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# Measure Applications Partnership (MAP) Clinician Workgroup: 2022 Measure Set Review Meeting

*Meeting Summary*

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# Meeting Summary

## Measure Applications Partnership (MAP) 2022 Measure Set Review (MSR) Clinician Workgroup Web Meeting

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) on June 27, 2022. The purpose of the meeting was for the MAP Clinician Workgroup to provide input on measures under review with a lens to measurement issues impacting clinicians, particularly in the office setting. There were 75 attendees at this meeting, including MAP members, NQF staff, government representatives, and members of the public.

### Welcome, Introductions, and Review of Web Meeting Objectives

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP Measure Set Review (MSR) Clinician Workgroup Web Meeting and thanked all participants for providing their time and support to the MSR initiative. Ms. Williams-Bader provided an overview of the WebEx platform functionality and the meeting agenda. Dr. Dana Gelb Safran, President & CEO, NQF, joined Ms. Williams-Bader in thanking MAP participants and provided opening remarks noting the multistakeholder representation of MAP. Dr. Safran spoke about how the 2022 MSR process expanded upon the 2021 MSR pilot by bringing the three setting-specific Workgroups (Clinician, Hospital, and Post-Acute/Long-Term Care (PAC/LTC)) and two Advisory Groups (Rural Health and Health Equity) into the process. This process follows congressional direction on the multistakeholder representation of MAP. She also spoke on the points of discussion for workgroup members to consider during review measures. Following Dr. Safran, opening remarks were provided by the Clinician Workgroup co-chairs, Dr. Rob Fields, and Dr. Diane Padden.

Ms. Williams-Bader then moved on to the disclosure of interests (DOI) section and introduced Ivory Harding, manager, NQF, to take roll call for the meeting. Ms. Williams-Bader started by explaining how the DOI process is split into two parts, as the workgroup has organizational members and subject matter experts (SMEs).

Of the sixteen organizational members, thirteen attended the meeting. In addition, there were two co-chairs, and four subject matter experts, totaling nineteen voting members in attendance. There were no relevant conflicts disclosed during this section. The full attendance details are available in Appendix A. Ms. Harding concluded by introducing the nonvoting federal government liaisons.

Next, Ms. Williams-Bader introduced the NQF team and the CMS staff supporting the MAP activities. Ms. Williams-Bader then reviewed the following meeting objectives: provide a review of 2022 MSR process and measure review criteria, provide MAP members with an opportunity to discuss and recommend measures for potential removal, and seek feedback from the workgroup on the MSR process.

### CMS Opening Remarks

Dr. Michelle Schreiber, deputy director of the Centers for Clinical Standards & Quality (CCSQ) for CMS and the group director for the Quality Measurement and Value-Based Incentives Group (QMVIG), offered opening remarks and thanks to all MAP members. Dr. Schreiber acknowledged the CMS staff and measure stewards at the meeting and their expertise. Dr. Schreiber noted the importance of the

workgroup member recommendations on measures for removal from value-based programs. Dr. Schreiber mentioned the positive feedback received on the MSR process so far, particularly from the Rural Health and the Health Equity Advisory Group members and the Hospital Workgroup members. Dr. Schreiber emphasized the MAP Coordinating Committee will make the final recommendations on the removal of measures; these recommendations will be taken into consideration by CMS for incorporation into next year's rule writing. Lastly, Dr. Schreiber extended thanks to NQF staff, Dr. Safran, the members of the Clinician Workgroup and the workgroup co-chairs.

Dr. Schreiber noted the representatives from the Medicare Shared Savings Program (MSSP) had a scheduling conflict but that CMS representatives from the Merit-Based Incentive Payment System (MIPS) program would assist MAP members with their questions during the MSSP section of the agenda. Ms. Williams-Bader introduced an NQF consultant, Dr. Taroon Amin, who would be facilitating parts of the meeting agenda.

## Review of MSR Process and Measure Review Criteria

Ms. Harding reviewed the 2022 MSR process, measure review criteria (MRC), 2022 MSR decision categories, key voting principles, and the process for the meeting discussion. Ms. Harding provided an overview of the 2022 MSR process, including the steps to prioritize, survey, prepare, and discuss the measures for review, with the output being a set of final recommendations and rationale for measure removal provided to CMS. Ms. Harding presented the 10 measure review criteria MAP members used to evaluate measures during the survey process and again during the web meeting. Ms. Harding reviewed the four MSR decision categories (support for retaining, conditional support for retaining, conditional support for removal, and support for removal) and the key voting principles to achieve quorum and consensus. Quorum was defined as 66 percent of the voting members being present virtually for live voting to take place. Consensus for MAP was defined as a threshold greater than or equal to 60 percent of voting participants voting positively and a minimum of 60 percent of the quorum figure voting positively. Ms. Harding noted abstentions do not count in the denominator. Lastly, Ms. Harding reviewed the process for the meeting. Each program would be introduced by NQF staff before the public was given an opportunity to provide comment on each of the measures within that program. For each measure, CMS program leads would have the opportunity to provide a clarifying statement after NQF provides the measure description and the selected measure review criteria. The lead discussants would provide their evaluation of the measure and advisory group volunteers or NQF staff would provide an overview of advisory group discussion of the measure before the discussion was opened to workgroup members. Workgroup members would then participate in a vote to provide their recommendation on retaining a measure within a program.

A CMS program lead asked for clarification on the time period when program leads could provide a statement on the measure. Ms. Williams-Bader answered that statements from CMS could be given after NQF staff reviews the measure title, description, and endorsement status. Dr. Schreiber noted the specific representatives from MSSP who were able to join the call-in preparation for the first measures to be reviewed by the meeting attendees.

## Clinician Programs

### Medicare Shared Savings Program (MSSP) Measures

Ms. Williams-Bader provided an overview of the MSSP program, including program type, incentive structure, and goals. Details of the program can be reviewed in the meeting slides (PDF). Ms. Williams-Bader then introduced Dr. Fields to lead members of the public through public comment.

### *Opportunity for Public Comment on Medicare Shared Savings Program (MSSP) Measures*

Dr. Fields provided instructions to members of the public on the public commenting process. A CMS program lead asked if a comment on measures could be made at this time and Ms. Williams-Bader clarified that comments for each measure could be made during the next section. A member of the public commented on the challenge provided by the limited time to provide public comments on measures during the comment period prior to web meetings and also noted the challenge of commenting without the added context of knowing which measures would be added to the measure set. The commenter noted that members from their accountable care organizations (ACOs) stakeholder group provided feedback that not knowing which measures would be added in replacement of the measures recommended for removal made it difficult to evaluate these measures. The member of the public further commented that the time allowed for public comments was not enough, especially for the first year of the MSR process. Lastly, the member of public requested information on the procedure for who received the invitation to nominate measures for removal during the MSR process. Ms. Williams-Bader clarified that MAP members (advisory group members and workgroup members) received an email with information on how to complete the survey to nominate measures for discussion across the three settings (hospital, clinician, and post-acute/long-term care (PAC/LTC)). Ms. Williams-Bader also clarified that due to the number of measures being reviewed in the summary (approximately 200-250), basic information was provided, including measure specifications, endorsement status, data sources used, and whether the measure was required by federal statute. The member of the public noted appreciation for the background provided and additionally expressed that the context of the measures within the MSSP is really important. Dr. Fields responded to clarify the intent of the survey completed by advisory group and workgroup members was to cast a broad net in order to curate a smaller list of measures to be discussed during the MSR meetings. The member of the public commented that other members of the public and relevant stakeholders did not have access to the context on the measures being provided within this meeting.

During public comment, a MAP member asked if NQF staff would be providing background as to why each measure was recommended for removal. Dr. Fields asked Ms. Williams-Bader to confirm if stakeholders were able to see the measure summary sheets (MSSs), which contained background information on each measure, including the reasons for nomination for discussion, ahead of the workgroup meeting. Ms. Williams-Bader answered that measure summary sheets were made public and posted a week ahead of the meeting with the other meeting materials. NQF staff posted a link to the meeting materials on the Clinician Workgroup project page for attendees to immediately access. Another MAP member commented on their review of the measure summary sheets and highlighted that while the selected measure review criteria were listed in the documents, the reason why members selected the specific criteria were not included for review. Ms. Williams-Bader answered that unless free-text notes were provided by the MAP members, NQF did not know why members selected certain criteria. A separate member of the public commented in the chat that public comment by stakeholders was due May 25 and the measure summary sheets were dated June 6. Ms. Williams-Bader confirmed due to the timeline, summary sheets were completed during the time of public comment.

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

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. Ms. Williams-Bader noted this measure was the web-interface version of the measure and it would be sunset within the MSSP in performance year 2025. Ms. Williams-Bader further noted the next version of the measure to be discussed would be the electronic clinical quality measure (eCQM) version. Ms. Williams-Bader stated during that time, MAP members could provide feedback on the eCQM version and the registry-based version of the measure. During the

survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- 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
- Measure leads to a high level of reporting burden for reporting entities

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead stated measures were included in MSSP based on specific priority areas and mental health is a high priority topic within the program. The program lead also commented that the measure was previously NQF-endorsed. Another CMS program lead commented that this measure, for the web-interface reporting version, has been a part of the program since the program's inception. A separate program lead stated that the original intent of the measure was for it to be reported by all eligible clinicians, not those specific to treating depression; the intent was also to ensure screenings and referrals were being completed for treatment and follow-up and to identify new and early cases of depression.

A MAP member opened the discussion as a lead discussant, commenting that the measure assumes depression is prevalent, is increasing, is under diagnosed, and early identification can lead to treatment outcomes. The MAP member commented the focus should be on longitudinal outcomes and process measures help improve those outcomes. The MAP member commented that the measure does not address longitudinal outcomes for patients with depression and because of this, there has not been an increase in the treatment of care. The MAP member also noted screening has to be targeted or the burden will be large for everyone (providers and patients). The MAP member suggested making the measure more targeted. The MAP member also noted physicians find F- and G-codes burdensome because they are laborious to capture and difficult to remember; specifically, clinicians report that G-codes must be used to capture this interaction and then a follow-up plan must be documented. The MAP member also stated the follow-up plan is not always available to the next clinician. The MAP member noted an examination of the statistics shows a natural neutralization of the outliers and measure performance tends to cluster around the average when reported. The MAP member recommended the group vote on conditional support for removal and the labor to capture this measure should be considered.

The second lead discussant agreed with the need for better longitudinal outcomes but emphasized this is an important measure. The MAP member reported receiving feedback from clinicians on the difficulty in identifying patients with undiagnosed depression. Further, the MAP member noted broad screening questions may bring in more individuals who are in need of treatment but have not yet been identified. The MAP member highlighted comments received during the public comment period ahead of the workgroup meeting; one comment, in particular, noted the increase in mental health conditions during COVID and the importance of proper identification and treatment for patients with depression. The MAP member also highlighted improvement within the measure data despite stagnation.

A third lead discussant suggested a condition for removal – a new, improved measure with better sensitivity and specificity be added to the program. Additionally, the MAP member noted collaborative care models would assist patients when they do screen positive within the care setting. The MAP member stated differentiation between high and low performers is of interest.

Ms. Williams-Bader then provided an overview of the discussion on this measure from the Rural Health and Health Equity Advisory Groups. Ms. Williams-Bader reported Rural Health Advisory Group members did not support retaining the measure in the program at 57%. Ms. Williams-Bader noted the group expressed concern for a lack of resources for patients who screened positive and a shortage of behavioral healthcare workers found in the complete Rural Health Advisory Group meeting summary. Ms. Williams-Bader noted Health Equity Advisory Group members highlighted the impact of COVID-19 on the mental health of adolescents and therefore supported retaining the measure within the program to ensure adolescents are able to be captured. Ms. Williams-Bader also noted Health Equity Advisory Group members highlighted the disproportionate access to portals for telehealth services among patients and healthcare systems with more affluent patients with access to these portals would have an easier time reporting on this measure. Ms. Williams-Bader stated Health Equity Advisory Group members also mentioned the usefulness of the measure in regard to equity by capturing the under-identification of depression in minority patients and women found in the complete Health Equity Advisory Group meeting summary.

Dr. Fields then opened the discussion for MAP members. Several MAP members echoed previous comments that if the measure were retired from a program, a better measure would need to be available to replace it. Additionally, MAP members expressed concerns regarding the evaluation of measure performance – if a clinician is not performing well, MAP members reported it is currently difficult to determine if the patient was not screened or if the follow-up plan was difficult to document according to the measure specification. A MAP member noted quality improvement funds from CMS for providers would also be helpful, especially in rural health areas and smaller practices. A MAP member asked for the plan from CMS regarding the measure at -large and improvements or replacement. Dr. Schreiber responded with current plans to transition this measure to an eCQM to be more robust and less burdensome. Dr. Schreiber also noted there is an outcome measure within the program that clinicians found to be burdensome due to patient follow-up. Dr. Schreiber also provided guidance to the workgroup to vote on measure retention or removal from programs without concern for future plans of CMS and focus on the merit of the measure only. A CMS program lead stated there are not currently any plans for a replacement measure if this measure were to be removed from the program.

MAP members suggested retaining the measure within the program with a condition that movement is made towards outcomes, such as 6-month or 12-month remission rates. Dr. Fields noted follow-up guidance currently in place is not evidence-based and the specifications are extremely narrow. After discussion on the decision categories, MAP agreed to start the voting process with the decision category that would best address the gaps within the program if the measure were to be removed. Additional points made by MAP members included the appropriate placement of this measure within the MSSP because team care is required to address mental health. CMS program leads shared the intent behind the measure during the early stages of development was to encourage screening for mental health by all clinicians because some patients do not see their primary care physician regularly and the signs for a positive diagnosis are not always obvious. Dr. Fields left a comment in the chat clarifying that the removal of this measure would leave only one clinical measure within the program (01246-C-MSSP: Controlling High Blood Pressure). Dr. Schreiber acknowledged this comment and confirmed it was correct. Dr. Schreiber further clarified that recommendations from the Clinician Workgroup are not binding and CMS is required to have clinical measures within the program.

The process for voting on the recommendation began with confirmation of quorum being 15 members. Twelve members would be needed to reach consensus on a voting category. The vote proceeded on the decision category for “Support for Retaining” the measure within the program. Clinician Workgroup

members voted to retain the measure in the program at 72%. Full voting results can be reviewed in Appendix B.

### eCQM ID:CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. Ms. Williams-Bader noted the measure is the eCQM version of the measure previously discussed and discussion of the measure would focus on the eCQM version. Ms. Williams-Bader also noted comments would be welcomed on the registry-based or CQM version of the measure for future consideration by CMS. Ms. Williams-Bader stated there would only be one vote. Lastly, Ms. Williams-Bader stated this version of the measure was not included in the original survey completed by advisory and workgroup members, so selected measure review criteria were not available.

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented that the eCQM version of the measure was added to the MSSP as part of the Alternative Payment Models Performance Pathway (APP) and is another way in which ACOs can meet reporting requirements within the MSSP. The program lead also noted the measure is utilized by the Merit-Based Incentive Payment System (MIPS) program. Dr. Schreiber clarified that the MSSP is working to transition measures to eCQMs, which this measure is accomplishing. Dr. Schreiber also stated most of the eCQM measures are all-payer, so more robust data is received.

A MAP member opened the discussion as a lead discussant and commented on the need for a collaborative measure with longitudinal outcomes. The MAP member stated they were more supportive of retaining this version of the measure in the program compared to the previous measure version that was discussed. Another MAP member commented as a lead discussant that this version of the measure would help to alleviate reporting burden for providers.

Ms. Williams-Bader then provided an overview of the discussion on this measure from the Rural Health and Health Equity Advisory Groups. Ms. Williams-Bader reported Rural Health Advisory Group members did not support retaining the measure in the program at 43%. Ms. Williams-Bader noted the group expressed support for the decreased burden on providers with the eCQM version of the measure found in the complete Rural Health Advisory Group meeting summary. Ms. Williams-Bader commented Health Equity Advisory Group members provided no additional comments to what was provided for the previous measure found in the complete Health Equity Advisory Group meeting summary.

Dr. Fields then opened the discussion for MAP members. A MAP member posed a question in the chat regarding the definition of burden being experienced by providers. Dr. Fields clarified that the type of burden experienced by providers with the previous version of the measure is a manual chart review that has to occur depending on what type of follow-up plan is chosen for the patient. Dr. Fields noted there is a reporting burden and not a performance burden. Dr. Fields also clarified the eCQM version of this measure would include all specialists, which would impact performance due to the denominator and potential patient encounters the clinician will have. A MAP member asked in the chat if there were exclusions to encounters in the denominator. A CMS program lead answered that existing depression or bi-polar depression are the exclusions for the denominator because the intent of the measure is to identify new cases of depression.

Dr. Fields suggested starting the vote with the decision category of "Support for Retaining". Clinician Workgroup members voted to retain the measure in the program at 89%. Full voting results can be reviewed in Appendix B.

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

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure is duplicative of other measures within the same program
- Measure does not contribute to the overall goals and objectives of the program
- 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
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented that for this particular measure, stakeholders do not need to submit data, but they are assessed based on the way the measure is structured.

A MAP member opened the discussion as a lead discussant and commented on their support for retention of the measure within the program. The MAP member noted there are several reasons why a patient may be readmitted to the hospital, such as social determinants of health or the lack of proper follow-up care because they do not have primary care. The MAP member noted their support for the exclusion of specialties such as oncology and psychiatry because those readmission rates are difficult to predict. A second lead discussant agreed with the recommendation to retain this measure within the program. The MAP member then asked for the differences between the measure under discussion and a similar, endorsed measure (NQF #1789), as the measure under discussion is not endorsed. A CMS program lead answered that the measure under discussion has been respecified and the team is working towards NQF endorsement status. The CMS program lead noted there are established reliability thresholds and requirements for minimum group and case size. Another CMS program lead reported this measure is a combination of the hospital version of the measure and the MIPS version of the measure. The program lead also noted measure performance is correlated for ACOs.

Ms. Williams-Bader provided an overview of the discussion on this measure from the Rural Health and Health Equity Advisory Groups. Ms. Williams-Bader reported Rural Health Advisory Group members support retaining this measure in the program at 43% and 57% of the members did not support retaining the measure in the program. Ms. Williams-Bader noted that the Rural Health Advisory Group discussion focused on inclusion of rural health providers within the measure, the lack of stratification for conditions, and concerns for rural health provider challenges with low case volume, which could introduce validity concerns. Ms. Williams-Bader also noted that advisory group members commented performance data could be impacted by small fluctuations found in the complete Rural Health Advisory Group meeting summary. Ms. Williams-Bader stated Health Equity Advisory Group members noted the need for greater specificity for conditions, rather than global readmissions. Ms. Williams-Bader also summarized the advisory group's comments that there is a need for comprehensive risk adjustment for

socio-economic status and other factors that could impact outcomes and that are unrelated to the quality of care provided. Ms. Williams-Bader stated an advisory group member noted findings in the literature reported that readmissions post the 7-day window are more attributed to social or structural determinants of health issues and questioned the responsibility of the hospital for readmissions outside of a 3-day window found in the complete Health Equity Advisory Group meeting summary.

Dr. Fields then opened the discussion for MAP members and started the discussion by asking about the correlation between the measure and the older version for ACOs. The measure developer clarified that testing was completed with the MIPS version of the measure with pre-COVID data because that was what was available. The measure developer stated the hospital version of the measure (NQF #1789) was collecting data for the last several years. Dr. Fields responded the attribution methodology for both measures are different and that is important. The measure developer responded that the attribution methodology for this version of the measure is at the clinician level and it is a multiple-attribution technique.

A MAP member asked if the measure's denominator included patients that were already in the physician group's panel before they went to the hospital for the first time or if the measure included a physician (like a primary care physician) in the denominator that received a patient for the first time from the hospital. The measure developer answered that three different clinician groups would be included, the discharging clinician group during the hospitalization, the primary in-patient care provider group (responsible for the patient's care and who bill the most charges during the hospitalization), and the outpatient primary care physician group (responsible for care outside of the hospital, based on 12 months prior to the hospitalization). The measure developer noted if a physician is seeing a patient for the first time, they would most likely not be included in any of these groups.

Another MAP member expressed the importance of this measure for physician and public accountability and the measure should be retained within the program.

Dr. Fields recommended that voting begin with the "Support for Retaining" decision category. Clinician Workgroup members voted to retain the measure in the program at 100%. Full voting results can be reviewed in Appendix B.

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

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure leads to a high level of reporting burden for reporting entities
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented that similar to the previous measure discussed, the measure is included in the MSSP as part of the APP and the measure does not put any reporting burden on ACOs because the data is calculated on their behalf. The program lead noted the reliability threshold has been established and there are requirements for minimum group and case size for the measure. The program lead also noted the measure was correlated with the previous ACO version of the measure within the MIPS program.

A MAP member opened the discussion as a lead discussant and commented with a recommendation for the measure to be removed from the program. The MAP member explained the basis for this recommendation came from the premise that increased care coordination or care management can reduce admissions, but the evidence base on that is quite weak, even when high-performing systems are examined. The MAP member also put forth for consideration the basic premise that the measure is a quality measure and not a utilization measure. Additionally, the MAP member noted there are methodological issues, such as the influence of socio-economic status and other aspects of access to care to primary care that influence the measure. The MAP member noted the method for socio-economic status was in contrast to the recommendation from NQF's disparities standing committee. The MAP member also noted dual eligibility was not factored into the measure. The MAP member also noted one of the defining conditions out of eight is actually an acute condition (acute myocardial infarction (AMI)), and that this condition leads to expected admissions in the first year after the event for planned vascularization or device management.

A second lead discussant stated the concept of focusing on a specific population for improved admissions or improved care coordination is an admirable goal and speaks to the MSSP priority of promoting accountability for patient populations. The MAP member noted there is good variability in the rates, but questioned what the variability is actually reflecting, asking if improved care coordination for specific measures really relate to decreased rates of admission or if reduced rates are instead related to the risk adjustment process. The MAP member recommended the measure should be retained with conditions. The MAP member also noted there are about 500 ACOs reporting the measure and this should be taken into account when there is consideration on what to do with the measure within the program.

A third lead discussant endorsed the suggestion of retaining the measure with conditions. The MAP member commented the measure meaningfully assesses quality care team integration and noted its ability to decrease utilization in high-risk populations. The MAP member also commented many systems are pushing transitional care teams with primary care providers and social workers. The MAP member noted limitations of the measure, including that it is clinically based and there are population-based factors that affect performance, so revisions are recommended.

Ms. Williams-Bader provided an overview of the discussion on the measure from the Rural Health and Health Equity Advisory Groups. The Rural Health Advisory Group members supported retaining the measure in the program at 57% and 29% of the members did not support retaining the measure in the program. Ms. Williams-Bader noted no specific concerns were raised from the rural health perspective found in the complete Rural Health Advisory Group meeting summary. A Health Equity Advisory Group volunteer recapped discussion of the measure by the group and noted challenges with chronic condition management in historically marginalized populations. The volunteer noted, from a health equity perspective, stratification would be helpful to have deeper insight into whether there are areas of the population where the measure is more challenged than others. The volunteer also noted there is the recognition that the measure includes components that are outside of the provider's locus of control, and this is an area that should be re-engineered found in the complete Health Equity Advisory Group meeting summary.

Dr. Fields then opened the discussion for MAP members. Dr. Fields noted comments in the chat from MAP members regarding the counting of episodes of readmission within the measure and asked if there any exclusions. The measure developer answered the measure counts admissions, but it does exclude admissions that occur within 10 days of a recent admission as a buffer period. Dr. Fields asked for additional background on the intent of including AMIs in the measure as one of the conditions. A CMS

program lead answered that the qualifying condition starts with an acute event such as a ST-elevation myocardial infarction (STEMI) or a non-STEMI, but the event happens before the performance period. The program lead commented the measure is a marker for patients who have coronary artery disease, which is a chronic condition.

A MAP member and lead discussant raised a question regarding a denominator exclusion for post-hoc patients not at risk for hospitalization during the measurement year. The measure developer answered this exclusion is for patients admitted to the hospital at the beginning of the performance year who are not in the outpatient setting or a nursing home and have no person-time at risk during the performance year. The measure developer noted there were a few specific scenarios where this occurred, but it was rare. The MAP member clarified their support for retaining the measure within the program with the idea that more consideration be given to risk adjustment and not capturing things already evaluated by other measures. The MAP member noted additional explanations are needed for changes in performance and more specifically, recent declines in performance that may be attributed to COVID-19. Another MAP member questioned if care coordination and home care can prevent original hospital admissions for patients with chronic conditions. The MAP member noted there are conflicting beliefs on this and most ACOs believe this arrangement works. Dr. Fields asked CMS if the measure was mandated by statute or regulation. Dr. Schreiber confirmed the measure is not mandated by statute.

Dr. Fields guided the conversation towards agreement on the conditions for the decision category. The measure developer clarified the 10-day buffer period for readmissions, by explaining the 10-day period is the time when patients are being transferred back into community-based care. The measure developer noted the intent of the measure is not to hold clinicians and clinician groups accountable during this short timeframe after the patient is discharged. Dr. Fields expressed concerns for MIPS measures within the ACO measure set because the intents are different. Dr. Fields commented the work of a group and an ACO is different from that of an individual clinician and the level of responsibility is different. A MAP member put forth a question in the chat regarding coronary artery disease (CAD) codes. The member referenced the previous conversation on AMIs and mentioned there are specific codes for the chronic conditions and the acute conditions and asked how the metric was developed. The member noted the data on the outcomes metric would be very useful. The measure developer clarified the measure captures multiple chronic conditions, so patients with AMIs also had another condition and the AMI occurred before the performance year. The measure developer further clarified planned admissions for revascularizations are not counted in the outcomes of the measure. The measure developer also noted there is an evidence base regarding what clinicians and hospitals can do to reduce admissions, including care coordination, continuity of care, and various programs that help dispense medications to patients in a safe fashion and guard against adverse effects of medication. Dr. Schreiber commented that one of the reasons for including AMI is that it is an indicator of the worsening underlying CAD and the hope is the clinician or the ACO is taking the proper steps to prevent an AMI if possible.

Dr. Fields asked a final clarifying question on the risk adjustment component of the measure. Dr. Fields noted the previous version of the MIPS measure contained this component but the previous version of the ACO measure did not contain this component. The measure developer confirmed the measure was tested at the ACO level and separately at the MIPS and clinician level.

MAP members agreed on the following conditions:

- Re-evaluating the definitions of readmissions for uniformity across the MIPS and MSSP measure sets

- Evaluating the validity of a 10-day buffer rule at the ACO level

Voting began with the "Conditional Support for Retaining" decision category. Clinician Workgroup members voted to retain the measure in the program with conditions at 83%. Full voting results can be reviewed in Appendix B.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey**

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- 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
- Measure leads to a high level of reporting burden for reporting entities
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

Additional survey feedback from respondents was as follows:

- Have received feedback from stakeholders that the questions, feedback and rates from the CG-CAPHS 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

Ms. Williams-Bader provided a clarifying statement on the measure, noting MSSP recently removed the CAHPS for ACOs survey from their program and is now incorporating the CAHPS for MIPS survey into the program. The CAHPS for ACOs survey was last administered for the MSSP for ACOs during the 2019 performance year. CMS waived the CAHPS for ACOs survey for the 2020 performance year. Beginning with the 2021 performance year, MSSP ACOs were required to administer the CAHPS for MIPS survey as part of APM performance pathway reporting. The surveys are nearly identical, however, there are some scoring differences and these surveys are also similar to CG-CAHPS. Given how new the CAHPS for MIPS survey is within the program, the information provided in the MSSs was for the CAHPS for ACOs survey and the CG-CAHPS surveys. NQF did not discuss the measure with the advisory groups, however, since it was nominated for discussion during the survey, NQF asked the Clinician Workgroup to discuss and vote on the measure.

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented all ACOs are required to report the measure, whereas the option to report on the measure under MIPS is voluntary. Another CMS program lead commented that the measure has been in the program since the beginning and work has been occurring to align both versions of the survey for ACOs and for MIPS and to reduce the number of measures and burden. The program lead noted one question differed between surveys; this question focused on internet access and it was not scored.

Dr. Fields then opened the discussion for MAP members and mentioned the change in calculation rates from flat benchmarks to a change in percentiles. A CMS program lead responded that in the past,

summary survey measures (SSMs) were each scored differently; under MIPS, the score is determined from a single survey. The program lead stated the 2021 performance year will be the first year where results are available under the revised scoring mechanism. Several MAP members expressed support for retaining the measure in the program because it is one of the few measures that captures patient feedback on their healthcare and improves patient outcomes. Another MAP member noted the potential for the measure to address and mitigate disparities within patient experience. Another MAP member highlighted that low performance scores for the measure is an important reason to retain the measure within the program, especially for questions addressing stewardship of patient resources.

Voting began with the "Support for Retaining" decision category. Clinician Workgroup members voted to retain the measure in the program at 100%. Full voting results can be reviewed in Appendix B.

### 01246-C-MSSP: Controlling High Blood Pressure

Dr. Amin provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities
- Measure leads to a high level of reporting burden for reporting entities

Dr. Amin clarified this is the web-interface version of the measure and MSSP will sunset this version of the measure starting with the 2025 performance period. Dr. Amin further clarified the discussion will focus on the web-interface version of the measure and the next measure will be the eCQM version. Dr. Amin noted comments will also be received for the registry based or CQM version during the discussion of the eCQM version of the measure.

Dr. Amin then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented this measure is a high-priority intermediate-outcome measure. The program lead stated the measure has been a part of the web-interface measure set since inception of the program. The program lead noted the measure differs slightly from the NQF-endorsed version and that is why the NQF ID is not referenced.

A MAP member commented as a lead discussant that the measure is a notable goal for CMS and clinicians to use while monitoring their patients. The MAP member commented that although the measure has been topped out at 60-70% performance, the measure may still be a good measure to retain to keep the focus of the health systems on this condition. The MAP member suggested a condition of the measure being retained in the program is the removal of the use of the most recent blood pressure. The MAP member noted a more appropriate measure would be an average of several blood pressure readings or the incorporation of a time in therapeutic range model that is more consistent with recent literature. The MAP member commented this is burdensome with the current version of the measure but would be much easier with an electronic version of the measure. The MAP member highlighted public comments that focused on the absence of home readings. The MAP member commented this is a measure flaw that should be corrected. Additionally, the MAP member noted that they did not notice any encounter exclusions and asked CMS to speak to this point.

Another MAP member as a lead discussant agreed with supporting to retain the measure in the program, with the conditions that the measure include readings from home blood pressure monitors. The MAP member also commented there should be a "pass/fail" based on one specific number and there should be a more longitudinal approach. Another MAP member as a lead discussant expressed the importance of the measure for patient care regarding upstream interventions and cost control.

A volunteer from the Rural Health Advisory Group provided an overview of the discussion of the measure from the group. The advisory group was split on their support of retaining the measure in the program, with 43% polling in favor of retaining the measure in the program and 43% polling that the measure should not be retained in the program. The volunteer noted there was some concern that the version of the measure used by CMS had not been endorsed, related to a modification in the measure specification. The volunteer also noted there was concern around the focus on essential hypertension, but it was confirmed that the health plan measure, the MIPS measure, and the MSSP measure all focus on essential hypertension. The volunteer reported that the measure steward recently started to accept home blood pressure readings during a virtual visit or any time. The volunteer noted blood pressure readings related to an acute visit, a hospital visit, or an emergency room visit are excluded in the measure calculation found in the complete Rural Health Advisory Group meeting summary. Dr. Amin noted Health Equity Advisory Group members commented that patients suffering from high blood pressure also deal with equity issues found in the complete Health Equity Advisory Group meeting summary.

Dr. Fields then opened the discussion for MAP members. MAP members wanted clarity on measure exclusions and the differences between the current measure and the NQF-endorsed version of the measure. A CMS program lead answered the difference between the two measures are the timeframes between diagnoses. The program lead clarified the MIPS CQM has the diagnosis of hypertension before the current performance period or within the first six months of the performance period and the NQF-endorsed version has the diagnosis of hypertension anytime in the 2-year period. The program lead also noted the NQF-endorsed version has a requirement of two visits and the MIPS CQM version only has a requirement of one visit. The program lead also stated there are differences with hospice and frailty exclusions with patients. The CMS program lead clarified the health plan measure version and the NQF-endorsed measure version are consistent with one another.

MAP members agreed on the following conditions:

- Having multiple encounters in the measure is important
- Change the last reading requirement to an average or time in therapeutic range
- Allow ambulatory or at-home blood pressure readings to be included in measure

Voting began with the "Conditional Support for Retaining" decision category. Clinician Workgroup members voted to retain the measure in the program with conditions at 100%. Full voting results can be reviewed in Appendix B.

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

Dr. Amin provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. The measure was not presented in the original survey, so the criteria and rationale selected by members during the survey nomination process was unavailable. Dr. Amin clarified the discussion of the measure will focus on the eCQM version and comments on the registry-based version of the measure are welcomed.

Dr. Amin then turned over to the CMS for any clarifying comments on the measure. A CMS program lead commented that the measure is an eCQM and the program is trying to move towards the inclusion of more eCQMs in the program. The program lead noted the measure would be a requirement if an ACO chose to report on eCQMs; under the program, there are currently three eCQM measures identified.

A MAP member commented as a lead discussant in agreement with all of the comments provided for the previous measure and found them to be applicable to this measure version as well. The MAP member noted time in therapeutic range or average scores are easier to achieve with eCQMs.

MAP members agreed on the following conditions:

- Having multiple encounters in the measure is important
- Change the last reading requirement to an average or time in therapeutic range
- Allow ambulatory or at-home blood pressure readings to be included in measure

Although this concern was not put forth as an official condition, MAP members noted future considerations for segmented subpopulations were warranted, such as patients 75 years or older or 85 years or older. Voting began with the "Conditional Support for Retaining" decision category. Clinician Workgroup members voted to retain the measure within the program with conditions at 100%. Full voting results can be reviewed in Appendix B.

## Merit-Based Incentive Payment System (MIPS) Measures

Ms. Williams-Bader provided an overview of the Merit-Based Incentive Payment System (MIPS) program, including program type, incentive structure, and goals. Details of the program can be reviewed in the meeting slides (PDF). Ms. Williams-Bader introduced Dr. Padden to lead members of the public through public commenting on the measures for review within the MIPS program.

### *Opportunity for Public Comment on Merit-Based Incentive Payment System (MIPS) Measures*

Dr. Padden opened the web meeting to allow for public comment for the measures nominated in the MIPS program.

One commenter shared support for retaining 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery, 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, and 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care in the MIPS program. The commenter noted their organization was in favor of a robust measure set that covers the breadth and scope of medical care but noted there needs to be a balance between managing the measure set to ensure measures are clinically relevant and ensuring valuable measures are available to all clinicians. The commenter observed that for the retina specialty, there are currently only six benchmarked quality measures in the MIPS programs and two of those measures were under discussion by the workgroup. The commenter also noted that if the two measures are removed from the MIPS program, retinal specialists will be forced to report on completely unrelated measures rather than measures that are meaningful to their clinical practice. The commenter concluded by stating that the measures are important for the CMS strategy for health equity as Black and Latinx individuals have significantly higher rates of diabetes related complications, including blindness, as well as higher odds of worse visual outcomes after retinal detachment repair surgery.

Another commenter shared support for retaining 01101-C-MIPS: Barrett's Esophagus in the MIPS Program. The commenter noted their organization supports the measure as they believe it contributes

to the overall goals and objectives of the program and can indirectly lead to better patient outcomes as notation of dysplasia is critical for making patient care decisions. The commenter also emphasized that, due to the unique features of the practice of pathology, there are a limited number of MIPS performance measures pathologists can report. The commenter concluded by noting that the measure lost endorsement not because of a failed measure review but rather because the measure developer did not have the resources to maintain endorsement.

A third commenter shared support for retaining 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery, 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, and 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report in the MIPS Program. The commenter stated that their organization supports ophthalmology practices in reporting MIPS measures and noted that only six benchmark measures currently exist in the MIPS program for ophthalmology and only four measures available to report as eCQMs. The commenter highlighted that their organization sees ophthalmology practices try to report non-germane measures such as immunizations or body mass index just to meet reporting requirements. The commenter stressed the importance of the measures for health equity and care coordination reasons. The commenter also stated that while 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report has not had much reporting, their organization has begun to encourage the use of the measure, which will likely increase reporting. The commenter concluded by noting that practices that now use the measure are seeing the importance of the measure to encourage care coordination and those practices now acknowledge they have been neglecting both sending and receiving specialist reports.

### 00641-C-MIPS: Functional Outcome Assessment

Dr. Amin provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure leads to a high level of reporting burden for reporting entities
- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contributions to health disparities

Dr. Amin then turned over to the CMS for any clarifying comments on the measure. A CMS program lead noted that the measure is a high priority measure and has broad applicability. The program lead also noted the measure was previously endorsed but the measure steward chose not to renew endorsement based on resource constraints. The program lead also highlighted the use of standardized assessment tools based on clinician preference, which reduced reporting burden. The program load also noted the assessment only needs to be completed at 30-day intervals despite the measure tag being by visit. The program lead noted that while the measure was topped out for a second year, it is broadly applicable which helps to reduce the overall number of measures in the MIPS program and allows for comparisons across clinicians in the program. The program lead concluded by noting that while the measure may be considered a checkbox measure as it looks to see that a functional assessment was documented, it does

require a plan of care be completed for patients that screen positive, which supports optimal patient care.

Dr. Amin read a statement from an absent lead discussant, which noted the measure is one of a very small number of functional outcome measures in MIPS and the combination of use of a standardized functional assessment tool with documentation of a care plan based on patient-identified deficiencies is an important measure. The lead discussant disagreed with commenters that it is a check box assessment, as the measure requires clinicians to act on patient-identified deficits through a care plan. The MAP member also noted while there has been a push for greater use of patient-reported outcomes (PROs), their use in clinical practice remains very limited. The MAP member commented that, if maintained, the measure will continue to encourage clinicians to use standardized tools of patient functioning. The MAP member noted the few, existing PRO performance measures are focused on change in outcomes from specific procedures and attempts to build PROs for general medical conditions have largely been unsuccessful given the need for risk adjustment and a recognition that for many patients, maintaining function is the goal. The MAP member commented there are no unintended consequences associated with use of the measure and while overall reported performance is high, there are no data regarding results by subpopulation. The MAP member did not support removal of the measure of functional assessment without a replacement measure in MIPS that supports the routine incorporation of functional assessments into clinical care. The second lead discussant noted the measure is a compound metric, making it difficult to determine if poor performance on the measure is due to low utilization of the assessment or if the care plan has not been made for certain populations. The MAP member also noted little public support for continuing the measure for reasons previously stated, including the checkbox nature of the measure and the measure being topped out.

A representative of the MAP Rural Health Advisory Group summarized their discussion on the measure. The advisory group member noted zero members supported retaining the measure in the program, four did not support retaining, and two members were unsure. The advisory group member noted that the advisory group considered the measure to have a great concept, but the advisory group's main concern was the denominator being too broad by expecting a functional status assessment at every visit for all patients aged 18 and older. The advisory group member concluded by noting that there could be benefit if the denominator was focused on certain conditions and not an expectation for all patients 18 and older found in the complete Rural Health Advisory Group meeting summary. Ms. Williams-Bader then summarized the discussion of the MAP Health Equity Advisory Group on the measure. Ms. Williams-Bader noted the advisory group mentioned equity concerns relating to recovery from strokes and other significant events. However, Ms. Williams-Bader also noted the advisory group was concerned that the measure is too broad. Ms. Williams-Bader concluded the advisory group noted more insight regarding the absence of functional outcome assessments in certain populations by stratification would be helpful to fully assess the measure found in the complete Health Equity Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. A MAP member stated that the measure is very broad and asked if the measure could be narrowed. The member also asked if there was a registry or eCQM version of the measure. A CMS program lead responded that the measure originally was developed as a measure for non-physician clinicians, primarily physical therapists. The program lead also noted that the measure was expanded to other specialists at their request. The program lead also noted it is a registry measure. The MAP member asked a clarifying question: would the measure be removed for all clinicians if MAP voted for the measure's removal from the MIPS program? A CMS program lead responded that if the measure were removed, it would be completely removed from the program. The program lead noted there may be some specialties that do not have sufficient measures in the MIPS program who want to report a broader measure and reaffirmed that the measure is being considered

for complete removal from the MIPS program. In response to these comments, the MAP member noted that physical therapists might not consider the measure as too broad as they might see it as very targeted and specific to their patient population. A MAP Rural Health Advisory Group member shared that the advisory group was not aware of history of the measure and that the advisory group's assessment was from the perspective of broad use in physician practices.

Another MAP member noted the denominator only records events when a clinician uses a standardized assessment tool for functional outcomes, which seemed appropriate to the MAP member. A CMS program lead confirmed the measure denominator includes all visits for patients 18-64, but is CPT code specific. The program lead also confirmed the measure numerator identifies events where the functional outcome assessment and care plan are completed, so the measure would only be reported by clinicians who think it is appropriate for their practice. A MAP member confirmed that if a clinician chooses to report the measure, they will report all visits, but a clinician who does not use functional assessments would generally not use this measure. Another MAP member concurred that the measure's broad denominator would deter clinicians who do not use functional assessments from reporting the measure.

A MAP member asked a clarifying question that if a clinician feels that the measure is too broad for them to use, do they have a choice to not include it in their MIPS portfolio? Dr. Schreiber confirmed all MIPS measures are voluntary and that physical and speech therapists may want to report the measure given their regular use of functional assessments. The MAP member noted the fact that the measure is voluntary should weigh against comments that the measure is too broad.

Another MAP member noted public comments that articulated support for the measure because it is broadly applicable across specialties and CMS programs, as well as public comments noting the need to advance use of PROs in routine care. The MAP member noted they were confused about the denominator throughout the measure discussion. The MAP member also noted that according to the measure summary sheet, there is a denominator exception for patients where a functional outcome was not documented as being performed. A different MAP member noted that the exclusion is based on documentation that a functional assessment is not required for a patient, and that patients are only eligible for functional assessments every 30 days under the measure specifications.

Ms. Williams-Bader noted the presence of broadly applicable encounter codes in the denominator and asked CMS to confirm. A CMS program lead confirmed those codes are in the denominator and they had been added at the request of chiropractor specialists who use those codes in their practice. A MAP member asked a clarifying question about the numerator and denominator: if a patient has a status assessment and it is negative, does that patient come out of the denominator? The program lead noted that only patients who have a positive functional status and have a documented care plan would be considered for the numerator. The program lead also noted the denominator seeks to include all patients who are eligible, have an assessment done and a plan of care developed. The program lead also noted the provider would have to document there are no functional deficiencies. A MAP member clarified the denominator is the visit, not the assessment being positive or negative.

Dr. Padden suggested starting the vote with the category of "Support for Retaining." Clinician Workgroup members voted to retain the measure in the program at 82%. Full voting results can be reviewed in Appendix B.

### 01101-C-MIPS: Barrett's Esophagus

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination

process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure is not reported by entities due to low volume, entity not having data, or entity not selecting to report a voluntary measure

Ms. Williams-Bader then turned over to CMS for any clarifying comments on the measure. A CMS program lead noted removal of the measure would have a negative impact on the specialty as removal would drop the number of measures in the specialty below the MIPS threshold of six measures. The program lead also noted the measure reflects clinical guidelines and does not encourage endoscopy as it looks for a leading indicator in previously performed endoscopies. The program lead concluded by noting the measure was not submitted for renewal of CBE endorsement and has a benchmark.

A MAP member serving as lead discussant noted adoption of the measure is not high and has been stagnant in recent years. The MAP member also noted the measure may be topped out with performance of 99% in the last measurement year. The MAP member also observed the measure is highly specialized and referenced public comment as supportive of the measure because of its specificity to pathology. The MAP member could not identify potential downsides to the measure in the measure summary sheet as the measure is a preventative measure, which could potentially lead to positive health outcomes.

The second lead discussant noted there is no role for continuous improvement in the measure. The MAP member also stated the measure seems like a standard of care for the specialty. The MAP member concluded they would not be supportive of continuing the measure in the MIPS program for those reasons.

A MAP Rural Health Advisory Group volunteer noted the advisory group was split about continuing the measure in the program (polling results were three members for not retaining the measure, four for retaining, and one member was unsure). The volunteer also noted the advisory group recognized that the measure is topped out and represents a standard of care found in the complete Rural Health Advisory Group meeting summary. The MAP Health Equity Advisory Group volunteer noted the advisory group did not have specific concerns from a health equity perspective. From a more general perspective, the advisory group volunteer noted advisory group comments that the measure is topped out and the measure is important for pathologists due to the lack of other pathologist measures in the MIPS program. The volunteer concluded by noting advisory group comments that the measure is not stratified to identify health disparities and the recognition that it is difficult to determine health disparities solely from a pathology report found in the complete Health Equity Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. Dr. Padden noted a comment in the chat from Dr. Schreiber that the MIPS program does have a statutory requirement to have measures for all MIPS eligible specialties and that pathology has few measures to choose in the program. A MAP member asked a clarifying question about the measure: is the measure a basic standard of care or does the pathologist's commentary on dysplasia represent an additional step beyond the standard report? The measure developer responded that there are no standard criteria for the commentary on dysplasia except what the ordering clinician expects from the pathologist and that information about dysplasia in the report determines the need for follow-up care and the follow-up care timeline. The measure developer also noted that the way Barrett's esophagus is described is variable across pathologists and that while mean performance of the measure is good, the long tail of poor performance in the measure

is where additional performance improvement in the measure is possible. The MAP member asked a follow-up question to determine if the measure has a requirement for the pathologist to make a recommendation for length of follow-up care. The measure developer stated the measure does not require a determination of follow-up in the report as that would be determined by the initial requesting clinician. The MAP member then suggested possibly changing the measure because it is topped out but noted that changes in the measure may be difficult as the ordering clinician will make follow-up care decisions based on the pathology report. The measure developer could not make any suggestions for modifying the measure and again noted the small number of pathology measures in the MIPS program. Another MAP member noted the difficulties of getting pathology measures into the MIPS program. The MAP member also stated there may be opportunities to expand reporting to a wider population of pathologists and to see if that changes measure performance.

A different MAP member suggested that the workgroup could apply the "Conditional Support for Removal" voting category to allow for maintaining the measure in the MIPS program until a replacement measure is identified. Dr. Padden summarized the workgroup as having a general level of support for that category based on the gap that would be created in the MIPS program if the measure were removed without a substitute. Dr. Padden suggested starting the vote with the category of "Conditional Support for Removal." Clinician Workgroup members voted to remove the measure from the program with conditions at 94%. Full voting results can be reviewed in Appendix B.

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

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criterion:

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

Ms. Williams-Bader then turned over to the CMS for any clarifying comments on the measure. A CMS program lead noted the measure is a high priority outcome measure that reflects current guidelines. The program lead also noted that retinal specialties only have three measures within the MIPS program and stressed the importance of having measures for all specialties in the MIPS program. The program lead stated the measure's benchmark was removed for the 2020 performance year due to a substantive change in the measure. The program lead concluded by noting that the MIPS Value Pathways (MVP) framework will seek to boost reporting for these types of measures by reaching a wide variety of specialists.

A MAP member serving as lead discussant noted the measure is not CBE endorsed, is a new outcomes measure, and was supported by stakeholders in public comment as a measure for their members to report a meaningful outcome.

A MAP Rural Health Advisory Group volunteer noted the advisory group was split when polling on the measure (results were two members not supporting retaining in the program, four members in support of retaining the measure and 2 members were unsure). The volunteer noted the advisory group's main concern was the potential for low case volume in rural areas due to the prevalence of the condition being only 5 to 7% of the general population found in the complete Rural Health Advisory Group meeting summary. Ms. Williams-Bader then summarized the discussion of the MAP Health Equity Advisory Group on the measure. Ms. Williams-Bader acknowledged the advisory group was also concerned about the potential for low case volume and noted difficulty in assessing health equity issues

in various subgroups when case volume is low. Ms. Williams-Bader mentioned the advisory group also acknowledged a public comment recognizing outcomes for certain groups are worse following retinal attachments and this disparity could highlight a health equity concern found in the complete Health Equity Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. A MAP member asked CMS to clarify how many measures are available in the MIPS program for the ophthalmology specialty. A CMS program lead answered that there are 15 measures for general ophthalmology and three retinal specialty measures. Another MAP member noted a public comment where the number of measures was listed as six. A different CMS program lead clarified that there are six benchmarked measures due to different reporting versions of the diabetic retinopathy measures, but there are only three unique retina measures in the MIPS program.

Another MAP member asked CMS if they had numbers on the number of retinal specialists who use the measure. A CMS measure lead noted that, in 2020, 120 group practices and 381 individual clinicians reported the measure but cautioned that reporting was optional due to the public health emergency. Dr. Padden asked if CMS had the number of clinicians who were eligible to report the measure. The CMS measure lead answered that CMS does not have that data. The measure lead also noted more clinicians reported the measure in previous years with 153 group practices and 447 individual clinicians reporting in 2019 and 147 group practices and 466 individual clinicians reporting in 2018. Dr. Schreiber noted CMS does not assess a clinician's practice to determine if they should have reported a given measure and stated it is an interesting concept going forward. A different CMS measure lead noted multiple specialist groups can have ophthalmologists embedded inside them which allows them to not report and stated that as the MVP framework and similar models come online, ophthalmologists in those practices will be forced to report.

Another MAP member noted they found the measure developer's support for the measure compelling. The MAP member also noted disagreement in the public comment on the cause of a lack of measure benchmarks and asked CMS to comment if the lack of benchmarks was due to the low number of providers reporting the measure or due to low case volume for the condition. A CMS program lead commented that the rarity of the condition makes it harder to calculate measure benchmarks and noted that groups of retinal specialties will make it easier to calculate benchmarks. Dr. Schreiber also restated the previous note that ophthalmologists are often embedded in primary care practices and multispecialty care groups and noted transitions in the MIPS program, including increased use of eCQMs, will increase measure reporting in the future. Another MAP member noted the increased use of eCQMs to increase reporting is encouraging even though the condition is not very widespread. The MAP member also noted that the surgery has a significant impact on patient quality of life and emphasized that the low number of ophthalmology measures in the MIPS program makes this measure extremely important. A MAP member noted visual acuity is an important patient-centered outcome and expressed their opinion that MAP should maintain or increase the number of patient-centered outcomes in the measure set.

A MAP member noted public comments by retinal specialists made important proposals to improve the measure and asked the representative from the measure developer if they could support those changes. That representative noted that the Academy was open to working with retina specialists to improve the measure. The representative also noted that the Academy had worked with retinal specialists in writing public comment and asked for additional time for public comment in future MSR cycles to allow for better collaboration. The MAP member stated there are approximately 4,000 retinal surgeons in the

country and noted a significant percentage of retinal specialists had been reporting for the past several years based on CMS data.

Dr. Padden summarized the workgroup's discussion as demonstrating a general level of support for retaining the measure in the MIPS program with conditions. MAP members agreed on the following conditions:

- Lengthen the follow-up period
- Add additional exclusions (e.g., macular involvement)
- Obtain CBE endorsement for the measure

Dr. Padden suggested starting the vote with the category of "Conditional Support for Retaining." Clinician Workgroup members voted to retain the measure in the program with conditions at 100%. Full voting results can be reviewed in Appendix B.

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

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Performance or improvement on the measure does not result in better patient outcomes
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure leads to a high level of reporting burden for reporting entities

Ms. Williams-Bader then turned over to CMS for any clarifying comments on the measure. A CMS program lead noted that CMS considers this measure to be a high priority measure. The program lead also stated the measure is not topped out. The program lead noted some stakeholder support for the measure and that the measure was proposed for removal in the 2022 Physician Fee Schedule proposed rule, but the measure was not removed due to significant public opposition to removal. The program lead also stressed the importance of the measure as diabetic retinopathy serves as a warning sign for other major conditions and removal of the measure would drop the number of retinal measures below MIPS requirements. The program lead concluded by noting that the measure developer did not seek continued endorsement of the measure due to a lack of resources.

A MAP member serving as lead discussant noted that the NQF standing committee expressed significant concerns about reliability and validity when the measure was considered for endorsement. The MAP member expressed an understanding that each specialty needs a specific number of MIPS measures to report but cautioned that MAP should ensure the measure is appropriate and measures what it intends to measure. The MAP member also noted that the clinical value of the communication was called into question by the NQF standing committee and questioned if primary care and other clinicians had seen value and changed their treatment plans based on receiving a report. Another MAP member serving as lead discussant agreed with concerns that the measure did not meet NQF criteria in endorsement review. The MAP member also noted that the measure was reported as topped out. The MAP member appreciated the public comments from stakeholders that expressed the importance of care coordination. The MAP member concluded by stating that they were concerned about removing a measure from the program without an appropriate measure to replace it. A third MAP member serving as lead discussant expressed agreement with the other lead discussants.

A MAP Health Equity Advisory Group volunteer noted that the advisory group acknowledged known challenges with diabetes in historically marginalized populations and that stratification is important for evaluating the measure moving forward found in the complete Health Equity Advisory Group meeting summary. Ms. Williams-Bader then summarized the discussion of the MAP Rural Health Advisory Group on the measure. Ms. Williams-Bader noted the results of the poll on the measure were: one member did not support retaining the measure in the program, seven members supported retaining, and no members were unsure. The advisory group did not have any specific concerns about the measure from a rural health perspective found in the complete Rural Health Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. A MAP member noted a public comment that indicated the American Diabetes Association is leading a research initiative to address performance gaps and improve the communication and transfer of relevant information between clinicians. Another MAP member noted a public comment from the American Ophthalmological Society. The MAP member also stated the need for ophthalmologists to close the loop with the clinician who is managing the diabetes for the patient but appreciated that the locus of control for the measure lies with the physician who is treating the patient's diabetes. The MAP member concluded by stating they agreed with stakeholders who asked for the measure to be retained in the program. Another MAP member noted that the measure is well-designed but also noted that the measure may possibly disadvantage smaller, rural-based providers without an electronic health records (EHR) system. A different MAP member stated that communication in care is important to patients and is an important part of managing care in coordination with their care team. The MAP member noted that they would support retaining the measure for those reasons.

A MAP member noted the measure is an important concept but could benefit from improvements. The MAP member noted they would support the category of "Conditional Support for Removal" for the measure as they did not want to ignore the NQF review information and would recommend additional measure development related to the measure's concept. Another MAP member noted they would support the category of "Conditional Support for Retaining" due to the length of use of the measure in the MIPS program.

Ms. Williams-Bader asked the workgroup to outline specific conditions they would want to include with the workgroup vote. A MAP member noted their concerns about the loss of NQF endorsement. Another MAP member stated they believed the workgroup's discussion had noted that the measure had a good concept, but the evidence base does not support the measure. The MAP member suggested that one possible condition is to incorporate best practices and move the measure from a process measure to a measure that improves patient outcomes. A separate MAP member recommended another possible change to the measure could be for the measure to encourage the coordination of timely follow-up. The MAP member also noted the goal of wanting to move towards outcome measures and suggested a change to diabetes indicators such as hemoglobin A1C could be a way to assess patient outcomes for this measure. A different MAP member suggested a condition of working with the American Diabetes Association to improve the evidence base.

Dr. Padden summarized the workgroup's discussion as indicating a general level of support for retaining the measure in the MIPS program with conditions. MAP members agreed on the following conditions:

- There needs to be a look at the evidence to see if there are processes with clearer links to outcomes
- Coordination with the American Diabetes Association on their work to improve the evidence base

Dr. Padden suggested starting the vote with the category of "Conditional Support for Retaining." Clinician Workgroup members voted to retain the measure in the program with conditions at 100%. Full voting results can be reviewed in Appendix B.

### 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Ms. Williams-Bader provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure leads to a high level of reporting burden for reporting entities

Ms. Williams-Bader then turned over to CMS for any clarifying comments on the measure. The CMS program lead did not have any additional comments for this version of the measure. All MAP members serving as lead discussants noted they did not have any additional comments for this version of the measure.

The MAP Health Equity Advisory Group member noted they had no additional comments for the advisory group's discussion of this version of the measure found in the complete Health Equity Advisory Group meeting summary. Ms. Williams-Bader then summarized the discussion of the MAP Rural Health Advisory Group on the measure. The advisory group's polling results for the measure were two members who did not support retaining the measure in the program, six members who supported retaining the measure, and one member who was unsure. Ms. Williams-Bader noted the advisory group discussed the measure's loss of endorsement and that, since the measure is voluntarily reported, balancing burden and benefit is more manageable than in other settings found in the complete Rural Health Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. There were no comments from the workgroup. Based on the lack of discussion, Dr. Padden proposed carrying forward the previous decision category of support for retaining the measure in the MIPS program with the same conditions.

MAP members agreed on the following conditions:

- There needs to be a look at the evidence to see if there are processes with clearer links to outcomes
- Coordination with the American Diabetes Association on their work to improve the evidence base

Dr. Padden suggested starting the vote with the category of "Conditional Support for Retaining." Clinician Workgroup members voted to retain the measure in the program with conditions at 100%. Full voting results can be reviewed in Appendix B.

### 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report

Dr. Amin provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure leads to a high level of reporting burden for reporting entities
- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes

Dr. Amin then turned over to CMS for any clarifying comments on the measure. A CMS program lead noted that the measure is a high priority measure and is an eCQM. The program lead also noted the measure is not topped out. The program lead stated that care coordination is a priority for CMS. The program lead concluded by noting that clinician groups can choose how to report the measure so having the measure available as an eCQM does not penalize clinicians without an EHR system.

A MAP member serving as lead discussant noted that the measure is different from the previous diabetes communication measure as this measure assesses a loop, which places the burden on the referring provider to follow-up. The MAP member stated that clinicians in integrated practices would have an easier time meeting the measure's requirements than other entities. The MAP member also observed that the reporting rate for the measure is low with only 3% of groups and 1% of individual clinicians reporting the measure. The MAP member noted the variable performance rate for the eCQM and registry options, with lower performance of clinicians reporting by eCQM, which the member found counterintuitive. The MAP member concluded by noting there is work to do to improve the measure, including possibly changing the measure to focus more on the specialist rather than the referring clinician and increase a focus on individual clinicians and rural providers without EHR systems to improve reporting. Another MAP member serving as lead discussant noted that care coordination measures are difficult to develop and maintain and stated that MAP may not want to remove any of those measures, even if they are not perfect measures. The MAP member also noted the different performance between those clinicians reporting on the registry and eCQM versions and stressed the importance of understanding what is causing those differences in performance. The MAP member concluded by noting that the measure did not seem to have any unintended consequences and provides a key incentive for practices to engage in clinician-to-clinician communication. For those reasons, the MAP member stated they would support retaining the measure in the MIPS program.

Dr. Amin then turned to a representative of the MAP Health Equity Advisory Group to summarize their discussion on the measure. The MAP Health Equity Advisory Group member stated that the advisory group recommended stratifying the measure to determine how referrals are happening for historically marginalized groups found in the complete Health Equity Advisory Group meeting summary. Dr. Amin then summarized the discussion of the MAP Rural Health Advisory Group on the measure. Dr. Amin stated the advisory group noted the difficulty that rural providers may have in limited technology to receive feedback from referrals to urban centers. The results of the advisory group's polling on the measure were: two members did not support retaining the measure in the program, six members were in favor of retaining the measure, and one was unsure found in the complete Rural Health Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. Dr. Padden noted that there seemed to be support in the workgroup to retain the measure but was unclear if the workgroup needed to outline conditions to improve the measure. A MAP member suggested possibly adding a condition to change the measure to something similar to 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care, so the responsibility shifts to the specialist as opposed to the referring clinician. Another MAP member noted that they would want the workgroup to closely look at both measures' specifications before supporting a direct combining of measures. The MAP member

also commented that they wanted to emphasize understanding why the measure performance is so different for eCQM versus registry reporting. Dr. Padden noted that the measure includes all referrals, not just those for diabetes, and therefore it may not be quite as easy for some of the other specialty areas to send information back and forth. Dr. Padden also commented that MAP should try to understand how closing the loop impacts patient outcomes. Dr. Padden also noted that while diabetic retinopathy is one example of referrals impacting patient outcomes, there are other places where closing the loop is equally as important. Dr. Padden observed that if a patient is uncomfortable with a specialist they have only seen once or twice, they will return to their primary care physician for the next steps in the care process, so ensuring those referring clinicians get results back is crucial for care continuity. Dr. Padden concluded that she would support retaining the measure. Another MAP member noted that a referral falling through can be devastating for the patient and that the measure can apply broadly to all kinds of referral situations. The MAP member concluded by noting that they would support retaining the measure in the MIPS program without conditions due to the measure's value in improving care coordination.

Dr. Padden suggested starting the vote with the category of "Support for Retaining." Clinician Workgroup members voted to retain the measure within the program at 94%. Full voting results can be reviewed in Appendix B.

**05837-E-MIPS: Children Who Have Dental Decay or Cavities**

Dr. Amin provided an overview of the measure for review, including the measure description, the measure endorsement status, and the number of votes received during the survey nomination process by advisory and workgroup members. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

Dr. Amin then turned over to CMS for any clarifying comments on the measure. A CMS program lead stated that the measure is a high priority outcome measure. The program lead also noted that removal would negatively impact dentists as there are a limited number of dental measures in the MIPS measure set. The program lead stated the measure is not duplicative of other measures in the MIPS measure set and was initially endorsed by NQF in 2011. The program lead then concluded by noting the measure was removed from Pediatric Performance measure phase 2.

Dr. Amin then reviewed the above criteria and rationale for survey selection and additional feedback received on the MSR survey as lead discussants were not available. Dr. Amin then summarized the discussion of the MAP Health Equity Advisory Group on the measure. Dr. Amin noted the advisory group had significant discussion around the difficulties for primary care physicians to educate family members and patients regarding the dangers and preventative care required to prevent tooth decay. Dr. Amin also noted the advisory group discussed how the measure was important from an equity perspective. Dr. Amin stated the advisory group had concerns that the measure only examines prevalence but noted that the measure contributes to overall holistic health care. Dr. Amin also stated the advisory group noted that the measure may disincentive physicians or dentists who work in communities that have a lack of health food or available dental care and that there are various structural components to consider when implementing the measure found in the complete Health Equity Advisory Group meeting summary. Dr. Amin then summarized the discussion of the MAP Rural Health Advisory Group on the

measure. Dr. Amin stated the advisory group noted the high costs of treating tooth decay and cavities can be a barrier for accessing care in the rural environments. Dr. Amin noted the advisory group stated that it may not be most appropriate to hold dentists accountable for these outcomes found in the complete Rural Health Advisory Group meeting summary.

Dr. Padden then opened the floor for measure discussion. Dr. Padden asked CMS to clarify if the measure was meant for dentists or primary care physicians. A CMS program lead clarified that the measure is specific to dentists. Dr. Padden then asked CMS to confirm that there are only two dentistry specific measures in the MIPS program. A CMS program lead confirmed. Another CMS program lead noted that was a critical point because dentists must be in the MIPS program.

A MAP member noted that MAP should try to mitigate the unintended consequences of removal and suggested that the measure should look at cavity incidence rather than prevalence so that dentists can coach patients to better dental habits. Another MAP member noted that dentists are generally not part of the Medicare program and took notice of the fact that the American Dental Association did not provide public comments on the measure. A CMS program lead noted that dentists are eligible for the MIPS program. The MAP member further asked CMS if Medicare covered cavity treatments. Dr. Schreiber clarified that Medicare does sometimes cover those procedures for Medicare and Medicaid dual-eligible patients. A different MAP member noted that dual-eligible patients are a difficult population, and the measure might exasperate disparities if it only applies to that patient population. The MAP member concluded that MAP should ask if the measure accomplishes what it is trying to do. A MAP member noted that the measure may only apply to a disadvantaged population if dual-eligible patients are the only population for the measure and commented that the workgroup is lacking information because the specialist organization did not submit a public comment. A separate MAP member commented that they were not sure that the measure exacerbates disparities and that MAP wants to ensure that dual-eligible patients are receiving adequate care. Dr. Padden noted that the measure summary sheet did not include how many clinicians are reporting the measure, as other summary sheets did report. A MAP member noted that the measure seems poorly designed as it applies to a narrow group of clinicians and many patients will only see a dentist when there is an acute tooth issue. Another MAP member suggested a possible condition could be to redefine the usefulness of the measure from absolute percent of cavities towards practices that improve dental health. Ms. Williams-Bader asked CMS to speak to the patient population for the measure and how long the measure has been in the program. A CMS program lead noted that patients included in the measure come from all payers, not just dual-eligible patients, and that the measure has been in the program since at least 2011. Another CMS program lead noted that dentists are not required to report the measure and have a choice to accept Medicaid or Medicare. The program lead further noted that renumeration for the MIPS program is based on their Medicare charges, but dentists are not required to participate.

Dr. Padden then asked the committee to consider possible conditions and the decision category for the measure. A MAP member noted that one evidence-based item from the U.S. Preventative Services Task Force was a fluoride-based varnish, and that MAP could consider similar conditions for preventing cavities. A different MAP member suggested that the measure should have a method for attributing a patient to a practice for a set period so that the performance of the dental clinician can be accurately accessed for patients they have actual responsibility for rather than patients they have just started seeing. A CMS program lead noted that the other dental measure in the MIPS program is a cavity prevention measure that is fluoride based. A MAP member proposed that the decision category should be “Support for Removal” as MAP has significant concern regarding measure design and intended value. Another MAP member commented on the limited options for dentistry in the MIPS measure set and

indicated they would propose "Conditional Support for Removal" to retain the measure in the measure set until a better measure becomes available.

Dr Padden summarized the workgroup's discussion as indicating a general level of support for that category based on the gap that would be created in the MIPS program if the measure were removed without a substitute. Dr Padden suggested starting the vote with the category of "Conditional Support for Removal." Clinician Workgroup members voted to remove the measure from the program with conditions at 89%. Full voting results can be reviewed in Appendix B.

## Public Comment

Dr. Padden opened the web meeting to allow for public comment. A member of the public noted that the context of the MSSP measure set matters and that MAP should think about what measures would be left in the measure set. The commenter also stressed the importance of providing whatever information possible about what measures may possibly be added to the measure set to provide that context. The commenter also noted a possible measure gap in the set around health equity and noted there are some measures that look at social determinants of health screenings; they also commented that health equity is an important area for testing and trying out new measures in that area. The commenter agreed with many of the comments around MSSP measures but wanted to highlight the concerns with the depression screening measures' specifications as well as possible additional problems when pulling in additional specialists after moving the measure to an eCQM. The commenter also noted that MAP did not have significant discussion around the scoring changes for ACOs on the CAHPS for MIPS survey measure. The commenter urged caution and suggested monitoring performance for how it may be altered by the scoring changes.

## MAP Clinician Workgroup Discussion of Gaps in Clinician MSR Programs

Ms. Williams-Bader provided instructions to the MAP workgroup members to provide broader feedback on the program or identified gaps. A MAP member expressed appreciation on the incorporation of feedback on measures from the Rural Health and Health Equity Advisory Groups.

Dr. Fields commented on the inability to know what new measures may be coming into the program in the future, acknowledging the main goal is to evaluate current measures on their merit. Dr. Fields noted for the MSSP program, there is still concern regarding the application of an all-payer approach to eCQMs and its impact on those facilities and clinicians with large populations of disadvantaged patients, particularly Medicaid or uninsured patients. Dr. Fields commented this inclusion could cause skewed results with eCQMs. Dr. Fields also noted it is problematic to adopt measures that are meant for individual clinicians for large groups like ACOs because performance issues could arise. Dr. Fields stated correlation studies on the performance at each level is helpful.

Another MAP member commented on the benefit of having this type of discussion around gaps and population health needs that are not being met within the current measure set at the start of the meeting. The MAP member also noted that the workgroup could discuss different specialties, provider groups or patient groups that do not have enough important options at the beginning of the meeting when members are more energized.

## MAP Clinician Workgroup Feedback on MSR Process

Ms. Williams-Bader asked the workgroup to share feedback on the MSR process. Three poll questions were presented to the workgroup, and the full results are detailed in Appendix C. Dr. Fields noted that stakeholders would like visibility earlier in the process about why the measures were nominated as well

as more context for why they were nominated. A MAP member noted that the process was well organized and well run. The MAP member noted they would like to see how the measures perform in vulnerable groups when considering measures to nominate. A different MAP member expressed appreciation that NQF staff helped members complete the survey. The MAP member also commented that they would prefer to get advisory group feedback prior to the review meeting. The MAP member also noted that they were confused why measures were not resubmitted for endorsement, but stewards supported the measure during the discussion.

Another MAP member noted that the meeting went very well but they had a hard time filling out the survey and felt ill-equipped to provide recommendations based on the information provided. The MAP member stated that they would prefer a smaller set of measures to consider and that there could be criteria to narrow the list of measures. Ms. Williams-Bader asked if there was specific information the MAP member would want to see given the large number of measures under review in the MSR process. The MAP member answered that they would need time to think about that question and restated that they would prefer some type of triggering criteria to narrow the list of measures before it comes before MAP. Another MAP member noted that there could be ways to make the Rural Health Advisory Group's comments even more helpful to the workgroup, including asking for advice on how to make things feasible for measures in a rural setting.

Ms. Williams-Bader then asked the workgroup if they had ideas for criteria for NQF to use to pull a measure onto a list for discussion or reason to exclude a measure from discussion. A MAP member noted that there had been a couple buckets of discussions during the review meeting: 1) how important is the measure concept for inclusion in the program (i.e., an important population health topic or a measure is important to certain types of patients or providers) and 2) what the measure actually measures. Another MAP member noted that duplicative measures in a program could trigger review and suggested low utilization of a measure with a backup measure in a program for providers to use could be another criterion for review. A different MAP member noted that specialties who have a small measure set ensures that no measure will be fully removed. The MAP member suggested this as a condition for not being reviewed as the highest possible decision category is "Conditional Support for Removal" until a replacement measure is added to the measure set.

A MAP member stated that it would be helpful to have information about how long the measure had been in effect, the number of providers reporting, and performance data trends. Another MAP member noted that it was helpful to the workgroup to have measure stewards available to answer questions and provide their perspective during the review meeting. The MAP member noted that getting additional perspectives from stakeholders such as the American Dental Association to comment on specialist measures would have been helpful to the workgroup.

## Next Steps

Joelencia LeFlore, associate, NQF, shared the Clinician Workgroup's meeting will be followed by the last setting-specific workgroup meeting (PAC/LTC on June 30) and Coordinating Committee meeting (August 24 and August 25). The second public commenting period on the MSR list will run from July 22, 2022, to August 5, 2022, and the final recommendations of the measures under review will be submitted to CMS by September 22, 2022.

Ms. Williams-Bader then turned the floor over to Dr. Schreiber for closing comments. Dr. Schreiber extended her thanks to NQF staff, co-chairs, and measure discussants. She noted that the conversation is the most important part of the review meeting and that the workgroup had had a lot of thoughtful discussion around the measures. Dr. Schreiber thought that the meetings were the first step in MSR

becoming a complementary process to the Measures Under Consideration process that runs every winter. She recognized that CMS solicits significant input into the process of these measures going into their respective program through public rulemaking. Dr. Schreiber stated that workgroup members could look forward to the Physician Fee Schedule (PFS) rule impacting the MIPS and MSSP programs coming out soon. Dr. Schreiber concluded her closing remarks by thanking CMS for coordinating the attendance of measure stewards at the review meetings. Dr. Fields, Dr. Padden, and Ms. Williams-Bader thanked all participants for their time and contributions to the day's discussions and adjourned the meeting.

## Appendix A: MAP Clinician Workgroup Attendance (Voting Only)

The following members of the MAP Clinician Workgroup were in attendance:

### Co-chairs

- Rob Fields, MD
- Diane Padden, PHD, CRNP, FAANP

### Organizational Members

- American Academy of Family Physicians
- American College of Cardiology
- American College of Radiology
- Blue Cross Blue Shield of Massachusetts
- Council of Medical Specialty Societies
- Genentech, Inc.
- HealthPartners, Inc.
- Kaiser Permanente
- Magellan Health, Inc.
- Patient Safety Action Network
- Pharmacy Quality Alliance
- Purchaser Business Group on Health
- St. Louis Area Business Health Coalition

### Individual Subject Matter Experts (SMEs)

- Amy Nguyen Howell, MD, MBA, FAAFP
- Nishant Anand, MD, FACEP
- Stephanie Fry, MHS
- William Fleischman, MD, MHS

## Appendix B: Full Voting Results

Some MAP members were unable to attend the entire meeting. The voting totals reflect members present and eligible to vote.

| Measure Name | Program | Decision Category | Yes (N/%) | No (N/%) | Total (N/%) |
|---|---|---|---|---|---|
| 00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan | MSSP | Support for Retaining | 13 (72%) | 5 (28%) | 18 (100%) |
| eCQM ID:CMS2v11: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM) | MSSP | Support for Retaining | 17 (89%) | 2 (11%) | 19 (100%) |

| Measure Name | Program | Decision Category | Yes (N/%) | No (N/%) | Total (N/%) |
|---|---|---|---|---|---|
| 06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups | MSSP | Support for Retaining | 18 (100%) | 0 (0%) | 18 (100%) |
| 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | MSSP | Conditional Support for Retaining | 15 (83%) | 3 (17%) | 18 (100%) |
| Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey | MSSP | Support for Retaining | 17 (100%) | 0 (0%) | 17 (100%) |
| 01246-C-MSSP: Controlling High Blood Pressure | MSSP | Conditional Support for Retaining | 17 (100%) | 0 (0%) | 17 (100%) |
| eCQM ID:CMS165v10: Controlling High Blood Pressure (eCQM) | MSSP | Conditional Support for Retaining | 18 (100%) | 0 (0%) | 18 (100%) |
| 00641-C-MIPS: Functional Outcome Assessment | MIPS | Support for Retaining | 14 (82%) | 3 (18%) | 17 (100%) |
| 01101-C-MIPS: Barrett's Esophagus | MIPS | Conditional Support for Removal | 16 (94%) | 1 (6%) | 17 (100%) |
| 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery | MIPS | Conditional Support for Retaining | 17 (100%) | 0 (0%) | 17 (100%) |
| 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care | MIPS | Conditional Support for Retaining | 17 (100%) | 0 (0%) | 17 (100%) |
| 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care | MIPS | Conditional Support for Retaining | 18 (100%) | 0 (0%) | 18 (100%) |

| Measure Name | Program | Decision Category | Yes (N/%) | No (N/%) | Total (N/%) |
|---|---|---|---|---|---|
| 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report | MIPS | Support for Retaining | 16 (94%) | 1 (6%) | 17 (100%) |
| 05837-E-MIPS: Children Who Have Dental Decay or Cavities | MIPS | Conditional Support for Removal | 16 (89%) | 2 (11%) | 18 (100%) |

## Appendix C: MSR Process Feedback Polling Results

Some MAP members were unable to attend the entire meeting. The polling totals reflect members present and eligible to vote.

| * | Poll Question | Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree | Total |
|---|---|---|---|---|---|---|---|
| 1 | The MSR survey to nominate measures for discussion worked well | * | 3 | 7 | 3 | 1 | 14 |
| 2 | I had what I needed to respond to the MSR survey | 1 | 3 | 5 | 4 | * | 13 |
| 3 | The advisory group review of the measures under review worked well | * | * | 1 | 11 | 2 | 14 |

*This cell intentionally left blank.