is also low-burden measure for pathologists in small or rural practices.

A recent study of data from the Gastrointestinal Quality Improvement Consortium Registry (GIQuIC) suggests there may be disparities in recommendations for appropriate surveillance intervals for Black patients as opposed to white patients (Jones, B et al 2021) although Barrett's esophagus appears to be more common in the non-Hispanic white population. While this measure does not cover recommendation of an appropriate surveillance interval, the interval is based on dysplasia and grade, so consistent performance of this measure may help reduce disparities.

References:
Jones B; Williams JL; Komanduri S; Muthusamy VR; Shaheen NJ; Wani S. Racial Disparities in Adherence to Quality Indicators in Barrett's Esophagus: An Analysis Using the GIQuIC National Benchmarking Registry. The American Journal of Gastroenterology. June 2021 -- 116(6):1201-1210.

Shaheen, Nicholas J; Falk, Gary W; Iyer, Prasad G; Souza, Rhonda F; Yadlapati, Rena H; Sauer, Bryan G; Wani, Sachin. Diagnosis and Management of Barrett's Esophagus: An Updated ACG Guideline, The American Journal of Gastroenterology: April 2022 - 117(4): 559-587

Wani, Sachin; Rubenstein, Joel H; Vieth, Michael; Bergman, J. Diagnosis and Management of Low-Grade Dysplasia in Barrett's Esophagus: Expert Review From the Clinical Practice Updates Committee of the American Gastroenterological Association Gastroenterology: November 2016 – 151(5): 822 - 835

Public Comments Post-Workgroup Meeting

College of American Pathologists

Do you support retaining this measure in the program? Yes

1. Does the measure contribute to the overall goals and objectives of the program?

Yes: MIPS is designed to measure and improve care provided by clinicians serving Medicare beneficiaries. A significant majority of medical decisions are made based on data generated by pathology and laboratory medicine. It is therefore important that pathologists be evaluated across the breadth of practice to ensure they are providing timely, accurate, and complete information to partner clinicians and patients. However, pathology has proven to be a difficult specialty to identify and construct MIPS measures for, given the unique payment structure of laboratory medicine (many common tests are not reimbursed by Medicare) and the attribution issues inherent in laboratory-based care. Therefore measures such as QID 249 are critical to ensuring that the MIPS program is fulfilling its intent.

Furthermore, with the advent of the Cures Act, pathology reports are more readily available to patients. Thus the completeness of reports is even more important to reduce patient anxiety and promote meaningful discussions between patients and their clinicians. Maintaining a robust set of publicly available, low burden, quality measures for pathology is critical.

2. Does the measure result in better patient outcomes?

Yes: since Barrett's esophagus is a precursor to esophageal cancer, early detection and grading of Barrett's is important to reduce subsequent disease burden. Dysplasia is the best histologic marker for cancer risk, driving treatment decisions and outcomes. Grading of dysplasia is critical to medical decision making: the American College of Gastroenterology (ACG) recommends that endoscopic surveillance be performed in patients with Barrett's esophagus at intervals dictated by the degree of dysplasia noted on previous biopsies (Shaheen, N et al 2022). In fact, Barrett's esophagus with high-grade dysplasia is an

actionable diagnosis while low-grade is often not. Therefore appropriate grading is essential to proper treatment and outcomes such as avoidance of esophageal carcinoma.

3. Does the measure reflect the current evidence?

The guideline cited in the original version of the measure (Wani, S et al 2016) has since been retired. However, a new guideline regarding the diagnosis and management of Barrett's esophagus was recently published by the ACG in March 2022 (Shaheen, N et al 2022). This measure is consistent with the recommendations in that guideline.

4. Is there a high level of reporting burden for reporting entities?

No: in fact, this measure is critical for small practices with limited resources because it has a low reporting burden. QID 249 can be reported via claims for the MIPS program, an option only available to small practices but one which has very little burden. The same is not true of all pathology measures in MIPS; for example QID 440 has a higher reporting burden because it must be reported via a registry not through claims.

Even for larger practices who cannot report MIPS through claims, the burden for this measure is low. Pathologists who use the CAP's Pathologists Quality Registry can have this measure automatically extracted from their pathology report or can work with their billing/practice management company to send the relevant G codes to the Registry. Therefore the measure is among the lowest burden options for many practices.

5. Does the measure have negative unintended consequences?

No; there is no evidence that statements about dyplasia and grade lead to any unintended consequences such as overtreatment or overuse. Barrett's is not a malignancy treated with radiation or chemotherapy, which could have significant side effects. Furthermore, the recent ACG guideline (Shaheen, N et al 2022) is explicit about what treatments are appropriate and inappropriate for certain populations based on grading of dysplasia. Therefore this measure could actually help avoid unnecessary treatment by promoting appropriate grading.

There is no evidence this measure has a disparate impact on rural populations. Access to endoscopy in rural areas may be limited, similar to other forms of specialty care in rural areas, but that is not within the control of this measure. The quality action indicated by this measure does not require sophisticated equipment or techniques so in fact it would be accessible to pathologists with limited resources in rural areas. As noted above, this measure is also low-burden measure for pathologists in small or rural practices.

A recent study of data from the Gastrointestinal Quality Improvement Consortium Registry (GIQuIC) suggests there may be disparities in recommendations for appropriate surveillance intervals for Black patients as opposed to white patients (Jones, B et al 2021) although Barrett's esophagus appears to be more common in the non-Hispanic white population. While this measure does not cover recommendation of an appropriate surveillance interval, the interval is based on dysplasia and grade, so consistent performance of this measure may help reduce disparities.

References:
Jones B; Williams JL; Komanduri S; Muthusamy VR; Shaheen NJ; Wani S. Racial Disparities in Adherence to Quality Indicators in Barrett's Esophagus: An Analysis Using the GIQuIC National Benchmarking Registry. The American Journal of Gastroenterology. June 2021 -- 116(6):1201-1210.

Shaheen, Nicholas J; Falk, Gary W; Iyer, Prasad G; Souza, Rhonda F; Yadlapati, Rena H; Sauer, Bryan G; Wani, Sachin. Diagnosis and Management of Barrett's Esophagus: An Updated ACG Guideline, The American Journal of Gastroenterology: April 2022 - 117(4): 559-587

Wani, Sachin; Rubenstein, Joel H; Vieth, Michael; Bergman, J. Diagnosis and Management of Low-Grade Dysplasia in Barrett's Esophagus: Expert Review From the Clinical Practice Updates Committee of the American Gastroenterological Association Gastroenterology: November 2016 – 151(5): 822 - 835

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

02381-C-MIPS Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	02381-C-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Patients aged 18 years and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.
Numerator	Patients who achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye
Numerator Exclusions	N/A
Denominator	Patients aged 18 years and older who had surgery for primary hematogenous retinal detachment
Denominator Exclusions	Patients with a pre-operative visual acuity better than 20/40 Surgical procedures that included the use of silicone oil
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	American Academy of Ophthalmology

Field Label	Field Description
Data Reporting Begin Date	Merit-Based Incentive Payment System: 2018-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 9. Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure Notes from survey respondents: • The incidence of this condition is 1 in 10,000 per year may pose small volume problems

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed, Never Submitted
Consensus-Based Entity Number	9999
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

There is no publicly available data for this measure.

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	NQF does not have information on the feasibility of this measure.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

NQF does not have information on potential negative unintended consequences associated with this measure.

Section 8: Additional Information

NQF does not have additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 2
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program – 2

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member expressed approval of the outcome measure but questioned its applicability to rural areas due to small volume concerns.

MAP Health Equity:

An advisory group member noted their concern with the measure due to low volume and the difficulty assessing equity issues based on various subgroups. The member acknowledged the public comment recognizing outcomes for certain groups are worse following retinal detachments, highlighting the health equity concern.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) lengthen the follow-up period, 2) add additional exclusions (e.g., macular involvement) and 3) CBE endorsement. Workgroup members recommended lengthening the follow-up period to allow for additional corrections to visual acuity and adding exclusions in order to account for starting visual acuity. Workgroup members also indicated that review of the measure by a CBE would be useful.

Public Comments

MarsdenAdvisors

Do you support retaining this measure in the program? Yes

MarsdenAdvisors opposes the MAP recommending removal of Measure 385. Currently, the retina subspecialty has only six benchmarked MIPS quality and QCDR measures. Because of this, we have been working with our clients to encourage reporting on Measure 385 this year, and our practices have been receptive to this measure as an outcome measure that is germane to retina. With the MAP considering recommending removal of two of the few available retina measures, however, this would leave clinicians in the retina subspecialty to try to find and report on measures completely unrelated to their clinical practice, rather using than meaningful measures that truly evaluate the care they provide.

American Society of Retina Specialists

Do you support retaining this measure in the program? Yes

ASRS supports removing this measure from the MIPS program. Because of the way it is defined, the measure is flawed in that it is based on achieving visual acuity as opposed to anatomic success, which is typically the goal retina specialists have for these procedures. For example, it doesn't take into account whether the macula was attached or detached preoperatively; and for the 30-60% of patients presenting with retinal detachment who have attached maculas, visual acuity usually doesn’t improve. In addition, phakic patients may often have worse vision at the 3-month time point due to developing a cataract post-vitrectomy despite improved potential vision from the repair of the retinal detachment. Finally, if a scleral buckle is performed, a patient might develop a refractive error that may not be corrected by a new prescription at the 3-month time point.

Furthermore, retina specialists often have difficulty achieving the denominator minimum of 20 eligible patients for the measure. This inability to meet denominator minimums is borne out by the fact that

CMS has not been able to calculate benchmarks for this measure for the last several years due to low performance across the specialty. Surgeons who are able to meet denominator thresholds, however, may be unwilling to report the measure because of the reasons listed above that could prevent them from achieving the targeted visual acuity.

American Academy of Ophthalmology

Do you support retaining this measure in the program? Yes

02381-C-MIPS- Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery

As the leading society in ophthalmology with 27,000 members, the American Academy of Ophthalmology understands the need for quality measures that are clinically relevant and improve patient outcomes. We are providing support for the following criteria that were utilized by the MSR process and rebut the proposed removal of the measure. We strongly support the maintenance of this measure for the MIPS program to continue to meet the goal of quality improvement for Medicare beneficiaries:

1. Measure does not contribute to the overall goals and objectives of the program

The patient care objectives of the Quality Payment Program are as follows (https://qpp.cms.gov/about/qpp-overview): to improve beneficiary population health; to improve the care received by Medicare beneficiaries, to lower costs to the Medicare program through improvement of care and health, to advance the use of healthcare information between allied providers and patients, to educate, engage and empower patients as members of their care team. This measure directly contributes to these overall objectives and is categorized by CMS as aligned with this domain of the National Quality Strategy to address the most common health concerns that Americans face: Effective Clinical Care, and aligned with this Meaningful Measure Area: Functional Outcomes.

2. Measure is duplicative of other measures within the same program

There are no other measures within MIPS that are duplicative.

4. Performance or improvement on the measure does not result in better patient outcomes

This is a patient outcome measure, because it measures visual acuity after retinal detachment surgery, so it directly results in better patient outcomes for functional activity and

5. Measure does not reflect current evidence

This is a patient outcome measure and does reflect the current evidence and thinking regarding the optimal patient outcome.

6. Measure performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the electronic Clinical Quality Measure, the measure is marked as NO for topped out.

7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

In the 2021 MIPS Historical Quality Benchmarks (reflecting 2020 performance year results), for the electronic Clinical Quality Measure, the measure is marked as NO for topped out, so the performance is not uniformly high and does have variation in performance overall and by subpopulation, as per CMS.

8. Measure leads to a high level of reporting burden for reporting entities

This does not impose a high level of reporting burden because the majority of ophthalmologists are on EHR and on the IRIS Registry and can report this measure via automated data extraction from their EHR, and for the ophthalmologists not on EHR, the volume of cases would not impose a high level of reporting burden for reporting the visual acuity outcome of these procedures.

9. Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure

CMS does not publish the number of entities reporting each measure in the MIPS program, so this is difficult to ascertain. However, this appears to be a measure reported by a significant number of participants, including entities with low volumes. For the 2021 MIPS reporting year, 230 entities reported QPP19 through the IRIS Registry, including entities with low volume of patients eligible for this measure. In addition, we would urge that there be consideration that 2020, 2021 and probably for the 2022 performance year, we have been in the midst of the COVID-19 pandemic. A large number of clinicians have opted out of MIPS reporting, and certainly surgery rates, MIPS participation and performance rates may have been affected by the pandemic. We need additional time for consideration of measure performance, particularly for the small practices without EHRs which may be practicing in rural, inner-city, and underserved areas of the country.

10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

There are no negative unintended consequences of this measure, including potential negative impacts to the rural population or possible contribution to health disparities, because ophthalmologists will perform retinal detachment repair surgeries for the potential to restore or maintain sight. There is no risk that this surgery will be withheld because of any concerns about performance rates because this surgery is appropriate and necessary for these patients.

It seems as though the only criteria not met is #3, Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement. The stipulation that measures are approved by a consensus-based entity was never a criterion for approval into the MIPS program and many CMS measures were included in the MIPS program without consensus-based entity approval. Consensus-based entity approval required costly requirements for testing and validation, which is why it is onerous for specialty societies to apply for and maintain our NQF approval. Societies also incur high costs to maintain NQF membership. It is disingenuous to impose this requirement 7 years after quality measures have been accepted and used in the MIPS program without having had to meet this requirement. This imposes a high and costly burden on measure stewards to maintain existing quality measures, in addition to the testing requirement burden that is now enforced on all QCDR measures. These costly unfunded mandates take funding away from specialty societies to develop quality measures.

Should you have any questions or want a further discussion, please contact Brandy M. Keys, MPH, AAO Director of Health Policy at bkeys@aao.org or 202-737-6662.

Public Comments Post-Workgroup Meeting

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

05826-E-MIPS Closing the Referral Loop: Receipt of Specialist Report (eCQM)

Section 1: Brief Measure Information 1: Brief Measure Information

Field Label	Field Description
CMIT Number	05826-E-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
Numerator	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
Numerator Exclusions	N/A
Denominator	Number of patients, regardless of age, who were referred by one provider to an provider, and who had a visit during the measurement period
Denominator Exclusions	N/A
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare
Measure Steward	Centers for Medicare & Medicaid Services
Data Reporting Begin Date	Merit-Based Incentive Payment System Program 2018-01-01; Doctors & Clinicians Compare 2018-01-01

Field Label	Field Description
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • Redundant to measure 02527-C-MIPS, could combine. • Penalizes those not in systems of care; benefits those who are in such systems - no requirement to demonstrate that report was read

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed, Never Submitted
Consensus-Based Entity Number	9999
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP for MIPS Date reviewed: 2011-2012 Recommendation: Medicare and Medicaid EHR Incentive Program for Eligible Professionals: Do Not Support Date reviewed: 2012-2013 Recommendation: Physician Quality Reporting System: Submit for NQF endorsement Date reviewed: 2013-2014 Recommendation: Physician Compare: Do Not Support; Value-Based Payment Modifier/Physician Feedback Program: Do Not Support
Rationale for MAP Recommendation	This measure has not been reviewed by MAP for the Merit-Based Incentive Payment System.

Section 4: Performance and Reporting Data

Year	Total number of measure reporters (group)	Measure reporting rate (group)	Total number of measure reporters (individuals)	Measure reporting rate (individuals)
2018	2,409	3.31%	5,302	0.51%
2019	2,458	3.24%	6,122	0.54%
2020	2,485	3.28%	7,068	0.61%

- 2018: Total number of reporters for all measures: groups – 72,839; individuals – 1,049,233
- 2019: Total number of reporters for all measures: groups – 75,979; individuals – 1,133,482
- 2020: Total number of reporters for all measures: groups – 75,704; individuals – 1,150,636

Year	Mean performance (registry submission groups)	Mean performance (EHR submission groups)	Mean performance (registry individuals)	Mean performance (EHR submission individuals)
2018	67.15	39.81	77.82	41.48
2019	77.89	39.77	81.33	40.64
2020	76.10	34.54	73.60	29.64

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	NQF does not have information on the feasibility of this measure.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

NQF does not have information on potential negative unintended consequences associated with this measure.

Section 8: Additional Information

NQF does not have information on potential negative unintended consequences associated with this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 2
- No (Do Not Support Retaining in Proposed Program) – 6
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member agreed with public comments that the measure puts extraneous burden on the referring physician and reflects on the that physician if the report is not returned. The member also noted rural providers may not have the technology to receive feedback from referrals to urban centers.

MAP Health Equity:

An advisory group member noted coordination of care is important with populations that have less access to healthcare, however, there is uncertainty the measure will accurately capture coordination of care. Another advisory group member noted if systems with more resources provide better quality, that reflects true differences in the care patients are receiving in different systems. The member stated this may lead to equity concerns regarding where patients receive care. The member also commented systems with more resource may have higher performance because their EHR system makes it easier to document, highlighting equity concerns from this perspective. An advisory group member noted this measure may not have a strong health equity perspective because it is not a true reflection in differences in quality. Additionally, an advisory group member highlighted if this measure was stratified by race, then the measure may show inequities in continuum of care for minority patients.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted the measure has value in improving care coordination and the importance of referrals being completed for a patient's care. Workgroup members, however, noted the difference in performance results for clinicians reporting via registries versus electronic health records, and suggested that it is important to understand why this difference exists.

Public Comments

MarsdenAdvisors

Do you support retaining this measure in the program? Yes

MarsdenAdvisors opposes the MAP recommending removal of Measure 374 as this important measure that encourages meaningful and regular care coordination.

We use this measure with many of our practices. Improved care coordination is an important movement in medicine. According to the Agency for Healthcare Research and Quality (AHRQ), care coordination is vital to achieve safer, more effective, and more cost-efficient care.

NQF's EHR Care Coordination Committee wrote and emphasized the following statement in its Environmental Scan Report last year:

"Measurement using EHRs in this area is critical, as measurement will drive quality improvement efforts to enhance care communication and care coordination, two processes that are essential to achieving the Quadruple Aim of enhancing the patient experience, improving population health, improving the work life of healthcare providers, and reducing costs."

When we introduce measure 374 to practices, they often realize that care coordination (both sending and receiving specialist reports) is something they have neglected. Often, after discussing this measure, the practice decides to use this measure as a motivation to improve their care coordination. This measure provides a key incentive to practices to engage in clinician-to-clinician communication and practices find this to be a meaningful measure to their patients and their practice.

Covenant Physician Partners

Do you support retaining this measure in the program? No

We continue to have difficulty with specialist understanding CCDA and or not willing to obtain/provide secure direct emails.

As this measure is dependent on other provider offices proving reports, I do not support the continued use of this measure.

American Urological Association

Do you support retaining this measure in the program? Yes, Under certain conditions

Thank you for the opportunity to comment on the MAP's Measure Set Review (MSR). We agree that MAP input on removal of measures from federal quality programs is needed. We are disappointed, however, that NQF did not publicize the MSR process earlier and more broadly (i.e., outside of a MAP meeting). We are also disappointed that NQF did not share the survey results that underpin the selection of measures for the MSR. Without knowing which criteria were of most concern for the various measures, it is difficult to provide useful comments to the workgroups and advisory groups, particularly given the fairly short turn-around time for commenting. We look forward to better understanding the concerns with the various measures, and to the upcoming MAP discussions.

American College of Physicians

Do you support retaining this measure in the program? No

The ACP supports the removal of Quality ID #374. This measure represents an important clinical concept; however, implementation may lead to an unintended consequence of encouraging unnecessary care. The specifications are not well defined and should include an evidence-based time interval and some element of risk-adjustment. The measure outcome is based on the level of integration of the participating information system rather than on how well the individual clinician tracks the referral. Information can appear to be 100% transmitted in a well-integrated system, whereas an independent practice network does not generate this data trail as a byproduct of its work. Additionally, it is not necessary for clinicians to close all referral loops. For instance, clinicians may refer a patient to a disease specialist for a condition that resolves prior to their appointment date. Also, depending on the urgency to complete the referral within a given time frame, the patient may not see the specialist within the measurement period. In this case, the referring clinician would fail the measure. Lastly, the burgeoning use of electronic health records (EHRs) will make this measure become far less relevant in the next several years.

Public Comments Post-Workgroup Meeting

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

05837-E-MIPS Children Who Have Dental Decay or Cavities (eCQM)

Section 1: Brief Measure Information 1: Brief Measure Information

Field Label	Field Description
CMIT Number	05837-E-MIPS
CMS Program(s) for Which Measure is Being Discussed for Removal	Merit-Based Incentive Payment System Program
Measure description	Percentage of children, 6 months - 20 years of age at the start of the measurement period, who have had tooth decay or cavities during the measurement period
Numerator	Children who had a diagnosis of cavities or decayed teeth in any part of the measurement period
Numerator Exclusions	N/A
Denominator	Children, 6 months - 20 years of age, with a clinical oral evaluation during the measurement period
Denominator Exclusions	Exclude patients who are in hospice care for any part of the measurement period
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	Centers for Medicare & Medicaid Services
Data Reporting Begin Date	Merit-Based Incentive Payment System Program 2018-01-01

Field Label	Field Description
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • Need more information; while this outcome needs to be measured because it is important for childhood dental health, it could disincentivize a dentist from treating patients with inadequate dental care or at high risk for dental problems.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed, Never Submitted
Consensus-Based Entity Number	9999
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

CMS Performance Data: Not available for 2018-2020.

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	The measure's feasibility is not known as the measure has not been reviewed by NQF.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 0
- No (Do Not Support Retaining in Proposed Program) – 7
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

One member noted the measure had not been submitted for endorsement. Another advisory group member commented the denominator does not allow the measure to reveal the full picture of access to dental care, as it only represents children who already have dental care and not the children who are not coming in. An advisory group member also commented that high costs of treating tooth decay or cavities can be a barrier for accessing care, and it may not be fair to bring that accountability back to the dentist.

MAP Health Equity:

An advisory group member noted the measure is important from an equity perspective. Another advisory group member agreed with this sentiment, further adding there is concern that the measure is examining only prevalence, but overall, the measure contributes toward holistic healthcare.

Another advisory group member highlighted the measure may disincentivize dentists who work in communities that have a lack of healthy food and dental care. The member also noted there are various upstream components from a community perspective and structural components from an equity perspective to consider.

An advisory group member posed the question whether clinicians are penalized if they have a high degree of children with cavities. Another member noted if there are payment consequences, patient populations should be adjusted accordingly due to populations with limited resources.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Removal

Workgroup Rationale

MAP supported removing the measure from the program on the condition that a replacement measure entered the program. Workgroup members noted the small number of dental measures in the MIPS program and removing the measure could create a gap. Workgroup members had significant concerns about the measure's value and design and suggested a measure designed around preventing cavities might be a better fit for the program. The workgroup also noted the measure should focus on incidence, rather than prevalence, of cavities.

Public Comments

Carilion Clinic

Do you support retaining this measure in the program? No

Depends on who this is measuring, primary care physicians do not want to be held accountable/responsible for patients with dental decay or cavities given limited to no dental access or coverage.

Public Comments Post-Workgroup Meeting

See **Letter submitted as part of public comment from the Physician Clinical Registry Coalition (PCRC)** under 00254-C-MIPS Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

00515-C-MSSP Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	00515-C-MSSP
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Numerator Exclusions	N/A
Denominator	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.
Denominator Exclusions	Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.
Denominator Exceptions	Patient Reason(s) Patient refuses to participate OR Medical Reason(s) Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status).
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System Program; Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Doctors & Clinicians Compare; Medicaid: Health Home Core Set

Field Label	Field Description
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Medicare Shared Savings Program: 2012-01-01; Doctors & Clinicians Compare: 2018-01-01; Merit-Based Incentive Payment System Program: 2018-10-01; Medicaid: Health Home Core Set: 2012-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program, • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement, • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation • Criteria 9. Measure leads to a high level of reporting burden for reporting entities Notes from survey respondents: • None

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed
Consensus-Based Entity Number	0418
History of CBE Endorsement	Initial Endorsement: 2008 Last Endorsement: 2017 Endorsement Removed: 2020 Endorsement removed due to measure steward declining to re-submit measure for endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

CMS Performance Data: Data reported through the CMS Web Interface shows the number of reporting ACOs between 2018 and 2020 were ~500. The mean performance rate for these ACOs was ~70. The distribution of performance rates (percentiles) showed variation over time and between ACOs.

PY	N	Mean	P0	P10	P25	P50	P75	P90	P100
2018	546	66.60	0.00	42.86	55.56	68.84	80.97	87.99	100.00
2019	534	70.40	0.40	48.12	60.73	72.95	83.16	89.62	99.69
2020	505	71.46	5.31	48.96	61.85	74.62	83.52	89.74	99.23

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Larger results are better
- Adjustment applied: None
- Trend category: Improving
- Average annual percentage change (AAPC): 14.8
- AAPC 90% confidence interval: [14.7, 15.0]
- Score (standard deviation) [provider interquartile range]
    - 2016: 54.3 (49.8) [31.0]
    - 2017: 61.7 (48.6) [26.8]
    - 2018: 67.1 (47.0) [25.4]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	For this measure, data is collected from electronic clinical sources and reported through the CMS Web Interface. No implementation challenges were reported by the 2016-2017 Standing Committee. To note, one committee member from the Standing Committee indicated concerns regarding the difficulty of documenting the follow-up plan. Additionally, the measure developer noted that data elements are generated or collected by and used by healthcare personnel during the provision of care, and coded by someone other than the person obtaining original information. Regarding data availability, the measure's reporting is facilitated by the use of Quality Data Codes in claims and registry data.
Source and Date of Feasibility Data	Data comes from NQF's Behavioral Health 2016-2017 Technical Report and information from measure steward.

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information on for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 1
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program – 2

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

An advisory group member noted that due to the rise in mental illness during the COVID-19 pandemic, screening for depression should remain a priority, including in rural areas. Advisory group members raised concerns about the lack of behavioral health specialists available to rural populations, noting primary care providers who might be most likely to see these patients may be uncomfortable doing depression screenings. Additionally, primary care physicians in rural settings may be reluctant to conduct screening with no additional resources available for follow-up or referral. Advisory group members expressed a strong desire to see this topic addressed and a focus for improvement given increasing prevalence of mental health challenges across age groups but noted uncertainty as to whether the measure was the correct path forward.

MAP Health Equity:

An advisory group member noted, while primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show PCPs fail to recognize depression in up to 56% of patients and only 36-44% of depressed children and adolescents actually receive treatment. The member stated these statistics suggest the majority of depressed youth are undiagnosed and untreated. One advisory group member commented in the chat that systems that have a higher proportion of patients with access to portals for digital screening have a much easier time reporting on the electronic version of the measure than systems with less affluent patients. Another advisory group member commented in the chat the measure (and/or eCQM version) is useful for assessing equity given under-identification of depression in minority populations. The advisory group member noted there may also be an intersectionality value given under-identification in women.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted the measure is important as it promotes the identification of depression, which may not always be apparent to clinicians. They also noted removing the measure could create a gap in the program, as there is only one other clinical measure in MSSP. However, workgroup members expressed concerns about the difficulty in determining if poor performance is due to the patient not being screened or if the follow-up plan was difficult to document.

Public Comments

Otsuka Pharmaceutical Development & Commercialization, Inc.

Do you support retaining this measure in the program? Yes

Given the increase in mental health conditions during COVID, including depression and anxiety, I believe it is essential to keep depression screening measures in measure sets to encourage proper identification and treatment for patients. Unless this measure is duplicative of another measure, I would argue for retaining it in MSSP.

Public Comments Post-Workgroup Meeting

No public comments received.

CMS eCQM ID:CMS2v11; MIPS Quality ID: 134 Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	CMS eCQM ID:CMS2v11; MIPS Quality ID: 134
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.
Numerator Exclusions	N/A
Denominator	Equals initial population; defined in the measure description: All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period
Denominator Exclusions	Patients who have been diagnosed with depression or with bipolar disorder
Denominator Exceptions	Patient Reason(s): Patient refuses to participate OR Medical Reason(s): Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

Field Label	Field Description
CMS Program(s) in Which Measure is Used	Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Medicare Shared Savings Program: Data not yet available for performance year 2021.
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: The eCQM version of this measure was not included in the survey for MSSP.
Rationale for Removal Consideration	N/A

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed
Consensus-Based Entity Number	9999
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	This measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

CMS Performance Data: Not yet available for 2021. Data reported in the future will measure the all-payer population.

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	The measure's feasibility is not known as the measure has not been reviewed by NQF.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 2
- No (Do Not Support Retaining in Proposed Program) – 3
- Unsure of Retaining in Proposed Program – 2

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns, although one member noted eCQMs may be less burdensome than paper-based measures and expressed this difference was enough to change the balance in its favor (when considering whether to retain the measure in the program).

MAP Health Equity:

Comments were carried forward for this measure from the non-eCQM version.

An advisory group member noted, while primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show PCPs fail to recognize depression in up to 56% of patients and only 36-44% of depressed children and adolescents actually receive treatment. The member stated these statistics suggest the majority of depressed youth are undiagnosed and untreated. One advisory group member commented in the chat that systems that have a higher proportion of patients with access to portals for digital screening have a much easier time reporting on the electronic version of the measure than systems with less affluent patients. Another advisory group member commented in the chat the measure (and/or eCQM version) is useful for assessing equity given under-identification of depression in minority populations. The advisory group member noted there may also be an intersectionality value given under-identification in women.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted that this version of the measure can reduce reporting burden when compared to the non-eCQM version of the measure.

Public Comments

Core Solutions

Do you support retaining this measure in the program? Yes, under certain conditions

My comment is that there is only one measure that has anything to do with mental health and/or substance use. Given the recognized importance of addressing behavioral health issues in an integrated manner the current measures do not allow federal programs to have any effect in this area. There are several measures that could be included from the 25 measures that have been approved by the Behavioral Health and Substance Use Committee and would suggest that the MAP go back to the drawing board and select some of those measures that might have the highest impact. Follow up from hospitalizations and from ED visits are important as well as at least screening for substance use disorders.

Thank you for the opportunity to comment
Michael Lardieri, LCSW
Member of the Behavioral Health and Substance Use Committee

Public Comments Post-Workgroup Meeting

No public comments received.

01246-C-MSSP Controlling High Blood Pressure

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	01246-C-MSSP
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.
Numerator	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	N/A
Denominator	Patients 18-85 years of age who had a visit and a diagnosis of hypertension overlapping the measurement period.
Denominator Exclusions	Hospice services given to patient any time during the measurement period, documentation of end stage renal disease (ESRD), dialysis, renal transplant before or during the measurement period or pregnancy during the measurement period. Patients aged 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care with POS code, 32, 33, 34, 54, or 56 for more than 90 consecutive days during the measurement period. Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period. Patients 66-80 years of age with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period. Patients 81 years of age and older with at least one claim/encounter for frailty during the measurement period.
Denominator Exceptions	N/A

Field Label	Field Description
CMS Program(s) in Which Measure is Used	Merit-Based Incentive Payment System; Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	Medicaid: Adult Core Set; HEDIS Quality Measure Rating System; Marketplace Quality Rating System
Measure Steward	National Committee for Quality Assurance
Data Reporting Begin Date	Medicare Shared Savings Program: 2012-01-01; Merit-Based Incentive Payment System (MIPS): 2018-01-01; Medicaid: Adult Core Set: 2013-12-01; HEDIS Quality Measure Rating System: 1999-01-01; Marketplace Quality Rating System: 2015-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 6
Rationale for Removal Consideration	Rationale for nominations: • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 4. Performance or improvement on the measure does not result in better patient outcomes • Criteria 8. Measure leads to a high level of reporting burden for reporting entities • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • We consider this being a good measure and wonder why it is not endorsed. • Uncertain as to strength of data in those >75 years of age

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	The version of this measure currently in use by CMS differs significantly from the version of this measure last endorsed in 2020 (NQF 0018). For this reason, CMS considers this measure not to be currently endorsed.
Consensus-Based Entity Number	9999

Field Label	Field Description
History of CBE Endorsement	A summary of the NQF 2020 endorsement for 0018 is provided; however, CMS considers 01246-C-MSSP to differ significantly from NQF 0018. The NQF Standing Committee voted to pass this measure on evidence and performance gap. The Standing Committee discussed challenges with setting appropriate blood pressure goals and the nuances of blood pressure measurement. It mentioned that treatment to a single set target for both diastolic and systolic blood pressure can be difficult and may not be appropriate at the individual patient level. The Standing Committee and the developer discussed measuring based on a point measure versus an average of readings and the data challenges related to obtaining an average reading. The Standing Committee was pleased to see the inclusion of some forms of remote monitoring in the updated specifications but noted that only monitors that auto-transmit data are currently included. The Standing Committee discussed the simplicity of having one blood pressure measure versus having multiple measures split by age. They noted that as age increases, the absolute risk reduction gained through treatment also increases; however, the potential for adverse events also rises with age. A Standing Committee member noted that age does not correspond perfectly with physiological state. Ultimately, the Standing Committee decided that this measure is appropriate for use at a population level for health plans, noting that the measure performance goal is not 100 percent. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Y-11; N-0

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2014-2015 Recommendation: Conditional support
Rationale for MAP Recommendation	MAP discussed the ongoing controversy and changing guidelines around BP target values. MAP noted concerns about guidelines not being finalized and changing measure specifications too frequently. MAP supports the measure conditional on review by NQF pending final hypertension guidelines from AHA/ACC due in 2015.

Section 4: Performance and Reporting Data

CMS Performance Data: Data reported through the CMS Web Interface shows the number of reporting ACOs between 2018 and 2020 were ~500. The mean performance rate for these ACOs was ~70. The distribution of performance rates (percentiles) showed variation between ACOs.

PY	N	Mean	P0	P10	P25	P50	P75	P90	P100
2018	544	73.12	2.82	65.22	68.50	73.07	77.85	81.85	92.77
2019	534	75.04	6.74	66.54	70.88	75.08	79.97	84.23	95.24
2020	505	72.87	0.00	63.46	68.35	72.94	78.21	82.39	94.55

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Larger results are better
- Adjustment applied: None
- Trend category: Improving
- Average annual percentage change (AAPC): 1.7
- AAPC 90% confidence interval: [1.6,1.8]
- Score (standard deviation) [provider interquartile range]
    - 2016: 70.6 (45.5) [9.2]
    - 2017: 71.7 (45.1) [8.1]
    - 2018: 73.2 (44.3) [9.3]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	For the version of the measure endorsed by the CBE, the Standing Committee did not express any concerns about the feasibility of the measure. They agreed that the benefits outweighed the harms and the measure passed on use and usability.
Source and Date of Feasibility Data	Cardiovascular, Fall 2019 Cycle Track 2: CDP Technical Report

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information about negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 2
- No (Do Not Support Retaining in Proposed Program) – 2
- Unsure of Retaining in Proposed Program – 3

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member commented that patients suffering from high blood pressure deal with equity issues, so the measure is important but suggested the measure could be improved.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) having multiple encounters is important, 2) change the last reading requirement to an average or a therapeutic window, and 3) allow ambulatory or at-home blood pressure readings to be included in measure. Workgroup members included these conditions to bring the measure in line with recent literature and allow for documentation of home reading of blood pressures.

Public Comments

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
No improvement in the NCQA Controlling High Blood Pressure Measure and its derivatives (such as 01246-C-MSSP over past 15 years

Background
Measure continues to be the only single measure used in both federal and commercial quality incentive programs. Raises a significant question of face validity and importance without questioning why the measure appears to be "topped out". Multiple concerns about this measure, such as recently raised by the American College of Physicians. Relevant population now estimated to be more than 115 million Americans.

Recommendation
Convene a multistakeholder group of professional societies and other key stakeholders to make evidence-based recommendations to NCQA and CMS for a new foundation for more effective and valid patient-centered quality measurements designed to align with a nation-wide BP control initiative.

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Does not require confirmation and documentation of measurement accuracy or certified validation of measurement device used in accordance with published scientific and guideline-based BP measurement standards.

Background
BP measurements for numerator consideration should be obtained by the evidence-based "Standards Based Method" promulgated by AMA & AHA, HHS, HRSA, etc. using measurements obtained from devices found on the US Blood Pressure Validated Device Listing (VDL™)

Recommendation
Improve reporting requirements to assure that BP measures used for numerator inclusions and exclusions meet accuracy and validation standards. The over-reliance on inaccurate BP measurements is hazardous to high quality patient care.

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Uses the last measurement value for the year for numerator inclusion/exclusion

Background
Based on longstanding traditional "ease of use" reporting using "hybrid" models.

Recommendation
Consider moving to a "Time in Therapeutic Range" model now consistently used in clinical trials for BP control

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Does not permit the addition of BP readings obtained by Self-Monitoring (SMBP)

Background
Prior considerations of including SMBP measurements limited by technical and validity concerns.

Strong recommendations with high quality evidence now support the regular use of SMBP in determining effectiveness of BP control. Should include alignment with Issues of Accurate Measurement and use of Time in Therapeutic Range noted in my other comments.

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Excludes patients with Heart Failure (HF)

Background
See 2022 HEDIS® Advanced Illness and Frailty Exclusions Guide. Unsure of the original reasoning and (?documented?) source of decision making for not including this critically important and large population in need of effective BP control.

Recommendation
Include patients with all phenotypes of Stages B and C Heart Failure in accordance with recently published 2022 ACC/AHA/HFSA HF Guidelines for BP control in patients with HF.

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Blood Pressure Control separated from other variables for 10-year ASCVD risk

Background
Other Risk Score variables evaluated by other quality measures assessed separately and not “bundled” into a composite summary of overall ASCVD Risk and Risk Reduction opportunities at the patient level.

Recommendation
The primary purpose of effective BP control is to reduce cardiovascular risk. Patients and their clinicians must better understand their BP readings in this larger context, rather than just being concerned about a single BP reading. This is an important root cause of "Therapeutic Inertia".

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Ignores 2021 Kidney Disease: Improving Global Outcomes (KDIGO) BP Guideline control target of < 120 mm Hg SBP for patients with non-dialysis CKD

Background
Current NCQA definition of control is SBP measurement < 140 mm Hg discordant with strong evidence-based recommendation for patients with CKD (included in denominator of current version of the NCQA Measure).

Recommendation
Include KDIGO and the National Kidney Foundation in the stakeholder convening noted in Recommendation #1 above.

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Current measure is only for patients with ACC/AHA Stage 2 High Blood Pressure.

Background
Measure ignores patients with Stage 1 HBP as promulgated by 11 multidisciplinary and diverse professional societies in the 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline and the Centers for Disease Control

Recommendation
Consider adding a new "paired" measure that would report BP control below a threshold target of < 130 SBP

Patient Experience & Function Committee Member

Do you support retaining this measure in the program? Yes, under certain conditions

Strongly encourage members of the MAP to review this recently published article in the American Journal of Medical Quality (AJMQ): Controlling High Blood Pressure, An Evidence-Based Blueprint for Change

Available at
https://journals.lww.com/ajmqonline/pages/articleviewer.aspx?year=2022&issue=01000&article=00004&type=Fulltext

Carilion Clinic

Do you support retaining this measure in the program? No

Given the imprecise measures of control that are used and the ongoing debate about appropriate blood pressure targets, our recommendation is to remove this measure.

American Society of Nephrology

Do you support retaining this measure in the program? Yes

The American Society of Nephrology appreciates the opportunity to comment on considerations for measure set removal in federal programs. The controlling high blood pressure measure is being reviewed in the Medicare Shared Savings Program. Controlling high blood pressure is a leading public health priority. High blood pressure is a leading cause of cardiovascular morbidity and premature death in the United States. Current rates of controlled blood pressure in the National Health and Nutrition Examination Survey (NHANES) are declining (Muntner et al., JAMA 2020), highlighting the urgent need for increased efforts to improve blood pressure control.

The controlling high blood pressure measure contributes to the overall goals of the Medicare Shared Savings Program, which is to form accountable care organizations that prioritize comprehensive patient care. Controlling high blood pressure results in better patient outcomes and is a cornerstone of primary care, nephrology, and cardiology. The controlling high blood pressure measure is also part of the proposed Nephrology MIPS Value Pathway. Removal of the controlling high blood pressure measure may make it more difficult for nephrologists who are part of MSSPs to participate in the Nephrology MIPS Value Pathway via the APM participation option.

The controlling high blood pressure measure targets a blood pressure goal of <140/90 mm Hg. We recognize that current guidelines through the American College of Cardiology/American Heart Association recommend a blood pressure goal of <130/80 mm Hg. Removal of the controlling high blood

pressure measure, without simultaneous replacement with a similar measure targeting a blood pressure of <130/80 mm Hg, is likely to have deleterious effects on patient outcomes. Given the lack of complete consensus across professional societies regarding blood pressure goals, a performance measure targeting <140/90 mm Hg is reasonable, unless a more suitable alternative exists. There are no known unintended consequences of targeting a blood pressure goal of <140/90 mm Hg, ensuring appropriate patient exclusions. This measure is well suited towards rural populations, especially with the rise of telehealth and remote patient monitoring. There are significant racial/ethnic and socioeconomic disparities in blood pressure control. Working towards improvement in blood pressure control is the focus of many efforts to reduce health disparities.

National Kidney Foundation

Do you support retaining this measure in the program? Yes

May 25, 2022

The National Quality Forum (NQF)
1099 14th Street NW
Suite 500
Washington DC 20005

The National Kidney Foundation (NKF) appreciates the opportunity to provide our perspective on the measures proposed for removal under the Measure Set Review (MRP). We are writing today regarding Quality ID #236 (NQF 0018): Controlling High Blood Pressure, which is being recommended for removal from the Medicare Shared Savings Program (MSSP). NKF respectfully requests that NQF not remove the Controlling High Blood Pressure measure from the MSSP.

Hypertension is one of the leading causes of chronic kidney disease (CKD). CKD affects 37 million U.S. adults. CKD is overrepresented in the 65 and older Medicare-eligible population. Claims-based analysis of the traditional and Medicare Advantage populations find a prevalence of 14.2 and 15.6, respectively. Data from the National Health and Nutrition Examination Survey (NHANES) indicate that the prevalence of CKD in the Medicare eligible population is likely closer to 40%.

As of January 1, 2022, 11 million Medicare beneficiaries received care from a Medicare Shared Savings Program Accountable Care Organization (ACO), including a disproportionate number of CKD patients. The CY2022 Physician Fee Schedule rule finalized Controlling High Blood Pressure for use in the 2022-2024 APM Performance Pathway Measure Set. The Controlling High Blood Pressure measure has special relevance to CKD because of the feedback loop between blood pressure and kidney damage, in which constricted blood vessels damage the kidney leading to extra fluid in the body which further raises blood pressure. Thus, blood pressure targets are a key component of CKD management.

The Kidney Disease: Improving Global Outcomes (KDIGO) clinical practice guideline on the management of blood pressure in CKD recommends patients are treated to target systolic BP (SBP) of <120 mm Hg, with stronger evidence to support the recommendation in patients older than fifty and younger than 80. The American College of Cardiology (ACC) and American Heart Association (AHA) Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults recommend a blood pressure target for CKD patients of <130/80. Although blood pressure control is a critical component of CKD management, studies have found blood pressure control is only achieved in approximately half of diagnosed CKD patients in office-based ambulatory care practices.

Given the importance of blood pressure control to CKD management in the Medicare population, persistent gaps in the quality of CKD care with regards to achieving blood pressure control, and that Controlling High Blood Pressure does not appear to be topped out in MSSP, we recommend that NQF

reconsider its proposal to remove the measure. We appreciate NQF's consideration of our recommendation. Please contact Miriam Godwin, Health Policy Director, at 80iriam.godwin@kidney.org to discuss further.

American Geriatrics Society

Do you support retaining this measure in the program? Yes

The AGS believes this measure should be retained as it reflects current evidence and contributes to the overall goals and objectives of the Medicare Shared Savings Program. Hypertension is an independent risk factor for conditions affecting morbidity and mortality, such as coronary artery disease and stroke. Identifying and treating this risk factor would help to reduce morbidity from such conditions and improve mortality.

While there is high reporting burden for entities given the large population of patients, identification and treatment of hypertension is crucial in improving morbidity and mortality. The AGS believes this is a simple measure that may help certain communities who may be at higher risk for hypertension and other related conditions. The AGS would welcome the consideration of other measures that are more direct patient cardiovascular outcomes.

Public Comments Post-Workgroup Meeting

No public comments received.

CMS eCQM ID: CMS165v10 Controlling High Blood Pressure (eCQM)

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	CMS eCQM ID: CMS165v10
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
Numerator	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period
Numerator Exclusions	N/A
Denominator	Equals initial population; defined in the measure description as: Patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period.
Denominator Exclusions	Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: • Advanced illness with two outpatient encounters during the measurement period or the year prior • OR advanced illness with one inpatient encounter during the measurement period or the year prior • OR taking dementia medications during the measurement period or the year prior Exclude patients 81 and older with an indication of frailty for any part of the measurement period. Exclude patients receiving palliative care during the measurement period.

Field Label	Field Description
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	National Committee for Quality Assurance
Data Reporting Begin Date	Medicare Shared Savings Program: Data not yet available for performance year 2021.
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: The eCQM version of this measure was not included in the survey for MSSP.
Rationale for Removal Consideration	N/A

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed
Consensus-Based Entity Number	N/A
History of CBE Endorsement	N/A

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	The eCQM version of this measure has not been reviewed by MAP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

CMS Performance Data: Not yet available for 2021. Data reported in the future will measure the all-payer population.

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	The measure's feasibility is not known as the measure has not been reviewed by NQF.
Source and Date of Feasibility Data	N/A

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on potential negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 3
- No (Do Not Support Retaining in Proposed Program) – 3
- Unsure of Retaining in Proposed Program - 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group members did not have rural health concerns.

MAP Health Equity:

Comments were carried forward for this measure from the non-eCQM version.

An advisory group member commented this measure disproportionately affects patients from lower socioeconomic statuses, and this effect is also seen within the Medicare Advantage program, making this measure doubly importantly in regard to health equity. Another advisory group member commented within the state of Massachusetts, this is one of the most stark inequities observed within provider systems and within fully insured patient populations.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) having multiple encounters is important, 2) change the last reading requirement to an average or a therapeutic window, and 3) allow ambulatory or at-home blood pressure readings to be included in measure. Workgroup members included these conditions to bring the measure in line with recent literature and allow for documentation of home reading of blood pressures.

Public Comments

Member, Patient Experience and Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
No improvement in the NCQA Controlling High Blood Pressure Measure and its derivatives (such asCMS 165 v.10) over past 15 years

Background
Measure continues to be the only single measure used in both federal and commercial quality incentive programs. Raises a significant question of face validity and importance without questioning why the measure appears to be "topped out". Multiple concerns about this measure, such as recently raised by the American College of Physicians. Relevant population now estimated to be more than 115 million Americans.

Recommendation
Convene a multistakeholder group of professional societies and other key stakeholders to make evidence-based recommendations to NCQA and CMS for a new foundation for more effective and valid patient-centered quality measurements designed to align with a nation-wide BP control initiative.

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Does not require confirmation and documentation of measurement accuracy or certified validation of measurement device used in accordance with published scientific and guideline-based BP measurement standards.

Background
BP measurements for numerator consideration should be obtained by the evidence-based "Standards Based Method" promulgated by AMA & AHA, HHS, HRSA, etc. using measurements obtained from devices found on the US Blood Pressure Validated Device Listing (VDL™)

Recommendation
Improve reporting requirements to assure that BP measures used for numerator inclusions and exclusions meet accuracy and validation standards. The over-reliance on inaccurate BP measurements is hazardous to high quality patient care.

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Uses the last measurement value for the year for numerator inclusion/exclusion

Background
Based on longstanding traditional "ease of use" reporting using "hybrid" models.

Recommendation
Consider moving to a "Time in Therapeutic Range" model now consistently used in clinical trials for BP control

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Does not permit the addition of BP readings obtained by Self-Monitoring (SMBP)

Background
Prior considerations of including SMBP measurements limited by technical and validity concerns.

Strong recommendations with high quality evidence now support the regular use of SMBP in determining effectiveness of BP control. Should include alignment with Issues of Accurate Measurement and use of Time in Therapeutic Range noted in my other comments.

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Excludes patients with Heart Failure (HF)

Background
See 2022 HEDIS® Advanced Illness and Frailty Exclusions Guide. Unsure of the original reasoning and (?documented?) source of decision making for not including this critically important and large population in need of effective BP control.

Recommendation
Include patients with all phenotypes of Stages B and C Heart Failure in accordance with recently published 2022 ACC/AHA/HFSA HF Guidelines for BP control in patients with HF.

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Blood Pressure Control separated from other variables for 10-year ASCVD risk

Background
Other Risk Score variables evaluated by other quality measures assessed separately and not “bundled” into a composite summary of overall ASCVD Risk and Risk Reduction opportunities at the patient level.

Recommendation
The primary purpose of effective BP control is to reduce cardiovascular risk. Patients and their clinicians must better understand their BP readings in this larger context, rather than just being concerned about a single BP reading. This is an important root cause of "Therapeutic Inertia".

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Ignores 2021 Kidney Disease: Improving Global Outcomes (KDIGO) BP Guideline control target of < 120 mm Hg SBP for patients with non-dialysis CKD

Background
Current NCQA/CMS definition of control is SBP measurement < 140 mm Hg discordant with strong evidence-based recommendation for patients with CKD (included in denominator of current version of the NCQA/CMS Measure).

Recommendation
Include KDIGO and the National Kidney Foundation in the stakeholder convening noted in Recommendation #1 above.

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Issue
Current measure is only for patients with ACC/AHA Stage 2 High Blood Pressure.

Background
Measure ignores patients with Stage 1 HBP as promulgated by 11 multidisciplinary and diverse professional societies in the 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline and the Centers for Disease Control

Recommendation
Consider adding a new "paired" measure that would report BP control below a threshold target of < 130 SBP

Member, Patient Experience & Function Committee

Do you support retaining this measure in the program? Yes, under certain conditions

Strongly encourage members of the MAP to review this recently published article in the American Journal of Medical Quality (AJMQ): Controlling High Blood Pressure, An Evidence-Based Blueprint for Change

Available at
https://journals.lww.com/ajmqonline/pages/articleviewer.aspx?year=2022&issue=01000&article=00004&type=Fulltext

Carilion Clinic

Do you support retaining this measure in the program? No

Given the imprecise measures of control that are used and the ongoing debate about appropriate blood pressure targets, our recommendation is to remove this measure.

Comments Post-Workgroup Meeting

No public comments received.

02816-C-MSSP Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	02816-C-MSSP
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	Annual risk-standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MC-Cs).
Numerator	The outcome for this measure is the number of acute, unplanned hospital admissions per 100 person-years at risk for admission during the measurement period.
Numerator Exclusions	N/A

Field Label	Field Description
Denominator	Our target population is Medicare FFS patients aged 65 years and older whose combinations of chronic conditions put them at high risk of admission and whose admission rates could be lowered through better care. The National Quality Forum's (NQF s) Multiple Chronic Conditions Measurement Framework, which defines patients with multiple chronic conditions as people having two or more concurrent chronic conditions that require ongoing clinical, behavioral, or developmental care from members of the healthcare team and whose conditions act together to significantly increase the complexity of management, and affect functional roles and health outcomes, compromise life expectancy, or hinder self-management [1]. Operationally, the measure cohort includes patients with diagnoses in two or more of eight chronic disease groups: 1. Acute myocardial infarction (AMI) 2. Alzheimer s disease and related disorders or senile dementia 3. Atrial fibrillation 4. Chronic kidney disease (CKD) 5. Chronic obstructive pulmonary disease (COPD) and asthma 6. Depression 7. Diabetes 8. Heart failure 9. Stroke and transient ischemic attack (TIA) This approach captures approximately 25% of Medicare FFS beneficiaries aged 65 years and older with at least one chronic condition (about 5 million patients in 2012). Citations: 1. National Quality Forum (NQF). Multiple Chronic Conditions Measurement Framework. 2012; http://www.qualityforum.org/WorkArea/linkit.aspx Link Identifier=id&ItemID=71227
Denominator Exclusions	The cohort excludes the following patients: 1) Patients without continuous enrollment in Medicare Part A or B during the measurement period. 2) Patients who were in hospice at any time during the year prior to the measurement year or at the start of the measurement Exclusions: year. 3) Patients who had no Evaluation & Management (E&M) visits to a MIPS-eligible clinician type. 4) Patients assigned to clinician who achieve QP status and therefore do not participate in MIPS. 5) Patients attributed to hematologists and oncologists. 6) Patients not at risk for hospitalization during the measurement year. Note: Exclusions 1-3 are applied prior to attribution, while exclusions 4-6 are applied after the attribution algorithm is run.
Denominator Exceptions	N/A

Field Label	Field Description
CMS MAP Program(s) in Which Measure is Used	Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	Centers for Medicare & Medicaid Services (CMS)
Data Reporting Begin Date	Medicare Shared Savings Program: 2015-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities • Criteria 8. Measure leads to a high level of reporting burden for reporting entities • Criteria 1. Measure does not contribute to the overall goals and objectives of the program Notes from survey respondents: • I would wonder how often this is being reported and does it have unintended consequences for groups who take care of higher underserved populations? • This is not quality measure. It is a utilization measure.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed, based on an endorsed measure
Consensus-Based Entity Number	2888

Field Label	Field Description
History of CBE Endorsement	This history is based on previous measure nomenclature - Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS. 2016: Initial Endorsement 2021: Endorsement Renewed Consensus Standards Approval Committee (CSAC) Vote: Y-12; N-0 The Standing Committee recommended the measure for continued endorsement. The Standing Committee did not raise any concerns related to evidence or performance gap and passed the measure on these criteria. This measure was deemed complex and was evaluated by the NQF Scientific Methods Panel (SMP), which passed the measure with a high rating for reliability and a moderate rating for validity. The Standing Committee did not raise any questions or concerns related to reliability and upheld the SMP's high rating. The Standing Committee noted that despite concerns regarding four of the five comparator measures hypothesizing a weak or poor relationship with the measure and a slight negative but insignificant correlation with the control of high blood pressure measure, the SMP passed the measure on validity.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2019-2020 Recommendation: Do Not Support with Potential for Mitigation This measure was evaluated by the NQF MAP in 2019, who did not support for rulemaking with potential for mitigation, including applying the measure to clinician groups, not to individual clinicians, a higher reliability threshold (e.g., 0.7; 3), consideration of patient preference and selection as a method of attribution and NQF endorsement. While we agreed with the MAP that NQF endorsement of measures is preferred, NQF endorsement is not a requirement for measures to be considered for MIPS if the measure has an evidence-based focus as required by section 1848(q)(2)(D)(v) of the Act. This measure has been submitted for endorsement as part of the fall 2020 NQF cycle. The measure developer indicated the measure will be used for clinician group reporting with a mean reliability score for groups of>l5 clinicians with at least 18 MCC patients at 0.873. While the developer indicated that the patient attestation is not yet available for testing, based on research of the available information presented at the MAP, we believe the measure is evidence-based and represents an important clinical practice addressing a large Medicare patient population.

Field Label	Field Description
Rationale for MAP Recommendation	This measure has not been reviewed by MAP for the Medicare Shared Savings Program.

Section 4: Performance and Reporting Data

CMS Performance Data: Data for this claims-based measure shows the number of reporting ACOs between 2018 and 2020 were ~500. The mean performance rate for these ACOs was between 50 and 60. The distribution of 38 performance rates show substantial variation between ACOs. Mean measure rates were similar in 2018 and 2019 but decreased (improved) in 2020. The numerator for this measure is based on assigned beneficiaries' acute inpatient admissions, which were likely influenced by the COVID-19 pandemic.

PY	N	-	Mean	P0	P10	P25	P50	P75	P90	P100
2018	548	-	59.05	34.88	50.68	54.57	58.94	63.49	67.73	86.80
2019	541	-	58.15	32.31	49.32	53.33	58.32	62.53	66.51	85.02
2020	513	-	49.50	31.00	41.31	45.29	49.17	54.02	57.14	71.16

Cells marked by a dash (-) are intentionally left blank.

Updated versions of these measures will be used in performance year 2021, so measure rates may change due to new measure definitions. The population for these measures will shift from Medicare SSP assigned beneficiaries in PY 2021 to an all-Medicare population in PY 2022.

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Smaller results are better
- Adjustment applied: Risk adjusted
- Trend category: Improving
- Average annual percentage change (AAPC): -0.6
- AAPC 90% confidence interval: [-1.4, 0.2]
- Score (standard deviation) [provider interquartile range]
    - 2016: 59.8 (10.2) [12.4]
    - 2017: 61.8 (7.5) [9.8]
    - 2018: 59.0 (7.0) [8.9]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	The Standing Committee regarded the measure as feasible. Regarding usability and use, the Standing Committee discussed how this measure attributes patients to Accountable Care Organizations (ACOs). The developer clarified that the ACO program has an attribution algorithm that the measure will adopt. Therefore, this is not part of the measure specification; nonetheless, the attribution decisions are at the program level. The Standing Committee passed the measure on use and usability.
Source and Date of Feasibility Data	2021-09-20: All Cause Admissions and Readmissions, Fall 2020 Cycle: CDP Report

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

The measure developer did not identify any unexpected findings during the implementation of the previously used measure. They continued to monitor the updated measure's use and assess potential unintended consequences over time, such as the inappropriate shifting of care, increased patient morbidity and mortality, and other negative unintended consequences for patients.

Section 8: Additional Information

At this time, NQF has no additional information on for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 4
- No (Do Not Support Retaining in Proposed Program) – 2
- Unsure of Retaining in Proposed Program – 1

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

Advisory group members did not have rural health concerns.

MAP Health Equity:

An advisory group member commented from an equity perspective, chronic conditions do have equity differences and utilization is tied to quality. Additionally, the member stated there are compounding factors related to patients with chronic conditions but noted management of chronic conditions as it related to equity is important.

Another advisory group member noted literature indicates there are inequities in Black, Indigenous, and people of color (BIPOC) populations related to chronic illness and disease and for this reason, it is important to assess.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Conditional Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program with the following conditions: 1) re-evaluating the definitions of readmissions for uniformity across the MIPS and MSSP measure sets and 2) evaluating the validity of a 10-day buffer rule at the accountable care organization (ACO) level. Workgroup members noted that if the purpose of the measure is care coordination, the definition of readmissions should be the same across the MIPS and MSSP measure sets. Workgroup members also noted that the exclusion of readmissions that occur 10 days after discharge may not be appropriate for ACOs given their focus on care coordination, and urged the measure developer to re-evaluate that exclusion for the ACO version of the measure.

Public Comments

Multiple Chronic Conditions Resource Center

Do you support retaining this measure in the program? Yes

Primary/Specialty integration of symptom management/palliative care in multiple chronic conditions (MCCs) to reduce disease exacerbation and admission into hospital. Palliative interventions in MCCs are distinct and separate from cancer and hospice care.

CHF and COPD exacerbations are the mostly care for Americans largely because of poorly managed symptoms (dyspnea, fatigue, fluid retention, exercise intolerance etc.). Focus on symptoms through palliative interventions proactively prevents exacerbation of symptoms that lead to acute care utilization.

Public Comments Post-Workgroup Meeting

No public comments received.

06040-C-MSSP Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	06040-C-MSSP
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	This measure is a re-specified version of the measure, "Risk-adjusted readmission rate (RARR) of unplanned readmission within 30 days of hospital discharge for any condition" (NQF 1789), which was developed for patients 65 years and older using Medicare claims. This re-specified measure attributes outcomes to MIPS participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology. Measure specifications slightly differ between NQF QPS (1789) and CMIT based on measure updates. CMIT measure specifications are provided here.
Numerator	The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as a subsequent inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. Any readmission is eligible to be counted as an outcome, except those that are considered planned. To align with data years used, the planned readmission algorithm version 4.0 was used to classify readmissions as planned or unplanned.
Numerator Exclusions	N/A
Denominator	Patients eligible for inclusion in the measure have an index admission hospitalization to which the readmission outcome is attributed and includes admissions for patients: Enrolled in Medicare Fee-For-Service (FFS) Part A for the 12 months prior to the date of admission; Aged 65 or over; Discharged alive from a non-federal short-term acute care hospital; and, Not transferred to another acute care facility.

Field Label	Field Description
Denominator Exclusions	1. Patients discharged against medical advice (AMA) are excluded. 2. Admissions for patients to a PPS-exempt cancer hospital are excluded. 3. Admissions primarily for medical treatment of cancer are excluded. 4. Admissions primarily for psychiatric disease are excluded. 5. Admissions for "rehabilitation care; fitting of prostheses and adjustment devices" (CCS 254) are excluded. 6. Admissions where patient cannot be attributed to a clinician group.
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	Centers for Medicare & Medicaid Services
Data Reporting Begin Date	Medicare Shared Savings Program: 2021-01-01
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 5

Field Label	Field Description
Rationale for Removal Consideration	Rationale for nominations: • Criteria 1. Measure does not contribute to the overall goals and objectives of the program • Criteria 2. Measure is duplicative of other measures within the same program • Criteria 3. Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • We think this is a good measure and it should be endorsed. • Would need very large sample size to be valid at the individual group level over an actionable timeframe • This is not quality measure. It is a utilization measure.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Not Endorsed; based on an endorsed measure.
Consensus-Based Entity Number	Based on 1789 (Hospital-Wide All-Cause Unplanned Readmission Measure [HWR])
History of CBE Endorsement	Initial endorsement: 2012 Last endorsement: 2018 (All-Cause Admissions and Readmissions Spring Cycle 2018).

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	Date reviewed: 2019-2020 Recommendation: Merit-based Incentive Payment System: Conditional Support for Rulemaking
Rationale for MAP Recommendation	This measure has not been reviewed by MAP for the Medicare Shared Savings Program.

Section 4: Performance and Reporting Data

CMS Performance Data: Data for this claims-based measure shows the number of reporting ACOs between 2018 and 2020 were ~500. The mean performance rate for these ACOs was ~15. Overall, measure performance is in a narrow range, and mean rates do not change much over time.

PY	N	Mean	P0	P10	P25	P50	P75	P90	P100
2018	548	14.98	13.47	14.36	14.66	14.96	15.30	15.58	16.67
2019	541	14.86	12.57	14.15	14.49	14.87	15.23	15.51	16.64
2020	513	15.07	13.08	14.49	14.76	15.06	15.40	15.72	16.60

Updated versions of these measures will be used in performance year 2021, so measure rates may change due to new measure definitions. The population for these measures will shift from Medicare SSP assigned beneficiaries in PY 2021 to an all-Medicare population in PY 2022.

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Proportion
- Measure direction: Smaller results are better
- Adjustment applied: Risk adjusted
- Trend category: Stable
- Average annual percentage change (AAPC): -0.2
- AAPC 90% confidence interval: [-0.3, -0.1]
- Score (standard deviation) [provider interquartile range]
    - 2016: 14.7 (0.7) [0.9]
    - 2017: 15.0 (0.4) [0.6]
    - 2018: 15.0 (0.5) [0.6]

Section 5: Feasibility

Field Label	Field Description
Summary of Measure's Feasibility	CMIT 06040-C-MSSP has not been endorsed. However, there is a similar measure that is endorsed (NQF 1789). Below, we provide information about the similar measure's feasibility. For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order). Data elements generated include the DRG and ICD-9 codes on claims. The required data elements are available in electronic health records or other electronic sources.
Source and Date of Feasibility Data	Measure data submitted for endorsement maintenance in 2020.

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

At this time, NQF has no information on negative unintended consequences for this measure.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

- Yes (Support Retaining in Proposed Program) – 3
- No (Do Not Support Retaining in Proposed Program) – 4
- Unsure of Retaining in Proposed Program - 0

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

Advisory group members were not certain rural providers, particularly in critical access hospitals or rural clinics, would be reported in the measure in the way it is currently structured due to exemptions. One advisory group member noted because the measure is not stratified by condition and because rural facilities have low case-volume challenges, there may be validity concerns for rural settings and the measure could be affected by small fluctuations. However, others commented the measure does provide a way to monitor performance and to assist in keeping patients out of the hospital past their discharge.

MAP Health Equity:

An advisory group member stated data published within Health Affairs shows that post the Affordable Care Act (ACA), imposing readmission reduction programs through ACOs has led to worsened mortality regarding heart failure as opposed to pneumonia. The member also noted the measure is too broad from an equity perspective. Additionally, the member raised the need for comprehensive risk-adjustment for socioeconomic status and other social determinants of health (SDOH) factors that can impact outcomes and that are unrelated to quality of care provided.

An advisory group member commented on their review of the literature and findings that admission post the seven-day window are really related more to SDOH issues or structural determinant of health issues. The member questioned how much a hospital system should be responsible for outside of the seven-day window.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted the importance of the measure for physician and public accountability.

Public Comments

American Academy of Neurology

Do you support retaining this measure in the program? Yes

The American Academy of Neurology (AAN) appreciates the opportunity to review and comment on the draft proposal. The AAN notes the review criteria is not transparent and without clear guidance on criteria used for removal then the measures should remain in the program. There is an opportunity to potentially utilize a framework like the proposed Quality Measure Index (QMI) and it is unclear how these criteria and the QMI will be utilized in the future. Further, there appears to be a disconnect between the criteria used and CMS priorities. For example, CMS is utilizing the MSSP Hospital-Wide 30

Day All Cause Unplanned Readmit measure as a foundational layer of MIPS Value Pathways (MVPs) being implemented in 2023, but under this review it has been identified for retirement.

Public Comments Post-Workgroup Meeting

No public comments received.

11087-C-MSSP Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Section 1: Brief Measure Information

Field Label	Field Description
CMIT Number	Not available
CMS Program(s) for Which Measure is Being Discussed for Removal	Medicare Shared Savings Program
Measure description	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.
Numerator	The survey does not include numerators and denominators. Refer to CMIT.
Numerator Exclusions	N/A
Denominator	The survey does not include numerators and denominators. Refer to CMIT.
Denominator Exclusions	Refer to CMIT.
Denominator Exceptions	N/A
CMS Program(s) in Which Measure is Used	Medicare Shared Savings Program Link to the CMS 2022 Program-Specific Measure Needs and Priorities document
Other Program(s) in Which Measure is Active	N/A
Measure Steward	Agency for Healthcare Research & Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS)

Field Label	Field Description
Data Reporting Begin Date	Medicare Shared Savings Program: 2012-01-01 – 12/31/2019. Date CAHPS for MIPS survey administration began 1/1/2021
Votes for Removal Consideration from Survey	Total number of votes from workgroup and advisory members: 3
Rationale for Removal Consideration	Rationale for nominations: • Criteria 7. Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation • Criteria 8. Measure leads to a high level of reporting burden for reporting entities • Criteria 10. Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities Notes from survey respondents: • Have received feedback from stakeholders that the questions, feedback and rates from the CG-CAHPS tools are very hard to impact/ improve. Additionally, the vendor requirements around administration were so burdensome we actually had state legislature prohibiting the statewide quality and measurement program including these metrics and we stopped collecting and aggregating this information • People with intellectual disabilities are unlikely to be able to participate.

Section 2: Consensus-Based Entity (CBE) Endorsement History

Field Label	Field Description
CBE Endorsement Status	Endorsed
Consensus-Based Entity Number	0005

Field Label	Field Description
History of CBE Endorsement	2007: Initial Endorsement 2019: Endorsed Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-14; No-2 Within the Patient Experience and Function Spring 2019 Final Report, there was some discussion on whether CAHPS measures in general should be considered process measures, but several Committee members pointed out that patient-reported experience of care is its own form of outcome according to NQF current classification, and that further discussion was beyond the current scope of the Committee. The Committee noted that the measure passed each of the criteria and is suitable for continued endorsement.

Section 3: Measure Applications Partnership (MAP) Review History

Field Label	Field Description
Date and Recommendation from Last MAP Review	CAHPS measures were previously reported as individual measures. MAP has not reviewed the new composite measure for APP.
Rationale for MAP Recommendation	N/A

Section 4: Performance and Reporting Data

CMS Impact Assessment Data: CAHPS measures were previously reported as individual measures in the Shared Savings Program. Future data will be reported as a composite measure in the APP.

The following information is from the 2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report.

- Result type: Mean
- Measure direction: Larger results are better
- Adjustment applied: Risk adjusted
- Trend category:
    - ACO-1 through ACO-4, ACO-6 and ACO-7: Stable.
    - ACO-5: Improving.
    - ACO-34: Declining.

ACO-1: Getting Timely care, Appointments, and Information

- Average annual percentage change (AAPC): -0.2
- AAPC 90% confidence interval: [-0.2,-0.2]
- Score (standard deviation) [provider interquartile range]

    - 2016: 79.9 (3.7) [4.7]
    - 2017: 80.2 (3.8) [4.6]
    - 2018: 86.2 (3.3) [3.9]

ACO-2: How Well Your Providers Communicate

- Average annual percentage change (AAPC): 0.0
- AAPC 90% confidence interval: [0.0, 0.0]
- Score (standard deviation) [provider interquartile range]
    - 2016: 92.6 (2.0) [1.8]
    - 2017: 92.8 (1.8) [1.9]
    - 2018: 93.8 (1.6) [1.7]

ACO-3: Patients' Rating of Provider

- Average annual percentage change (AAPC): 0.1
- AAPC 90% confidence interval: [0.1, 0.1]
- Score (standard deviation) [provider interquartile range]
    - 2016: 91.9 (1.8) [1.9]
    - 2017: 92.0 (1.8) [2.1]
    - 2018: 92.3 (1.7) [1.9]

ACO-4: Access to Specialists

- Average annual percentage change (AAPC): -0.5
- AAPC 90% confidence interval: [-0.5, -0.5]
- Score (standard deviation) [provider interquartile range]
    - 2016: 83.5 (2.3) [2.8]
    - 2017: 83.4 (2.5) [3.2]
    - 2018: 81.9 (2.8) [3.6]

ACO-5: Health Promotion and Education

- Average annual percentage change (AAPC): 1.6
- AAPC 90% confidence interval: [1.6, 1.6]
- Score (standard deviation) [provider interquartile range]
    - 2016: 60.0 (3.8) [4.9]
    - 2017: 61.9 (3.8) [5.4]
    - 2018: 59.0 (4.4) [6.2]

ACO-6: Shared Decision Making

- Average annual percentage change (AAPC): 0.4
- AAPC 90% confidence interval: [0.4, 0.4]
- Score (standard deviation) [provider interquartile range]
    - 2016: 75.3 (2.5) [3.4]
    - 2017: 75.6 (2.4) [3.4]
    - 2018: 61.9 (3.8) [4.6]

ACO-7: Health Status/Functional Status

- Average annual percentage change (AAPC): 0.6
- AAPC 90% confidence interval: [0.6, 0.6]
- Score (standard deviation) [provider interquartile range]

- 2016: 71.8 (2.7) [2.9]
- 2017: 72.6 (2.7) [3.0]
- 2018: 73.0 (2.4) [2.8]

ACO-34: Stewardship of Patient Resources

- Average annual percentage change (AAPC): -1.1
- AAPC 90% confidence interval: [-1.2, -1.1]
- Score (standard deviation) [provider interquartile range]
  - 2016: 27.5 (4.7) [6.2]
  - 2017: 26.5 (4.8) [6.5]
  - 2018: 26.9 (4.4) [6.0]

CMS Performance Data: CAHPS measures were previously reported as individual measures in the Shared Savings Program. Future data will be reported as a composite measure in the APP.

Data for individual CAHPS measures (ACO-1 through ACO-7, ACO-34, ACO-45, and ACO-46) that were used in the Shared Savings Program are as follows:

- How Well Your Providers Communicate (ACO-2) and Patients' Rating of Provider (ACO-3): These measures had little change over time or variation across ACOs. These measures may not be as helpful for detecting improvement over time or differences between ACOs.
- Getting Timely Care, Appointments, and Information (ACO-1), Access to Specialists (ACO-4), and Health Status/Functional Status (ACO-7): These measures had some degree of change over time or variation between ACOs but did not show a clear pattern.
- Health Promotion and Education (ACO-5), Shared Decision Making (ACO-6), and Stewardship of Patient Resources (ACO-34): These measures show greater changes in mean performance rate over time and differences between ACOs within a given performance year. These measures may be more sensitive to change than other CAHPS measures.
- The Courteous and Helpful Office Staff (ACO-45) and Care Coordination (ACO-46):These measures were introduced in the 2019 performance year, so there is no data for these measures in 2018.

CAHPS was waived as a requirement for ACOs in the 2020 performance year due to the pandemic. Therefore, there is not data for these measures for 2020.

Section 5: Feasibility

Summary of Measure's Feasibility

The Standing Committee commented on:

- How electronic and paper versions are available, mail, phone, email, and web-based modes available and deployed.
- While the measure developer did not evaluate the burden on providers associated with measure implementation in the form of fees from retention of an approved CAHPS vendor to administer the surveys during the submission, they offered an analysis during discussion that satisfied the Committee

From the measure developer's CBE submission:

Data used in the measure are collected by survey of providers´ patients. Though mixed-mode administration (i.e., mail and phone) is a viable strategy for the collection of CAHPS surveys, mail continues to be the most frequent mode for most CAHPS surveys. Users then create electronic databases of results after receipt of the completed hard copy survey through scanning or data entry. However, vendors may set up their database before data collection by populating the frame to assist in identifying non response. Traditionally, the rationale for not using electronic sources more broadly is that mail and telephone are the best ways to obtain representative samples of patients based on the contact information that is available for sampling and data collection. E-mail has been added as a mixed mode strategy for physician groups with reliable email addresses for their patient population.

To address data collection efficiency and to improve response rates, the CAHPS Consortium endorsed e-mail notification for webbased surveys as an additional mode of data collection (Drake et al., 2014; McInnes et al., 2012). The CAHPS Consortium recommends a mixed mode that would have two e-mail reminders and a follow-up by mail or telephone to all who are in the survey sample. The follow-up to the entire sample is necessary to get a representative set of responses from a practice's population, as not all patients may have e-mail.

Studies have shown that phone follow-up can improve CAHPS response rates compared to mail-only (Burkhart et al., 2014; Fowler et al., 2002; Gallagher et al., 2005; Klein et al., 2011). A study of Medicare beneficiaries found that response rates continue to improve when up to 4 follow-up calls are made (Burkhart et al., 2014). In addition, phone follow-up calls help to achieve better representation of patients in terms of income, literacy/education, health status, age, gender, and race/ethnicity, above and beyond mail surveys alone (Tesler and Sorra, 2017).

The Consortium continues to conduct research to develop and test survey administration methods that can improve the efficiency of data collection, enhance response rates, and gather more information about the experiences of those segments of the patient population that have been hard to reach through more traditional means. This research includes: 1) studies comparing the effect of administration modes on response rates, survey scores, and data collection costs (e.g., mode comparisons have included in-office distribution vs. mail; email vs. mail); 2) studies assessing the effect of survey length on response rates and survey scores; 3) studies examining the impact of incentives on response rates; and 4) studies comparing the effect of different survey formats and design on survey responses. As part of this ongoing work, the Consortium sponsored a one-day invitational research meeting in September 2018 that convened a small group of survey users, researchers, CAHPS stakeholders, and policymakers to share results from recent research on survey methodologies that affect response rates and the representativeness of CAHPS survey data.

A summary of AHRQ's CAHPS Fall 2018 Research meeting is available at

https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/survey-methods-research/summary-researchmeeting.pdf.

References:

Burkhart Q, Haviland A, Kallaur P, et al. (2014) How much do additional mailings and telephone calls contribute to response rates in a survey of Medicare beneficiaries. Field Methods. 27(4):409-25.

Drake KM, Hargraves JL, Lloyd S, Gallagher PM, Cleary PD. (2014) The Effect of Response Scale, Administration Mode, and Format on Responses to the CAHPS Clinician and Group Survey. Health Serv Res. Aug;49(4):1387-99.

Fowler Jr FJ, Gallagher PM, Stringfellow VL, et al. (2002) Using telephone interviews to reduce nonresponse bias to mail surveys of health plan members. Med Care 40(3):190-200.

Gallagher PM, Fowler FJ, Stringfellow VL. (2005) The nature of nonresponse in a Medicaid survey: causes and consequences. J Off Stat 21(1):73-87.

Klein DJ, Elliott MN, Haviland AM, et al. Understanding nonresponse to the 2007 Medicare CAHPS survey. (2011) Gerontologist 2011;51(6):843-55.

McInnes DK, Brown JA, Hays RD, Gallagher P, Ralston JD, Hugh M, Kanter M, Serrato CA, Cosenza C, Halamka J, Ding L, Cleary PD. (2012) Development and evaluation of CAHPS questions to assess the impact of health information technology on patient experiences with ambulatory care. Med Care. Nov;50 Suppl:S11-9.

Tesler, R. and Sorra, J. CAHPS Survey Administration: What We Know and Potential Research Questions. (Prepared by Westat, Rockville, MD, under Contract No. HHSA 290201300003C). Rockville, MD: Agency for Healthcare Research and Quality: October

2017. AHRQ Publication No. 18-0002-EF. Accessible at https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/aboutcahps/research/survey-administration-literature-review.pdf.

The CAHPS Clinician and Group survey is available to users free of charge. In addition to the survey instrument, users can access comprehensive fielding, analysis, and reporting guides as well as SAS programming code that performs analysis and significance testing. These tools are available at: https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html. Requirements for submitting data to the CAHPS Database, and for using the CAHPS name on an instrument, include:

- All core items must be present on the user's questionnaire
- No changes to core item wording are permitted
- Instruments must not omit any of the survey items related to respondent characteristics

Source and Date of Feasibility Data

Patient Experience and Function Spring 2019 Cycle: CDP Report
CBE Measure Submission, 10/25/2019

Section 6: Similar Measures in the Program

Field Label	Field Description
Similar Measures in the Same Program	There are no similar measures in the same program listed in CMIT.

Section 7: Negative Unintended Consequences

The measure developer did not report any unexpected findings during implementation of this measure in the testing information for review during the 2019 endorsement process.

Section 8: Additional Information

At this time, NQF has no additional information for this measure.

Section 9: Advisory Group Discussion

Polling Results

MAP Rural Health:

Polling was not conducted.

MAP Health Equity:

Polling was not conducted.

Additional Comments from MAP Advisory Group Meetings

MAP Rural Health:

The advisory group did not comment on the measure.

MAP Health Equity:

The advisory group did not comment on the measure.

Section 10: Workgroup Recommendation

Workgroup Recommendation

Support for Retaining

Workgroup Rationale

MAP supported retaining the measure in the program. Workgroup members noted that the measure is one of few measures that captures patient feedback on their healthcare and improves patient outcomes. Workgroup members also noted the possibility for the measure to address and mitigate disparities within patient experience.

Public Comments

PSCG

Do you support retaining this measure in the program? No

Unduly burdensome

Carilion Clinic

Do you support retaining this measure in the program? Yes, under certain conditions

Want credit for the full survey, don't piecemeal it. Consider an acceptable threshold and eliminate the "normative grading" approach that encourages gaming.

American Geriatrics Society

Do you support retaining this measure in the program? No

While the AGS agrees with the removal of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the MIPS Survey, we encourage the measure developers to refine some of the measures within CAHPS that are validated and more focused on respect, communication, and other domains that relate to the essence of patient-reported outcomes. We believe CAHPS contains good questions such as “did someone show respect or listen to you?” However, there are others (i.e., did the visit start on time?) that is not in the provider’s control and therefore should not be of equal weight.

Based on anecdotal data, due to the low response rate for the CAHPS survey—which tend to be highly rated—a small change in the rating can lead to a big shift in percentile ranking. However, it was not clear to us the level of variation among different providers and health systems. Further, the AGS is not aware of any evidence that CAHPS measures are linked to patient outcomes, on reporting burden, and unintended consequences.

In its current form, CAHPS seems to be a mixture of different domains, not all of which relate to the essence of patient-reported outcomes, and does not achieve what it is intended to do.

Public Comments Post-Workgroup Meeting

No public comments received.