# Measure Applications Partnership 2022 Considerations for Measure Set Review in Federal Programs: Clinician, Hospital, and Post-Acute Care/Long-Term Care

*Final Report*

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## 1. Executive Summary

The Measure Applications Partnership (MAP) provides multistakeholder, consensus-based input on measures most appropriate for public reporting, performance-based payment, quality, and efficiency to the Centers for Medicare & Medicaid Services (CMS). A December 2020 omnibus appropriations legislation included funding for Medicare Extenders as well as language related to potential activities that MAP may undertake to review measures for potential removal from regularly assessed federal quality and performance programs. Subtitle A— Section 102 of the Consolidated Appropriations Act of 2020 grants the consensus-based entity that provides input on the selection of quality and efficiency measures used in various Medicare programs the authority to provide input on the removal of quality and efficiency measures as well.

During the 2022 cycle, MAP reviewed 32 measures during the Measure Set Review (MSR) for Medicare payment and reporting programs. MAP submitted recommendations (XLSX) to the United States (U.S.) Department of Health and Human Services (HHS) on September 22, 2022. Of the 32 measures, MAP expressed support for retaining nine measures, conditional support for retaining sixteen measures, conditional support for the removal of four measures, and support for the removal of three measures. Table 1 provides a summary of setting-specific decision categories for review.

| **Clinician Workgroup Measures** | * |
|---|---|
| Support for Retaining | 6 |
| Conditional Support for Retaining | 6 |
| Conditional Support for Removal | 2 |
| Support for Removal | 0 |
| **Total Measures** | 14 |
| **Hospital Workgroup Measures** | * |
| Support for Retaining | 2 |
| Conditional Support for Retaining | 4 |
| Conditional Support for Removal | 1 |
| Support for Removal | 1 |
| **Total Measures** | 8 |
| **Post-Acute Care/Long-Term Care Workgroup Measures** | * |
| Support for Retaining | 1 |
| Conditional Support for Retaining | 6 |
| Conditional Support for Removal | 1 |
| Support for Removal | 2 |
| **Total Measures** | 10 |

Table 1. 2022 MAP MSR Workgroup Recommendations
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MAP's recommendations for measures included in the MSR reflect priorities to ease the burden associated with increased number of performance measures and identify measures that no longer meet program priorities and no longer provide valuable information for public reporting and payment programs. The measure review criteria guide MAP members in their review of measures for recommendation for removal in MSR meetings.

This report will inform members of the healthcare quality community of key issues in measure development across the hospital, clinician, and post-acute care/long-term care (PAC/LTC) care settings.

## 2. Background: MAP Structure and Composition

MAP operates under a three-tiered structure consisting of a Coordinating Committee along with three setting-specific Workgroups and two Advisory Groups. MAP Workgroups and Advisory Groups are representative of a broad range of stakeholders that have an interest in, or are affected by, the use of quality and efficiency measures. Such stakeholders may include, but are not limited to, health plans, healthcare providers and practitioners, research entities, measure developers, national policymakers, patient advocates, patients and families, purchasers, and employers.

The Coordinating Committee, along with the setting-specific Workgroups and Advisory Groups, consist of organizational members, individual subject-matter experts, and federal agency liaisons:

- Organizational members represent leading stakeholder groups and contribute to a balance of stakeholder interests.
- Individual subject-matter experts add content expertise to critical areas, and their knowledge should help to fill gaps that are not met by the organizational membership.
- Federal liaisons represent government agencies and serve as ex-officio, non-voting members.

### 2.1 Rural Health Advisory Group

The Rural Health Advisory Group delivers input to the pre-rulemaking process and the MSR. It reviews all measures under review and highlights measures that may be particularly pertinent to issues in the rural population (e.g., access, costs, or quality issues encountered by rural residents; data collection and/or reporting challenges; and potential unintended consequences for rural providers). The Rural Health Advisory Group helps to accomplish the following tasks:

- Provide input to the MAP Workgroups on the rural health perspective on the Measures Under Consideration (MUCs) during MAP's annual pre-rulemaking process and measures under review during the MSR
- Identify rural-relevant gaps in measurement
- Provide recommendations regarding priority rural health issues, including the challenge of low case-volume and access

The Rural Health Advisory Group reviewed all 32 measures for the 2022 MSR across six programs.

### 2.2 Health Equity Advisory Group

During the 2021–2022 MUC cycle, National Quality Forum (NQF), with CMS funding, launched the Health Equity Advisory Group to ensure that perspectives on health inequities and disparities were adequately considered. The Health Equity Advisory Group reviews all measures under review and delivers input on measures with a lens to measurement issues affecting health disparities and the 1,000+ U.S. critical access hospitals (CAHs).

The Health Equity Advisory Group provides input on MUCs and measures under review with the goal of reducing health differences linked with social, economic, or environmental disadvantages. It is charged with accomplishing the following tasks:

- Provide input to the MAP Workgroups on measurement issues affecting health disparities and CAHs on MUCs during MAP's annual pre-rulemaking process and measures under review during MSR
- Identify health disparity gaps in measurement
- Provide recommendations to reduce health differences that are closely linked to social determinants of health (SDOH)

The Health Equity Advisory Group reviewed all 32 measures for the 2022 MSR across six programs.

## 2.3 Clinician Workgroup

The Clinician Workgroup provides recommendations for coordinating clinician performance measurement across federal programs. This is achieved by ensuring the alignment of measures and data sources to reduce duplication and burden, identifying the characteristics of an ideal measure set to promote common goals across programs, and implementing standardized data elements.

The Clinician Workgroup reviewed 14 measures for the 2022 MSR for two programs:

- Medicare Shared Savings Program (MSSP)
- Merit-Based Incentive Payment System (MIPS)

The following program did not have any measures reviewed during the 2022 MSR:

- Medicare Part C and D Star Ratings Program

## 2.4 Hospital Workgroup

The Hospital Workgroup provides input to the Coordinating Committee on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals.

The Hospital Workgroup reviewed eight measures for the 2022 MSR across three programs:

- Hospital Outpatient Quality Reporting Program (Hospital OQR Program)
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The following programs did not have any measures reviewed during the 2022 MSR:

- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Inpatient Quality Reporting Program (Hospital IQR Program)
- Medicare Promoting Interoperability Program for Hospitals
- Hospital Value-Based Purchasing (VBP) Program
- Hospital-Acquired Conditions Reduction Program (HACRP)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

## 2.5 Post-Acute Care/Long-Term Care Workgroup

The PAC/LTC Workgroup reviews measures for PAC and LTC programs. Its aim is to establish

performance measurement alignment across PAC/LTC settings while emphasizing that alignment must be balanced with consideration for the heterogeneity of patient needs across settings.

The PAC/LTC Workgroup reviewed 10 measures for the 2022 MSR in the following program:

- Home Health Quality Reporting Program (HH QRP)

The following program was reviewed during the 2022 MSR; however, no measures in this program were selected for discussion:

- Hospice Quality Reporting Program (HQRP)

The following programs did not have any measures reviewed during the 2022 MSR:

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

## 3. MSR Process Review

In collaboration with CMS, NQF created a four-step process to convene MAP members and provide input on measures for review and potential removal from federal healthcare programs. The four-step process included Prioritize, Survey, Prepare, and Discuss. During the Prioritization step, CMS and NQF selected federal programs to be reviewed by MAP Advisory and Workgroup members. A survey was constructed by NQF staff with a list of measures within each selected program. During the Survey step, MAP Advisory and Workgroup members nominated measures for discussion and removal using the measure review criteria as a guide for evaluation. The measure review criteria utilized by MAP members to nominate measures in the reviewed programs consisted of the following:

- The measure does not contribute to the overall goals and objectives of the program.
- The measure is duplicative of other measures within the same program.
- The measure is not endorsed by a Consensus-Based Entity (CBE), or it lost endorsement.
- Performance or improvement on the measure does not result in better patient outcomes.
- The measure does not reflect current evidence.
- The measure's performance is topped out, such that performance is uniformly high and lacks variation in performance overall and by subpopulation.
- The measure's performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation.
- The measure leads to a high level of reporting burden for reporting entities.
- The measure is not reported by entities due to low volume, the entity not having data, or the entity not selecting to report a voluntary measure.
- The measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities.

- Feedback from end users or implementers identified negative unintended consequences (e.g., premature discharges, overuse, and/or inappropriate use of care or treatment).
- The measure does not support rural health by negatively impacting issues relevant to the rural population (e.g., access, costs, and data collection and/or reporting challenges).
- The measure does not support health equity by negatively impacting disparities (e.g., race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, and geographical consideration).

Information provided by CMS and NQF staff on measures during the Survey step was minimal and included the following:

- The CMS Measures Inventory Tool (CMIT) reference number
- Measure title
- CMS program name
- Measure type
- Description
- Numerator
- Denominator
- CBE ID
- CBE endorsement status
- Data sources
- If the measure is required by statute
- NQF staff notes

The measures with the most votes were pulled forward for discussion during each setting-specific MSR meeting. During the Preparation step, the measures with the most votes were posted for a one-week public comment while NQF staff prepared measure summary sheets (MSSs) for distribution to the MAP Advisory Groups and Workgroups. Additional detailed information on the measures provided within the MSSs included the following:

- Measure specific information
- Program use
- Reporting data
- Performance data
- Measure review history provided by CBE and MAP
- Similar measures in the same program
- Rationale for nomination of the measure
- Negative unintended consequences of the measure

During the Discussion step, the Rural Health and Health Equity Advisory Groups convened for their respective virtual MSR meetings and discussed whether the measures would worsen or negatively impact health outcomes in the rural health setting or increase health disparities. A summary of the Advisory Groups' discussions was included in the updated MSSs that were shared with each Workgroup for review prior to their meeting. The Workgroups reviewed each measure and voted on their support for retaining the measure within the program. For any measures in which consensus was not met for a full vote, the voting decision was made by the Coordinating Committee during its virtual MSR meeting.

For other measures in which a vote was reached by the Workgroups, the Coordinating Committee discussed and voted to uphold or change the original recommendations.

During the 2022 MSR, NQF piloted a consent calendar for the Coordinating Committee virtual MSR meeting. NQF placed measures on the consent calendar if they had 80 percent or greater of voting Workgroup members voting for the same decision category; no new information was received through public comment that was not available or discussed during the Workgroup's review meeting, which was conflicting to the Workgroup's recommendation; and no process concern(s) that may have affected the recommendation of the measure were identified. Coordinating Committee members were able to nominate measures to pull from the consent calendar before and during the meeting. During the review meeting, Committee members were asked whether they wanted to pull any measures from the consent calendar for discussion. Objections were discussed, then the Committee decided whether to pull any additional measures from the consent calendar. For measures that were not pulled, the Workgroups' recommendations became the Coordinating Committee's recommendations. Measures pulled by Committee members were discussed, after which the Committee voted whether to support the Workgroups' recommendations.

# 4. Themes

## 4.1 Health Equity Advisory Group Themes

### *4.1.1 Measures organized by focus areas or categories*

The Health Equity Advisory Group discussed the importance of evaluating measures grouped by specific equity concerns, such as care delivery or community resource issues that lead to unintended consequences. Additionally, the Advisory Group noted the importance of having stratification data available for measure evaluation and the determination of disparities-sensitive measures.

### *4.1.2 Engagement of the scholarly community*

The Advisory Group suggested incorporating the expertise of the scholarly community in the creation of a framework to better assess measures for equity sensitivity. The Advisory Group also suggested that it would be helpful to have additional input from measure developers during measure discussions to close the feedback loop on measure concerns raised by Advisory Group members.

## 4.2 Hospital Workgroup Themes

### *4.2.1 Innovative approaches in emergency department care*

The Hospital Workgroup commented on the limited number of measures selected for discussion that shape priorities within imaging services and emergency department (ED) care. The Workgroup noted that the gap in measures for these areas could lead to opportunities for innovative approaches to be created that address the priorities of outpatient care raised during the Workgroup's discussion.

### *4.2.2 Critical focus on ambulatory surgical centers and patient safety*

The Hospital Workgroup raised a concern regarding the difficulty outpatient quality reporting programs face in developing measures that address the wide range of services provided in ambulatory surgical centers (ASCs). A Workgroup member noted the importance of keeping the number of patients being served at the forefront of future measures being developed.

The Workgroup mentioned that a shift has occurred in measures addressing patient safety since the start of the coronavirus disease 2019 (COVID-19) pandemic across the three hospital programs reviewed

during MSR. The Workgroup also suggested evaluating measures based on the degree to which they addressed patient safety and to balance measure discussions between setting-specific concerns and disease states to identify gaps.

### 4.3 Clinician Workgroup Themes

#### *4.3.1 Advocacy for accountable care organizations and consideration of the requirement for MIPS eCQMs*

The Clinician Workgroup raised a concern regarding the application of an all-payer approach to electronic clinical quality measures (eCQMs) within the MSSP. Facilities and clinicians with large populations of disadvantaged patients, particularly Medicaid or uninsured patients, may be negatively impacted. The Workgroup noted inclusion of these patients could cause skewed results for eCQMs.

### 4.4 PAC/LTC Workgroup Themes

#### *4.4.1 Measure alignment regarding function, systems, and care initiation*

The PAC/LTC Workgroup presented interest in measure alignment across function and symptoms (e.g., dyspnea), systematic issues associated with care initiation, preventative measures (e.g., influenza immunization), and the assessment of measure relevance across all PAC/LTC settings. The Workgroup also suggested measure alignment could be achieved with the focus on outcomes of functional measures across programs.

#### *4.4.2 Stabilization and risk mitigation*

The PAC/LTC Workgroup observed that the goals for certain populations are stabilization and risk mitigation rather than improvement.

#### *4.4.3 Capturing disparities in access to care*

The PAC/LTC Workgroup raised the importance of recognizing when SDOH are important risk adjusters and which measures would best capture disparities. The Workgroup also highlighted systemic barriers for patients accessing home health. The Workgroup noted that the more patients receive care, the better measures can capture areas for improvement.

#### *4.4.4 EHRs and Interoperability*

The PAC/LTC Workgroup emphasized the importance of using electronic health records (EHRs) for more consistent measurement and becoming more familiar with the United States Core Data for Interoperability (USCDI). The Workgroup noted these efforts would fill a gap in this measurement area and contribute to preventing errors and keeping patients at home in rural areas. Specifically, the Workgroup suggested a tiered-approach to using EHRs in home health, mandated by regulation and funding.

### 4.5 Rural Health Advisory Group Themes

The Rural Health Advisory Group did not have common themes arise from their measure discussions.

## 5. Considerations for Specific Programs

### 5.1 PCHQR Program

Section 3005 of the Affordable Care Act (ACA) added subsections to section 1866 of the Social Security Act and established the PCHQR Program for hospitals referred to as PPS-Exempt Cancer Hospitals or

PCHs. These hospitals (currently, 11 have been granted with this distinction by CMS) are excluded from payment under the Inpatient Prospective Payment System (IPPS). The PCHQR Program is a voluntary quality reporting program. There are no payment implications for these hospitals, and data are published on the Provider Data Catalog (PDC) website. The PCHQR Program is intended to encourage hospitals and clinicians to improve the quality of care, to share information, and to learn from each other's experiences and best practices. For the 2022 MSR deliberations, MAP reviewed one measure for the PCHQR Program.

#### *5.1.1 05735-C-PCHQR: Proportion of Patients Who Died From Cancer Not Admitted to Hospice*

*Proportion of Patients Who Died From Cancer Not Admitted to Hospice* is a measure that examines the proportion of patients who died from cancer not admitted to hospice.

MAP supported retaining the measure in the program with the following conditions: (1) CBE endorsement, (2) encourage the measure to be paired or harmonized with other measures in the program related to hospice and intensive care units, and (3) consider the health equity and rural health implications. The Hospital Workgroup recognized that this is a new claims-based version of the measure and it may be premature to remove it. The Workgroup also noted that removing the measure may create a gap in the program. The Workgroup acknowledged concerns from the Rural Health Advisory Group, which expressed that hospice services may not always be available in rural settings. The Workgroup also acknowledged concerns from the Health Equity Advisory Group, which expressed that hospice, in its current form, may not be appropriate for all populations and that equity issues may exist as it relates to hospice care. For complete details of the Hospital Workgroup MSR meeting, please refer to the meeting summary.

A Rural Health Advisory Group member commented that the metric does not allow for discernment of the reason a patient may not have accessed hospice care, and if the measure cannot discern this information, it becomes difficult to understand the impacts on or any negative unintended consequences to rural populations. Another member noted it is not possible to discern through the measure whether patients are not being offered any services or whether the services they are offered do not qualify as hospice, which may be more of a concern in rural areas with fewer providers. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted the importance of tracking differential access with regard to health equity; therefore, it would be premature to recommend this measure for removal from the program. They also noted it is okay if patients do not want hospice because hospice care in this country does not meet the needs of everyone, and in particular, it does not meet the structural issues people of color face. The member expressed that in terms of an equity lens, this measure does have implications. They expressed support for the removal of this measure. Another Health Equity Advisory Group member commented that this measure only applies to cancer-exempt institutions and works under the assumption that hospice care is the right outcome. Another member agreed with this comment, stating that this care is important as an end-of-life resource and overall patient and family experience. This member also highlighted challenges experienced by patients whose first language is not English. They stated that this care option is not explained in a way that is understood by all and also noted the need for cultural and ethical components to be considered during this type of care. The member also expressed that needs are not addressed or often ignored. Regarding an equity perspective, the member stated that this measure is needed with regard to race/ethnicity and language. Another

Health Equity Advisory Group member asked for clarification on previous comments about the potential for the measure to promote care that may not be aligned with patients' values. Another member responded, noting that if hospice is not designed for and responsive to the needs of the whole population and it falls short of important cultural components, then the desired goal should not be to have the highest proportion of patients who died from cancer be admitted to hospice. Another Health Equity Advisory Group member noted that the distinction of a patient not having the choice of care in the first place due to hospice being unavailable is a different question with equity implications. This member recommended that CMS consider a better equity lens for palliative care in the future. One of the Health Equity Advisory Group co-chairs responded with an idea to consider equity with a lens of systems and structures as opposed to personal choice. The co-chair noted that choice becomes relative depending on where a patient lives and their insurance status. They also highlighted the nuance of the discussion so far between evaluating the current limitations of the measure and the importance of the measure with regard to health equity if certain changes were made. A Health Equity Advisory Group member commented in the chat that hospice is associated with improved quality of life among minority communities enrolled, as well as bereaved caregivers. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

## 5.2 ASCQR Program

The ASCQR Program was enacted by section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, and Title I of the Tax Relief and Health Care Act (TRHCA) of 2006. The statute provides the authority for requiring ASCs paid under the ASC fee schedule (ASCFS) to report on process, structure, outcomes, patient experience of care, efficiency, and costs of care measures. The goals of this quality payment and public reporting program are to progress towards paying providers based on the quality rather than the quantity of care they give patients and to provide consumers information about ASC quality so that they can make informed choices about their care. For the 2022 MSR deliberations, MAP reviewed two measures for the ASCQR Program.

### *5.2.1 01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery*

*Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery* is a measure that examines the percentage of patients ages 18 and older who had cataract surgery and improvement in visual function achieved within 90 days following the cataract surgery based on completing a preoperative and postoperative visual function survey.

MAP supported retaining the measure in the program with the following conditions: (1) The measure developer must integrate the new survey instrument and (2) The measure must align to use the same survey version across programs. The Hospital Workgroup discussed survey burden and reporting burden and acknowledged that this measure is a patient-reported outcome performance measure (PRO-PM) that measures patient functioning, not visual acuity. As this measure is used in multiple programs, the Workgroup recommended alignment across measures regarding which version of the survey is used. For complete details of the Hospital Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about this measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

Health Equity Advisory Group members highlighted the PRO-PM structure of the measure and its use of a pre/post-surgery survey, noting that the measure may not be equity-sensitive because it does not identify who does not complete the survey. Regarding health equity implications, a member noted that potential measure design issues may exist. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.2.2 02936-C-ASCQR: Normothermia Outcome*

*Normothermia Outcome* is a measure that examines the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU).

MAP supported retaining the measure in the program. The Hospital Workgroup noted that this measure has an overall high performance; however, there are outliers and room for improvement. The Hospital Workgroup questioned whether the measure data could be captured by something other than manual review. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group did not have any concerns about the measure from a health equity perspective. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### 5.3 Hospital OQR Program

The Hospital OQR Program was enacted by section 109 of the Tax Relief and Health Care Act (TRHCA) of 2006. The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care. The goals of this pay-for-reporting and public reporting program are to progress towards paying providers based on the quality rather than the quantity of care they give patients and to provide consumers information about Hospital Outpatient Departments' (HOPD) quality so that they can make informed choices about their care. Data are publicly reported on the CMS Hospital Compare website. For the 2022 MSR deliberations, MAP reviewed five measures for the Hospital Outpatient Quality Reporting (HOQR) Program.

#### *5.3.1 00922-C-HOQR: Left Without Being Seen*

*Left Without Being Seen* is a measure that examines the percent of patients leaving without being seen by a qualified medical personnel.

MAP recommended the removal of the measure from the program. The Hospital Workgroup noted the measure by itself may not be providing useful information to patients. The Hospital Workgroup also noted the measure may not have enough granularity to give value. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

A Rural Health Advisory Group member noted that the measure could be an internal performance improvement metric but would not be useful in a national context for a public quality reporting

program. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted that this measure can highlight certain important inequities (e.g., a lack of basic interpreter services within a hospital could cause certain patients to experience extreme wait times before being effectively triaged). The member also noted that the measure is equity-sensitive. Another Advisory Group member concurred that certain equity trends could be tracked within this measure, such as lack of childcare, transportation issues, employment conflicts, or other reasons preventing patients from being available to wait in the ED for long periods of time. Additionally, another member highlighted that some minority populations rely on access to the ED for care rather than primary care services; therefore, removing the measure could impact access issues. Another member agreed that removing the measure could impact access issues by highlighting that some patients leave the ED due to transphobia or homophobia. Another member noted that it was helpful to know that the measure is not tied to payment, as hospitals would not be penalized for serving lower income populations or people who utilize the ED as a primary care alternative. This member also suggested that the measure could be improved if it could track subpopulations. Another Advisory Group member suggested using a stratification variable of population size or acuity to better examine the communities being served by EDs. The member also suggested that the measure should gather data at an aggregated level. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.3.2 00930-C-HOQR: Median Time From ED Arrival to ED Departure for Discharged ED Patients*

*Median Time From ED Arrival to ED Departure for Discharged ED Patients* is a measure that calculates the median time from the ED arrival to time of departure from the emergency room for patients discharged from the ED. The measure is calculated using chart-abstracted data, on a rolling quarterly basis, and is publicly reported in aggregate for one calendar year. The measure has been publicly reported since 2013 as part of the ED Throughput measure set of the CMS HOQR Program.

MAP supported removing the measure from the program on the condition that a replacement measure be included in the program. The Hospital Workgroup noted the measure may not be burdensome; however, inaccuracies may be present in the measure. The Hospital Workgroup also suggested stratification by case complexity and acknowledged that removing the measure may create a gap in the program. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

A Rural Health Advisory Group member noted rural hospitals could potentially perform well on this measure, and so, its removal would take away one of those opportunities for higher performance; nevertheless, they still expressed support for removing the measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

Multiple Health Equity Advisory Group members provided support for retaining this measure in the program because of the implications of throughput in EDs along with the health equity implications. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.3.4 00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain*

*Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain* is a measure that evaluates the percentage of magnetic resonance imaging (MRI) of the lumbar spine studies for patients with low back pain performed in the outpatient setting where antecedent conservative therapy was not attempted prior to the MRI. Antecedent conservative therapy may include claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI, claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI, or claim(s) for evaluation and management at least 28 days but no later than 60 days preceding the lumbar spine MRI. The measure is calculated based on a one-year window of Medicare Claims. The measure has been publicly reported, annually, by the measure steward (i.e., CMS since 2011 as a component of its HOQR Program.

MAP supported retaining the measure in the program with the condition of CBE endorsement. The Coordinating Committee requested CBE endorsement to include stakeholder feedback on the measure and ensure that the CBE found the measure's validity to be acceptable. The Coordinating Committee noted that claims data may not be a useful proxy for the outcomes the measure is interested in impacting. The Coordinating Committee also expressed concern regarding the lack of improvement in the measure over time but noted significant variation in the measure's performance and that more quality improvement resources may need to be implemented to improve the measure's performance. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

One Rural Health Advisory Group member noted that the measure's performance lacks variation; therefore, it is not seen as a helpful measure for performance evaluation and may not offer any benefit in a rural setting. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted the significance of imaging utilization and its potential impact on health equity; they also noted that literature published by the National Health Interview Survey suggests that Black, Hispanic, and Asian participants are less likely to report ever undergoing a computed tomography (CT) scan compared to White participants. Furthermore, this member noted that differences are present in ED diagnostic imaging at U.S. children's hospitals, which found approximately a 20–30 percent difference in the use of imaging services among African American and Hispanic populations. Additionally, the member noted a meta-study that found greater overuse among White patients, highlighting that the equity concerns may not be an inappropriate use or overuse but potentially an underuse. Another member commented that the measure is more about overuse and how decreased access to these services within minority communities contributes to equity impacts. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.3.5 02599-C-HOQR: Abdomen Computed Tomography (CT)—Use of Contrast Material*

*Abdomen Computed Tomography (CT)—Use of Contrast Material* is a measure that calculates the percentage of abdomen and abdominopelvic CT studies that are performed without and with contrast out of all abdomen and abdominopelvic CT studies performed (i.e., those without contrast, those with contrast, and those with both) at each facility. The measure is calculated based on a one-year window of Medicare Claims. The measure has been publicly reported, annually, by the measure steward (i.e., CMS) since 2011 as a component of its HOQR Program.

MAP supported retaining the measure in the program with the condition of CBE endorsement. The Hospital Workgroup acknowledged that the initial CBE endorsement attempt was made in 2008 and that changes have been made to the measure since then. The Hospital Workgroup noted that removing the measure may create a gap in the program. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

The Rural Health Advisory Group members did not have any rural health concerns about the measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted comparable findings across the demographic categories but also noted geographic differences, which may be due to the availability of resources in smaller and rural areas. The member also noted that intersectionality was not accounted for, such as the experience lived by an older Black male. Additionally, the member stated that there are known racial and ethnic differences attributed to pain treatment. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.3.6 02930-C-HOQR: Hospital Visits After Hospital Outpatient Surgery*

*Hospital Visits After Hospital Outpatient Surgery* is a facility-level measure, post-surgical, risk-standardized hospital visit ratio (RSHVR) of the predicted to expected number of all-cause, unplanned hospital visits within seven days of a same-day surgery at a HOPD among Medicare fee-for-service (FFS) patients ages 65 and older.

MAP supported retaining the measure in the program. Additionally, the Hospital Workgroup acknowledged that having information across settings can be useful for consumers and quality improvement. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Hospital Workgroup MSR meeting summary.

The Rural Health Advisory Group members did not have any rural health concerns about the measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted differences that were present in performance by age, income, and dual-eligibility status, highlighting that this measure could be helpful in the examination of health disparities. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### 5.4 MSSP

The MSSP Program was established by section 3022 of the ACA to facilitate coordination and cooperation among healthcare providers to improve the quality of care
for Medicare FFS beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. The goals for this value-based program include the promotion of accountability for a patient population, the coordination of items and services for the accountable care organizations' (ACOs) patient population Medicare FFS beneficiaries, and the encouragement of investment in high quality and efficient services. Beginning with performance year 2021, ACOs are required to report their quality data to CMS via the Alternative Payment Model (APM) Performance Pathway (APP). Their performance will be evaluated in the following four categories:

- Quality (50 percent)

- Cost (0 percent)
- Promoting interoperability (30 percent)
- Improvement activities (20 percent)

For the 2022 MSR deliberations, MAP reviewed seven measures for the MSSP.

#### *5.4.1 00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan*

*Preventive Care and Screening: Screening for Depression and Follow-Up Plan* is a measure that examines the percentage of patients ages 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

MAP supported retaining the measure in the program. Clinician Workgroup members noted the importance of the measure, considering it promotes the identification of depression, which may not always be apparent to clinicians. They also noted that removing the measure could create a gap in the program, as there is only one other clinical measure in the MSSP. However, MAP members expressed concerns about the difficulty in determining whether poor performance is due to the patient not being screened or whether the follow-up plan was difficult to document. For complete details of the Clinician Workgroup MSR meeting, please refer to the meeting summary.

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

A Health Equity Advisory Group member noted that while PCPs serve as the first line of defense in the detection of depression, studies show PCPs fail to recognize depression in up to 56 percent of patients and only 36–44 percent of depressed children and adolescents actually receive treatment. The member stated that these statistics suggest that the majority of depressed youth are undiagnosed and untreated. One Health Equity Advisory Group member commented in the chat that systems that have a higher proportion of patients with access to portals for digital screening have a much easier time reporting on the electronic version of the measure than systems with less affluent patients. Another member commented in the chat that the measure (and/or eCQM version) is useful for assessing equity, given the under-identification of depression in minority populations. This member also noted that an intersectionality value may be present, given the under-identification of depression in women. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

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

*Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)* is a measure that examines the percentage of patients ages 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented.

MAP supported retaining the measure in the program. Clinician Workgroup members noted that this version of the measure can reduce reporting burden when compared to the non-eCQM version of the measure. For complete details of the Clinician Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any rural health concerns about the measure, although one member noted eCQMs may be less burdensome than paper-based measures and expressed this difference was enough to change the balance in its favor (when considering whether to retain the measure in the program). For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group comments were carried forward for this measure from the non-eCQM version.

A Health Equity Advisory Group member noted that while PCPs serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize depression in up to 56 percent of patients and only 36–44 percent of depressed children and adolescents actually receive treatment. This member explained that these statistics suggest that the majority of depressed youth are undiagnosed and untreated. Another member commented in the chat that systems that have a higher proportion of patients with access to portals for digital screening have a much easier time reporting on the electronic version of the measure than systems with less affluent patients. Another member commented in the chat that the measure (and/or eCQM version) is useful for assessing equity, given the under-identification of depression in minority populations. Another member noted that an intersectionality value may be present, given the under-identification of depression in women. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.4.3 06040-C-MSSP: Hospital-Wide, 30-Day All-Cause Unplanned Readmission (HWR) Rate for MIP-Eligible Clinician Groups*

*Hospital-Wide, 30-Day All-Cause Unplanned Readmission (HWR) Rate for MIPS-Eligible Clinician Groups* is a re-specified version of the measure titled *Risk-Adjusted Readmission Rate (RARR) of Unplanned Readmission Within 30 Days of Hospital Discharge for Any Condition* (NQF #1789), which was developed for patients 65 years of age and older using Medicare claims. This re-specified measure attributes outcomes to MIPS-participating clinician groups and assesses each group's readmission rate. The measure comprises a single summary score, derived from the results of five models, one for each of the following specialty cohorts (i.e., groups of discharge condition categories or procedure categories): medicine, surgery/gynecology, cardio-respiratory, cardiovascular, and neurology.

MAP supported retaining the measure in the program. Clinician Workgroup members noted the importance of the measure for physician and public accountability. For complete details of the Clinician Workgroup MSR meeting, please refer to the meeting summary.

Rural Health Advisory Group members were not certain that rural providers, particularly in CAHs or rural clinics, would be reported in the measure in the way it is currently structured due to exemptions. One member noted that because the measure is not stratified by condition and because rural facilities have low case-volume challenges, there may be validity concerns for rural settings and the measure could be affected by small fluctuations. However, others commented that the measure does provide a way to monitor performance and assist in keeping patients out of the hospital past their discharge. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member explained that data published within *Health Affairs* show that post–ACA, imposing readmission reduction programs through ACOs has led to worsened mortality regarding heart failure as opposed to pneumonia. The member also noted that the measure is too broad from an equity perspective. Additionally, this member expressed the need for comprehensive risk adjustment for socioeconomic status and other SDOH factors that can impact outcomes and are unrelated to the quality of care provided. Another member commented on their review of the literature and findings, expressing that admission following the seven-day window is truly more related to SDOH issues or structural determinant of health issues. This member also questioned how much a hospital system should be responsible for outside of the seven-day window. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.4.4 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions*

*Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients With Multiple Chronic Conditions* is a measure that examines the rate of risk-standardized acute, unplanned hospital admissions among Medicare FFS patients 65 years of age and older with multiple chronic conditions (MCCs).

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

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member commented from an equity perspective, chronic conditions do have equity differences and utilization is tied to quality. Additionally, the member stated there are compounding factors related to patients with chronic conditions but noted management of chronic conditions as it related to equity is important. Another Health Equity Advisory Group member noted literature indicates there are inequities in Black, Indigenous, and people of color (BIPOC) populations

related to chronic illness and disease and for this reason, it is important to assess. For complete details of the Health Equity Advisory Group MSR Meeting, please refer to the meeting summary.

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

*Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey* is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months.

MAP supported retaining the measure in the program. Clinician Workgroup members noted that the measure is one of few measures that captures patient feedback on their healthcare and improves patient outcomes. Clinician Workgroup members also noted the possibility for the measure to address and mitigate disparities within patient experience. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Clinician Workgroup MSR meeting summary.

The Rural Health Advisory Group did not comment on the measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group did not comment on the measure. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.4.6 01246-C-MSSP: Controlling High Blood Pressure*

*Controlling High Blood Pressure* is a measure that examines the percentage of patients 18–85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

MAP supported retaining the measure in the program with the following conditions: (1) Allow multiple encounters, which is important; (2) Change the last reading requirement to an average or a therapeutic window; (3) Allow ambulatory or at-home blood pressure readings to be included in measure; and (4) CBE endorsement. Clinician Workgroup members included these conditions to bring the measure in line with recent literature and to allow for documentation of the home reading of blood pressures. The Coordinating Committee added the CBE endorsement condition. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Clinician Workgroup MSR meeting summary.

The Rural Health Advisory Group did not have any rural health concerns for this measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member commented that patients suffering from high blood pressure deal with equity issues, thus reinforcing the importance of the measure. However, they suggested that the measure could be improved. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

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

*Controlling High Blood Pressure (eCQM)* is an eCQM that examines the percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

MAP supported retaining the measure in the program with the following conditions: (1) Allow multiple encounters, which is important; (2) Change the last reading requirement to an average or a therapeutic window; (3) Allow ambulatory or at-home blood pressure readings to be included in measure; and (4) CBE endorsement. Clinician Workgroup members included these conditions to bring the measure in line with recent literature and to allow for documentation of the home reading of blood pressures. The Coordinating Committee added the CBE endorsement condition. MAP also agreed to apply the recommendations from this version of the measure to the registry version of the measure. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Clinician Workgroup MSR meeting summary.

The Rural Health Advisory Group did not have any rural health concerns for this measure. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group comments were carried forward for this measure from the non-eCQM version.

A Health Equity Advisory Group member commented that this measure disproportionately affects patients from lower socioeconomic statuses, and this effect is also seen within the Medicare Advantage program, thus making this measure doubly importantly with regard to health equity. Another member commented that in the state of Massachusetts, this is one of the starkest inequities observed within provider systems and within fully insured patient populations. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

## 5.5 MIPS Program

The MIPS Program was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to consolidate pre-existing Medicare incentive and quality reporting programs for clinicians into a single program. The Quality Payment Program (QPP) goals for the MIPS Program include improved quality of patient care and outcomes for Medicare FFS, rewarding clinicians for innovative patient care, and driving fundamental movement toward value in healthcare. The MIPS Program makes positive and negative payment adjustments for eligible clinicians (ECs) (including clinical social workers and midwives) based on their performance in four categories:

- Quality (30 percent)
- Cost (30 percent)
- Promoting interoperability (25 percent)
- Improvement activities (15 percent)

For the 2022 MSR deliberations, MAP reviewed seven measures for the MIPS Program.

### *5.5.1 00641-C-MIPS: Functional Outcome Assessment*

*Functional Outcome Assessment* is a measure that examines the percentage of visits for patients ages 18 and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

MAP supported retaining the measure in the program. Clinician Workgroup members noted that the measure was appropriate for specialists such as physical therapists, who regularly use functional assessments in their practice, and the optional reporting nature of the MIPS Program ensures that

clinicians who do not use functional assessments do not have to report the measure. For complete details of the Clinician Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted that equity concerns relating to recovery from strokes and other significant events may exist. Another member noted that more insight regarding the absence of functional outcome assessments in certain populations by stratification would be helpful to fully assess the measure. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.5.2 01101-C-MIPS: Barrett's Esophagus*

*Barrett's Esophagus* is a measure that examines the percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia.

MAP supported removing the measure from the program on the condition that a replacement measure be included in the program. Clinician Workgroup members noted the small number of pathology measures in the MIPS Program and how removing the measure could create a gap. Clinician Workgroup members also noted that the measure is topped out with no role for continuous improvement. For complete details of the Clinician Workgroup MSR meeting, please refer to this meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member expressed difficulty in understanding equity implications because the measure appeared topped out at 99 percent, indicating that the majority of reports contain the dysplasia statement. The member also noted that health equity concerns with the screening aspects may exist. Another member did not support retainment in the program because they were uncertain of the benefit of the measure, and if the measure was stratified, they would be uncertain of whether the data would showcase high rates of patients with diverse backgrounds. Additionally, another member restated that the health equity perspective is hard to determine due to the topped-out status of the measure and the data not being stratified. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.5.3 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery*

*Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery* is a measure that examines patients ages 18 and older who had surgery for primary rhegmatogenous retinal detachment and achieved an improvement in their visual acuity, from their preoperative level, within 90 days of surgery in the operative eye.

MAP supported retaining the measure in the program with the following conditions: (1) lengthen the follow-up period, (2) add additional exclusions (e.g., macular involvement), and (3) obtain CBE endorsement. Clinician Workgroup members recommended lengthening the follow-up period to allow

for additional corrections to visual acuity and adding exclusions to account for starting visual acuity. Clinician Workgroup members also indicated that a CBE-conducted review of the measure would be useful. For complete details of the Clinician Workgroup MSR meeting, please refer to this meeting summary.

A Rural Health Advisory Group member expressed approval of the outcome measure but questioned its applicability to rural areas due to small volume concerns. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.
A Health Equity Advisory Group member noted their concern with the measure due to low volume and the difficulty assessing equity issues based on various subgroups. The member acknowledged the public comment recognizing that outcomes for certain groups are worse following retinal detachments, highlighting the health equity concern. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.5.4 00254-C-MIPS: Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care*

*Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care* is a measure that examines the percentage of patients ages 18 and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

MAP supported retaining the measure in the program with the following conditions: (1) The evidence must be observed to see whether there are processes with clearer links to outcomes and (2) Coordination with the American Diabetes Association (ADA) on their work to improve the evidence base must occur. Clinician Workgroup members included those conditions to ensure the measure improves patient outcomes and incorporates the latest ongoing work to improve the evidence base for the measure. For complete details of the Clinician Workgroup MSR meeting, please refer to this meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted the measure is valuable because of the substantially higher prevalence of diabetes in the African American and Hispanic populations and disparities in the diabetes quality measures in general. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.5.5 05796-E-MIPS: Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care*

*Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care* is a measure that examines the percentage of patients ages 18 and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

MAP supported retaining the measure in the program with the following conditions: (1) The evidence needs to be observed to see whether there are processes with clearer links to outcomes and 2) Coordination with the ADA on their work to improve the evidence base must occur. Clinician Workgroup members included those conditions to ensure the measure improved patient outcomes and incorporated the latest ongoing work to improve the evidence base of the measure. For complete details of the Clinician Workgroup MSR meeting, please refer to this meeting summary.

The Rural Health Advisory Group members did not have rural health concerns about the measure, although one member noted that the lack of endorsement influenced their vote to support removal of the measure and that the standards for measures should be high, given the small volume challenges in rural populations. The member also noted that since these measures are voluntarily reported in MIPS, the balance of burden and benefits for the measure would be more manageable in other settings. Another member shared a stronger preference for outcome measures than intermediate outcome measures that reflect a standard of care or processes and reiterated the preference for endorsed measures. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory group carried comments forward from the non-eCQM version of the measure. A Health Equity Advisory Group member noted the value of the measure due to the substantially higher prevalence of diabetes in the African American and Hispanic populations and disparities in the diabetes quality measures in general. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.5.6 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report*

*Closing the Referral Loop: Receipt of Specialist Report* is a measure that examines the percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

MAP supported retaining the measure in the program. Clinician Workgroup members noted the measure's value in improving care coordination and the importance of referrals being completed for a patient's care. However, they noted the difference in performance results for clinicians reporting via registries versus EHRs and suggested that it is important to understand why this difference exists. For complete details of MAP's discussion, please refer to the Coordinating Committee MSR meeting summary and the Clinician Workgroup MSR meeting summary.

A Rural Health Advisory Group member agreed with the public comments, which stated that the measure puts extraneous burden on the referring physician and reflects on that physician if the report is not returned. The member also noted rural providers may not have the technology to receive feedback from referrals to urban centers. For complete details of the Rural Health Advisory Group MSR meeting, please refer to this meeting summary.

A Health Equity Advisory Group member noted the importance of coordination of care with populations that have less access to healthcare; however, uncertainty surrounds whether the measure will accurately capture coordination of care. Another member noted that if systems with more resources provide better quality, this will reflect true differences in the care patients are receiving in different systems. The member also commented that this may lead to equity concerns regarding where patients receive care and that systems with more resources may have higher performance because their EHR system makes it easier to document, highlighting the equity concerns from this perspective. Another

member noted that this measure may not have a strong health equity perspective because it is not a true reflection of the differences in quality. Additionally, another member highlighted that if this measure were stratified by race, then the measure may show inequities in the continuum of care for minority patients. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.5.7 05837-E-MIPS: Children Who Have Dental Decay or Cavities*

*Children Who Have Dental Decay or Cavities* is a measure that examines the percentage of children, six months to 20 years of age at the start of the measurement period, who have had tooth decay or cavities during the measurement period.

MAP supported removing the measure from the program on the condition that a replacement measure be included in the program. Clinician Workgroup members noted the small number of dental measures in the MIPS Program and removing the measure could create a gap. Clinician Workgroup members had significant concerns about the measure's value and design and suggested a measure that is designed with regard to preventing cavities might be a better fit for the program. The Clinician Workgroup also noted the measure should focus on incidence, rather than prevalence, of cavities. For complete details of the Clinician Workgroup MSR meeting, please refer to this meeting summary.

A Rural Health Advisory Group member noted that the measure had not been submitted for endorsement. Another member commented that the denominator does not allow the measure to reveal the full picture of access to dental care, considering it only represents children who already have dental care and not the children who are not coming in for dental care. Another member also commented that high costs of treating tooth decay or cavities can be a barrier to accessing care, and it may not be fair to bring that accountability back to the dentist. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted the importance of the measure from an equity perspective. Another member agreed with this sentiment, further adding that concern exists because the measure is examining only prevalence; overall, however, the measure does contribute toward holistic healthcare. Another member highlighted that the measure may disincentivize dentists who work in communities that have a lack of healthy food and dental care. The member also noted that there are various upstream components from a community perspective and structural components from an equity perspective to consider. Another Health Equity Advisory Group member asked whether clinicians are penalized if they have a high degree of children with cavities. Another member noted that if there are payment consequences, patient populations should be adjusted accordingly due to populations with limited resources. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### 5.6 HH QRP

The Home Health Quality Reporting Program was established by section 1895 of the Social Security Act. The goals of this pay-for-reporting program include alignment with the mission of the National Academy of Medicine (NAM), which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness. For the 2022 MSR deliberations, MAP reviewed 10 measures for the HH QRP.

### *5.6.1 00187-C-HHQR: Improvement in Dyspnea*

*Improvement in Dyspnea* is a measure that examines the percentage of home health episodes of care during which the patient became less short of breath or dyspneic.

MAP supported retaining the measure in the program with the following conditions: (1) CBE endorsement, (2) reassessment of the measure's components within OASIS, and (3) reevaluation of the measure's reliability and how dyspnea is reported. PAC/LTC Workgroup members noted the potential for subjectivity in the measure as assessment scores are established by observation. The PAC/LTC Workgroup also acknowledged concern from the Health Equity Advisory Group about inequities in referrals to home health. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about this measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group did not mention any health equity concerns for this specific measure; however, the Advisory Group agreed specifically that for the functional outcome measures, limitations in access to home health cause challenges when evaluating equity. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.2 00196-C-HHQR: Timely Initiation of Care*

*Timely Initiation of Care* is a measure that examines the percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered start of care/resumption of care (SOC/ROC) date (if provided); otherwise, it was within two days of the referral date or inpatient discharge date, whichever is later.

MAP supported retaining the measure in the program with the following conditions: (1) a clarification of the definition of a valid referral and referral start time and (2) CBE endorsement. The PAC/LTC Workgroup acknowledged the importance of timely home healthcare, but it agreed that challenges exist with regard to finding home health agencies to provide services during the COVID-19 public health emergency. The PAC/LTC Workgroup also acknowledged a concern a Health Equity Advisory Group member raised during the Workgroup meeting about the lack of access and referrals to home health for historically marginalized populations. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about this measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group did not have any concerns about this measure from a health equity perspective. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.3 00185-C-HHQR: Improvement in Bathing*

*Improvement in Bathing* is a measure that examines the percentage of home health quality episodes of care during which the patient improved at bathing themselves.

MAP supported retaining the measure in the program with the following conditions: (1) address patients for whom maintenance is the goal rather than improvement, potentially with exclusions for certain populations and (2) review the measure for redundancy once the cross-setting functional measure is finalized. The PAC/LTC Workgroup noted that bathing is one part of a whole functional assessment. The PAC/LTC Workgroup acknowledged concern from the Health Equity Advisory Group about lack of access and referrals to home health for historically marginalized populations. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted that communication barriers and other disability concerns could be present, which undermine the validity of the measure. Another member expressed that understanding what percentage of patients have difficulty bathing would add important context from an equity perspective. Another Health Equity Advisory Group member stated that from an equity perspective, fewer patients from historically marginalized communities or patients with cultural differences compared to their provider, are referred for home health. Another member agreed that a programmatic access problem exists due to a limited population. Overall, the Health Equity Advisory Group agreed specifically that limited equity implications were present for the functional outcome measures; however, limitations in access to home health cause challenges when evaluating equity. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

#### *5.6.4 00189-C-HHQR: Improvement in Management of Oral Medications*

*Improvement in Management of Oral Medications* is a measure that examines the percentage of home health episodes of care during which the patient improved in their ability to take their medicines correctly (by mouth).

MAP supported retaining the measure in the program with the condition to address patient populations who would not exhibit improvement, potentially through exclusions. PAC/LTC Workgroup members acknowledged the importance of the measure for safety and adherence. Collectively, the PAC/LTC Workgroup acknowledged concerns from the Health Equity Advisory Group about lack of access and referrals to home health for historically marginalized populations. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

A Rural Health Advisory Group member noted rural populations perform slightly better on the measure, but similar to other measures in this program, there is no stratification for patients who cannot expect to perform this function or for whom management of oral medications is not part of their goals of care. Another member stated that a patient's ability to independently manage oral medications reliably and safely is critical to patient safety, and this is especially important for underserved and rural populations to prevent hospitalizations and acute care. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

The Health Equity Advisory Group did not mention any health equity concerns for this specific measure; however, the Advisory Group agreed specifically that for the functional outcome measures, limitations

in access to home health cause challenges when evaluating equity. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.5 01000-C-HHQR: Improvement in Bed Transferring*

*Improvement in Bed Transferring* is a measure that examines the percentage of home health quality episodes of care during which the patient improved in their ability to get in and out of bed.

MAP supported retaining the measure in the program with the condition to evaluate populations in which there would not be an expectation of improvement but rather maintenance. The PAC/LTC Workgroup did not note any issues with variability of the measure's data but did note differences in the overall outcomes, which indicated potential disparities for patients who are non-White, younger, have lower income, and are living in the western U.S. The PAC/LTC Workgroup noted the concern a Rural Health Advisory Group member raised during the Workgroup meeting regarding the correct standard for an individual with a disability. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member stated that the improvement component of the measure may not be the correct standard for someone with a disability, and a more fitting standard may be maintenance of current functionality. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.6 00212-C-HHQR: Influenza Immunization Received for Current Flu Season*

*Influenza Immunization Received for Current Flu Season* is a measure that examines the percentage of home health quality episodes of care during which patients received influenza immunization for the current flu season.

MAP supported retaining the measure in the program with the following conditions: (1) CBE endorsement and (2) a review of how the measure addresses patients who do not receive the vaccine, as covered by items #4, #5, and #7 in the survey. The PAC/LTC Workgroup acknowledged the importance of vaccines but questioned whether this was the right measure. The PAC/LTC Workgroup acknowledged comments from the Rural Health Advisory Group about the potential lack of vaccine accessibility in rural settings. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group noted the potential lack of vaccine accessibility in rural settings. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member stated when examining flu vaccination rates between 2019 and 2021, the rate remained around 79 percent; however, there are certain races and ethnicities that demonstrate lower rates. The member noted that from an equity perspective, the measure may highlight complications in accessing or scheduling vaccinations. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.7 02943-C-HHQR: Total Estimated Medicare Spending per Beneficiary (MSPB) – Post-Acute Care (PAC) HHQRP*

*Total Estimated Medicare Spending per Beneficiary (MSPB) – Post-Acute Care (PAC) HHQRP* is a measure that examines the assessment of the Medicare spending of a home health agency's (HHA) MSPB-PAC HH episodes, relative to the Medicare spending of the national median HHA's MSPB-PAC HH episodes across the same performance period. Note: An MSPB-PAC HH measure score of less than 1 indicates that a given HHA's resource use is less than that of the national median HHA during the same performance period.

MAP supported removing the measure from the program. The PAC/LTC Workgroup noted the CBE's Standing Committee's decision to not endorse the measure based on the lack of scientific acceptability. The PAC/LTC Workgroup suggested connecting cost with outcomes, such as moving towards a value-based metric. The PAC/LTC Workgroup acknowledged the concerns a Rural Health Advisory Group member raised during the Workgroup meeting about the validity of the measure and the small sample size in rural populations. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member expressed concern that the measure may incentivize home health agencies to spend less on certain patient populations. Another member expressed concern that stratifying the measure would reveal less spending on certain populations. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.8 02944-C-HHQR: Discharge to Community – Post-Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)*

*Discharge to Community – Post-Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)* is a measure that assesses successful discharge to the community from a HHA, with successful discharge to the community, including no unplanned hospitalizations and no death in the 31 days following discharge. It assesses a HHA's risk-standardized rate of Medicare FFS patients who are discharged to the community following an HH episode, who do not have an unplanned admission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home/self-care without HH services based on the Patient Discharge Status Codes 01 and 81 on the Medicare FFS claim.

MAP supported retaining the measure in the program. The PAC/LTC Workgroup noted the value of this measure's use across post-acute care settings. The PAC/LTC Workgroup noted although the measure was risk-adjusted, it may be beneficial to stratify the data by dual-eligible and non–dual-eligible patients. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about this measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted existing equity concerns in rural populations and concerns that some patients may not relate to resources for discharge to home. Another member agreed that health equity concerns do exist for rural populations and other disadvantaged ZIP codes. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.9 03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)*

*Application of Percent of Residents Experiencing One or More Falls With Major Injury (Long Stay)* is a measure that examines the percentage of quality episodes in which the patient experiences one or more falls with major injury (defined as bone fractures, joint dislocations, and closed-head injuries with altered consciousness, or subdural hematoma) during the home health episode.

MAP supported removing the measure from the program with the condition that a replacement measure be included in the program. The PAC/LTC Workgroup acknowledged that falls are significant but questioned whether this is the right measure for the program. The PAC/LTC Workgroup also noted concern with the use of a measure in home health that was developed in a setting where patients have 24-hour care. The PAC/LTC Workgroup also questioned whether the measure should be indicated as a rate per thousand patient days as it is in other post-acute care settings. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member noted the absence of a health equity component to the measure. Another member stated that a health equity component may be present if an individual lives at home alone and does not have social support systems. The member additionally noted that the measure should be examined further for differences based on race or geographic location. The Health Equity Advisory Group agreed that equity concerns with measures that have a self-reporting component are present. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

### *5.6.10 05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*

*Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function* is a measure that examines the percentage of home health quality episodes in which patients mobility and self-care functional status was documented and at least one discharge goal was recorded.

MAP supported removing the measure from the program. The PAC/LTC Workgroup noted that the performance scores were high, lacked variation, and may have topped out. The PAC/LTC Workgroup also acknowledged that no other measures in the home health program address functional goals in the program. For complete details of the PAC/LTC Workgroup MSR meeting, please refer to the meeting summary.

The Rural Health Advisory Group did not have any concerns about the measure from a rural health perspective. For complete details of the Rural Health Advisory Group MSR meeting, please refer to the meeting summary.

A Health Equity Advisory Group member expressed concerns with self-reported measures and the health equity implications. Additionally, this member stated that from an equity perspective, certain populations may be missing from the measure's data, highlighting the difficulties in assessing for disparities or inequities. For complete details of the Health Equity Advisory Group MSR meeting, please refer to the meeting summary.

## 6. Future Considerations for the MSR Process

MAP members were provided opportunities at the conclusion of each MSR virtual web meeting to provide feedback on the MSR process and future considerations. MAP members stated that evaluating measures as part of an overall measure set would be most beneficial in future MSR cycles. MAP members additionally highlighted that information on measures in development would assist in the discussions of measures recommended for removal to ensure gaps in the programs are not created. MAP members valued the use of the piloted consent agenda as well.

## 7. Conclusion

The recommendations submitted by MAP during the 2022 MSR aim to improve the quality, safety, and value of U.S. healthcare through federal healthcare payment and public reporting programs. Further, these recommendations aim to ease the burden associated with the increased number of performance measures. MAP convened representatives from quality measurement, research and improvement, purchasers, public/community health agencies, health professionals, health plans, consumers, and suppliers. The balance of diverse stakeholder interests ensured the federal government received varied and thoughtful input on recommendations to retain measures within programs. As the ecosystem of quality measurement drives ahead, discussions involving health equity, person-centered care, measure alignment, and stratification will continue. MAP looks forward to future opportunities to inform and educate all those who are invested and committed to advancing measurement science.

# Appendices

## Appendix A: MAP Rosters and NQF Staff

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