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Measure Applications Partnership (MAP) Clinician Workgroup: 2022-2023 Measures Under Consideration (MUC) Review Meeting

Meeting Summary
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Meeting Summary

Measure Applications Partnership (MAP) Clinician 2022-2023 Measures Under Consideration (MUC) Review Meeting

The National Quality Forum (NQF) convened a two-day, public virtual meeting for members of the Measure Applications Partnership (MAP) Clinician Workgroup on December 15 and 16, 2022, on behalf of the Centers for Medicare & Medicaid Services (CMS). The purpose of the meeting was to review and provide recommendations for the 2022-2023 Measures Under Consideration (MUCs) proposed for the CMS clinician programs. There were 225 attendees at this meeting including MAP Clinician Workgroup members, NQF staff, government representatives, and members of the public.

Welcome, Introductions, Disclosures of Interest, and Review of Web Meeting Objectives

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP Clinician MUC Review Meeting, and reviewed housekeeping reminders, meeting ground rules, and the meeting agenda. Ms. Williams-Bader invited NQF leadership to provide opening remarks.

Dr. Dana Gelb Safran, CEO, NQF, provided opening remarks by welcoming participants and expressing that it is NQF's privilege to continue to partner with CMS in convening the MAP and provide multistakeholder feedback and recommendations regarding measures for use in federal programs. Dr. Safran thanked the Clinician Workgroup, colleagues at CMS, and measure developers for supporting the MUC discussions and handed the meeting to Ms. Williams-Bader.

Ms. Williams-Bader introduced the Clinician Workgroup co-chairs, Dr. Robert Fields and Dr. Lisa Hines, to provide opening remarks. The co-chairs expressed gratitude for the discussions and contributions of the Workgroup regarding the MUCs proposed for the pre-rulemaking cycle.

Dr. Tricia Elliott, vice president, NQF, performed roll call and disclosures of interest (DOIs). Of the 18 organizational members, 18 attended the meeting. In addition, there were two co-chairs, and four subject matter experts, totaling 24 voting members. Sixteen members was the minimum quorum for voting. One MAP member disclosed involvement with the development of MUC 2022-125 and indicated recusal from voting. Another MAP member disclosed that their organization was involved with the development of MUC2022-098 and MUC2022-111 and indicated recusal from voting. The full attendance details are available in Appendix A. Dr. Elliott also introduced the nonvoting federal government liaisons.

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

1. Review the MAP Clinician Workgroup programs
2. Review the MAP decision categories and voting process
3. Review and provide input on the MUCs for the MAP programs.

Centers for Medicare & Medicaid Services Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for CMS and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG),

welcomed participants to the meeting. Dr. Schreiber thanked NQF and Workgroup members and emphasized how the MAP discussions and considerations help shape CMS programs. Dr. Schreiber discussed and shared the CMS National Quality Strategy, highlighting a system of resiliency, safety, equity, improved quality, and outcomes. Dr. Schreiber stated the importance of the Merit-based Incentive Payment System (MIPS) is to engage clinicians in conversations and accountability regarding value. Dr. Schreiber noted that CMS is transitioning to MIPS Value Pathways (MVPs) to create more cohesive sets of quality measures. Dr. Schreiber further noted that the Medicare Shared Savings Program has a lack of MUCs this pre-rulemaking cycle due to CMS efforts to move current measures to electronic clinical quality measures (eCQMs) and data aggregation, however, a lack of new MUCs should not be interpreted as a lack of interest on behalf of CMS for the Medicare Shared Savings Program. Dr. Schreiber handed the meeting to Dr. Fields to open the meeting for any questions.

A MAP member inquired about the usage of standardized data sets for organizations to improve health equity by capturing characteristics such as race, ethnicity, and language. Dr. Schreiber responded that CMS is actively discussing the right data elements to capture and how those variables should be used for measure stratification. A MAP member inquired if funding of measures is within the scope of the Workgroup to discuss. A co-chair responded that the scope of the Workgroup is to not address funding of measures. Ms. Williams-Bader agreed that funding is outside of the scope of Workgroup, however, burden is an aspect for the Workgroup to consider. Another MAP member expressed concern with the implications that might arise from a large number of measures that are recently finalized for rulemaking. Dr. Schreiber responded that clinicians that participate in MIPS choose which measures to report and that there is variation in the selection of measures that clinicians report. Dr. Fields then handed the meeting to Ms. Williams-Bader.

Overview of MAP Clinician Workgroup and Programs

Ms. Williams-Bader provided an overview of the Clinician Workgroup's charge which is to provide recommendations on issues related to measures that would impact clinicians, particularly in the office setting. Ms. Williams-Bader provided a brief overview of the clinician programs that MUCs were submitted to for this pre-rulemaking cycle. Ms. Williams-Bader reviewed the program type, incentive structure, and program goals of the CMS programs: MIPS and Medicare Part C & D Star Ratings.

A MAP member inquired about the uptake percentage of MIPS for providers in healthcare systems. Dr. Schreiber responded the uptake is quite high. Dr. Schreiber reminded MAP that MIPS covers not only physicians but also many other providers such as therapists, certified social workers, certified nurse midwives, and more. Dr. Schreiber clarified that in order to participate in MIPS a clinician must bill for a certain number of Medicare fee-for-service patients so providers who see mainly children or Medicaid patients may not be participating in MIPS.

A MAP member raised a question about specialty areas where there are only a limited number of measures available and if that makes the measures mandatory. Dr. Schreiber responded it is correct that for some specialties there are a limited number of measures. Dr. Schreiber added CMS makes every effort to work with specialty societies to be sure these are measures of importance to those specialties, and to have adequate choice for providers. Another CMS representative stated if a clinician or a practice decides to report measures within a specialty set and if the specialty set includes fewer than six measures, the clinician/practice will be required to report all the measures within the specialty set in order to meet reporting requirements under MIPS.

Overview of 2022-2023 MUC Voting and Decision Categories

Ms. Williams-Bader provided an overview of the pre-rulemaking approach for the Measures Under Consideration (MUC). Ms. Williams-Bader reviewed the MUC decision categories: support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, and do not support for rulemaking. Ms. Williams-Bader noted that the decision categories were standardized for consistency and the Workgroups must reach a decision on every measure under consideration accompanied with a rationale for the decision. Ms. Williams-Bader reviewed that for the Workgroup to reach quorum, 66 percent of the voting members of the Workgroup must be present virtually for live voting, and quorum was present. Ms. Williams-Bader shared that MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting for a decision category and a minimum of 60 percent of the quorum figure voting positively for a decision category. Ms. Williams-Bader provided an overview on the voting process which started with NQF staff providing an overview of the measure with the preliminary recommendation, CMS presenting contextual background on the MUC, and lead discussants providing their findings. Ms. Williams-Bader further stated that the co-chairs will open the discussion among the Workgroup and the Workgroup will vote on the acceptance of the preliminary analysis decision. Ms. Williams-Bader noted that further discussion and decision voting on the MUCs will occur if less than 60 percent of the Workgroup accepts the preliminary analysis decision and then NQF will tally the votes.

Ms. Williams-Bader opened the meeting for questions regarding voting. A MAP member asked if there is a decision category for abstaining from a vote and a process for indicating absence from the meeting. Ms. Williams-Bader responded that if a MAP member would like to abstain from a vote, the individual can indicate that in the chat and inform the NQF staff of any absence during the meeting. Ms. Williams-Bader facilitated a test question with the Workgroup utilizing the voting platform before handing the meeting to Dr. Taroon Amin, NQF consultant, to begin discussion of the measures under consideration.

Measures Under Consideration

Cost Measures

Dr. Amin introduced the cost measures under consideration:

- **MUC2022-129:** Psychoses and Related Conditions *(MIPS)*
- **MUC2022-100:** Emergency Medicine *(MIPS)*
- **MUC2022-101:** Depression *(MIPS)*
- **MUC2022-106:** Heart Failure *(MIPS)*
- **MUC2022-097:** Low Back Pain *(MIPS)*

Public Comment

Dr. Fields opened the meeting for public comment. A public commenter expressed support for MUC2022-100, noting that the measure will allow emergency physicians to address quality and patient safety, and adopt processes that make care more efficient and cost effective. The public commenter stated that the development of the measure considered the input from patient and family stakeholders, decision making was rigorous and informed by Medicare administrative data as well as peer-reviewed literature, and impacts strategic clinical priorities that meet the target of the National Quality Strategy.

A public commenter did not support MUC2022-129, stating concerns about the effectiveness of the measure due to the factors such as inadequate funding or resources in the inpatient setting for psychiatric services, which limits or impedes care coordination efforts. The public commenter also expressed concern for MUC2022-101, noting that the measure should examine mild to moderate

depression to achieve cost savings and that there should be a further examination of attribution methods for the measure.

Another public commenter supported MUC2022-100, however, noted they that the measure should be stratified based on the size and type of the hospital, and the length of the episode period should be shortened to 7 to 10 days.

MUC2022-129: Psychoses and Related Conditions (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the five public comments received during the public comment period, all of which were not supportive of the measure. Dr. Amin stated the major themes from the public comments included concerns that the episode-based cost measurement does not add value or improve patient outcomes in a primary care context. Dr. Amin further noted that commenters raised concerns regarding attribution of cost across multiple physicians and/or care settings, that the measure holds inpatient psychiatrists accountable for costs that occur after the patient is discharged, and the risk adjustment methodologies do not fully recognize the social and economic context of the patient. Dr. Amin shared that the public comments raised potential unintentional consequences related to not capturing downstream benefits from upstream spending. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott stated the Health Equity Advisory Group raised concerns for underserved populations not receiving evidence-based care if the clinician is overly focused on costs. Dr. Elliott stated the Health Equity Advisory Group believed the measure should take into account primary care interventions upstream. Dr. Elliott further noted the Health Equity Advisory Group's concern that these interventions can lead to lower overall costs downstream through proper clinical management, and this concern should be monitored for underserved populations. Dr. Elliott shared that the Rural Health Advisory Group expressed concerns about comparing costs of rural versus urban care due to the availability of resources. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber shared that cost measures are one of the four mandated elements of MIPS, and it is statutorily required to have cost measures that cover at least 50 percent of Medicare spending. Dr. Schreiber explained that cost categories are high impact and high cost, and present an important opportunity for driving value. Dr. Schreiber stated the cost and quality measures counterbalance each other within MIPS. Dr. Schreiber handed the meeting to CMS representatives to provide more comments related to the measure.

A CMS representative stated that psychosis is one of the most common diagnoses of inpatient hospitalizations, highlighting that the measure has strong potential to impact Medicare spending. The CMS representative shared that the measure addresses gaps in MIPS, noting that there are no cost measures that focus on mental and behavioral health or inpatient psychiatric care. The CMS representative noted the measure is an updated version of a measure reviewed by MAP in prior years and key changes were made including shortening the episode period from 90 to 45 days, adding exclusions for specific scenarios such as involuntary holds and transfer to state hospitals, and adding a risk-adjustment methodology to account for differences between Inpatient Prospective Payment System (IPPS) and Inpatient Psychiatric Facility (IPF) hospitals. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant echoed concerns from the public comments around psychiatrists being held accountable for the cost of care after discharge. The lead discussant noted concerns about the disjointed nature of current behavioral healthcare systems and receiving care at multiple sites. The lead discussant further highlighted challenges with access to care by stating that patients with psychosis and other related conditions may require a significant amount of community support and resources may not be available in their geographic area. Another lead discussant echoed concerns about attribution of the measure as it relates to inpatient versus outpatient responsibility for care. A lead discussant expressed support for the NQF staff recommendation, however, reiterated concerns regarding validity of the attribution model in the measure, noting that the measure may be ineffective in assessing quality of care in the target population.

Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup. A co-chair posed a question regarding the appropriateness of cost measures for a program primarily designed for individual clinicians compared to organizations that have total cost of care accountability. Dr. Schreiber responded that quality and cost measures are both needed to drive value in MIPS. Dr. Schreiber noted the goal is to achieve the highest quality care at the lowest cost. Dr. Schreiber acknowledged challenges in determining cost attribution and that there are ongoing discussions with experts to determine the best models.

A MAP member raised a question around denominator exclusions specifying involuntary holds at admission, and noted these possibly represent a large patient population. The MAP member further raised concerns regarding patients treated by inpatient behavioral health providers and discharged, noting that there is a loss of follow-up through the continuum of care. A CMS representative replied that the exclusion for involuntary holds was a recommendation from MAP in a previous cycle. A measure developer commented that the denominator exclusion was evaluated by clinician experts using empirical results that examined if episodes regarding involuntary holds are different in terms of cost. The measure developer stated that evidence indicates that episodes involving involuntary holds comprise about less than five percent of all episodes.

The measure developer commented on the theme of the continuum of care for patients and stated feedback from patients and families regarding the importance of care coordination was considered in measure development. The measure developer further commented that measure performance variation based on availability of outpatient therapy did not vary significantly, and that reliability of the measure ranged from 0.78 to 0.87 depending on the case minimum.

A MAP member inquired how the measure attributes cost to the correct physician in the correct clinical setting. The measure developer replied that there is an episode framework that has distinct rules for distinct clinical types and billing for conditions such as psychosis is based on evaluation and management codes.

A MAP member commented that it is contextually important to remember that MIPS enables clinicians to choose what metrics to use. Dr Schreiber clarified for the Workgroup that cost measures are assigned by CMS to any provider that meets the case minimum for that clinical condition. Another MAP member asked for clarity on situations when the leadership of a clinical group chooses to adopt a measure, but individual clinicians are not in support of the adoption. A CMS representative stated that groups have the option to report at either the group or clinician level in MIPS. A co-chair commented that adoption of individual measures may be a point of negotiation and potential contention between individual providers and the leadership of their medical group, however that dynamic is outside the scope of MAP deliberations.

Another MAP member asked if billing of an evaluation and management code during a hospitalization ensures that the provider is engaged with the patient after discharge. A measure developer answered attribution is triggered for a clinician that has billed at least 30 percent of inpatient evaluation and management codes, indicating that the provider has taken an active role in the management of care. A MAP member commented that there is a significant disparity in community-based healthcare services that is more problematic for this clinical topic area versus other medical conditions.

Dr. Fields moved the Workgroup to a vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a consensus-based entity (CBE) for measure MUC 2022-129. Voting results were as follows: Yes – 16, No – 7, and percentage voting Yes – 70 percent. Complete voting results are in Appendix C.

MUC2022-100: Emergency Medicine (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the four public comments received during the public comment period, three of which were supportive of the measure and one which was not supportive of the measure. Dr. Amin summarized the major themes of the comments, which were support for measure exclusions around elements out of the provider's control, concern around the length of episode captured and stratification by size or type of hospital, and the potential unintentional consequences related to not capturing downstream benefits from upstream spending. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott stated the Health Equity Advisory Group raised concerns that underserved populations may not receive evidence-based care if the clinician is overly focused on costs. Dr. Elliott stated the Health Equity Advisory Group believed the measure should take into account primary care interventions upstream. Dr. Elliott further noted the Health Equity Advisory Group's concern that these interventions can lead to lower overall costs downstream through proper clinical management, and this concern should be monitored for underserved populations. Dr. Elliott shared that the Rural Health Advisory Group expressed concerns about comparing costs of rural versus urban care due to the availability of resources. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated the use of the emergency departments among Medicare beneficiaries represents a significant portion of Medicare spending. The CMS representative shared the intent of the measure is to comprehensively address emergency department care and gaps in MIPS as there are currently no cost measures focused on emergency department care. The CMS representative stated emergency medicine clinicians are a specialty that currently do not have cost measures. The CMS representative further stated that this measure has the potential to enhance adoption of best practices within the emergency medicine MIPS Value Pathway (MVP). The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for the measure and commented on the importance of this episode-based measure in improvement efforts for emergency physicians, however, the lead discussant suggested a reduction in the length of episode to 7 to 10 days and to consider stratification by size and type of hospital. Another lead discussant stated the measure has a large potential to reduce costs and thus expressed support for the measure. However, this lead discussant shared concerns related to potential unintended consequences for elderly and vulnerable patients as doctors may be negligent in discharging patients without appropriate community support services and place this population at higher risk of readmissions. Another lead discussant expressed support for this measure and

commented initial concerns around attribution had been resolved by comments from the measure developer. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

Dr. Fields called on the measure developer to address the concerns of the lead discussants. A measure developer stated inappropriate discharge was an important concern during measure development. The measure developer stated they avoided incentivizing not admitting patients by stratifying the measure by disposition status. The measure developer shared concerns around readmissions to emergency departments and noted a further examination of a shorter length of episode. The measure developer stated 14 days was chosen through public comment and empirical analyses with the workgroup. The measure developer also clarified there was no significant difference observed in rural versus urban settings. A lead discussant echoed concerns that emergency department physicians have on being held accountable for this measure and may feel inclined to discharge patients without considering all the necessary care required. The lead discussant also wanted to understand how patients discharged without community support were considered in measure development. A measure developer clarified that emergency department visits that end in inpatient visits would only be compared to like episodes and the same for patients discharged to the community. A MAP member asked if the measure is stratified based on observation status. The measure developer clarified that the measure is stratified by observation status and includes subgroups.

A co-chair asked if there is adjustment for regional variation of costs. A measure developer clarified the payment standardization algorithm determines allowed amount per claim and removes regional cost variations to ensure the cost assignment is similar for each service across the country. A MAP member asked about cost variation between teaching and nonteaching hospitals. A measure developer clarified the payment standardization removes any additional payments for teaching hospitals, such as Indirect Medical Education (IME) payment or Direct Graduate Medical Education (GME). The measure developer emphasized the testing and standardization that was done in developing this measure and stated there are very small differences in distributional performance across census regions in the performance score of this measure.

Dr. Fields moved the Workgroup to vote on the acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” pending endorsement by a CBE for measure MUC 2022-100. Voting results were as follows: Yes – 20, No – 1, and percentage voting Yes – 95 percent. Complete voting results are in Appendix C.

MUC2022-101: Depression (MIPS)

Dr. Amin introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the five public comments received during the public comment period, all of which were not in support. Dr. Amin stated the major themes of the comments included concern about whether episode-based measurement is appropriate for a primary care chronic condition context, appropriateness of attribution, whether the risk adjustment appropriately recognizes social economic context of the patients, and the potential unintentional consequences related to not capturing downstream benefits from upstream spending. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott shared feedback from the Advisory Groups. Dr. Elliott stated the Health Equity Advisory Group believed the measure should take into account primary care interventions upstream. Dr. Elliott further noted the Health Equity Advisory Group’s concern that these interventions can lead to lower overall costs downstream through proper clinical management, and this concern should be monitored for underserved populations. Dr. Elliott shared that the Rural Health Advisory Group expressed concerns

about comparing costs of rural versus urban care due to the availability of resources. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated the measure could be highly impactful as depression is a very common condition and a priority for CMS. The CMS representative shared depression is a highly prevalent condition among Medicare beneficiaries and a leading cause of psychiatric hospitalization in older adults which can lead to higher utilization and costs. The CMS representative added there are currently no cost measures for MIPS that focus on mental or behavioral health and this measure would fill an important gap by being the first cost measure to capture the specialties of clinical psychologists and licensed clinical social workers. The CMS representative handed the meeting to the measure developer to discuss the construction and methodology of the measure.

A measure developer shared context on the framework for chronic care measures. The measure developer shared they began working on the framework with expert panels in 2018. The measure developer stated their focus is on identifying the patient-provider relationship, which is currently identified by a Taxpayer Identification Number (TIN) who bills either two evaluation and management codes or an evaluation and management code and a condition-specific service within a certain period of each other. The measure developer further discussed subgrouping and risk adjustment models similar to those discussed for previous measures. The measure developer handed the meeting to Dr. Amin to introduce lead discussants.

A lead discussant expressed increased confidence in the measure based on the measure specification clarifications and discussions that preceded this measure. The lead discussant expressed support for the measure generally. The lead discussant stated the only outstanding question that remained was whether the measure included Part D costs given the importance of medication adherence.

Another lead discussant expressed general concern around the risk adjustment for this measure, specifically the lack of social determinants of health (SDOH) adjustment. The lead discussant was concerned that the lack of SDOH adjustment might embed disparities in the measure. The lead discussant stated this would be disadvantaging clinicians who care primarily for vulnerable populations.

Another lead discussant expressed agreement with “Conditional Support for Rulemaking.” The lead discussant stated there is evidence that better management of costs in clinical care not only improves depression outcomes but reduces overall healthcare cost and utilization. The lead discussant shared a concern about the appropriateness of including all levels of depression as opposed to only including or stratifying for mild to moderate depression. The lead discussant asked if there is variation in costs related to the severity of the diagnosis. The discussant also asked to clarify why the measure materials did not reflect any patient and provider perspective in measure development even though the developer mentioned working with clinician experts. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member asked for clarification as to how a depression episode is defined for this measure. A measure developer clarified that the episode represents a clinician group or clinician relationship with a patient over time. The measure developer explained that an episode is initiated by two services being provided by the same TIN within 180 days and each service must have a depression diagnosis as well. The measure developer went on to explain this initiates a 1-year assessment period from the first claim and the period can be extended if the relationship continues.

Another MAP member asked for clarification around the Current Procedural Terminology (CPT) codes used for attribution and inclusion of psychotherapy codes. A measure developer confirmed that psychotherapy codes are used in episode triggering and attribution methodology.

A CMS representative clarified price variations from Part D inclusion are standardized. A measure developer clarified that they convened clinical expert panels ranging from 14 members for the depression measure to 21 members for the low back pain measure. The measure developer added there was also input from patients, families, and caregivers gathered throughout the process. The measure developer further elaborated that Part D costs are standardized first, and additional subgrouping is done with and without Part D to remove incentives to prescribe Part D. The measure developer added empirical testing showed clinicians who submit more Part D claims tend to have lower adverse event outcome costs holding all else constant. The measure developer stated that in terms of SDOH, physicians are not penalized for their patient population due to risk adjustment. The measure developer also stated a robust cost analysis showed no significant difference in mild to moderate versus more severe depression episodes.

A MAP member asked for clarification about the validity of the model around SDOH. Dr. Schreiber responded that CMS is committed to equity and addresses these issues as measures are developed and tracked. Dr. Schreiber echoed concerns about not wanting to disincentivize providers caring for vulnerable populations but also not masking disparities or accepting poor performance for these populations. Dr. Schreiber commented that future measures may benefit from stratification as opposed to direct risk adjustment but that is not done at this time due to a current lack of standardized SDOH data and stratification models. A measure developer added when they stratified by the share of vulnerable patients, they did not see a systematic trend in lower scores based on vulnerable populations. The measure developer emphasized this measure does risk adjust for dual status, which is a key social risk factor in terms of Medicare enrollment.

A MAP member raised a question about concomitant diagnoses as depression commonly cooccurs with other chronic conditions. The MAP member asked if there is a way to ensure that the cost of care would not be counted more than once for the same patient who has treatments that target more than one diagnosis. A measure developer responded there is no risk of double counting as the measure only captures the cost of a service once per episode per provider.

Another MAP member asked for clarification about risk adjustment and whether the risk adjustment methodology leads to rewarding lower levels of care for some subpopulations. A measure developer responded that risk adjustment ensures that when patients require higher levels of care the providers caring for them are not penalized for additional costs. The MAP member followed up with another question about how coordination of care can be incentivized for chronic conditions when there may be barriers to access care for patients, and some providers may not select depression-related quality measures. A measure developer responded that cost measures are assigned based on administrative claims and therefore not chosen by the physician. The MAP member followed up with another question about how low cost is balanced with quality and how suboptimal care is reconciled when there is not an associated quality measure. A CMS representative clarified that CMS has studied the correlation of cost and related quality measures and the results appear to show that when providers perform well on cost measures, it does not negatively impact their quality performance.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” pending endorsement by a CBE, for measure MUC2022-101. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Complete voting results are in Appendix C.

MUC2022-106: Heart Failure (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis

recommendation. Dr. Amin summarized the four public comments received during the public commenting period. Dr. Amin shared the major themes, which were related to ensuring the measure accounted for SDOH in risk adjustment, suggestion of removal of Part D costs, and potential unintended consequences related to not capturing downstream benefits from upstream spending. Dr. Amin also noted specific comments on this measure related to the cost effectiveness of various medications and moving past administrative data to alternate sources of clinical data, such as clinical registries, to ensure the data captures a more complete and accurate picture of patient information. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott shared feedback from the Advisory Groups. Dr. Elliott shared the Health Equity Advisory Group's concern that the measure should take into account how primary care interventions upstream can lead to lower overall costs downstream through proper clinical management, and this concern should be monitored for underserved populations. Dr. Elliott shared that the Rural Health Advisory Group expressed concern with comparing costs of rural versus urban care due to the availability of resources. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative commented the measure has high potential to be impactful as heart failure is a very common and costly condition among Medicare beneficiaries. The CMS representative stated studies show heart failure is one of the leading causes of hospitalizations and readmissions in the United States. The CMS representative added this measure would address gaps in MIPS as there are currently no measures that focus on heart failure costs and this measure would also have the potential to enhance the MVP of cardiovascular care. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed concern with measuring costs at the provider level but noted that there are clear issues in terms of overall costs of heart failure in the United States. The lead discussant stated that treatment of heart failure using devices and antiarrhythmic therapy is effective, but this measure would tag those costs to clinicians. The lead discussant also expressed concern with the attribution of high-cost services to proceduralists versus other providers in this measure. The lead discussant also raised concerns with capturing the value from high-cost care and the costs of Part D medications extending beyond the measurement period. The lead discussant stated there are newer classes of medications that have shown to be of value that are guideline-directed but are also major drivers of cost.

Another lead discussant asked if there are observed differences in cost attribution between cardiologists and primary care physicians involved in care. The lead discussant also asked if there has been an analysis of cost versus quality similar to what was discussed for the previous measure.

Another lead discussant commented on the reliability of the measure, noting it was just barely over the 0.6 threshold. The lead discussant stated the reliability seemed to be lower than many of the other cost measures.

Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup. Dr. Fields called upon CMS representatives to respond to concerns noted by lead discussants. A CMS representative stated NQF and MAP do not set the standard for reliability thresholds. The representative shared the applicable standard for MIPS is a mean reliability of 0.4.

A measure developer stated that, in regard to cost attribution, it is important to note that in 2019, 93 percent of MIPS participants reported as a group. The measure developer added that while proceduralists can contribute to costs they generally will be evaluated as part of a group. The measure developer explained individual providers would only be counted if they bill at least 30 percent of related

triggering and confirming claims so one procedure would not meet the threshold for attribution. The measure developer added that providers would also have to have billed two Part D heart failure medications to at least two different patients. The measure developer agreed with the discussion regarding the value provided by newer therapies and echoed concerns of the offsetting costs that could manifest downstream by providing upstream services. The measure developer further commented that quality measures are needed to offset when benefits provided by therapy extends past the measurement period. The measure developer also shared that an analysis was done regarding the inclusion of defibrillation devices and data was stratified into quartiles. The measure developer commented there was no significant difference in measure performance among the first three quartiles and only a slight increase in the measure score in the fourth quartile. The measure developer also reviewed that providers are compared to their peers and are only penalized when the cost of care exceeds that seen by similar episodes of care by other providers. The measure developer noted that rulemaking established the 0.4 mean reliability threshold.

A MAP member expressed concern regarding the emergence of MVPs and subgroup reporting that will be attributable to specialists. The MAP member expressed concern that early adopters of new therapies will still be penalized. A measure developer responded that subgroups will receive group-level scores for cost measures. The measure developer added that data shows trends where clinicians who spend more on Part D medications see lower cost of adverse events. The measure developer clarified that if a group or subgroup is unable to be scored on cost measures within an MVP, the cost performance category will be reweighted similar to traditional MIPS scoring policies.

Another lead discussant asked if the measure captures interventions not led by cardiologists or primary care physicians, such as nurse-led interventions or patient education activities. A measure developer responded that generally there is an emphasis on a package of services which could include nursing interventions. A measure developer added that empirical evidence has shown there are activities physicians can do early on in the episode that can drive down costs downstream. The measure developer also added that while patients are compared to predicted costs of similar patients, there is also risk adjustment by specialty profile.

A lead discussant asked if the spread of the cost ratio among cardiologists is similar to the spread among primary care physicians. A measure developer responded the risk adjustment by specialty profile did mitigate this concern. The measure developer stated, after risk adjusting for specialties, there is no observed systematic differences in score among specialties.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” pending endorsement by a CBE for measure MUC2022-106. Voting results were as follows: Yes – 15, No – 8, and percentage voting Yes – 65 percent. Full voting results are available in Appendix C.

MUC2022-097: Low Back Pain (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the six public comments received during the public commenting period, two of which were in support of the measure and four which were not. Dr. Amin noted that one comment in particular expressed support for this measure and suggested it might be the most meaningful new measure for physical therapy services for older populations and particularly for outpatient providers. Dr. Amin stated some of the concerns that were expressed were around performance gaps, episode-based measurement may not be value added or improve patient outcomes in the care context, and the risk adjustment methodology not including the socioeconomic context of

the patient. Dr. Amin added there were also concerns voiced about non-operative patients being attributed to neurosurgeons when the measure is intended to be a chronic condition measure. Dr. Amin also noted there was a comment noting the potential unintended consequences related to not capturing downstream benefits from upstream spending, and a comment encouraging CMS to include clinical data sources such as clinical registry data to better have a holistic image of patient care. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott summarized the Health Equity Advisory Group had concerns about underserved populations who might not receive evidence-based care if clinicians are overly focused on cost. Dr. Elliott shared the Health Equity Advisory Group's concern that the measure should take into account that more primary care services can lead to lower overall costs and this should be monitored for underserved populations. Dr. Elliott added the Advisory Group also commented that, specific to low back pain, access to supportive services may be of concern for underserved populations. Dr. Elliott summarized the Rural Health Advisory Group expressed concern about the difference in rural versus urban performance due to availability of resources. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated this measure uses various techniques to ensure fair comparisons amongst providers, such as risk adjusting for conditions like scoliosis and excluding low back pain from traumatic injury, but does include costs related to low back pain like routine treatment and management services as well as exacerbations. The CMS representative noted the measure addresses a gap in MIPS as it captures specialties which currently do not have cost measures such as chiropractors, physical therapists, and anesthesiologists. The CMS representative also noted low back pain is a very common and costly condition among Medicare beneficiaries. The CMS representative shared that rural providers tend to perform similarly or slightly better than urban providers on this measure and there is an observed correlation with related quality measures. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for the measure. The lead discussant stated this measure would allow for focused improvements for a condition in which early conservative care can have a significant impact, and would allow comparison of performance based on the entry point into the healthcare system. The lead discussant stated this measure would encourage more efficient care.

Another lead discussant echoed the comments of the first lead discussant. The lead discussant noted their initial concerns about the attribution had been addressed by the CMS representative. The lead discussant asked for the measure developer to comment on cost differences observed in specialty groups after risk adjustment. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup. Dr. Fields called upon CMS representatives to address concerns noted by lead discussants.

A CMS representative stated risk adjustment for specialties was included to address concerns of attribution. The CMS representative shared the top three specialties attributed are chiropractors, general practice, and rehabilitation in no particular order. The CMS representative noted these three specialties account for 87 percent of clinicians attributed to this measure. The measure developer added that the intent of the measure is to capture the cost of treatment for low back pain and sometimes this requires surgical episodes, but those episodes are subgrouped with other similar episodes for comparison.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE, for measure MUC2022-097. Voting results

were as follows: Yes – 22, No – 1, and percentage voting Yes – 96 percent. Complete voting results are in Appendix C.

Renal Measures

Dr. Amin introduced the renal measures under consideration:

- **MUC2022-060:** First Year Standardized Waitlist Ratio (FYSWR) *(MIPS)*
- **MUC2022-063:** Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) *(MIPS)*

Public Comment

Dr. Hines opened the meeting for public comment. No comments were presented.

MUC2022-060: First Year Standardized Waitlist Ratio (FYSWR) (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the four public comments received during the public commenting period, two of which were in support and two of which were not. Dr. Amin summarized the major themes. Dr. Amin stated there was a comment that the measure is a step in the right direction in acknowledging the responsibility of dialysis providers in ensuring patients are referred, evaluated, and waitlisted properly. Dr. Amin stated there was also concern around specifications, specifically related to insufficient denominator exclusions, and around accounting for preemptive transplants from nephrologists. Dr. Amin added there were concerns about the measure not passing validity criteria and racial bias in eligibility algorithms, specifically related to black patients being less likely to receive transplants. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott summarized the Health Equity Advisory Group commented that racial differences are not just socioeconomic, and it would be helpful to stratify this measure. Dr. Elliott added the Health Equity Advisory Group also shared it would be helpful to consider the upstream impacts of health for this measure. Dr. Elliott stated the Rural Health Advisory Group commented on the low utilization of home dialysis and the limited access to home services for dialysis. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber stated dialysis care is expensive and very important, and this measure is looking to support patients in their journey to transplantation. Dr. Schreiber expressed that it is the responsibility of dialysis facilities to start having conversations for patients to get them onto the transplant list. Dr. Schreiber added this is an important equity issue because certain populations historically have not received transplants at the same rates.

A CMS representative stated this measure encourages active and ongoing conversations after dialysis initiation to identify patients who opt to have transplantation, optimize their health, refer to a transplant center, and support the completion of all items required by the transplant center for waitlisting. The CMS representative added it is critical that nephrology teams are actively involved in the process to ensure timely waitlisting for patients who may wait several years for an organ. The CMS representative noted the measure fills an important gap and, along with the upcoming measures, would be the first transplant utilization measure at the clinician level. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussed stated support of the NQF Renal Standing Committee and their recommendation. The lead discussant expressed concern with the inclusion methodology.

Another lead discussant shared support of the idea that moving more patients to transplant does improve outcomes and quality of life. The lead discussant expressed concern with the attribution and CMS 2728 form and added many patients are discharged and sent to neighboring areas or states and do not follow up with the provider who filled out the 2728 form. The lead discussant also added the exclusion criteria need to match what is needed to qualify for transplant. The lead discussant also expressed that the measure should utilize prevalence on the transplant list rather than the active component given that there are many things that move patients on and off the list that are out of the provider's control. The lead discussant also commented that the measure should align with all other CMS kidney measures.

Another lead discussant expressed support for the NQF recommendation. The lead discussant shared concerns with the numerator exclusions for preemptive transplant and unclear justification for the focus on living donor transplants conducted during the first year of dialysis as opposed to further out. The lead discussant also asked for clarification on whether MUC2022-063 was given preference over MUC2022-060 based on his reading of the preliminary analyses. A CMS representative noted that both measures are meant to be complementary. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

Ms. Williams-Bader added clarification that the NQF Renal Standing Committee endorsed one component of MUC2022-063 but if concerns were mitigated this measure could also be supported. Dr. Amin added that both measures were looked at individually and were not weighed against each other. The original discussant asked if both measures could go through if conditions were met. Dr. Amin responded yes. Ms. Williams-Bader also responded yes and added the potential mitigation for this measure would be to address the concerns raised by the Renal Standing Committee regarding the evidence base and specifications and to resubmit the measure for endorsement by a consensus-based entity.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Do Not Support for Rulemaking with Potential for Mitigation" with the potential mitigation being to address the concerns of the Renal Standing Committee regarding the evidence base and specifications and to resubmit the measure for endorsement by a CBE. Voting results were as follows: Yes – 20, No – 3, and percentage voting Yes – 87 percent. Complete voting results are in Appendix C.

MUC2022-063: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the five public comments that were received during the public commenting period, two of which were in support of the measure and three of which were not. Dr. Amin shared there was support for the direction of the measure and acknowledgment of the responsibility of the dialysis provider to ensure patients are referred, evaluated, and waitlisted appropriately. Dr. Amin added there was concern that this is not a provider-based measure. Dr. Amin also reviewed concerns about specifications, insufficient denominator exclusions, accounting for preemptive transplants, one of the measures not passing NQF Renal Standing Committee endorsement, and racial bias in determining eligibility. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott summarized the Health Equity Advisory Group feedback commenting on the importance of health equity. Dr. Elliott added the Advisory Group noted racial differences are not just socioeconomic, it would be helpful to stratify versus risk adjust, and there is a need to consider upstream impacts. Dr. Elliott summarized the Rural Health Advisory Group feedback, which noted the measure's importance for rural communities and added concerns related to low utilization and access of home dialysis. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated this measure is focused on maintaining patients on the kidney transplant waitlist and complements the previous measure. The CMS representative added the PPPW rate accounts for all patients on the waitlist and the aPPPW rate accounts for only those on active status. The CMS representative added it is critical that nephrology practitioners and teams are continually optimizing the health of patients for transplant and addressing issues that might move patients out of active status, and effectively collaborating with transplant centers. The CMS representative noted the more time a patient spends in active status the more likely they are to receive an organ when available. The CMS representative added this measure would fill an important gap as the first transplant utilization measure at the clinician level. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant commented on the importance of this area for measure development. The lead discussant commented it would be helpful to see the list of variables to understand the risk adjustment methodology and understand the ability of the renal physician to influence the variables that might result in transplantation and desirability of including the patient on a waitlist. The lead discussant expressed a need to make sure physicians would not be inadvertently penalized for failure to waitlist based on not meeting criteria.

Another lead discussant echoed the need for the criteria to match the transplant list criteria. The discussant asked about accounting for those patients who go through the transplant evaluation and do not quality for transplant for various reasons. The discussant expressed support for the PPPW rate but not for the aPPPW rate. Another lead discussant expressed support for the NQF staff recommendation. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

A co-chair asked for clarification on whether the aPPPW rate was submitted through NQF endorsement. A CMS representative replied the measure was submitted but not endorsed.

A measure developer shared the list of covariates in the risk-adjusted model with the Workgroup. A MAP member asked for clarification on the dual eligibility risk adjustment variable. A CMS representative clarified dual eligibility refers to Medicare and Medicaid eligibility, which is used as a sociodemographic variable.

The measure developer stated there is a consideration for geographic variability at the transplant center level in taking waitlist patients and thus the measure is well risk-adjusted. The measure developer also noted the measure was constructed to compare providers against their peers on a relative scoring scale using statistical outlier identification flagging. The measure developer commented that the measure was constructed using this methodology to minimize providers being identified as an outlier due to one or two cases.

A lead discussant asked if the plurality of claims for attribution would be more accurate than the 2278 form. A CMS representative clarified this measure is based mostly on incident comorbidities, but prevalent comorbidities are included as well. The measure developer added that 64 prevalent comorbidities are included. The measure developer stated these 64 were chosen based on mortality modeling analysis.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" with the condition of updating the measure specifications to include only the PPPW (National Quality Forum #3695) rate that was recommended for endorsement by NQF's Renal Standing Committee. Voting results were as follows: Yes – 18, No – 4, and percentage voting Yes – 82 percent. Complete voting results are in Appendix C.

COVID Measure

Dr. Amin introduced the COVID measure under consideration:

- **MUC2022-052:** Adult COVID-19 Vaccination Status *(MIPS)*

Public Comment

Dr. Hines opened the meeting for public comment. A public commenter shared concerns about the implementation of MUC2022-052 for MIPS, stating that evidence indicates that the vaccine is constantly changing, the numerator of the measure holds physicians accountable for factors outside of their control, and there are logistical challenges with administering the vaccine.

MUC2022-052: Adult COVID-19 Vaccination Status (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the eight public comments, five of which supported the measure and three of which were not in support of the measure. Dr. Amin shared that the comments expressed concern regarding attribution to a single provider, noting that the measure should only be adopted at the system or health plan level. Dr. Amin further noted that comments expressed concern of risk adjustment, noting that there is variability of risk factors across patient populations and the measure should be stratified by key demographic subgroups such as race/ethnicity, people with physical and/or mental health disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Dr. Amin noted concerns about the evidence, with comments stating that there have been 17 updates to the Advisory Committee on Immunization Practices (ACIP) recommendations since the pandemic started and the measure, as written, is out of date since the current recommendation recommends the new bivalent booster after completing the primary series. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott shared the Health Equity Advisory Group expressed the importance of COVID measures and the Rural Health Advisory Group discussed it is important to rural health communities. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber stated that the goal of the measure is to incentivize clinicians to have conversations with their patients about the COVID vaccine and check whether the patients are up to date. Dr. Schreiber reminded the Workgroup that clinicians can choose whether to report the measure in MIPS. Dr. Schreiber noted that there is not a refusal exclusion for the measure because the performance data should be indicative of the patients who are truly vaccinated. Dr. Schreiber handed the meeting to other CMS representatives to provide more comments on the measure.

A CMS representative stated that the measure is constructed with the intent to increase levels of vaccination in the general population. The CMS representative stated that the measure assesses the percentage of patients 18 years and older who have completed or reported ever completing a COVID-19 vaccination series and one booster dose. The CMS representative noted that average measure

performance is approximately 44 percent with an interquartile range of 28 percent to 58 percent, signifying a gap in quality. The CMS representative stated that the measure enhances the concept of increasing vaccination among a clinician's panel of patients, even if the clinician is not necessarily providing the vaccination themselves. A CMS representative reminded the Workgroup that primary care physicians' (PCPs') recommendations are respected by patients, and that there is agreement that the primary series with at least one booster is the standard for all patients. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant stated it is important to know the vaccination status of patients, however, the measure needs to be further examined to determine if it is applicable to those who choose to report the measure and how the measure will address vaccine hesitancy. Another lead discussant echoed the concerns of vaccine hesitancy and the impact on physician-patient relationships. The lead discussant further expressed concerns that the incentive structure of the measure may disproportionately impact providers with patients who choose not to be vaccinated. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

A MAP member inquired if the measure can be added to other comprehensive vaccine measures, the impact of the vaccine in use under Emergency Use Authorization (EUA), and if there is there is risk-stratification for groups that are at higher risk for more complications of COVID-19. A CMS representative responded that the measure does not currently risk stratify due to the limited access to information that would support specific stratification variables, however, there is an intent to monitor the data to identify a risk stratification approach that could or should be applied. A Centers for Disease Control and Prevention (CDC) representative responded that the COVID vaccine has been rigorously studied in terms of efficacy and safety, and EUA would not affect the measure.

A MAP member inquired if the measure has a patient self-reported component or if the measure has to be confirmed by claims. A CMS representative confirmed that patient self-reported data counts as an indicator of measure performance and the measure is a hybrid measure designed as a clinical quality measure (CQM) or registry-based measure. Another MAP member asked if the measure should reflect a patient's up-to-date status with vaccination. The CMS representative responded that up-to-date vaccination status can be considered in the future, however, the specifications reflect the available recommendations at the time testing data were collected.

A CMS representative shared with the Workgroup that patients are hesitant regarding various physicians' recommendations, and there is always a risk of hesitancy at every patient encounter. A MAP member noted that the measure concerns raised can be applicable to many primary care measures, however, concerns raised regarding the lack of specification of vaccine boosters in the measure can contribute to a gap in quality.

A MAP member noted that the measure is important because it increases education among patients, noting that the conversation between the provider and patient may not result in a change in vaccination status, however, discussions regarding vaccines are essential to protect families and the communities. A MAP member noted that the measure is unique because it measures a vaccine that has become explicitly political. Dr. Schreiber responded by stating that over a million individuals have died from COVID, and CMS is bringing this measure forward to MAP because it is a public health issue. Dr. Schreiber stated that there should be no risk stratification for geographic location because vaccination rates are held to the same standard across the country. Dr. Schreiber commented on the incentive structure of the measure by stating that there is anticipation that clinicians who choose to report will do well and receive credit in MIPS, which is how the program is designed.

A MAP member inquired if there any concerns of unintended consequences that physicians would be less likely to provide care to patients who were not vaccinated. Dr. Schreiber responded that there is limited concern because clinicians can choose whether to report this measure.

A MAP member inquired if there are studies that support herd immunity or prevention of "breakthrough" dosing. A CDC representative stated that the science is evolving but that vaccines reduce hospitalizations and serious outcomes, including death.

A MAP member inquired about the requirements for mitigation or refinement of the measure. Ms. Williams-Bader responded that MAP suggests mitigation strategies for MUCs, however, it is still ultimately a decision by CMS whether the measure moves forward. Dr. Schreiber reminded the Workgroup that if a measure is believed to have merit, then it should be voted for a decision category with conditional support or support for rulemaking.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Do Not Support with Potential for Mitigation" with potential mitigation being a re-specification of the measure to address concerns raised during the expert panel interviews, and endorsement by a CBE. Voting results were as follows: Yes – 6, No – 16, and percentage voting Yes – 27 percent. The Workgroup did not reach consensus. Full voting results are available in Appendix C.

Dr. Hines recommended that the Workgroup consider "Conditional Support for Rulemaking" pending CBE endorsement. A MAP member suggested an additional condition stating the measure should define vaccination as up-to-date with CDC guidelines. Dr. Schreiber responded that for this condition, the measure would have to be re-specified. A MAP member inquired if stratification could be a condition. Dr. Schreiber responded that there could be stratification of the measure, however, the measure cannot be risk-adjusted. A MAP member noted that the measure should move forward as "Support for Rulemaking" because the measure should not be delayed as an option for providers to report due to the impact on patients.

Dr. Amin asked the measure developer to clarify the level of testing that has been completed and reminded the Workgroup that the decision is up to MAP to determine if the information suffices. The measure developer responded that the measure demonstrated a significant performance gap and there was a mean performance among testing sites of 44 percent with an interquartile range of 28 to 58 percent. The measure developer noted that reliability was tested at three different testing sites and mean reliability was 0.95. The measure developer noted that in terms of validity, the feedback was mixed in terms of face validity due to concerns of lack of empirical validity and supporting analysis and data. Dr. Amin inquired if the measure is considered fully developed. The measure developer responded that the measure is fully developed.

A MAP member inquired about benchmarking of the measure. Dr. Schreiber responded that performance of the measures in MIPS are based on the prior year's data, and CMS does not have the flexibility to set benchmarks based on other metrics.

Dr. Hines moved the Workgroup to vote on acceptance of "Support for Rulemaking" after consideration of the additional measure specification and testing information presented by the developer. Voting results were as follows: Yes – 16, No – 6, and percentage voting Yes – 73 percent. Full voting results are available in Appendix C.

Medicare Part C & D Star Ratings Measure

Dr. Amin introduced the Medicare Part C & D Star Rating measure under consideration:

- **MUC2022-043:** Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans *(Part C & D Star Ratings [Medicare])*

Public Comment

Dr. Fields opened the meeting for public comment. No comments were presented.

MUC2022-043: Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans (Part C & D Star Ratings [Medicare])

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the nine public comments received during the public commenting period, all of which were in support. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott summarized that the Health Equity Advisory Group shared concerns about using race neutral eGFR and that the measure may need to wait until health plans have adopted race neutral eGFR. Dr. Elliott added the Advisory Group urged the measure developer to include new neutral codes. Dr. Elliott added the Rural Health Advisory Group commented the denominator exclusions were good to address rural health issues and the measure supports better healthcare for rural health communities. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated the measure aligns with guidelines and has the potential to fill a gap by preventing chronic kidney disease among older populations, including minorities who are at increased risk. The CMS representative noted that the National Committee for Quality Assurance (NCQA) has incorporated the race-free GFR code into this measure. The CMS representative also noted the measure has a mean performance score of 40 percent among the Medicare Advantage population so there is room for improvement. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant commented this measure highly correlates to the American Diabetes Association guidelines. The lead discussant also added that this measure has the potential for cost savings as it addresses chronic disease prevention. The lead discussant expressed support for the NQF recommendation. Another lead discussant asked for clarification on the level of evidence being level B or higher. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member asked for comment around labs that are not currently reporting all elements and therefore may be recorded as not performing. A co-chair commented that, from a quality perspective, that happens frequently, and measure specifications cannot always address that issue. A co-chair added that lab participants have to change their processes to ensure all elements to calculate the measure are reported.

Dr. Fields invited commentary on the outstanding question regarding the category B level of evidence. A measure developer clarified that the measure is based on the American Diabetes Association level B evidence and further clarified how level B evidence is defined. The CMS representative added it is not unusual for a measure to be based on level B guidelines and the measure is also supported by other similar guidelines.

Another lead discussant asked for clarification around the rationale of a four day or less timeframe versus seven to 10 days. A measure developer clarified that the specification is more about providing guidance for what is acceptable in claims data and knowing that something happened on the same day.

A measure developer further added that the timeframe is more about accounting for a delay in claims data and not necessarily about when the test was done.

Another lead discussant emphasized their support for the measure and added they have seen the measure demonstrate a very clear need for improvement through the use of the measure in initiatives across their region.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE. Voting results were as follows: Yes – 23, No- 0, and percentage voting Yes – 100 percent. Full voting results are available Appendix C.

Patient Safety and Experience Measures

Dr. Amin introduced the patient safety and experience measures under consideration:

- **MUC2022-007:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) *(MIPS)*
- **MUC2022-014:** Ambulatory palliative care patients' experience of feeling heard and understood *(MIPS)*

Public Comment

Dr. Fields opened the meeting for public comment on patient safety and experience measures. A public commenter who led the development of MUC2022-007 stated there is a tremendous quality gap in CT and a need to minimize radiation exposure. The public commenter stated there is evidence that elevated doses can be reduced through audit. The public commenter added this measure addresses the key process components that determine the dose in the type of CT and the technical settings used for the scan. The public commenter noted both of these components are under the control of the radiologist. Another public commenter added support for MUC2022-007 and expressed belief this measure can drive quality in radiology broadly at scale.

Another public commenter expressed support for MUC2022-007 and stated the measure is very important due to the risk of death associated with excessive radiation exposure. The public commenter added at least one third of those deaths could be avoided through a reduction in radiation doses. The public commenter stated this measure would help incentivize guideline-driven care.

Another public commenter expressed full support for MUC2022-007. The public commenter expressed that it is encouraging that the measure is a patient-centered outcomes measure and added there is data to support this measure. The commenter also spoke favorably on the feasibility of this measure.

MUC2022-007: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the 41 public comments received during the public commenting period, 39 of which were in support and two of which were not. Dr. Amin summarized that the major themes included there is currently no national oversight for radiation dosing and there is wide variation in current dosing. Dr. Amin added there were concerns that due to the measure's multiple components the intended improvement activity was unclear. Dr. Amin also noted there were concerns that it is premature to measure performance on excessive radiation dose based on thresholds by clinical indication until standardization and availability of national benchmarks are further along. Dr. Amin

added there was a comment that the measure conflates the protocol for clinical indication and radiation dose optimization. Dr. Amin turned to Dr. Elliott for Advisory Group feedback.

Dr. Elliott summarized that the Health Equity Advisory Group did not find any issues with this measure and expressed the measure helps fill a gap. Dr. Elliott summarized the Rural Health Advisory Group comments that the measure has strong applicability in the rural health setting. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber commented that CMS is pleased to bring forward a patient safety measure and believes this measure addresses an important gap area for radiation safety.

Another CMS representative stated CMS is hoping to add this measure to the MIPS measure set which already contains seven radiology-specific measures. The CMS representative reminded the Workgroup that program requirements for this program require six measures to be reported and the addition of this measure will add to the options for radiologists to report. The CMS representative then spoke to the two public comments that were not in support. The CMS representative stated the software for translation will be provided to healthcare systems without charge and updates to the measure can be addressed during the annual update process. The CMS representative also added testing was done across three electronic health record systems and all data was accessible in structured fields. The CMS representative noted the burden for implementation is on information technology, administrative, and radiology staff and not for the clinicians as there is no change to the clinician workflow. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed that this measure is important to patient safety and that the combined view of the measure related to dosing and the quality of the imaging seems to meet an important need. The lead discussant commented that the details provided by CMS have also resolved their concerns about burden. The lead discussant expressed full support for this measure.

Another lead discussant emphasized the importance of this measure to patient safety and urged full support of the measure.

Another lead discussant also expressed full support of the measure and added they believe there is still burden regardless of the free provision of software but that it does not outweigh the importance to patient safety. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member emphasized the importance of mitigating radiation. The member noted that one of the limitations of this measure is that it does not really address the appropriateness of imaging. The MAP member also noted that clinicians do not always have autonomy and the measure may be better specified to a facility-level than a clinician-level. The MAP member also suggested there may be challenges in capital spending for supporting compatible systems and software required for implementation. The MAP member also pointed out, with respect to the measurement gap, there are several radiation exposure metrics. A measure developer stated that the measure was also submitted for hospital programs and was voted by MAP to move forward for rulemaking. The measure developer stated that if this measure gets support in both the clinician and hospital programs that will generate more alignment. The measure developer added that the Hospital Workgroup very strongly supported this measure for inclusion in hospital quality reporting programs. The measure developer also clarified the hospital program is pay for reporting while the clinician program is pay for performance.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Support for Rulemaking” for measure MUC 2022-007. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix C.

MUC2022-014: Ambulatory palliative care patients' experience of feeling heard and understood (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin summarized the seven public comments that were received during the public commenting period, six of which were in support and one which was not. Dr. Amin noted the major themes for support included providers needing to understand how well the care meets the patients' needs and preferences and how to improve the care provided. Dr. Amin also shared a comment that patients with severe illness and their families and caregivers will be offered a way to share feedback about the desired care they received. Dr. Amin also noted a theme around the evidence linked to improved outcomes. Dr. Amin stated there was a concern that the measure will most likely not change patient outcomes and therefore provides limited value beyond internal quality improvement efforts at the clinic level, and the implementation burden would outweigh any benefit to the patient or physician. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott summarized that the Health Equity Advisory Group expressed support for the measure but expressed concern surrounding the language that was used and the barriers to access for specialty care that varies by population. Dr. Elliott summarized that the Rural Health Advisory Group stated the measure is strongly applicable in the rural setting and expressed strong support. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated this measure will be the first of its kind in MIPS. The CMS representative added this measure captures patient experience and shared decision making. The CMS representative commented that an assessment of how well a patient feels heard adds an important dimension to quality measures. The CMS representative addressed the public comment not in support and noted that the intent of the measure is to improve effective provider communication. The measure developer also added that the survey only contains four questions and therefore the implementation burden should be minimal. The measure developer commented that capturing the patient experience is a healthcare priority topic for CMS and performance data indicates a gap in care.

The measure developer added that qualitative interviews with palliative care physicians resulted in physicians expressing that the measure would inform quality improvement efforts and help to better understand potential gaps in care and overall felt very positive about the measure’s value for capturing patient experience. The measure developer also noted physicians commented about the usefulness and appropriateness of this measure since it does not focus on the patient’s medical status or other quality metrics. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for this measure but noted that there may be issues with low response rates.

Another lead discussant expressed support for the measure as a patient-reported outcome performance measure and commented that the measure covers an important population. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

One MAP member asked for clarification on whether there is a way to distinguish between the use of provider or team versus provider and team in the wording so that patients can differentiate between the two. A measure developer responded that palliative care is a team sport and therefore it is important to include the two together. The measure developer clarified that the survey does identify the care provider and patients understood who their care providers were during focus groups and in

testing. The MAP member also asked for clarification as to why the language states the measure is to be provided in English only and if this specification would cause certain patients to be left out of the survey. The measure developer stated the survey has been translated to Spanish and has gone through some initial reviews in Spanish but has not been tested yet. The measure developer also added that the measure is risk-adjusted for mode of survey delivery.

Another MAP member asked for clarification around the time commitment for the survey and if that will discourage participation. Dr. Schreiber replied that the time commitment is minimal as the survey consists of four questions.

Another MAP member asked if caregivers can fill out the survey for patients. A measure developer responded that caregivers can assist the patient but not fill out the survey by themselves.

A co-chair asked if there is an exclusion for patients that need translations. A co-chair commented that no other patient satisfaction measures come to mind that are required to be completed in English. A measure developer stated the measure was tested in English, but the measure developer would not explicitly exclude those who do not speak English. A co-chair asked if practices would have to report performance even for Spanish-speaking patients. A co-chair asked for further clarification around the intent and the wording specifying completion in English. The measure developer stated that translation is important and takes a lot of time. The measure developer commented the intent would be that the survey can be translated but for now it has only been tested in English and is delivered in English. A co-chair expressed continued confusion around this detail and asked if the measure should only be reported for English-speaking patients.

Another MAP member expressed similar concerns as to why the survey was not translated. The MAP member suggested translation should be seemingly simple as the survey consists of just four questions. The MAP member commented that not being able to deliver the survey in patients' own languages hinders the value of this measure and even the use of an interpreter is not direct feedback.

Dr. Schreiber commented that it is not unusual for surveys to be delivered in English and there is frequently use of a translator or caregiver that can help patients answer the survey. Dr. Schreiber added that CMS is interested in language appropriateness and that translation of surveys into other languages will become more common. A co-chair repeated concern with the measure specifications requiring reporting in English. The co-chair agreed that there are many physician practices that translate surveys, but the measure developer has required English in the language for the measure due to testing results and that seems odd to exclude non-English-speaking populations in the measure specifications. Dr. Schreiber responded that the Workgroup could vote on conditional support contingent on changing that specification.

Another co-chair suggested the discussion may be overly critical and overlooking the value of the measure. The co-chair commented that although translation may be simple it still has to undergo testing for validation in that language so it may just be a matter of time and effort in this case. The co-chair proposed the Workgroup should suggest translation and validation.

A MAP member expressed agreement on the importance of the measure, but noted it is still concerning that the measure specifies the survey must be completed in English, as opposed to delivered in English.

Another MAP member spoke about the importance of the value that is derived from patients being able to answer the questions in their own language. The MAP member asked for clarification if the recommendation needs conditional support or if, at the time of implementation, the measure can be

rolled out with the survey translation into different languages. The MAP member asked if there is even a need for further testing or if the form could just be administered in different languages.

A co-chair agreed that the wording of the language requirement seems to be problematic and suggested that the Workgroup vote for conditional support for rulemaking with the condition of removing the language requirement from the measure specifications. Multiple MAP members expressed agreement with this suggestion.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Support for Rulemaking" for measure MUC2022-014. Voting results were as follows: Yes – 4, No – 18, percentage voting Yes – 18 percent. The Workgroup did not reach consensus on "Support for Rulemaking" for MUC2022-014.

A CMS representative clarified that the measure was only validated in English and thus reflected that way in the specifications. The CMS representative also clarified that CMS is open to having the measure disseminated to anyone. A co-chair responded in agreement that this is the intent of the Workgroup recommendation and people should be allowed to translate, and the importance of this survey outweighs the need for additional testing. The CMS representative acknowledged this and responded that they can make sure to remove the language limiting administration of the survey in English only from the specification.

A MAP member asked for clarification on whether the condition can be to include or urge translation. Dr. Schreiber responded that the conditional support as proposed should cover the intent of the Workgroup.

Dr. Fields moved the Workgroup to vote on "Conditional Support for Rulemaking" with the condition being that the requirement that the survey be conducted in English be removed from the measure specifications for measure MUC2022-014. Voting results were as follows: Yes – 23, No – 0, percentage voting Yes – 100 percent. Complete voting results are in Appendix C.

Dr. Amin thanked everyone for their support and participation and turned the meeting over to Ms. Williams-Bader to provide an overview of day two.

Preview of Day Two

Ms. Williams-Bader summarized the next steps for the MAP Clinician Workgroup. Ms. Williams-Bader detailed the agenda for day two and provided an overview of the measures the Workgroup will discuss.

Measure Applications Partnership (MAP) Clinician Workgroup Review Web Meeting- Day Two

Welcome, Preview of Day Two, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the MAP Clinician Workgroup 2022-2023 MUC Review Meeting, thanked participants for their attendance, reviewed housekeeping reminders and ground rules, and outlined the day two agenda (listed below). There were 176 attendees at this meeting, including MAP Clinician Workgroup members, NQF staff, governmental representatives, measure developers and stewards, and members of the public.

- Review of Measures Under Consideration
    - Social Determinants of Health (SDOH) Measures
    - Eye Measures
    - Behavioral Health Measures
    - Prevention and Patient Activation Measures
- Discuss Clinician Program Measure Gaps
- Discuss Measures Under Development – Hepatitis C Measure
- Opportunity for Public Comment
- Next Steps
- Adjourn

Ms. Williams-Bader turned the meeting to Dr. Elliott for a roll call of the Clinician Workgroup membership. Twenty four of 24 MAP members were present (see **Appendix B** for detailed attendance). Dr. Elliott turned the meeting to Ms. Williams-Bader to introduce the NQF team and CMS staff. Ms. Williams-Bader facilitated a test question with the Workgroup utilizing the voting platform before handing the meeting to Dr. Amin to begin discussion of the measures under consideration.

Measures Under Consideration

Social Determinants of Health (SDOH) Measures

Dr. Amin introduced the social determinants of health (SDOH) measures under consideration:

- **MUC2022-098:** Connection to Community Service Provider *(MIPS)*
- **MUC2022-111:** Resolution of At Least 1 Health-Related Social Need *(MIPS)*

Public Comment

Dr. Fields opened the meeting for public comment on the SDOH measures. A public commenter expressed support for MUC2022-098 and MUC2022-111, stating that Medicare and Medicaid patients face trade-offs between providing for families' basic needs and paying for medical care. The public commenter stated that the lack of screening, understanding of patients' barriers, and actions addressing social determinants for this population of patients drive poor health outcomes. The public commenter stated that voluntary measures will recognize and incentivize physicians' commitment to patients to act on SDOH.

Another public commenter expressed support for MUC2022-098 and MUC2022-111, stating that there is evidence that indicates screening for needs results in the improvement of community connections, increased understanding of the needs of patients, and increased documentation of needs that helps identify important gaps in response systems.

A public commenter expressed support for MCU2022-098 and MUC2022-111, highlighting that the measures were well-tested in the CMS Innovation Center's Accountable Health Communities (AHC) Model for over five years with two million beneficiaries at 44 clinical sites. The public commenter stated that drivers of health (DOH) increase burn out among physicians and financial risk for physicians caring for patients, however, the measures will recognize and incentivize the commitment on the part of physicians to act on the impact of DOH on their patient populations.

A public commenter expressed support for MUC2022-098 and MUC2022-111, noting that no other patient-level SDOH measures are under consideration [for this program] for this pre-rulemaking cycle and the proposed measures are well-tested in the CMS Innovation Center's AHC Model. The public commenter highlighted the importance of the measures by stating that the CMS Innovation Center's AHC evaluation of these measures found that beneficiaries of color disproportionately screened positive for unmet resource needs, 74 percent of navigation-eligible beneficiaries opted in for navigation, and higher than anticipated navigation accepted rates was attributed to the high level of health-related social needs (HRSNs) among beneficiaries.

A public commenter expressed support for MUC2022-098 and MUC2022-111, noting that physicians with data on SDOH drive quality in healthcare and the current absence of screening measures in federal programs impedes physicians' impact on communities of color.

A public commenter expressed support for MUC2022-098 and MUC2022-111, noting that the measures equip providers with data to identify and address unmet needs of patients, allow policymakers and payers to account for DOH, and highlight invisible social factors particularly for communities of color.

A public commenter expressed support for MUC2022-098 and MUC2022-111, highlighting the importance of identifying upstream factors to influence patient outcomes and equitable care in patient populations.

A public commenter expressed support for MUC2022-098 and MUC2022-111 by stating that quality measures are effective in incentivizing physicians to change their behaviors and address social determinants of health.

A public commenter expressed support for MUC2022-098 and MUC2022-111, stating that having a standardized metric would help facilitate and drive incentives for providers to address SDOH.

Another public commenter expressed support for MUC2022-098 and MUC2022-111, stating that patients appreciate screening of unmet needs by trusted providers and that the voluntary measures will recognize and incentivize clinicians' efforts to drive better quality and more equitable care.

Dr. Fields handed the meeting to Dr. Amin to begin discussion of MUC2022-098.

MUC2022-098: Connection to Community Service Provider (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the 12 public comments received during the public comment period, eight of which supported the measure and four which were not in support. Dr. Amin stated that comments in support of the measure noted that the measure reflects the overarching goal of incorporating knowledge on social risk into health care by explicitly measuring systems' and providers' efforts to assist patients in addressing their social needs. Dr. Amin further stated that the comments in support of the measure for rulemaking indicated that the measure demonstrated feasibility and reliability in a number of Medicare programs. Dr. Amin noted that comments raised concerns about the

measure specifications such as the process to contact a community service provider (CSP), commitment of network partners to comply with network standards, and the capacity of organizations and their resources to connect to a CSP. Dr. Amin further noted that comments indicated that providers cannot be held accountable for addressing issues outside their sphere of control. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group expressed that the measure's topic area is important and measurable. Dr. Elliott further noted that the Health Equity Advisory Group expressed concern about selection bias in the measure results and the range of readiness of providers related to access of resources. Dr. Elliott noted that Rural Health Advisory Group discussed concerns of MUC2022-098 such as rural environments' capacity to address the social needs of patients. Dr. Elliott further noted that the Rural Health Advisory Group discussed the availability of resources for rural populations and ability to stratify measure. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber reiterated to the Workgroup how important equity is to quality and noted the support the measure has from CMS and the Biden administration. Dr. Schreiber stated that CMS is putting forward a number of improvement activities to support equity such as proposing the SDOH screening measures for inpatient psychiatry settings, cancer exempt hospitals, and dialysis facilities. Dr. Schreiber stated that CMS is committed to having an equity component in each of the value-based programs and facilitating community connections. Dr. Schreiber then introduced CMS representatives to provide more comments about the measure. A CMS representative commented that the measure connects patients with a CSP for any identified HRSNs within 60 days of screening. The CMS representative addressed the concerns from public comments that clinicians should not be held accountable for addressing issues outside of their control by stating that the clinicians would have the ability to choose to report this measure under MIPS and there is no required tool, allowing for flexibility and implementation. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant noted support for the measure, stating that the measure identifies needs among patients which can affect their overall health in future years, especially in preventive areas of chronic diseases. The lead discussant further noted that there may be potential issues in remote and rural areas as these communities may not have community preventive services, however, this concern may be mitigated because a provider can choose to not report this measure. Another lead discussant stated that social needs are being addressed already by community clinics, and the measure can provide an opportunity for physicians to take an active role of documenting the needs in the community and that the collection of data will be useful for federal, state, and local officials to close gaps in care. Another lead discussant expressed support for the measure, however, they expressed concerns regarding potential selection bias, charges from EHR vendors to implement measure, and performance of the measure from resource-poor hospitals. The lead discussant further inquired about the level of evidence that supports the measure. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member posed a question regarding the operational definition of the term "independent" and "opt-out" in the measure's specifications. The measure developer responded that opt-out would be defined by patients who have screened positive for at least one HRSN but decline assistance or connection to services. Another MAP member inquired about referrals and the community organization's capacity to serve their community. The measure developer responded that an important aspect of the measure is that it will help understand the gap between the needs identified by screening and the community's ability to meet the need. The measure developer responded to the concern of

selection bias raised by a lead discussant by reminding the Workgroup that participants of MIPS have the option to choose to report the measure. The measure developer further noted that the potential for selection bias is inherent to the nature of voluntary measure sets and that the measure intentionally was not submitted to the MIPS Value Pathways (MVP). The measure developer responded to the concern of EHR implementation of the measure by stating that organizations do not have to pay extra for the ability to report.

A MAP member inquired about fraud and abuse that may occur from reporting the measure. The measure developer addressed concerns of fraud abuse by noting that the measure is not an eCQM and is reported by the patient or through the EHR. The measure developer stated that the concerns of fraud are no different from other measures that rely on patient reporting components or connection to other organizations. A CMS representative further noted that fraud may be an issue with any quality measure, however, there are various audit procedures and Center for Program Integrity (CPI) oversight review.

A MAP member asked if there are observed significant differences in performance among rural communities versus urban areas. A CMS representative responded that six of 30 AHC awardees served either mostly rural counties or served exclusively rural counties, highlighting that the measure was tested in rural environments. The measure developer further noted that there is no specific data for this measure in rural and urban areas, however, there is support for stratification of data. The measure developer discussed the feasibility of the measure by stating that by screening a million patients, the measure was found to be seamlessly integrated into the workflow of clinics.

A CMS representative reminded the Workgroup that screenings are already taking place in many facilities, however, this measure can advance the screening of patients as it relates to their social needs and assist with treating their conditions. A MAP member raised concerns that if the measure is finalized into rulemaking that it will be forced on physicians. Dr. Schreiber responded that in theory with implementation of quality measures, physicians should be given the resources by their appropriate healthcare leaders, however, any implementation issues between physicians and their health systems are outside the scope of CMS to regulate.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a consensus-based entity (CBE) for measure MUC2022-098. Voting results were as follows: Yes – 23, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix C.

MUC2022-111: Resolution of At Least 1 Health-Related Social Need (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the eight public comments received during the public comment period, of which four were in support of the measure and four were not in support of the measure. Dr. Amin stated that comments supporting the measure noted that the measure supports CMS’ commitment to advancing health equity and support for health equity measures within quality reporting and value-based programs. Dr. Amin noted that public comments stated that more detail is needed on how organizations will determine if a HRSN is resolved, reporting on resolved HRSNs misplaces accountability for the resolution on health care providers, and HRSNs are related to environmental and social conditions that are outside of the provider’s control. Dr. Amin further noted that public comments recommended that the 12-month timeframe for the measure should be shortened. Dr. Amin noted that public comments raised concerns regarding identifying patients in the

denominators and a gap in evidence for the effectiveness of attestation of the measure. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group expressed that the measure's topic area is important and measurable. Dr. Elliott further noted that the Health Equity Advisory Group expressed concern about selection bias in the results and the range of readiness of providers related to access of resources. Dr. Elliott noted that Rural Health Advisory Group discussed concerns with MUC2022-111 such as rural environments' capacity to address the social needs of patients, ability of the numerator to integrate rural needs with a greater state area, availability of resources, and ability to stratify the measure. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated that the intermediate outcome measure is not fully developed, however, it addresses CMS' high priority clinical topic area of health equity and enhances the measure set for the clinical gap area in MIPS. The CMS representative stated the measure differs from the recently finalized measure for social drivers of health that assesses the completion of health equity screenings by building upon MUC2022-098. The CMS representative further commented that the measure looks for the resolution of at least one HRSN for those patients who screen positive within 12 months of screening and represents a step forward in reducing health disparities and addressing a measurement gap in MIPS. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for this measure and addressed concerns of the resolution aspect of the measure, stating that relying on self-reporting data and developing a new encounter code that indicates a resolution are strategies to mitigate this concern. The lead discussant expressed support for the 12-month timeframe indicated in the measure specifications, stating that it allows patients to be reassessed in the clinical setting. Another lead discussant expressed support for the measure, however, expressed concern that there was no input on the final performance of the measure collected from patients or caregivers. The measure developer confirmed that the advisory panel for the measure did not contain any patient or caregiver perspectives, however, the advisory panel did contain providers from a variety of settings that provided face validity for the measure. The measure developer noted that clinicians who were part of the advisory group served as representatives of their communities and their patients. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member inquired if HRSNs are not resolved would the physician be at fault if the screening was completed and connection to a social service agency was established. The MAP member further inquired if it is feasible to combine MUC2022-098 and MUC2022-111 as a composite measure. Dr. Schreiber responded that MUC2022-098 and MUC2022-111 are separate measures that pose two different intents with different timeframes. Dr. Schreiber reminded the Clinician Workgroup that MUC2022-098 is a process measure, while MUC2022-111 is an outcome measure.

A MAP member Inquired If an entity or physician must report both measures and if resolution of the HRSN is more of a measurement of the reporting provider or a measurement of a community's resources. A CMS representative reminded the Clinician Workgroup that clinicians or entities have the option to choose which measures to report in MIPS, therefore, reporting of both measures is not mandatory. The measure developer addressed concerns of communities' resources by stating that the measure is intended to help understand the effectiveness of community resources by examining factors in the community that affect outcomes. A MAP member noted that there should be accountability for community-based providers to be more effective in working with community partners and that health systems have a responsibility for driving health outcomes and making partners with community-based organizations more effective. A MAP member asked if community agencies are certified or evaluated on

the effectiveness of their services. A co-chair responded by stating that there is a credentialing process for non-profit organizations to be included in some network organizations, ensuring some basic elements of quality and safety. The co-chair further noted that community organizations that are not licensed, such as food pantries and housing agencies, still provide great value to communities. Dr. Schreiber agreed with the co-chair and stated that, in general, community agencies are not "certified" and their funding rests on many variables since funding is also variable (direct government support, philanthropy, etc). Dr. Schreiber noted that there are no CMS metrics for community service providers.

The co-chair stated, in response to the lack of patient perspectives for the input of the measure, that physicians are not appropriate substitutes and that input on measures should always include the patient's voice.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a consensus-based entity (CBE) for measure MUC2022-111. MAP members emphasized that patient and family perspectives should be included in the final measure testing. Voting results were as follows: Yes – 23, No – 1, and percentage voting Yes – 96 percent. Full voting results are available in Appendix C.

Eye Measures

Dr. Amin introduced the eye measures under consideration:

- **MUC2022-114:** Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy *(MIPS)*
- **MUC2022-115:** Acute posterior vitreous detachment appropriate examination and follow-up *(MIPS)*
- **MUC2022-116:** Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up *(MIPS)*

Public Comment

Dr. Hines opened the meeting for public comment on the eye measures. No public comments were offered. Dr. Hines handed the meeting to Dr. Amin to begin discussion of MUC2022-114.

MUC2022-114: Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the nine public comments received during the public comment period, all of which were supportive of the measure. Dr. Amin noted that comments in favor of the measure highlighted that evidence indicates that elevated intraocular pressure (IOP) after intravitreal or periocular steroid therapy is a known risk and can lead to glaucoma, a potentially blinding condition that warrants close monitoring by the treating physician. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group discussed no issues from an equity perspective and that the measure has the potential to fill a gap within MIPS. Dr. Elliott noted that the Rural Health Advisory Group expressed that the measure is applicable in rural communities. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber stated that within MIPS there is a statutory mandate that there are enough measures for all specialists. Dr. Schreiber noted that ophthalmology is one of the specialties that has a gap in measures within MIPS. Another CMS representative commented that the measure is fully developed and reiterated that the measure will address a gap within MIPS for intraocular pressure screening and care quality measures that are diagnostic. The CMS representative stated that performance data submitted by the measure steward indicated a gap in care and that enhancing the ophthalmology related measure inventory is important when developing MVPs that are robust and meaningful to clinicians. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for this measure, however, noted a concern of loss to follow up as a denominator exception for the measure. The lead discussant stated that there should be incentivization of providers to follow up with patients in future measure development of ophthalmology measures, especially if the patient has a potentially blinding condition. Another lead discussant expressed support for the measure, however, expressed concerns of the testing of the measure as it relates to validity. The lead discussant further inquired if the previous version of the measure that did not include language of plan of care was endorsed by a CBE and if there was feedback collected from physicians or patients regarding meaningfulness of measure. A lead discussant echoed the concerns of the other lead discussants for this measure. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

A MAP member inquired about the number of measures for ophthalmology and the need for more measures for ophthalmology in MIPS. A CMS representative responded that although there are 15 measures within MIPS for ophthalmology, there are sub-specialties that have a fewer number of measures to report.

A MAP member raised a concern that the IOP threshold would be better substantiated at a certain percentage increase or at an IOP greater than 30 due to some patients having a IOP at or near 25 with hysteresis. The MAP member noted that if patients having a IOP at or near 25 with hysteresis were followed for ten years, patients will generally not develop glaucoma, however, they will receive an intravitreal or periocular corticosteroid injection. The measure developer acknowledged that there are some patients, especially with a thick cornea, who have a higher tolerance for high pressure and that a plan of care that would be acceptable would be to add an eye drop to lower pressure or refer the patient to a glaucoma specialist. The MAP member inquired if patients with IOP at or near 25 with hysteresis are excluded from the denominator. The measure developer noted that patients with IOP at or near 25 with hysteresis are not excluded from the denominator, and that only patients with hypotony are excluded.

The measure developer addressed concerns of the validity of the measure by stating that the only aspect of the measure that has not been validated against an electronic export and medical record review is the plan of care. The measure developer noted that face validity and reliability testing were conducted. The measure developer further noted that the measure score reliability testing using signal-to-noise testing was completed across 17 physicians at two retina specialty practices using data from calendar year 2021 and the total number of patients included in the analysis was 556.

The measure developer addressed concerns of the lack of the patient perspective when testing the measure by confirming that there was no request for feedback from patients in the testing of the measure, however, it is something that would be welcomed in the future. A MAP member inquired if the measure would replace a current measure in MIPS. A CMS representative stated that the measure would not replace any current measures in MIPS and that the proposed measure does address a gap in care for the current measure set in MIPS.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a consensus-based entity (CBE) for measure MUC2022-114. Voting results were as follows: Yes – 24, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix C.

MUC2022-115: Acute posterior vitreous detachment appropriate examination and follow-up (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the 11 public comments received during the public comment period, all of which were supportive of the measure. Dr. Amin noted that the public comments viewed this measure to be complementary to MUC2022-116 which requires a different timeline for follow-up given the increased risk of the preventable outcome. Dr. Amin further noted that public comments urged MAP members to consider that there are fewer sufficient measures in MIPS for sub-specialties such as retina specialists, cataract surgeons, and oculoplastic surgeons. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group noted no issues from an equity perspective and that the measure has the potential to fill a gap within MIPS. Dr. Elliott noted that the Rural Health Advisory Group expressed that the measure is applicable in rural communities. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated that the process measure is fully developed with strong reliability, patient encounter data elements, testing, and validity. The CMS representative further noted that the measure will address a lack of measures specific to retinal specialists and their scope of care. The CMS representative stated the measure developer submitted performance data demonstrating a distinct gap in care, and while the range of performance may be minimal, the measure does not represent an inverse analytic, suggesting homogeneity for the significant gap in care across clinicians. The CMS representative stated the measure is linked to health outcomes by appropriate care for posterior vitreous detachment (PVD) which can prevent retinal tears. The CMS representative stated that there has been discussion regarding the possible combining of the measure with MUC2022-116, however, the measure steward indicated that the measures examine two distinct patient populations and require different treatment and follow-up timelines. Dr. Amin handed the meeting to Ms. Williams-Bader to provide comments about the NQF staff recommendation. Ms. Williams-Bader commented that the reason why the recommendation is "Do Not Support for Rulemaking" is because testing indicates low performance rates with minimal variation. Ms. Williams-Bader further commented that the performance gap testing from 19 physicians across two practices showed performance varied from 0 to 5.3 percent, indicating a small range of performance and possible validity problems. Ms. Williams-Bader handed the meeting back to Dr. Amin to introduce the lead discussants.

A lead discussant commented that the measure reflects the standard of care, however, noted concerns about the complexity of the numerator which may be a source of validity issues. The lead discussant also noted that there is a relatively low five-case minimum which may be too low for a common condition among sub-specialists who report the measure. Another lead discussant expressed similar concerns regarding the low performance rate and validity of the measure. The lead discussant inquired about which decision category to give to measures that may need refinement but may be meaningful to sub-specialties. Dr. Schreiber responded that CMS has the discretion to use any of the measures submitted for the MUC cycle, and that the measure may be proposed for rulemaking or not proposed for rulemaking and refined. Dr. Schreiber reminded the Workgroup that the differentiation between the

decision categories is based on if the Workgroup identifies value in the measure. A lead discussant echoed other comments from lead discussants regarding the low performance rate and expressed concern regarding the measure specification of follow-up visits. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

Dr. Hines called on the measure developer to respond to questions regarding the performance of the measure. The measure developer acknowledged that the numerator of the measure is complex, however, this is intentional to set a high standard of care for a particularly older population of patients. The measure developer further commented that the measure presents an opportunity for improvement for patient outcomes and cost-effectiveness of care. A MAP member inquired about the identification of PVD and if there is an ICD-10 code specific for acute PVD versus chronic PVD. The measure developer responded that there has been a request for a SNOMED code to classify acute PVD versus chronic PVD. The measure developer noted that the measure defines acute PVD as one that had a recent onset of 30 days or less. A MAP member stated the measure is important from a patient perspective because it disproportionately affects an aging population who has an increased risk for retinal detachment, impacting quality of life. The measure developer responded to a previous inquiry from a MAP member regarding case minimum by stating that the denominator sizes varied from 72 to 359 patients. The measure developer further noted that minimum reliability for the measure was 0.6 using the 5-case minimum and there is confidence that the measure will stay reliable. The measure developer noted that the denominator will increase, and the performance will vary as clinicians improve with providing follow-up and appropriate care. A MAP member stated that the Workgroup should consider "Conditional Support for Rulemaking" because the measure addresses a gap in the MIPS measure set and that the measure sets a high standard of care.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Do Not Support for Rulemaking" for measure MUC2022-115. Voting results were as follows: Yes – 3, No – 21, and percentage voting Yes – 13 percent. The Workgroup did not reach consensus on the NQF staff recommendation. Full voting results are available in Appendix C.

Dr. Hines suggested the recommendation of "Conditional Support for Rulemaking" pending CBE endorsement. A MAP member responded that there should be additional conditions addressing the performance gap and specifications in the numerator of the measure. Another MAP member stated that the lack of variation could be related to the structure of the measure, however, it could also represent a problem and lack of quality of care within the community.

Dr. Hines moved the Workgroup to vote on acceptance of "Conditional Support for Rulemaking" pending endorsement by a CBE, with specific review of the validity and performance gap for measure MUC2022-115. Voting results were as follows: Yes – 23, No – 1, and percentage voting Yes – 96 percent. Full voting results are available in Appendix C.

MUC2022-116: Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the nine public comments received during the public comment period, all of which were supportive of the measure. Dr. Amin noted that the major themes of the public comments were regarding the evidence that acute PVD and related symptoms (flashes and floaters) significantly increases the risk of retinal tear, retinal detachment, and subsequent irreversible vision loss. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott reviewed that the Health Equity Advisory Group noted no issues from an equity perspective and that the measure has the potential to fill a gap within MIPS. Dr. Elliott noted that the Rural Health Advisory Group expressed that the measure is applicable in rural communities. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative emphasized that the measure addresses a particular condition and ensures that patients will get the care and treatment within a specific timeframe, ensuring better health outcomes. The CMS representative noted that the measure will increase the number of measures in MIPS that are for retina specialists. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support, stating that the measure aligns with technical guidelines put forth by the American Academy of Ophthalmology, and the measure demonstrated reliability. Another lead discussant expressed support for the measure by highlighting that the process measure improves patient safety outcomes by encouraging the physician to evaluate the patient in a timely manner. The lead discussant noted that the measure demonstrates variation in performance and has adequate face validity and reliability. The lead discussant inquired if there is a code to define what evaluation is appropriate and if there would be future development of outcome measures relating to diagnosis of acute PVD and acute vitreous hemorrhage. Another lead discussant shared support for the measure, however, raised concerns of the burden to capture criteria of the measure in the EHR and the minimal case eligibility for the measure. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

The measure developer responded to the concerns of the minimal case size of the measure by stating that the measure score reliability testing using signal-to-noise testing was completed across 18 physicians at two retina specialist practices using data from calendar year 2021 and the total number of patients included in the analysis was 455. Further, the measure developer noted the denominators varied from 13 to 41 patients. The measure developer clarified that an appropriate evaluation is defined as either a vitreous examination or a peripheral dilated examination with documentation of scleral depression of the affected eye or contact lens (e.g., 3-mirror Goldmann) that provides visualization to the ora for 360 degrees or if the retina cannot be adequately visualized, then a ultrasound or referral to another provider for additional examination (e.g., if retina cannot be visualized and ultrasound is not available).

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” pending endorsement by a CBE for measure MUC2022-116. Voting results were as follows: Yes – 22, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix C.

Behavioral Measures

Dr. Amin introduced the behavioral measures under consideration:

- **MUC2022-122:** Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder *(MIPS)*
- **MUC2022-127:** Initiation, Review, And/Or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk *(MIPS)*
- **MUC2022-131:** Reduction in Suicidal Ideation or Behavior Symptoms *(MIPS)*

Public Comment

Dr. Hines opened the meeting for public comment on the behavioral measures. No public comments were offered. Dr. Hines handed the meeting to Dr. Amin to begin discussion of MUC2022-122.

MUC2022-122: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the two public comments received during the public comment period, both of which were supportive of the measure. Dr. Amin noted that the public comments stated that the benefits of the measure outweigh the burden of implementation. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group commented that the measure fills an important gap in MIPS, and is disparities-sensitive on gender, age, and race/ethnicity. Dr. Elliott noted that the Health Equity Advisory Group suggested that stratification by age, illness severity, gender, and race/ethnicity would be important for interpreting results as well as prioritizing improvements. Dr. Elliott further noted that the Health Equity Advisory Group expressed the importance of getting complete demographic data for the population as it relates to the measure. Dr. Elliott noted that the Rural Health Advisory Group expressed the importance of behavioral health measures for rural communities and expressed loss to follow up as a concern for the measure. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

Dr. Schreiber commented that behavioral health is of importance to CMS, especially considering the COVID pandemic and the rise of behavioral health and substance use disorder problems. Dr. Schreiber noted that the United States has a high suicide rate and behavioral health measures will be an important contribution to MIPS. A CMS representative further commented that the patient-reported outcome performance measure (PRO-PM) is fully developed and previously implemented as a Qualified Clinical Data Registry (QCDR) measure in MIPS. The CMS representative stated that the measure has evidence of a performance gap and is not duplicative of any other measure in MIPS. The CMS representative stated that there are 23 measures in MIPS that address mental health, however only 16 are specialty-specific. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for this measure, however, they noted concerns of loss to follow up with patients due to the timeframe of 30 to 180 days after an index assessment, burden to providers as it relates to workflow, and the number of assessments already conducted with this patient population. Another lead discussant expressed support for this measure, however, they inquired why performance of the measure was not considered as a percentage improvement. Another lead discussant expressed support for this measure and did not have any additional concerns. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

A MAP member inquired about the case mix adjustment of the measure and the ability to distinguish performance of the measure. Another MAP member expressed a similar concern, commenting that the lack of case mix adjustment is a strong concern to accurately distinguish performance across an adjusted performance distribution. A MAP member asked if the consideration of the applicability of the measure to physical medicine and rehabilitation professionals was outside the scope of the Workgroup discussion. Dr. Schreiber responded that a behavioral or physical therapist has the potential to choose measures, however, the measure is specified around behavioral health patients and would most commonly apply to behavioral health providers or primary care providers.

The measure developer responded to concerns regarding performance of the measure by stating that a technical expert panel was convened in which a consensus was reached that improvement in functioning is sometimes difficult to attain for patients in this population. The measure developer further commented that if a patient is starting at a low level or high level of function, then it will be difficult to discern any level of change, therefore, the measure specifies the improvement or maintenance of functioning. A MAP member expressed support for the distinction of the measure to not penalize individuals who have not improved fast enough, however, raised questions regarding the 1-point reduction from the World Health Organization Disability Assessment Schedule (WHODAS) or Sheehan Disability Index (SDS). The measure developer responded that a change in score in the WHODAS indicates a category change from mild to moderate, moderate to mild, or mild to severe; therefore, a 1-point change is an acceptable indicator and a change in category. The measure developer noted that in the patient population, maintenance itself can sometimes be an improvement.

A measure developer addressed the low response rate and loss of follow up of the measure by stating that the concerns are the nature of PROMs and must be weighed with the potential benefits of using this measure. The measure developer responded to the concerns of the case mix adjustment by stating that due to the measure assessing improvement or maintenance of function of an individual patient, and providers having a mix of patients whose levels of change vary in their case load; thus, the concern of risk adjustment is mitigated. A MAP member inquired if the measure has low response rates and there are factors affect the patient's propensity to respond, how does the measure truly understand the population being measured. The measure developer responded that the measure was developed to incentivize physicians to keep patients engaged and drive quality care. A MAP member further raised concerns about the benchmarking of the measure due to the lack of information regarding who is truly in the denominator as a general comment regarding longitudinal PRO-PMs.

A MAP member inquired if similar scales are being considered in the future to provide more choice of assessments, which would help with adoption and attempt to decrease assessment burden. The measure developer responded that there would have to be incorporation of additional assessment tools in the testing sample to allow a crosswalk to be conducted to discern information about WHODAS and SDS scores. Another MAP member inquired if the CPT codes listed as those to identify the encounter are able to be updated by CMS or other payers or if the CPT codes are a fixed aspect of the measure. The measure developer responded that the CPT codes that are included were tested and noted any additional CPT codes would have to be tested.

A MAP member asked an additional question regarding case mix adjustment and evidence that certain populations are more likely to decline, impacting performance of the measure. The measure developer responded that evidence indicates if patients present at a lower level of functioning and if care is not implemented early and consistently, then there would be a decline and it is more difficult for them to improve. The measure developer reiterated that the measure is designed to incentivize follow up and continuing care to prevent decline of the patient population. A MAP member reiterated the concern of the case mix adjustment and that there is not enough testing to understand the stratification of patients and stability of the metric in performance. The measure developer responded that when a disparities analysis was conducted, the severely mental ill patients demonstrated improvements in performance, highlighting that there was a capturing of change in performance. The measure developer further noted that the severely mental ill patients did not negatively affect providers, however, younger individuals were more prone to be lost to follow up. The measure developer further addressed case mix adjustment and follow up concerns by stating that revisions were made to the measure during a technical expert panel to address follow up and was respecified from 30 to 100 days to 30 to 180 days, recognizing the different populations of patients and their propensity to follow up.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE for measure MUC2022-122. Voting results were as follows: Yes – 20, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix C.

MUC2022-127: Initiation, Review, And/Or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the two public comments received during the public comment period, both of which were not supportive of the measure. Dr. Amin noted that the public comments stated concerns of what percentage of suicidal patients would be identified and affected by the measure, noting that many suicidal patients are identified by PCPs and PCPs do not utilize the Clinician Rating of Potential Suicide Risk (CRPSR). Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group was pleased to see measures geared toward functional improvement and suicide reduction. Dr. Elliott further noted that the Health Equity Advisory Group commented that the evidence is good for implementing a safety plan. Dr. Elliott noted that the Rural Health Advisory Group expressed the importance of behavior health measures for rural communities and expressed concern for finding information in the EHR as a challenge for rural providers, thus, highlighting feasibility challenges for implementation. Dr. Elliott further noted that the Rural Health Advisory Group raised concerns regarding implementing the tools to capture items for the measure, noting the measure was tested in rural settings. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated that the measure is fully developed and addresses a measure gap within the clinical area of suicide prevention. The CMS representative noted that there are 23 measures for mental, behavioral health, and the psychiatry specialty, however, only two of them address suicide safety and are restricted to patients with a diagnosis of major depressive disorder. The CMS representative further noted that the current MIPS measures address if an assessment is completed and do not address clinical actions taken if the assessment is positive. The CMS representative stated that the measure encompasses a broader denominator patient population by including more diagnoses and requires for patients with a positive assessment that suicide safety plans are implemented and reviewed. The CMS representative addressed comments not in support of the measure due to PCPs not utilizing the CRPSR by stating that most EHRs have implemented suicide safety plans in their systems and tools are readily available. The CMS representative noted that the CRPSR is one option for assessment, however, clinician observation is another tool. The CMS representative stated that the measure addresses the provision of evidence-based care to individuals presenting to several health professionals across a variety of settings for the assessment and care of their mental health and/or substance use disorders. The CMS representative stated this involves initial and ongoing assessment of suicidal ideation and behaviors, as well as the initiation and ongoing review and update to suicide safety plans which provides the data to assess the treatment response, and the potential to develop a metric to define reduction in suicide risk. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant inquired how the 120 days were determined for numerator two of the measure and raised concerns of denominator exclusions not including care coordination with caregivers. Another lead discussant expresses support for the measure, however, raised concerns regarding the standardized

tool utilized in the measure, noting that this concern may be mitigated because the clinician may choose whether or not to report the measure. Another lead discussant expressed support for the measure, however, raised the concern of the lack of stratification of the measure outside of age, sex, and mental health comorbidity. The lead discussant further questioned if there was an opportunity to expand the measure to a population outside of the greater than 18-year-old population. The lead discussant additionally inquired on the lack of feedback from patients and clinicians regarding meaningfulness of the measure. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

Dr. Hines invited the measure developer to address concerns raised by the lead discussants. The measure developer responded to questions regarding 120 days specified in the numerator by clarifying that the measure indicates within 120 days, acknowledging that a patient is more likely to encounter health systems if highly suicidal and their suicide plan would be updated by the physician. The measure developer noted that the suicide safety plan is a way for clinicians to identify coping strategies and collaborate with patients to understand how to make sure they are safe. The measure developer addressed denominator exclusion concerns by acknowledging that there is the potential to incorporate care coordination with caregivers in future measure development. The measure developer noted that the rationale for excluding patients with caregivers is that they have closer observation due to the caregiver and may represent a slightly different clinical diagnosis cohort.

A measure developer responded that the lack of stratification of the measure was due to the evidence in the literature and limitations of data, however, they acknowledged that there is hope in the future to test a broader range of stratifications based on race, ethnicity, education, housing status, and other key factors. The measure developer responded to concerns of a limited population by stating that the rationale for a population age of greater than 18 was due to the lack of testing in younger individuals for the measure. A CMS representative noted that the measure is an all-payer measure and adolescents will be applicable, however, due to how the measure is currently specified, the measure would have to undergo additional testing to include patients younger than 18. A measure developer responded to the lack of feedback regarding meaningfulness for clinicians by stating that there was face validity information collected. A MAP member noted that the measure specifications manual provided by NQF indicated that the measure helped inform clinicians' care and decision making, and not necessarily the meaningfulness. The measure developer responded that there is literature published that indicates that patients and clinicians find the suicide safety plan indicated in the measure useful and the rationale for developing a quality measure around a safety plan was that it is evidence-based.

A MAP member inquired if there is any specific definition of what could be considered a valid safety plan, emphasizing that this may be a "check box" measure. A measure developer responded that the measure was designed to have inherent flexibility to address concerns on not being labor intensive, by specifying in the measure that determination by clinician of risk is regardless of the availability or results of a patient-reported assessment and does not depend on a specific clinician tool. The measure developer noted that there is additional flexibility in terms of the safety plan itself and that many safety plans are built into EHRs. The measure developer noted that the assessment tools including the suicide safety plan are public and freely available.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE for measure MUC2022-127. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix C.

MUC2022-131: Reduction in Suicidal Ideation or Behavior Symptoms (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the two public comments received during the public comment period, one of which was supportive and one of which was not supportive of the measure. Dr. Amin noted that the comment not in support of the measure expressed concern regarding the percentage of suicidal patients identified and effected, noting that many suicidal patients are identified by PCPs who do not utilize CRPSR. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group commented that the measure design makes stratification straightforward, however, they expressed concern regarding accommodations made for individuals with limited English proficiency (LEP). Dr. Elliott further noted that the Health Equity Advisory Group raised concerns regarding disparities in how the measure performs in younger subgroups of patients. Dr. Elliott noted that the Rural Health Advisory Group expressed the importance of behavioral health measures for rural communities and expressed concern for finding information in the EHR as a challenge for rural providers, thus, highlighting feasibility challenges for implementation. Dr. Elliott further noted that the Rural Health Advisory Group raised concerns regarding implementing the tools to capture items for the measure, noting the measure was tested in rural settings. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated that the PRO-PM was developed to address measure gaps in MIPS by addressing the clinical area of suicide prevention. The CMS representative reiterated that among the 22 measures in MIPS for mental, behavioral health, and psychiatry, only two measures are specific to suicide. The CMS representative reiterated that the measure encompasses a broader denominator of the patient population by including more diagnoses and assessment of the reduction in suicidal ideation based on a standardized screening tool. The CMS representative responded to concerns raised by public comments by stating that the denominator includes patients identified as a suicide risk who complete the Columbia Suicide Severity Rating Scale (C-SSRS). The CMS representative noted that the clinician rating of potential suicide risk tool is one option for assessment, however, it can also include clinician observation or a similar tool. The CMS representative stated that the measure includes reduction in suicidal ideation or behaviors and addressed the provision of evidence-based care to individuals presenting to a variety of health professionals across a variety of settings for the assessment of care of the mental health or substance abuse disorders. The CMS representative further noted that the measure will specifically aim to avert or reduce the risk of suicide and associated outcomes in a population that is at high risk for suicide. The CMS representative handed the meeting back to Dr. Amin to introduce lead discussants.

A lead discussant noted that it is encouraging to see additional measures regarding suicide reduction proposed for MIPS, especially because it is an important and serious public health problem in the U.S. The lead discussant inquired about the amount of reduction in suicidal ideation and/or behavior symptoms that is clinically meaningful in the measure. Another lead discussant inquired about the stratification of the measure as it relates to the various levels of care and health systems that a patient may experience. Another lead discussant echoed the importance of the measure, however, raised concerns of the measure specifications indicating a change in the patient's condition as the criteria for measure performance. The lead discussant further commented that the C-SSRS produces multiple scores and inquired what is the index score to track for this measure and if there is data that indicates a reduction in score is clinically meaningful. Dr. Amin passed the meeting to Dr. Hines to open the discussion for the Workgroup.

A measure developer responded to stratification concerns by stating that there was an examination of crisis evaluations (inpatient hospitalizations versus non-inpatient hospitalizations) and there was limited determination that scores of the measure were impacted. The measure developer responded to questions regarding the multiple versions of the C-SSRS. The Lifetime/Recent version allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior. The Since Last Visit version of the scale assesses suicidality since the patient's last visit. The Screener version of the C-SSRS is a truncated form of the full version. The measure developer noted that most clinical sites used for testing the measure did not use the Since Last Visit version and used the Screener because it is easier to implement and interpret. The measure developer noted that any additional assessment tools included for the measure would have to be tested and crosswalked to ensure that there is equivalent scoring.

A MAP member then inquired how much change can be measured considering variability in loss to follow up. The MAP member further expressed overarching concerns of longitudinal PRO-PMs and rewarding some clinicians due to either selection of patients with favorable outcomes or the natural improvement of some patients that is unrelated to the measure. The measure developer responded that physicians should be incentivized to engage patients in care and continue to assess and monitor patients with suicidal thoughts and behaviors as opposed to completing a suicide risk assessment or screening that is never reviewed again. The MAP member inquired about the role of longitudinal PRO-PMs due to variability in response and concerns of benchmarking. The measure developer reiterated that the measure examines a reduction in suicidal thoughts and behaviors, and the main focus is incentivizing the engagement of care.

A MAP member posed a question regarding the social and clinical factors used for stratification. A measure developer responded that available data such as age, sex, and diagnosis was used, however, there is desire to broaden the range in the future. Another MAP member asked if the benchmarking is at the overall population level. The measure developer responded that benchmarking can be done at a practice and population level. A CMS representative commented that within MIPS there is only one benchmark per quality measure, and that benchmark can be either a single performance rate within a measure or an aggregate performance rate (weighted or simple average). The CMS representative noted that within MIPS there is no stratification of benchmarks.

A MAP member agreed with other MAP members that there is concern regarding any level of reduction being considered clinically meaningful. The measure developer responded that any reduction is important regarding suicidal thoughts and behaviors. The measure developer noted that measuring percentage change is not possible within the measure or within the instrument.

Dr. Hines moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE for measure MUC2022-131. Voting results were as follows: Yes – 21, No – 2, and percentage voting Yes – 91 percent. Full voting results are available in Appendix C.

Prevention and Patient Activation Measures

Dr. Amin introduced the prevention and patient activation measures under consideration:

- **MUC2022-048:** Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized instrument *(MIPS)*
- **MUC2022-065:** Preventive Care and Wellness (composite) *(MIPS)*
- **MUC2022-125:** Gains in Patient Activation Measure (PAM) Scores at 12 Months *(MIPS)*

Public Comment

Dr. Fields opened the meeting for public comment on the prevention and patient activation measures. A public commenter expressed support for MUC2022-125, noting that the measure is used in programs to measure the impact and dynamic of peer mentors for patients with late-stage kidney disease.

A public commenter posed a question regarding MUC2022-065, inquiring if the individual measures included in the composite measure would be potentially removed from MIPS and the web interface if the proposed measure is finalized.

Another public commenter expressed support for MUC2022-125, noting that increases in the measure's score aligns with better outcome, lower costs, and improvement of patient experience and is supported in cancer care. Dr. Fields handed the meeting to Dr. Amin to begin discussion of MUC2022-048.

MUC2022-048: Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized instrument (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the four public comments received during the public comment period, three of which were supportive and one of which was not supportive of the measure. Dr. Amin noted that the comments that were not in support of the measure requested that the measure developer consider two assessments: one in the antepartum and one in the postpartum period to ensure the measure is aligned with the American College of Obstetricians and Gynecologists' (ACOG) current guidance, and recognized the importance of assessing for CVD risk in both phased of pregnancy. Dr. Amin noted that comments also requested clarification on whether this measure has been tested at the individual clinician level. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group discussed that the measure has important consequences on health equity and can address health inequities in maternal health. Dr. Elliott further noted that the Health Equity Advisory Group commented that patients may not be aware of their risk and the measure addresses an important topic for health equity because cardiovascular disease is an important contributor to maternal morbidity. Dr. Elliott noted that the Rural Health Advisory Group commented that the denominator exclusions for this measure address the issues with rural health. Dr. Elliott further noted that the Rural Health Advisory Group commented that identifying CVD in pregnancy in a rural setting could also allow for timely referral and decrease maternal morbidity and mortality by making sure the patient is aware that she delivers in the appropriate place which improves quality. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated the measure is fully developed and addressed care for pregnant and postpartum patients by assessing a standardized cardiovascular disease risk assessment. The CMS representative noted that while the measure was fully tested at the facility level, there is some encounter-level data element testing that adequately addresses the validity of the measure and ongoing clinician level testing. The CMS representative stated that the measure addresses a high priority clinical gap in MIPS under the wellness and prevention domain for maternal health. The CMS representative stated that there is the potential in the future to include cardiovascular disease measures that would measure and ensure that the patient receives care if identified as someone with increased risk. The CMS representative highlighted that the clinical topic area of the measure is not only a priority for CMS, but also an HHS priority. The CMS representative stated that regarding a health equity standpoint, African American patients have a three to 12 times higher maternal mortality due to cardiovascular conditions,

therefore, it is important to identify this population. The CMS representative handed the meeting back to Dr. Amin to introduce the lead discussants.

A lead discussant expressed support for the measure, noting that cardiovascular events during pregnancy are predictive of long-term cardiovascular health. Another lead discussant expressed support for the measure, noting that utilizing an algorithm that highlights cardiovascular risk is especially important for women of color who have increased cardiovascular risk up to a year after giving birth. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

A MAP member inquired if there is an overall assessment from a social needs perspective that the standardized instrument addresses the totality of social drivers for the measure. A CMS representative stated that there are measures that examine postpartum care and screen for substance abuse, et cetera.; however, this measure exclusively examines cardiovascular disease. A CMS representative commented that the measure does have identifying as African American as one of the elements of the algorithm and there is the intention to examine SDOH in the future. The CMS representative clarified that the proposed measure examines the percentage of patients who complete a cardiovascular risk assessment. The CMS representative highlighted that the common theme among patients who die of CVD-related conditions while pregnant is the lack of suspicion and delays of diagnosis of CVD.

Dr. Fields moved the Workgroup to vote on acceptance of the staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE for measure MUC2022-048. Voting results were as follows: Yes – 23, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix C.

MUC2022-065: Preventive Care and Wellness (composite) (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the six public comments received during the public comment period, two of which were supportive and four of which were not in support of the measure. Dr. Amin noted that the comments not in support of the measure raised concern that the measure does not add value or improve patient outcomes. Dr. Amin noted that one commenter opposed the inclusion of tobacco screening in the composite measure. Dr. Amin further noted commenters raised concerns that the influenza immunization measure does not reflect the latest Advisory Committee on Immunization Practices (ACIP) recommendations, and emergency physicians' ability to access all the data necessary to calculate and report on the measure and EDs may not have the resources and staffing required to conduct these surveys for every patient. Dr. Amin also noted that a commenter raised concerns with the complexity of the measure, with seven numerators, denominators and exclusions/exceptions, will directly impact the feasibility of the measure for use in MIPS and was concerned with the inability to find any information on how this measure is calculated/weighted. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group shared that the measure could help improve health equity and there is value in using the individual measure as a composite. However, there are concerns with a composite measure in that a composite may be challenging to implement, a composite has a weighting methodology, and the individual measures used in the composite may be updated within a program/measurement year. Dr. Elliott noted that the Rural Health Advisory Group shared that the screening aspects of the measure may be challenging for the rural health community members due to possible transportation issues. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative commented that the composite measure was designed with the intention of providing a comprehensive assessment of preventive care offered to patients. The CMS representative stated the purpose of the measure is not to assess clinicians on the delivery of any specific form of preventive care, but to assess the extent to which clinicians are providing preventive care to patients broadly. The CMS representative stated that each of the quality actions that are incorporated within the measure are drawn from an existing measure in MIPS and supported by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, the American Association of Clinical Endocrinology, and the American College of Endocrinology. The CMS representative stated the testing and feasibility of the measure is strong, due to each component of the measure being reported within the context of MIPS. The CMS representative noted that reliability of the measure score was high with a median reliability of 0.977 and internal and face validity was tested and deemed strong. Another CMS representative addressed a concern raised during public comment of the prevention and patient activation measures regarding the web interface measures by stating that there is no knowledge of the impact of the web interface measures if this measure is implemented.

Dr. Amin commented that the NQF staff preliminary recommendation should be “Conditional Support for Rulemaking” pending CBE endorsement to maintain consistency with the rationale of other proposed measures, and that the Workgroup should begin voting on this decision category. The co-chair agreed that the Workgroup should begin the voting on “Conditional Support for Rulemaking” pending CBE endorsement. The co-chair handed the meeting to Dr. Amin to introduce lead discussants.

A lead discussant expressed support for the measure by commenting that the availability of the measure would greatly influence the capacity and engagement of local provider groups in primary care. The lead discussant raised concerns regarding if the individual measures would be phased out if the proposed measure is implemented, and the lack of risk adjustment and stratification for the measure. Another lead discussant echoed the same concerns of the potential phase-out of individual measures if the proposed measure is implemented into MIPS. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

Dr. Fields called on CMS to clarify questions regarding the phase-out of individual measures that the composite measure contains. Dr. Schreiber responded that the intent is to replace the individual measures with a composite measure. A MAP member inquired if there is a timeline for the phase-out of individual measures. Dr. Schreiber responded that there is no prediction of timeline and that the philosophic construct behind preventive composite measures is that patients should receive all preventive care that is appropriate and not one aspect of preventive care. The MAP member further inquired if it is more important for patients to be assessed by individual measures versus a composite measure that is weighted. Dr. Schreiber responded that the composite measure provides feedback on if the patient received the entire constellation of appropriate care. A CMS representative commented that there is feedback on individual measures of the composite measures and identification of areas of improvement. Dr. Schreiber further confirmed that individual exclusions would apply for each component measure. A MAP member inquired if the CMS web interface measures are the same as the seven individual measures in the composite measure. A CMS representative responded that the following CMS web interface measures overlap with MUC2022-065: 110: Preventive Care and Screening: Influenza Immunization, 112: Breast Cancer Screening, 113: Colorectal Cancer Screening, and 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

A CMS representative addressed risk adjustment and stratification by stating that there is some evidence that indicates variation by gender, race, and insurance status and evidence is what is expected

by the available literature. The CMS representative noted that the rationale for the measure is that the care is provided as extensively as possible, therefore, risk stratification was not included in the measure.

A co-chair inquired if there is reconciliation against clinical guidelines during the endorsement by the CBE. Dr. Amin responded that the endorsement by the CBE begins with evidence review and then scientific assessment of reliability and validity properties. A MAP member commented that the measure may be classified as a complex measure, thus, have a strict criterion due to the complexity of the design of the measure and that MAP should not strive for methodological perfection. Another MAP member echoed support for the composite measure, noting many advantages such as the incentivization to increase attention to a particular component of the physician's score that is low.

A MAP member inquired how "topped out" measures affect the validity of the measure. The CMS representative responded that analysis was conducted regarding the correlation and coherence of indicators, and there was a correlation between body mass index (BMI) and other indicators and high correlation with the tobacco use screening cessation intervention measure. The CMS representative noted that the risk is relatively low that the clinicians who treat patients who only qualify for one indicator would artificially increase their measure score because the applicability of the measure is fairly broad and there is opportunity for variation in the composite as a whole. The MAP member further inquired if "topped out" means that there is less granularity with some of the measures. The CMS representative stated that if a measure is "topped out" across a population of clinicians, the results of the measure are going to be less strongly correlated with the results of other indicators where performance is not "topped out," due to other measures capturing a broader range of variation in performance among themselves. The CMS representative noted that "topped out" in terms of MIPS is challenging due to clinicians choosing which measures to report.

A CMS representative addressed concerns of individual components of the measure that may not be up to date with the latest clinical guidelines by stating that the individual component measures would be reviewed and updated on the individual measure maintenance cycle.

Dr. Fields moved the Workgroup to vote on acceptance of the staff recommendation, "Conditional Support for Rulemaking" pending endorsement by a CBE for measure MUC2022-065. MAP emphasized review of the evidence for the component measures by the CBE. Voting results were as follows: Yes – 23, No – 1, and percentage voting Yes – 96 percent. Full voting results are available in Appendix C.

MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months (MIPS)

Dr. Amin reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Amin presented a summary of the 12 public comments received during the public comment period, 10 of which were supportive and two of which were not supportive of the measure. Dr. Amin noted that comments in support of the measure indicated that the Patient Activation Measure (PAM) performance measure is important to the accountability picture and focuses providers on improving patient activation, helping them transition to value-based care. Dr. Amin further noted that comments in support of the measure indicated that providers should be accountable for differences in performance on patient-reported outcome measures and research shows that PAM scores are related to positive health and health care outcomes. Dr. Amin noted that the comments not in support of the measure raised concern that the measure would be better if it applied to a narrower set of patients, that the measure does not account for patient preference, and there may be instances where a patient may not need activation such as a sore throat or a sprained ankle. Dr. Amin further reviewed that comments noted that the measure may be burdensome to operationalize and can be difficult for physicians to integrate into their workflow. Dr. Amin noted that commenters requested clarification on whether this

measure has been tested for reliability and validity at the individual clinician level. Dr. Amin passed the meeting to Dr. Elliott to review Advisory Group feedback on the measure.

Dr. Elliott noted that the Health Equity Advisory Group discussed that the measure could help improve health equity (patient engagement in their health), however, that safety net providers may have challenges making gains in the measure. Dr. Elliott noted that the Rural Health Advisory Group discussed that the measure could have unintended consequences for the rural health community due to limited access to health care resources regarding attitudes, motivators, behaviors, and outcomes in seeking healthcare. Dr. Elliott passed the meeting to Dr. Amin to invite CMS to provide contextual comments on the measure.

A CMS representative stated that the fully-developed, patient-reported outcome performance measure (PRO-PM) has CBE endorsement and assesses gains in the patient activation measure across six to 12 months. The CMS representative noted that the patient activation measure would be a new concept for MIPS and would align with CMS' priorities of capturing the patient voice and ensuring that patients are able to be partners in healthcare. The CMS representative stated that the measure differs from other PRO-PMs currently in MIPS because it focuses on patients' competence and management of their healthcare overall versus an outcome specific to a diagnosis or health issue. The CMS representative stated that the measure developer submitted data indicating a gap in performance and evidence demonstrating a statistically significant relationship between patient activation measure scores and positive health actions indicating positive outcomes for patients. The CMS representative acknowledged public comment concerns of broad applicability and feasibility of the measure by stating that PAM scores can be calculated using a variety of modes, including a free online survey, and that the measure has proven to be feasible and accessible in a range of populations and clinical conditions. The CMS representative handed the meeting back to Dr. Amin to introduce the lead discussants.

A lead discussant expressed support for the measure, noting that the PAM is useful to identify an individual's capacity for self-engagement and participation is an important aspect of care. The lead discussant did acknowledge concerns with the tool being publicly available and licensing for integration into EHRs, noting that the tool is currently a proprietary tool. The lead discussant further inquired if there is an intention to harmonize the measure with other measures currently used in post-acute care/long-term care settings. Another lead discussant expressed support for the measure, however, expressed concern with the specificity of the denominator due to the nature of longitudinal PROMs. The lead discussant suggested that intellectual disabilities is specified with an ICD-10 code in the denominator exclusions. The lead discussant commented that the measure can also change physician behavior in an upstream manner and by helping physicians find effective ways to change patient behavior. Another lead discussant echoed similar concerns regarding the denominator and the level of evidence of the measure. Dr. Amin passed the meeting to Dr. Fields to open the discussion for the Workgroup.

Dr. Fields called on the measure developer to respond to concerns raised by lead discussants. The measure developer clarified that the measure is a change score, noting that the measure reflects the aggregate change in PAM scores for a provider's patient population within the measurement year. The measure developer noted that the provider is not judged by the baseline patient activation of their population, but only the degree to which those scores improve. The measure developer stated that in MIPS, the measure rewards providers who want to focus on supporting knowledge, skills, and competence building among their patients. The measure developer stated that there is evidence that activation scores are malleable and when scores change, outcomes improve and costs decrease. The measure developer addressed concerns of the EHR integration by stating that the goal is to make the

tool as accessible as possible. The measure developer addressed the concern regarding evidence by stating that there are over 750 peer reviewed publications in which there is a quantification of PAM and meta-analyses that summarize evidence across studies.

A MAP member inquired if the PAM is available in different languages. The measure developer responded that the PAM is available in the following languages: Arabic, Bengali, Bulgarian, Chinese (Mainland), Chinese (Singapore), Chuukese, Creole (Haitian), Czech, Danish, Dutch, English, English (UK), Filipino, Finnish French, French Canadian, German, Greek, Gujarati, Hebrew, Hindi, Hungarian, Italian, Japanese, Korean, Malay, Marshallese, Norwegian, Polish, Portuguese-Brazil, Portuguese-Portugal, Punjabi, Romanian, Russian, Samoan, Slovak, Somali, Spanish-Latin American, Spanish-Puerto Rico, Spanish-Spain, Swedish, Tagalog, Tamil, Turkish, Ukrainian, Urdu, and Vietnamese.

A MAP member reiterated that the questionnaire is online, however, expressed concern regarding the proprietary nature of the tool and difficulties for clinicians to access and use the tool. The lead discussant further commented that the implementation of the tool could create disparities in terms of access for organizations that are trying to implement the measure. The measure developer responded to concerns of EHR integration by stating that the goal is to work with CMS to make sure the tool is as accessible as possible. Another MAP member inquired if the scoring of the PAM is included in the free nature of the tool. The measure developer responded that scoring is included in the free nature of the tool. Another MAP member inquired if there is a licensing restriction due to the proprietary nature of the measure for the integration into an EHR. The measure developer responded that organizations that implement the measure may choose to do it in a way that incur cost for them, however, the goal is to not make cost a barrier to access. Dr. Schreiber stated to the Workgroup that CMS does not utilize measures that have a proprietary cost. A MAP member inquired if proprietary costs include use in EHRs. Dr. Schreiber responded that the goal of CMS is for there to be no licensing costs. A MAP member inquired about the aggregation at the individual level of benchmarking. The measure developer responded that data was collected that supported reliability and validity at a clinician level.

Dr. Fields moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Support for Rulemaking” for measure MUC2022-125. MAP expects that there will be no licensing cost for the implementation and use of this measure if finalized for rulemaking. Voting results were as follows: Yes – 21, No – 2, and percentage voting Yes – 91 percent. Full voting results are available in Appendix C. Dr. Amin handed the meeting to Dr. Fields to begin discussion of thematic gaps regarding the MUC List.

MAP Clinician Program Measure Gaps

Dr. Fields opened the discussion to the Workgroup to discuss high-level gaps that they would like to be addressed in future MUCs. A co-chair noted the lack of proposed measures for the Medicare Shared Savings Program (MSSP). Dr. Schreiber responded that there has been a limit to the number of measures in the program to reduce burden, especially as it relates to the requirement of eCQMs and data aggregation. The co-chair raised concern that there are few clinical quality measures in MSSP, which may be more impactable and directly related to the management of populations. MAP members commented there are gaps in interoperability measures and PRO-PMs. A MAP member commented that there is a lack of cost measures for non-physicians. A MAP member expressed there is a lack of requirements around health equity components in measures that are actionable. Dr. Schreiber responded that there is discussion and work being conducted at HHS around the correct standards and the most appropriate information to collect regarding health equity. A co-chair asked if there are discussions to introduce measures that are reported at the level of race and ethnicity. Dr. Schreiber responded that there is ongoing work regarding the proper kind of collection of variables to appropriately stratify. MAP members noted other gaps and concerns in MIPS such as appropriate

germline and tumor genetic testing to guide therapy selection for cancer care, the requirement of digital measures in 2025 creating significant challenges for clinicians and groups of clinicians, transitions of care between clinicians and settings of care, timely follow up and access, ways to allow longer term metrics, and the return of field test reports on cost measures to identify opportunities to improve.

Measures Under Development- Hepatitis C Measure

Due to time constraints, Dr. Schreiber asked MAP members to examine the Hepatitis C information presented in meeting materials and provide feedback on the modification of the measure by creating an action plan for patients' treatment by sending to CMS or NQF staff.

Opportunity for Public Comment

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

Next Steps

Ms. Williams-Bader summarized the next steps for MAP. Ms. Williams-Bader shared the timeline for upcoming MAP activities, including an opportunity for public comment on Workgroup recommendations from January 6 to January 12, 2023. Ms. Williams-Bader noted the MAP Coordinating Committee will review the measures and make final recommendations in late January and NQF will submit a spreadsheet of final recommendations to HHS by February 1, 2023.

Ms. Williams-Bader concluded the meeting by sharing MAP resources and NQF MAP contact information. Ms. Williams-Bader thanked the MAP members for participating in a two-day meeting and maintaining quorum. Ms. Williams-Bader handed the meeting to the co-chairs to provide closing remarks. Dr. Fields thanked the Workgroup for their time commitment over the last two days and efficiency in discussing all the measures, highlighting that the MUCs this cycle were very impactful in terms of SDOH. Dr. Hines expressed delight in the quality of measures that came forward this cycle and thanked the NQF staff and insights from the Workgroup.

A MAP member stated that they were uncomfortable with the affiliations of the organization for organizational representatives on MAP and urged NQF to deemphasize affiliations with organizations. Ms. Williams-Bader responded that MAP is convened to represent stakeholders that will be impacted by measures that are implemented, and organizational representatives are representing their organizations. Ms. Williams-Bader noted that individuals can share personal experiences and disclose that their view is not of their organization during the meeting. Ms. Williams-Bader handed the meeting to Dr. Schreiber for closing remarks on behalf of CMS.

Dr. Schreiber stated that the Workgroup discussions influence the measures and programs and contribute to making care better for all Americans. Dr. Schreiber also thanked co-chairs, CMS staff, measure stewards, and measure developers who participated in the meeting. Dr. Schreiber noted that CMS is operationalizing the direction of quality around equity and MAP is one of the important levers to shape quality in American health care, including quality, equity, safety, and resiliency.

Appendix A: MAP Clinician Workgroup Attendance (Voting Only) – Day One

The following members of the MAP Clinician Workgroup were in attendance on December 15, 2022:

Co-chairs

Robert Fields, MD
Lisa Hines, PharmD, CPHQ

Organizational Members

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

Individual Subject Matter Experts

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

Appendix B: MAP Clinician Workgroup Attendance (Voting Only) – Day Two

The following members of the MAP Clinician Workgroup were in attendance on December 16, 2022:

Co-chairs

Robert Fields, MD
Lisa Hines, PharmD, CPHQ

Organizational Members

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

Individual Subject Matter Experts

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

Appendix C: Full Voting Results

Some MAP members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained during voting periods.

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-129: Psychoses and Related Conditions	MIPS	16 (70)	7 (30)	23 (100)	Conditional Support for Rulemaking
MUC2022-100: Emergency Medicine	MIPS	20 (95)	1 (5)	22 (100)	Conditional Support for Rulemaking
MUC2022-101: Depression	MIPS	15 (75)	5 (25)	20 (100)	Conditional Support for Rulemaking
MUC2022-106: Heart Failure	MIPS	15 (65)	8 (35)	23 (100)	Conditional Support for Rulemaking
MUC2022-097: Low Back Pain	MIPS	22 (96)	1 (4)	23 (100)	Conditional Support for Rulemaking
MUC2022-060: First Year Standardized Waitlist Ratio (FYSWR)	MIPS	20 (87)	3 (13)	23 (100)	Do Not Support for Rulemaking with Potential for Mitigation
MUC2022-063: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)	MIPS	18 (82)	4 (18)	22 (100)	Conditional Support for Rulemaking
MUC2022-052: Adult COVID-19 Vaccination Status	MIPS	6 (27) 16 (73)	16 (73) 6 (27)	22 (100) 22 (100)	Do Not Support for Rulemaking with Potential for Mitigation Support for Rulemaking
MUC2022-043: Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans	Part C & D Star Rating [Medicare]	23 (100)	0 (0)	23 (100)	Conditional Support for Rulemaking

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-007: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level)	MIPS	21 (100)	0 (0)	21 (100)	Support for Rulemaking
MUC2022-014: Ambulatory palliative care patients' experience of feeling heard and understood	MIPS	4 (18) 23 (100)	18 (82) 0 (0)	23 (100) 23 (100)	Support for Rulemaking Conditional Support for Rulemaking
MUC2022-098: Connection to Community Service Provider	MIPS	23 (100)	0 (0)	23 (100)	Conditional Support for Rulemaking
MUC2022-111: Resolution of At Least 1 Health-Related Social Need	MIPS	22 (96)	1 (4)	23 (100)	Conditional Support for Rulemaking
MUC2022-114: Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy	MIPS	24 (100)	0 (0)	24 (100)	Conditional Support for Rulemaking
MUC2022-115: Acute posterior vitreous detachment appropriate examination and follow-up	MIPS	3 (13) 23 (96)	21 (87) 1 (4)	24 (100) 24 (100)	Do Not Support for Rulemaking Conditional Support for Rulemaking
MUC2022-116: Acute posterior vitreous detachment and acute vitreous hemorrhage appropriate examination and follow-up	MIPS	22 (100)	0 (0)	22 (100)	Conditional Support for Rulemaking
MUC2022-122: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder.	MIPS	20 (95)	1 (5)	21 (100)	Conditional Support for Rulemaking

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-127: Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk	MIPS	21 (100)	0 (0)	21 (100)	Conditional Support for Rulemaking
MUC2022-131: Reduction in Suicidal Ideation or Behavior Symptoms	MIPS	21 (91)	2 (9)	24 (100)	Conditional Support for Rulemaking
MUC2022-048: Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized instrument.	MIPS	23 (100)	0 (0)	23 (100)	Conditional Support for Rulemaking
MUC2022-065: Preventive Care and Wellness (composite)	MIPS	23 (96)	1 (4)	24 (100)	Conditional Support for Rulemaking
MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months	MIPS	21 (91)	2 (9)	23 (100)	Support for Rulemaking