NATIONAL QUALITY FORUM

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Task Order HHSM-500-T0003, Task Order Final Report: Multistakeholder Input on the Selection of Quality and Efficiency Measures as Part of the Pre-rulemaking Process Under Social Security Act Section 1890A

TASK ORDER FINAL REPORT COMPRISING 2017–2022

Contents

1. Executive Summary

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) to provide multistakeholder consensus-based recommendations to the United States (U.S.) Department of Health and Human Services (HHS) on the selection of performance measures for federal healthcare quality programs as required under Section 014, amendment 1890A(a) of the Affordable Care Act (ACA) of 2010. MAP brings together a variety of stakeholders from both public and private sectors, such as consumers, clinicians, purchasers, providers, researchers, health plans, and suppliers, to provide input that ensures the measures used in federal programs address national healthcare priorities, fill critical measurement gaps, and increase public-private payer alignment. MAP strives to achieve performance improvement, transparency, and value for all.

The MAP pre-rulemaking process to review measures under consideration (MUCs) includes a series of meetings and activities held each cycle, both internal and public facing. Public-facing activities include a call for nominations to seat each of the six MAP groups (i.e., Coordinating Committee, Hospital Workgroup, Clinician Workgroup, Post-Acute Care/Long-Term Care [PAC/LTC] Workgroup, Rural Health Advisory Group, and Health Equity Advisory Group), an annual strategic meeting to review MAP processes and procedures, a series of orientation meetings, the development and publication of preliminary analyses (PAs) of each MUC, a series of measure review meetings, and public commenting periods to collect broad input on MAP recommendations. Private activities include a Centers for Medicare & Medicaid Services (CMS)–NQF kick-off meeting, setting-specific cycle planning meetings and review meeting prep calls with CMS Program and Measure Leads, and a debrief meeting to close out the cycle and identify lessons learned. The results of the pre-rulemaking processes are captured in a final Recommendations Spreadsheet and Recommendations Report.

During Option Year 3 (2021–2022), CMS proposed a contract modification to introduce a new Measure Set Review (MSR) process, piloted in August and September 2021. The purpose of MSR is to provide a holistic review of the measures in Medicare quality programs; provide an opportunity for multistakeholder input, thus easing the burden of an increased number of performance measures; and continue to educate and inform those who are interested in advancing measurement science. During the pilot, NQF focused on developing a review process and criteria for evaluating measures within federal programs. In 2022, NQF expanded the process to include the workgroups and advisory groups. Public MSR activities conducted throughout the pilot and scaled-up cycle include an Education Meeting, a meeting for measure stewards to orient them to the process; the development and publication of measure summary sheet (MSS) documents for each measure being reviewed; a series of measure review meetings; and public commenting periods to collect broad input on MAP recommendations. Private activities include a kick-off meeting (pilot phase only), a planning meeting with CMS Program and Measure Leads, and a prep meeting with CMS Program and Measure Leads. The results of the MSR processes are captured in a final Recommendations Spreadsheet and Recommendations Report.

In total, MAP has reviewed 141 unique MUCs for pre-rulemaking cycles since 2017. Across cycles, MAP members have provided recommendations on specific measures and identified broader themes for consideration. Themes from MAP workgroups and advisory groups include the following:

- Measures must be meaningful, accurate, and actionable, and must hold the correct entity accountable for outcomes between clinicians and health systems

- Cost measures must be aligned with quality measures to understand efficiency while protecting against potential negative unintended consequences of cost measures
- There is broad support for the use of outcome measures and patient-reported outcome performance measures (PRO-PMs)
- There is need for alignment and harmonization in various hospital and setting-specific programs to reduce provider burden and assist consumers in making informed choices
- Measures should be informative for clinicians, health systems, and patients
- Important topics for measurement include coordination of care and transitions of care, coronavirus disease 2019 (COVID-19), the opioid crisis, and health equity/social determinants of health (SDOH)
- There is a need for measures that include appropriate risk adjustment and stratification

MAP has reviewed 54 measures in the MSR process since the inaugural pilot in the fall of 2021. During the pilot, MAP Coordinating Committee members decided to focus on five selected hospital programs. For the 2022 MSR, MAP made recommendations on 32 measures under review for six CMS quality reporting and value-based payment (VBP) programs covering ambulatory, acute, and PAC/LTC settings. Final recommendations will be published following the Coordinating Committee MSR meeting on August 24–25, 2022.

In addition to the process evolutions and findings described in this document, NQF continually revised its operational approach to maximize efficiencies and expand and improve stakeholder engagement. NQF has overcome challenges such as facilitating MAP conversations on critical topics, conducting a high workload during holiday timelines, and developing and implementing a new MSR process. In addition, NQF has successfully expanded project management capacities and processes and evolved complex content deliverables, such as PAs and final reports, to better serve CMS and the public. NQF is proud to lead this important work with continued, focused effort and recognition of the impact it has on healthcare quality.

2. Project Description

2.1 Introduction

This Task Order (TO) Final Report outlines NQF's operational and technical approach to MAP, funded by CMS. Included in this document is NQF's approach to implementing requirements listed in the Statement of Work (SOW) and Schedule of Deliverables (SOD), accomplishments throughout the last five years, and a summary of obstacles encountered and lessons learned. The MAP process involves convening the multistakeholder committees, including setting-specific Workgroups, Advisory Groups, and a governing Coordinating Committee, to recommend measures for addition via the MUC pre-rulemaking process and measures for removal via the MSR process. As this document summarizes work from 2017–2022, many sections are divided by year or pre-rulemaking cycle. For ease of reading, headers are included noting these overlaps and where the processes diverge.

2.2 Overview

Section 014 of the Affordable Care Act (ACA) of 2010, amending section 1890 and establishing 1890A(a) of the Social Security Act, requires the HHS Secretary (the Secretary) to establish a pre-rulemaking process under which a consensus-based entity (CBE) (currently NQF) would convene multistakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in

certain federal programs. The list of quality and efficiency measures under consideration by HHS for selection (i.e., the MUC List) is to be publicly published no later than December 1 of each year. No later than February 1 of each year, the CBE is to report the input of the multistakeholder groups, which will be considered by HHS in the selection of quality and efficiency measures.

MAP is a public-private partnership convened by NQF to provide multistakeholder consensus-based recommendations to HHS on the selection of performance measures for federal healthcare quality programs. MAP brings together a variety of stakeholders from both public and private sectors, such as consumers, clinicians, purchasers, providers, researchers, health plans, and suppliers. MAP's aim is to provide input to HHS that ensures the measures used in federal programs address national healthcare priorities, fill critical measurement gaps, and increase public-private payer alignment. MAP strives to achieve consistent performance improvement, transparency, and value for all.

MAP is composed of a Coordinating Committee, three setting-specific workgroups (i.e., Clinician, Hospital, and PAC/LTC), and two advisory groups (i.e., Rural Health and Health Equity). The Coordinating Committee provides strategic direction and is responsible for the final approval of the recommendations and guidance developed by the workgroups and advisory groups. The three workgroups advise the Coordinating Committee on measures for specific care settings, care providers, and patient populations. The two advisory groups provide feedback to the workgroups on specific cross-cutting priorities, such as rural health and health equity.

2.2.1 The MAP Process

2.2.1.1 Pre-rulemaking: Measures Under Consideration

MAP conducts a portion of its work as part of CMS' pre-rulemaking process. This includes a public call for measures, CMS' development and public release of the annual MUC List, MAP meetings to review and discuss the measures on the MUC List, and the publication of MAP's recommendations. The workgroups use MAP-developed measure selection criteria to assess how well each measure fits the needs of a specified program. The measure selection criteria are designed to demonstrate the characteristics of an ideal set of performance measures. MAP emphasizes the need for evidence-based, scientifically sound measures while minimizing the burden of measurement by promoting alignment and ensuring measures are feasible. MAP also promotes person-centered measurement, alignment across the public and private sectors, and the reduction of healthcare disparities. MAP then makes a recommendation for each candidate measure: support, do not support, conditionally support, or refine and resubmit. MAP's recommendations inform HHS' decisions about measures to use in their public healthcare quality programs, which HHS puts forth in a notice of proposed rulemaking in the *Federal Register*.

The process outlined here is the culmination of the last five years of development and represents current best practices. The MAP TO is divided into four contract periods, beginning with the Base Year (September 2017 – March 2019), then Option Years 1, 2, and 3 (March 2019 – March 2020, March 2020 – March 2021, and March 2021 – September 2022, respectively).

MAP's Coordinating Committee, three setting-specific workgroups, and two advisory groups consist of over 150 healthcare leaders and experts representing nearly 90 organizations, subject-matter experts, and seven federal agencies (as ex officio members). To elicit multistakeholder pre-rulemaking input on the MUC List, NQF partners with CMS and utilizes a three-step process:

1. **Review existing program measure set framework**. Using CMS' program-specific *Measure Needs and Priorities* document and the MAP measure selection criteria, NQF staff review each program's finalized measure set with the workgroups and advisory groups. The *CMS Needs and Priorities* document is used to better understand the current measures in the program and how well any new measures might align within the program. Workgroup and advisory group members identify gaps and potential areas of need.
2. **Evaluate the MUC for what they would add to the program measure sets**. MAP uses the measure selection criteria and a defined decision algorithm to determine whether the MUC will enhance the program measure sets. Staff perform a preliminary analysis (PA) based on the algorithm, and MAP workgroups and advisory groups discuss recommendations for each MUC during December meetings. The workgroup recommendations are released for a public commenting period and then reviewed and finalized by the Coordinating Committee.
3. **Identify and prioritize gaps for programs and settings**. Time permitting, MAP identifies gaps in measures within each program and provides measure ideas to spur development. MAP also considers gaps across settings, prioritizing by the importance and feasibility of addressing the gap when possible. MAP provides input on CMS' strategic priorities related to quality measurement.

To conduct this work efficiently, NQF staff have deployed a series of key elements to MAP that are continually refined each cycle:

- **Public participation.** To encourage early and broad public input, NQF incorporates a comment period before the setting-specific workgroup and advisory group meetings to gather stakeholder feedback immediately after CMS publicly releases the annual MUC List. In addition, NQF aims to maximize the length of public commenting periods on both the MUC List and draft recommendations (pending time constraints related to the MUC List publication and stakeholder availability for meeting dates). NQF provides open meetings and public commenting periods to maximize public input into MAP membership, its deliberations, and draft reports. For further transparency, NQF posts MAP information—including schedules that highlight opportunities for public participation—on NQF's public website.
- **MAP Member Guidebook.** The MAP Member Guidebook serves as a reference guide for all stakeholders involved with the MAP process. It contains background on NQF and MAP and serves as a central location for easy access to the measure selection criteria, MAP evaluation approach, standardized decision categories, and voting procedures. NQF staff update the Member Guidebook each year to reflect all new enhancements (such as the MSR process introduced in 2021), including a description of the review and voting processes, the updated PAs and decision categories, and any ongoing processes that may impact the workgroups' or advisory groups' review.
- **Measure selection criteria.** The MAP measure selection criteria identify characteristics associated with ideal measure sets for public reporting and payment programs. MAP uses the criteria to guide its recommendations, and the criteria are the basis for the evaluation algorithm that underlies the PAs. The measure selection criteria emphasize a central focus on the selection of high quality measures that optimally address national and CMS priorities, fill critical measurement gaps, and increase alignment across programs and payers.
- **Preliminary analyses.** To address stakeholder concerns about the timeline and volume of measures for review, NQF developed a PA approach that provides a succinct profile of each MUC. The PA is intended to provide MAP members with a profile of each measure and serves as

a starting point for MAP discussions. Staff review the format of the PA to ensure it captures all information of interest from the CMS MUC Entry/Review Information Tool (MERIT). As part of the MUC process, NQF compiles the PAs, public comments, and advisory groups' input into a user-friendly document that helps stakeholders navigate and review measure-specific information. For the 2021–2022 cycle, NQF staff explored ways to refine and improve the navigability of this document to further enhance its usability. For ease of reading, NQF added a footer to each page, simplified the table format into a bulleted narrative, and created groupings of measure information.

- **Standardized decision categories**. To ensure consistency in MAP's recommendations for each MUC cycle, NQF implemented a set of standardized decision categories and has refined them as needed based on input from CMS and other stakeholders. The MUC decision categories are based on evaluation criteria derived directly from the PA algorithm. The decision categories are "support for rulemaking," "conditional support for rulemaking," "do not support for rulemaking with potential for mitigation," and "do not support for rulemaking."
- **Standardized voting process.** MAP employs a standardized voting process to allow for more workgroup and advisory group discussion while maintaining consistency by ensuring the use of a uniform process across the committees. MAP utilizes a quorum procedure and consensus threshold for live voting to occur during meetings. Quorum is defined as 66 percent of the voting members of the committee present virtually for live voting to take place. MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting positively and a minimum of 60 percent of the quorum figure voting positively.

2.2.1.2 Measure Removal: Measure Set Review

Omnibus appropriations legislation in December 2020 (Section 102 of Division CC of the Consolidated Appropriations Act, 2021) included language granting the CBE providing input on the selection of quality and efficiency measures used in various Medicare programs the ability to also provide input on the removal of quality and efficiency measures. The purpose of MSR is to provide a holistic review of measures with multistakeholder input, thus easing the burden of an increased number of performance measures and continuing to educate and inform those who are interested in advancing measurement science. Initiated by CMS, NQF and CMS collaborated with the MAP Coordinating Committee to develop a process for a MSR pilot as part of the 2021–2022 MAP cycle. During the pilot, NQF focused on developing a review process and criteria for evaluating measures within federal programs. In 2022, NQF expanded the process to include the workgroups and advisory groups.

The process outlined here describes the process used for the 2022 review. Because MSR is a new process, it will likely evolve in the future.

1. **Identify measures for discussion of potential removal.** Advisory group and workgroup members nominate measures that they would like to discuss for potential removal via survey. They use measure review criteria as the rationale for nominating measures. NQF staff analyze the results of the survey and select measures for discussion in the review meetings. NQF staff then complete a measure summary sheet for each measure selected for discussion.
2. **Review preliminary recommendations.** MAP advisory groups review and discuss the measures selected for discussion and provide input on the rural perspective and measurement issues affecting health disparities. MAP workgroups meet to review and discuss the measures selected for discussion, taking into account feedback from the advisory groups. The workgroups make an initial recommendation to the Coordinating Committee for each measure being discussed. After

a public commenting period ends, the Coordinating Committee meets to review the workgroup recommendations and finalize the input to HHS.

3. **Release reports of MAP's recommendations.** MAP issues a series of reports detailing its recommendations. MAP also issues a list of measures with MAP's corresponding recommendations, as well as a final report summarizing the MSR process and MAP meeting discussions.

Like the key elements developed for the MUC process, NQF staff have deployed a series of key elements for MSR that will continue to be refined cycle to cycle:

- **Public participation.** As with the MUC process, NQF incorporates a comment period before the setting-specific workgroup and advisory group meetings to gather stakeholder feedback on the list of measures identified for discussion by the advisory group and workgroup members via survey. In addition, NQF aims to maximize the length of public commenting periods on both the list of measures under review and draft recommendations (pending time constraints related to the identification of measures for discussion and stakeholder availability for meeting dates). NQF provides open meetings and public commenting periods to maximize public input into MAP membership, its deliberations, and draft reports. For further transparency, NQF posts MAP information—including schedules that highlight opportunities for public participation—on NQF's public website.
- **MAP Member Guidebook.** NQF released an appendix to the MAP Member Guidebook describing the MSR process for 2022. The appendix serves as a reference guide for all stakeholders involved with the MAP process. It contains background on NQF and MAP and serves as a central location for easy access to the measure review criteria, MAP evaluation approach, standardized decision categories, and voting procedures. The MAP Member Guidebook, and possibly the appendix, will need to be updated in the future as the MSR process changes.
- **Measure review criteria.** In 2021, NQF developed the pilot measure review criteria (MRC) in collaboration with CMS and the MAP Coordinating Committee. The criteria were initially based on existing CMS measure removal criteria and were further refined during the pilot process. After the completion of the pilot cycle, NQF incorporated the Coordinating Committee's feedback in order to update the criteria for the 2022 MSR.
- **Measure summary sheets.** To provide stakeholders with information about the measures selected for discussion and to support stakeholder reviews, NQF developed measure summary sheets (MSSs). These sheets are intended to provide MAP members with a succinct profile of each measure, including available reporting and performance data, endorsement status, MAP review history, and public comments.
- **Standardized decision categories**. In 2021, NQF developed an initial voting process for the Coordinating Committee to use during MSR. Committee members voted, indicating support for removing the measure from the program using a "yes" (remove) or "no" (do not remove) vote. After the completion of the pilot cycle, NQF incorporated the Coordinating Committee's feedback in order to update the decision categories for the 2022 MSR. For the 2022 MSR, the voting categories are "support for retaining," "conditional support for retaining," "conditional support for removal," and "support for removal."
- **Standardized voting process.** The MSR standardized voting process aligns with the voting process used for MUC. MAP utilizes a quorum procedure and consensus threshold for live voting to occur during meetings.

3. MAP Timeline and Process Improvements

This award included five MUC cycles, beginning in September 2017, and continuing through March 2022. Outside of this, the MAP team piloted the MSR process in the fall of 2021 and held a complete MSR cycle in the summer of 2022.

Table 1 below shows a high-level overview of each MAP cycle included in the TO. The number of committees convened includes the setting-specific workgroups, advisory groups, and Coordinating Committee, while the Experts Engaged category describes the number of organizations and subject-matter experts who participate in MAP on one of the committees. Each MAP cycle is broken down in more detail in the report.

Table 1. Pre-rulemaking Process Year-Over-Year Summary

Descriptor	Base Year (9/27/2017-3/26/2019)	Option Year 1(3/27/2019-3/26/2020)	Option Year (OY) 2 (3/27/2020-3/26/2021)	Option Year (OY3) (3/27/2021-9/26/2022)	Notes
Committees Convened	4	5	5	6	*
Experts Engaged	159	131	146	161	*
Organizations Engaged	89	113	92	119	*
Measures Reviewed	35 measures (2017-2018) 39 measures (2018-2019)	18	20	29	Note: This is the number of unique measures reviewed. For example, the OY3 report calls out that several measures were cross-cutting (multiple categories), making the total number of reviewed measures to be 44.
Total Meetings	20	18	14	28	OY3 still in progress

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Table 2 below provides an overview of the number of measures reviewed during the MSR Pilot Year (2021) and the first MSR full cycle (2022). The information below is further expanded upon later in the report.

Table 2. MSR Year-Over-Year Measure Summary

Descriptor	MSR Pilot Year	MSR 2022	Notes
Committees Convened	1 (Coordinating Committee only)	6	*
Experts Engaged	23	141	*
Organizations Engaged	18	96	*
Measures Reviewed	22	32	Note: These measures will be considered by the MAP Coordinating Committee on August 25, 2022.
Total Meetings	3	7	*

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The MAP process includes a series of meetings and activities held in each cycle, both internal and public facing. Given the time, scheduling, and contractual constraints within the cycles, NQF leveraged the contract parameters to implement the most efficient and effective process within these constraints. This meeting series evolved over the years and the list below denotes what is now the standard process. Meetings and activities on this list not including each year are noted in their respective descriptions. Unless otherwise stated, all meetings listed below are held as part of MUC and MSR.

Public facing:

- Call for Nominations to seat new committee members each year, followed by public comment on the draft roster ahead of finalization
- Strategic meetings with the Coordinating Committee to discuss processes, lessons learned, and evaluation/review criteria
- MUC-specific orientation meetings for multistakeholder group members (these webinars orient new members to the MAP process, specific to each setting-specific workgroup and advisory group); this also includes an All-MAP Orientation for cross-cutting processes
- MUC-specific orientation meetings for measure developers and the public about the multistakeholder MUC List Review process (added as part of the 2020–2021 MUC cycle, this meeting provides education to new and experienced measure developers and the general public who are interested in learning more about the process, evaluation criteria, and structure of MAP)
- MSR-specific education meeting (added as part of the 2021 pilot and continued in 2022, this meeting orients workgroup and advisory group members to the MSR process and goals);
- MSR-specific measure steward prep call (added as part of the 2022 MSR, this meeting provides education to new and experienced measure developers about the MSR process and the role of measure stewards/developers in the process)
- Public comment on the MUC and MSR lists ahead of each round of review meetings
- Rural Health and Health Equity Advisory Group meetings to review the MUC and MSR lists and provide feedback (Rural Health met for the first time in 2019; the Health Equity Advisory Group was first convened for the 2021–2022 MUC cycle)
- Setting-specific multistakeholder group review meetings (i.e., Clinician, Hospital, and PAC/LTC Workgroup meetings) to review the MUC and MSR lists and make recommendations

- Public comments on the draft Recommendations Spreadsheet incorporating advisory group and workgroup input
- Coordinating Committee meeting to review MUC and MSR list recommendations made by the workgroups and advisory groups.

Internal (between NQF and CMS):

- Task Order Kickoff meeting with CMS at the start of each contract period to discuss the upcoming MUC and MSR cycles, including timeline, strategic aims, and operational approach
- Planning meetings with CMS Program and Measure Leads to discuss the upcoming MUC and MSR cycles, known changes to measures or programs, and the role of CMS partners in orientation meetings
- Setting-specific multistakeholder group prep meetings with CMS Program and Measure Leads to discuss PAs for the measures included on the MUC List and MSSs for MSR and strategizing for anticipated questions and discussions that may arise during review meetings
- Debriefing with CMS following each MUC and MSR cycle to discuss lessons learned, strategy, and continuing improvements for the next cycle (a debrief was not held for the 2022 MSR)

The MAP process involves the publication of several spreadsheets and reports. These spreadsheets and reports are listed and linked in the Appendix. Each year, the MAP team published the following information (unless otherwise noted; MSR reports and spreadsheets were only published in 2021 and 2022):

- MUC: MUC List (published by CMS and cross-posted to the NQF website for public comment)
- MSR: Spreadsheet for Public Comment (initial list of measures nominated for discussion posted to the NQF website for public comment); published for the pilot in 2021 and in 2022
- MAP Preliminary Recommendations Spreadsheet (MUC and MSR)
    - This spreadsheet is posted for the public commenting period before the creation of the final version.
- MAP Final Recommendations Spreadsheet (MUC and MSR)
- Final Recommendations Report containing considerations for implementing measures in federal programs or removing measures from federal programs (MUC and MSR)

Note: The structure of the Recommendations Spreadsheets and Recommendations Reports has evolved through the years; these changes are mentioned in each cycle description below.

Below is a summary of work for each award cycle, with an emphasis on the process changes year over year.

3.1 Base Year (2017–2018 and 2018–2019 Cycles)

This cycle began with the award of the MAP five-year contract, beginning in September of 2017, leveraging the completed nominations period from the last period of performance in the prior contract to sit the committees. The MAP team generated a workplan outlining the approach through the next two MUC cycles (2017–2018 and 2018–2019 cycles). This approach is described in the MUC Process section above, albeit without the advisory groups, as they were introduced in later years.

In September 2017, the MAP team introduced the PA, a document highlighting critical information for each MUC, which facilitates MAP members' review of measures and meeting discussions. The PA process was created to ensure accurate information regarding each measure was in front of NQF staff,

CMS, and the public ahead of the meetings. Over time, the PA has evolved into the single most important NQF tool/analysis for MAP deliberations. During the PA development process, the MAP team analyzes each measure, makes recommendations to the workgroups about a decision category for each measure, and identifies potential challenges with the measure to facilitate discussion and highlight relevant information. This process allows the MAP team to identify measures that could generate lengthy discussion ahead of the workgroup and later advisory group meetings.

In this cycle, the MAP team hosted the meetings outlined above with the following modifications:

- The Recommendations Spreadsheet was introduced in the 2020–2021 cycle. Prior to that, and as part of this 2017–2018 cycle, the MAP team drafted and posted for public comment a separate report containing recommendations from each of the setting-specific workgroups: Clinician, Hospital, and PAC/LTC.
- As the process evolved, the abovementioned Recommendations Spreadsheet was developed to allow for ease of use and a streamlined approach. This spreadsheet provides the recommendations given in the workgroup (and later advisory group as they were added) meetings and is posted for public comment. Additionally, the separate workgroup reports were combined into a single Recommendations Report, which incorporates the public comments from the Recommendations Spreadsheet and provides a greater context for the decisions made.

The MAP team then began the process of nominations for the next cycle, accepting applications and publishing the roster for public comment. This carried the MAP team into the pre-rulemaking cycle for the following year (2018–2019).

3.2 Base Year (2018–2019 Cycle)

The second half of the Base Year period of performance took place from September 2018 – March 2019 and completed another full MUC cycle. As a part of an ongoing process improvement approach adopted by NQF, the MAP team implemented the following changes:

- **Standardized decision categories**. To ensure consistency in MAP's recommendations, NQF refined a set of standardized decision categories as needed based on input from CMS and other stakeholders. In the 2018–2019 cycle, NQF implemented the category of "do not support with potential for mitigation" and eliminated the category of "refine and resubmit." This change was intended to clarify the intent of the categories.
- **Revised voting process**. In the 2018–2019 cycle, NQF implemented a revised voting process intended to simplify the process and allow for more workgroup discussion while maintaining consistency and ensuring the use of a standardized process across the committees.

For the 2018–2019 pre-rulemaking cycle, NQF continued to implement activities to improve MAP members' understanding of the pre-rulemaking process and CMS quality initiatives. NQF invited all MAP members to attend CMS' pre-rulemaking series of meetings. Additionally, NQF worked with CMS to refine and implement the communication plan to ensure all stakeholders were engaged throughout the process. This plan focused on promoting the attendance of non-CMS measure stewards and developers at MAP workgroup and Coordinating Committee meetings. Lastly, NQF revised definitions for the decision categories and clarified the review processes as needed. These changes were reflected in all subsequent iterations of the MAP Member Guidebook.

In this cycle, the MAP team hosted the same series of meetings and followed the same reporting and publication structure as the 2017–2018 cycle.

The MAP team then began the process of nominations for the next cycle: accepting applications and publishing the roster for public comment. This carried the MAP team into the pre-rulemaking cycle for Option Year 1.

3.3 Option Year 1 (2019–2020)

Option Year 1 ran from March 2019 – March 2020. Based on feedback obtained from briefing meetings with CMS to review lessons learned and gather feedback on opportunities for future improvements, NQF refined the pre-rulemaking process in numerous ways to increase efficiency and enhance the usefulness of MAP's input. Changes implemented at this stage included the following:

- **Rural Health Workgroup added to MAP.** The Rural Health Workgroup was initially seated as a committee under a separate TO and was then invited to participate in the 2019 MAP MUC List Review meetings to provide their unique perspective. The name was changed from workgroup to advisory group in 2021 to delineate between voting and non-voting members.
- **Preliminary Analyses**. To address stakeholder concerns about the timeline and volume of measures for review, NQF continued to refine the PA approach providing a succinct profile of each MUC.
- **Discussion Guide**. NQF compiled the PAs into a user-friendly electronic document that helped stakeholders navigate details during review meetings and review measure-specific information.

In this Option Period, the MAP team hosted the same set of meetings outlined above with the following modifications:

- An additional Orientation and MUC List Review meeting for the Rural Health Workgroup

This cycle continued the Base Year process of publishing three setting-specific reports for each workgroup. The MAP team then began the process of nominations for the next cycle: accepting applications and publishing the roster for public comment. This carried the MAP team into the pre-rulemaking cycle for Option Year 2.

3.4 Option Year 2 (2020–2021)

Option Period 2 ran from March 2020 – March 2021. This Option Period occurred at the height of the COVID-19 pandemic, impacting the MAP process, timeline, and content developed. Changes brought about by COVID-19 included the following:

- **Transition to a virtual platform.** The MAP team transitioned its in-person review meetings to a virtual platform to facilitate social distancing. This change carried over into the next option year (2021–2022).
- **Delay of the MUC List.** The MUC List release was delayed in 2020. The MAP team developed and implemented timeline contingency plans to maintain both the integrity of the process and meet statutory deadlines.
- **Combination of workgroup meetings.** Due to the delays to the MUC List release, the MAP team combined the Hospital and PAC/LTC Workgroup meetings for the first half of their respective

review meetings, then split for their setting-specific reviews for the second half. This allowed the team to deliver the Recommendations Spreadsheet and Recommendations Report on schedule.
- **COVID-19 measures under discussion**. To allow for greater discussion among the Coordinating Committee, NQF hosted an additional meeting to continue review of the COVID-19 measures. This meeting did not affect or change the recommendations of the workgroups.

Based on the feedback received from briefing meetings with CMS, NQF refined the pre-rulemaking process to increase efficiencies and enhance the usefulness of MAP's input. Changes implemented at this stage included the following:

- **Added time between the prep meetings with CMS and MUC List Review meetings.** The prep meetings occurred earlier in the cycle (two weeks ahead of the review meetings instead of one), allowing more time to review the PA documentation with measure leads and providing the opportunity to make edits.
- **Division of Rural Health meetings.** To review measures more effectively by program, the Rural Health Workgroup (changed to Advisory Group ahead of the 2021–2022 cycle) was split according to setting-specific expertise in alignment with the three workgroups. The Rural Health Workgroup met over three days to discuss each setting-specific topic (i.e., Clinician, Hospital, and PAC/LTC).
- **Addition of the Recommendations Spreadsheet and combination of final reports into one deliverable**. In this Option Year, initial workgroup recommendations (incorporating Rural Health input) were summarized in the first Recommendations Spreadsheet (versus the prior year report format), which was then posted for public comment ahead of the Coordinating Committee review meeting. The separate setting-specific reports were then streamlined into a single, comprehensive Recommendations Report, which was published later in the cycle. This format for both the spreadsheet and report carried over into Option Period 3.

All meetings from previous cycles were held in this virtual format. Final publications changed as noted above. With the conclusion of the 2020-2021 MUC cycle, the MAP team began work preparing for the next Option Year.

3.5 Option Year 3 (2021–2022)

MAP is currently in Option Period 3, which began in March 2021 and will conclude on September 26, 2022, following publication of this report. In this period, the MAP team completed nominations and hosted a complete MUC cycle from March 2021 – March 2022. Partway through Option Period 3, CMS proposed a contract modification to include the addition of the Health Equity Advisory Group and develop a process for discussion of potential measures for removal, known as MSR. MSR was piloted with the Coordinating Committee concurrent to the 2021 MUC cycle. Following the 2021 pilot, NQF hosted a full MSR cycle from March 2022 to September 2022. Below is a summary of each component of this Option Year.

3.5.1 Measure Set Review Pilot (2021)

To establish and execute the MSR process, NQF partnered with CMS to accomplish the following:

1. **Develop measure review criteria as part of the MSR pilot.**
2. **Pilot the process to review measures in federal quality programs**. Only the Coordinating Committee participated in the 2021 pilot; all workgroups and advisory groups were included in the 2022 MSR cycle.

3. **Seek feedback on the MSR and update the process**. MAP reviewed the pilot MSR and measure review criteria and revised them based on feedback gathered from the Coordinating Committee.

With this plan in place, the MAP team hosted the following meetings:

- One TO Kickoff Meeting with CMS
- One Education Meeting summarizing the purpose and processes of MSR
- One two-day review meeting with the Coordinating Committee

After the completion of the MSR pilot, the MAP team submitted a Final Recommendations Spreadsheet and Final Recommendations Report to CMS.

3.5.2 MUC Cycle (2021–2022)

The 2021–2022 MUC cycle incorporated the changes implemented in the previous year, both from process improvement and COVID-19 risk mitigation standpoints. Improvements implemented in this cycle included the following:

- **Transitioning Rural Health from a workgroup into an advisory group** (denoting voting versus non-voting).
- **Refining the Preliminary Analysis template**. To address stakeholder concerns about the timeline and volume of measures for review, NQF continued to refine the PA approach, providing a succinct profile of each MUC.
- **Seating and convening the Health Equity Advisory Group.** To capture this unique perspective, NQF convened the Health Equity Advisory Group, which met before the workgroup meetings (the same week as the Rural Health meeting), to provide insight on the MUC List with respect to health equity and health disparities. To support this convening, NQF developed a new polling scale specific to the Health Equity Advisory Group charge. This information was then incorporated into the PAs, along with the input provided by the Rural Health Advisory Group, and redistributed ahead of the workgroup meetings. This allowed for a more comprehensive discussion with the workgroups.

All meetings as noted above were held as part of this MUC cycle, with the addition of a Measure Developer Orientation and Health Equity Advisory Group MUC List Review Meeting. This MUC cycle concluded with the publication of the Recommendations Spreadsheet and Recommendations Report.

With the conclusion of the MUC cycle, the MAP team immediately began work on the implementation of the full MSR cycle (2022).

3.5.3 2022 Measure Set Review

With the completion of the pilot, the MAP team executed a full MSR cycle from March 2022 – September 2022. NQF and CMS worked closely together to define the meeting cadence, measure specifications, and measure analysis required for a full MSR. The MSR process included the following:

- **A multistep measure selection process**. First, NQF generated a global list of measures from the programs selected for the 2022 MSR. NQF staff then developed a survey with the list of measures from the identified programs. Workgroup and advisory group members nominated

measures to discuss for removal via the survey, using the measure review criteria as rationale for nomination. Once NQF received this input and finalized the list of measures for removal, the list was then posted for public comment.

- **Measure summary sheet**. NQF formulated an MSS for each measure. The MSS provides MAP members with a succinct profile of each measure, including available measure reporting and performance data, endorsement status, MAP history, program alignment, and public comments.
- **Standardized decision categories**. The MSR decision categories are based on evaluation criteria determined from the measure review criteria. In the 2022 cycle, MAP reviewed and further refined the MSR decision categories based on Coordinating Committee feedback gathered during the Coordinating Committee strategic meeting.
- **Standardized voting process.** MAP employs a standardized voting process for both MUC and MSR to allow for more workgroup and advisory group discussion while maintaining consistency by ensuring the use of a uniform process across the committees. MAP utilizes a quorum procedure and consensus threshold for live voting to occur during meetings.

In this cycle, MAP hosted the following meetings:

- One CMS Planning Meeting
- One Coordinating Committee Strategic Meeting
- One Prep Meeting With CMS Program and Measure Leads
- One MSR All MAP Education Meeting
- Two Advisory Group Review Meetings
- Three Workgroup Review Meetings
- One Coordinating Committee Review Meeting

NQF will publish the Recommendations Spreadsheet and Final Recommendations Report in September 2022.

While completing the MSR cycle, the MAP team also hosted nominations to seat the committees for the next MUC cycle.

4. Accomplishments and Final Deliverables

4.1 Measure Applications Partnership Base Year (2017–2018 Cycle)

4.1.1 2018 Pre-rulemaking Input

For the 2017–2018 MUC cycle, MAP made recommendations on 35 MUCs for eight HHS quality reporting and value-based payment programs covering ambulatory, acute, and PAC/LTC settings. The MAP recommendations for the 2017–2018 MUC cycle are described below in Table 3.

Table 3. 2017–2018 MAP Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	3	Support for Rulemaking
Clinician Workgroup	MIPS	17	Conditional Support for Rulemaking
Clinician Workgroup	MIPS	2	Refine and Resubmit

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Medicare Shared Savings Program (SSP)	3	Conditional Support for Rulemaking
Hospital Workgroup	End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	1	Support for Rulemaking
Hospital Workgroup	ESRD QIP	2	Conditional Support for Rulemaking
Hospital Workgroup	Prospective Payment system (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	1	Support for Rulemaking
Hospital Workgroup	Ambulatory Surgery Center Quality Reporting (ASCQR) Program	1	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Outpatient Quality Reporting (OQR) Program	1	Do Not Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program / Medicare and Medicaid Promoting Interoperability Programs	2	Conditional Support for Rulemaking
Hospital Workgroup	Hospital IQR Program/ Medicare and Medicaid Promoting Interoperability Programs	1	Refine and Resubmit
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	1	Support for Rulemaking

4.1.1.1 MAP Clinician Workgroup

An overarching theme of MAP's pre-rulemaking recommendations for measures in the MIPS and the Shared Savings Program was the need to balance driving improvements with accurate and actionable measurement. MAP recognized the tension between developing measures that address important outcomes and costs and concerns about accuracy and a clinician's locus of control. MAP members emphasized the importance of appropriate attribution and adequate risk adjustment. MAP members noted that measures that give actionable information are more likely to be acceptable to clinicians.

MAP emphasized the need to ensure that the information generated by these measures is actionable and allows clinicians to understand how they can improve their performance. MAP members encouraged CMS to provide detailed data to clinicians, as detailed data are more actionable for clinicians than an aggregated measure score alone. MAP also emphasized the importance of providing equitable care and that appropriate risk adjustment can help ensure that clinicians who care for more complex and vulnerable patients are not unfairly penalized with lower measure scores for factors that these clinicians cannot control.

4.1.1.2 MAP Hospital Workgroup

The MAP Hospital Workgroup noted the need to promote alignment and harmonization to reduce provider burden and provide better information to patients. MAP noted the need to balance addressing cost and quality issues through measurement with the finite resources available. MAP commented that greater alignment across public and private payers is a strategy to minimize the burden of measurement while maximizing the power of value-based purchasing incentives. Aligned measures could also help consumers make more informed choices about where to seek high quality care, especially for treatments that could be provided in different settings.

4.1.1.3 MAP PAC/LTC Workgroup

The MAP PAC/LTC Workgroup noted that important progress has been made in addressing critical measurement gaps but that important concepts remained unmeasured. In particular, MAP emphasized the importance of care coordination in post-acute and long-term care, as patients may frequently transition between sites of care. The PAC/LTC Workgroup also provided guidance on additional potential gaps in the Merit-Based Incentive Payment System (MIPS), noting that PAC and LTC clinicians may find it challenging to report measures that allow them to participate in the program.

4.2 Measure Science Application Partnership Base Year (2018–2019 Cycle)

4.2.1 MAP 2019 Pre-rulemaking Recommendations

For the 2018–2019 MUC cycle, MAP made recommendations on 39 MUCs for 10 CMS quality reporting and value-based payment programs covering ambulatory, acute, and PAC/LTC settings. A summary of this work is provided below. The MAP recommendations for the 2018–2019 cycle are described below in Table 4.

Table 4. 2018–2019 MAP Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	17	Conditional Support for Rulemaking
Clinician Workgroup	MIPS	3	Do Not Support with Potential for Mitigation
Clinician Workgroup	MIPS	1	Do Not Support for Rulemaking
Clinician Workgroup	Medicare Shared Savings Program (MSSP)	3	Conditional Support for Rulemaking
Clinician Workgroup	MSSP	2	Do Not Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	3	Conditional Support for Rulemaking
Hospital Workgroup	Prospective Payment system (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	1	Do Not Support with Potential for Mitigation
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	2	Conditional Support for Rulemaking

Workgroup	CMS Program	Number of Measures	Recommendation
PAC/LTC Workgroup	Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)	2	Conditional Support for Rulemaking
PAC/LTC Workgroup	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	2	Conditional Support for Rulemaking
PAC/LTC Workgroup	Home Health Quality Reporting Program (HH QRP)	2	Conditional Support for Rulemaking
PAC/LTC Workgroup	Hospice Quality Reporting Program (HQRP)	1	Do Not Support with Potential for Mitigation

4.2.1.1 MAP Rural Health Workgroup

In the fall of 2019, NQF convened the MAP Rural Health Workgroup (name changed to Advisory Group in 2021) to provide input to the CMS annual pre-rulemaking process, as recommended in the 2015 NQF report on rural health. The workgroup comprised experts in rural health; frontline healthcare providers who serve in rural and frontier areas, including tribal areas; and patients from these areas. The role of the workgroup is to provide rural perspectives on measure selection for CMS program use, including noting measures that are challenges for rural providers to collect data on or report about, and any unintended consequences for rural providers and residents. The workgroup reviewed and discussed the MUCs for various CMS quality programs. NQF provided a written summary of the workgroup's feedback to the Hospital, Clinician, and PAC/LTC Workgroups to aid in their review of the measures. A liaison from the Rural Health Workgroup attended each of the setting-specific workgroup meetings to provide additional input and represent the rural perspective.

4.2.1.2 MAP Clinician Workgroup

In the context of reviewing cost measures, MAP noted the need to reduce healthcare costs but cautioned that measures must be accurate and actionable. MAP noted that CMS and NQF's Cost and Efficiency Standing Committee should continue to evaluate the risk adjustment model and attribution models for appropriateness and ensure that cost measures truly address factors within a clinician's control. MAP also emphasized the importance of completing measure testing at the clinician level of analysis prior to implementation in the MIPS program.

4.2.1.2.1 Key Themes From the Pre-rulemaking Review Process – One overarching theme of MAP's pre-rulemaking recommendations for measures in the MIPS and the SSP emphasized appropriate attribution and level of analysis for the measures considered. MAP recognized the need to appropriately assign patients and their outcomes to the appropriate accountable unit (e.g., a clinician, a group of clinicians, or an ACO) for performance measures that are incorporated into payment programs. MAP members noted that measures that give actionable information are more likely to be acceptable to clinicians.

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) requires that cost measures implemented in MIPS include consideration of clinically coherent groups; specifically, patient condition groups or care episode groups. Through its pre-rulemaking work,

MAP emphasized the importance of aligning cost and quality measures to truly understand efficiency while protecting against potential negative unintended consequences of cost measures, such as the stinting of care or the provision of lower quality care. MAP provided several recommendations to safeguard the quality of care while measuring the cost of the care provided. These follow below:

- First, MAP recommended that measures that serve as a balance to cost-of-care measures be incorporated into the program when feasible. These balancing measures could include clinical quality measures, efficiency measures, access measures, and appropriate use measures.
- In addition to focusing on the quality of the care provided, MAP stated that CMS should continually monitor for signs of inequities in care. MAP specifically noted a concern for stinting on care, which would disproportionately impact higher-risk patients.
- Relatedly, MAP recommended clinical and social risk adjustment models to incentivize providers who demonstrate expertise when dealing with increased risk.
- Lastly, MAP commented on the need to link clinician behaviors to cost.

MAP members appreciated that CMS used technical expert panels (TEPs) to determine which components of cost an assessed clinician or group can control. MAP reinforced the need for this process to be transparent and understandable to clinicians who are being evaluated.

4.2.1.3 MAP Hospital Workgroup

4.2.1.3.1 Key Themes From the Pre-rulemaking Review Process – The MAP Hospital Workgroup noted an increasing need to align the measures included in the various hospital and setting-specific programs. Providers are performing a growing number of surgeries and/or procedures across the various settings that traditionally occurred in the inpatient setting (i.e., hospital operating room). MAP recognized that patients and their families might face challenges in distinguishing between inpatient and outpatient services while making informed choices about their care. MAP also noted CMS' focus on minimizing the duplication of measures across programs while focusing on measures in high-priority areas. MAP highlighted the importance of providing patient-focused care that aligns with patient and family preferences and recommended that future high-priority measures include patient- and family-focused care that aligns with the patient's overall condition, goals of care, and preferences.

4.2.1.4 MAP PAC/LTC Workgroup

4.2.1.4.1 Key Themes From the Pre-rulemaking Review Process – MAP noted that patients requiring post-acute and long-term care are clinically complex and may frequently transition across sites of care. As such, quality of care is an essential issue for PAC and LTC patients. Performance measures are vital to understanding healthcare quality, but measures must be meaningful and actionable if they are to drive true improvement.

MAP highlighted that patients who receive care from PAC and LTC providers frequently transition between sites of care. Patients may move among their home, the hospital, and PAC or LTC settings as their health and functional status change. Improving care coordination and the quality-of-care transitions is essential to improving post-acute and long-term care. MAP members appreciated that the measures allow for the current technology limitations in PAC/LTC settings by allowing for multiple modes of transmission of the required medication list.

MAP members recommended that CMS ensure that the measures appropriately address situations such as a patient leaving against medical advice or a transfer to an emergency department (ED). MAP also noted that the measures should ensure a timely transfer of information so that patients and receiving providers can ensure that they have the medications and equipment needed for a safe and effective transition of care. MAP stressed the importance of ensuring that measures produce meaningful information for all stakeholders. Measures should focus on areas that are meaningful to patients as well as clinicians and providers. MAP emphasized a need for measures that are person centered and address aspects of care that are most meaningful to patients and families. MAP members noted the need to engage patients and families in quality improvement efforts.

4.3 MAP Option Period 1 (March 2019 – March 2020)

4.3.1 MAP 2019–2020 Pre-rulemaking Recommendations

For the 2019–2020 MUC cycle, MAP made recommendations on 18 MUCs for nine CMS quality reporting and VBP programs covering ambulatory, acute, and PAC/LTC settings. This was the inaugural year of MAP's review of Part C and D MUCs. The MAP recommendations for the 2019–2020 MUC cycle are described below in Table 5.

Table 5. 2019–2020 MAP Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	1	Support for Rulemaking
Clinician Workgroup	MIPS	2	Conditional Support for Rulemaking
Clinician Workgroup	MIPS	1	Do Not Support With Potential for Mitigation
Clinician Workgroup	Medicare Shared Savings Program (SSP)	1	Conditional Support for Rulemaking
Clinician Workgroup	Medicare Part C and D Star Ratings	2	Support for Rulemaking
Clinician Workgroup	Medicare Part C and D Star Ratings	2	Conditional Support for Rulemaking
Clinician Workgroup	Medicare Part C and D Star Ratings	1	Do Not Support
Hospital Workgroup	End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	1	Conditional Support for Rulemaking
Hospital Workgroup	Inpatient Psychiatric Facility Quality Improvement Program (IPFQR)	1	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	2	Conditional Support for Rulemaking

Workgroup	CMS Program	Number of Measures	Recommendation
Hospital Workgroup	Prospective Payment system (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	2	Support for Rulemaking
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Home Health Quality Reporting Program (HH QRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Hospice Quality Reporting Program (HQRP)	1	Conditional Support for Rulemaking

4.3.1.1 MAP Rural Health Workgroup

The Rural Health Workgroup reviewed and discussed this year's MUCs for various CMS quality programs. NQF provided a written summary of the workgroup's feedback to the Hospital, Clinician, and PAC/LTC Workgroups to aid in their review of the measures. To provide additional input and to represent the rural perspective, a liaison from the Rural Health Workgroup attended each of the setting-specific workgroup meetings. Several themes emerged that should be considered when assessing quality in the rural settings: a shortage of behavioral health specialists creating a challenge for ensuring timely follow-up for behavioral health appointments, difficulties in information exchange at some rural facilities due to a lack of integrated data systems, cost of electronic clinical quality measure (eCQM) reporting infrastructure, and reporting rules that are difficult for rural providers to meet. Additionally, the workgroup noted that there may be a lack of transportation options for patients in rural settings; therefore, telehealth options for medical visits are especially pertinent for patients in this setting. Low case-volume also continues to be a challenge for performance measurement in rural areas.

4.3.1.2 MAP Clinician Workgroup

Within the MIPS measure set, MAP identified several gaps, specifically in the areas of primary care, access, continuity, comprehension, and care coordination. MAP also suggested that CMS consider adding measures that determine whether a course of therapy is indeed the best for the patient to optimize reductions in cost and harm. MAP also emphasized measures of diagnostic accuracy and primary care patient-reported outcome measures (PROMs).

4.3.1.2.1 Key Themes From the Clinician Workgroup Pre-rulemaking Review Process – Two key overarching themes emerged from MAP's pre-rulemaking recommendations for measures in the MIPS, SSP, and the Part C and D Star Ratings.

First, MAP emphasized the importance of shared accountability for performance measures of avoidable hospital admissions, readmissions, and ED use that are incorporated into public reporting and payment programs. Clinicians and health systems have the potential to implement care interventions that can offset disease progression and reduce high-cost, low-efficiency healthcare. Measures of patient outcomes require balancing the goals of shared accountability of clinicians and health systems and the appropriate attribution of outcomes that can be influenced by each entity. MAP expressed concern that many care coordination measures are process measures that assess steps along a patient episode of care, but do not measure if all care is coordinated through a centralized and shared care plan for the patient.

MAP also acknowledged that these measures may be appropriate in early stages of transition toward truly coordinated, holistic, and individualized care. MAP recognized that addressing social determinants is a critical element to effective care coordination for patient transitions. However, MAP also noted the challenges with addressing these social determinants through measurement. Patient outcomes may be influenced by a patient's health status and sociodemographic factors in addition to healthcare services, treatments, and interventions. MAP acknowledged that data limitations and data collection burden may limit risk adjustment, but measures of accountability should monitor for any incorrect inferences about provider performance. Clinicians and health systems need information to understand differences in outcomes among patient cohorts to drive improvement; however, MAP suggested caution on performance assessments involving social determinants.

Second, MAP discussed the need for appropriate measures to address the opioid crisis. MAP noted that the current phase of the opioid crisis is predominantly driven by an increased uptake of fentanyl-laced heroin, leading to increases in overdose and death. MAP acknowledged an important shared responsibility for individual providers, health systems, and health plans to address issues of pain management and function as well as to identify and address issues associated with opioid use disorder (OUD). MAP emphasized that the proper metrics need to be applied across the U.S. healthcare system such that opioid overdose deaths continue to decline in a manner that is verifiable. Furthermore, the metrics applied must minimize undesirable consequences such, as needless suffering from pain, increases in other substance use disorders (SUDs), or transitioning from prescription to illegal drugs due to being unable to obtain appropriate pain medication. This includes the need for increased, appropriate co-prescribing of naloxone with opioids (for pain or for persons with OUD). Similarly, MAP called for better initial prescribing measures to balance the appropriate use of opioids for pain management with associated risks. Additionally, MAP identified the need in federal quality and performance programs to include new measures assessing patient-centered analgesia treatment planning, including appropriate tapering strategies to reasonably decrease or discontinue opioid treatment, measures of long-term recovery from OUD, and measures of physical and mental health comorbidities with OUD. These overarching themes emphasize the significance of care coordination and attribution as well as appropriate opioid measurement.

4.3.1.3 MAP Hospital Workgroup

4.3.1.3.1 Key Themes From the Hospital Workgroup Pre-rulemaking Review Process – Major themes from the MAP Hospital Workgroup discussions included the need for patient safety measures and the importance of a systems-view for measurement.

MAP highlighted the need for patient safety measures for each of the hospital and setting-specific program discussions. Patient safety-related events occur across healthcare settings and include healthcare-associated infections, medication errors, and other potentially avoidable events. The measures considered by MAP spanned a variety of patient safety topic areas, including preventable infection, preventable blood transfusion, reducing maternal morbidity, reducing hyperglycemia events, and preventing harm through follow-up post-discharge. MAP emphasized that patients and consumers value patient safety measures in public accountability programs, and facilities can improve patient safety through quality improvement programs. Even for measures that MAP considered this cycle but ultimately did not support, MAP members

stressed the importance of each overall patient safety quality concept and the quality improvement activities that the measure would encourage.

MAP also discussed the need for using a system-level measurement approach to capture the patient episode of care, identifying priorities in measurement across settings, and determining the appropriate accountable entity and setting. Measures specified for a single care setting that address system-level issues with shared accountability, such as follow-up visits and transitions of care, pose challenges in determining which entity should be measured and how. MAP concluded that while it is necessary to review measures using a setting-specific approach, there is also a need to examine measures from a system-level perspective. MAP noted that a system-level approach also requires the transfer of health information and use of eCQMs. MAP supported CMS' efforts to drive towards digital measures and cited eCQMs as one tool to assist in the reduction of measurement burden.

4.3.1.4 MAP PAC/LTC Workgroup

4.3.1.4.1 Key Themes From the PAC/LTC Workgroup Pre-rulemaking Review Process – MAP noted that patients requiring post-acute and long-term care are clinically complex and therefore may frequently transition across sites of care. MAP's discussion of the PAC/LTC settings and programs focused on the following themes: capturing the voice of patients through PRO-PMs, making electronic health records (EHRs) and eCQMs more useful, and identifying measurement opportunities for the PAC/LTC population.

MAP identified PROs as one of the most important priorities for PAC/LTC programs. Thoughtfully soliciting and incorporating the voice of the patient into quality measurement will contribute to the alignment of care with patient goals and preferences. MAP members noted that traditional care goals focusing on improvement in function and health status may not be appropriate for the entire PAC/LTC population. The goal of care may be maintaining current functional status, limiting decline, and/or maximizing comfort. Assessment and measurement of patient goals should be an important focus in this population. MAP recommended thoughtful consideration of the burden associated with patient-reported outcome (PRO) completion. This burden should be balanced with the goal of providing information that is useful to patients to select providers and for providers to understand how to improve care.

Patients who receive care from PAC and LTC providers frequently transition among multiple sites of care. Patients may move among their home, the hospital, and other PAC or LTC settings as their health and functional status change. Improving care coordination and the quality-of-care transitions is essential to improving PAC and LTC. MAP identified care coordination as the highest-priority measure gap for PAC/LTC programs. MAP pointed out the potential of health information technology to improve quality and minimize the burden of measurement. MAP members also noted that EHR adoption in PAC/LTC settings often lags other care settings since PAC/LTC settings have had fewer incentives to implement new technology. Increased use of technology could help to improve transitions and the exchange of information across providers. MAP supported CMS in its effort to improve standardization and promote interoperability, specifically Health Level Seven's (HL7) Fast Health Interoperability Resources (FHIR) standards. MAP recommended that CMS work with vendors to improve EHR interoperability. Prioritizing interoperability across care settings will maximize its impact by allowing more organizations to

share and receive data. MAP members also cautioned about the potential burden introduced via technology. Specifically, MAP encouraged CMS to monitor the impact of auto-populating EHRs to fulfill regulatory or other nonclinical requirements. This additional auto-populated information can crowd out or obscure critical clinical information.

MAP identified nine concepts for measurement within all PAC/LTC programs: access to care, care coordination, chronic illness care (quality of life), interoperability, mental health, pain management, PROs, social determinants, and serious illness. MAP then prioritized the list, allowing two votes for each voting member present. The voting identified care coordination, interoperability, and PROs as the most important priorities for measurement for PAC/LTC programs. These key overarching themes highlight the importance of including the voice of the patient and patient-centered goals, the impact of technology and interoperability, and measurement opportunities for the PAC/LTC population.

4.4 MAP Option Period 2 (March 2020 –March 2021)

4.4.1 MAP Pre-rulemaking Recommendations

For the 2020–2021 MUC cycle, MAP made recommendations on 20 MUCs for eight CMS quality reporting and VBP programs covering ambulatory, acute, and PAC/LTC settings. The MAP recommendations for the 2020–2021 cycle are described below in Table 6.

Table 6. 2020–2021 MAP Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	4	Conditional Support for Rulemaking
Clinician Workgroup	MIPS	6	Do Not Support for Rulemaking With Potential for Mitigation
Clinician Workgroup	Medicare Shared Savings Program (SSP)	1	Conditional Support for Rulemaking
Hospital Workgroup	Crosscutting Measures	2	Conditional Support for Rulemaking
Hospital Workgroup	End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	1	Support for Rulemaking
Hospital Workgroup	Medicare and Medicaid Promoting Interoperability Programs	1	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	1	Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	1	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Outpatient Quality Reporting (Hospital OQR)	2	Conditional Support for Rulemaking

Workgroup	CMS Program	Number of Measures	Recommendation
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Hospice Quality Reporting Program (HQRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Inpatient Rehabilitation Quality Reporting Program (IRF QRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	1	Conditional Support for Rulemaking

4.4.1.1 Rural Health Advisory Group Recommendations

NQF works with the Rural Health Advisory Group to provide input on CMS' annual pre-rulemaking process. This advisory group provides input on issues that are particularly relevant 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). This advisory group consists of experts in rural health; frontline healthcare providers who serve in rural and frontier areas, including tribal areas; and patients from these areas. The aim of the Rural Health Advisory Group is to bring the rural health perspective to the annual pre-rulemaking process; identify rural-relevant gaps in measurement; and make recommendations on priority issues in rural health, such as low case-volume and access.

The Rural Health Advisory Group reviewed and discussed the 2020–2021 MUCs for various CMS quality programs. NQF provided a written summary of the advisory group's feedback to the Hospital, Clinician, and PAC/LTC Workgroups to aid in their review of the measures.

Key themes from the Advisory Group's discussion included the following:

- Elevated cost of care exists in rural areas due to limited availability of certain tools and treatments (e.g., specialized teams, home health services, and early intervention programs). There is also a tendency to identify disease at later stages (e.g., initial cancer diagnoses at more advanced stages). Cost measures should be paired with quality measures in the same topic area to prevent underutilization.
- Rural facilities with limited resources may need to transfer patients to an appropriate facility instead of performing all procedures on-site. Measures should account for transfers and different treatment modalities (e.g., measures that are scored on time-to-treatment OR time-to transfer).
- Shifts in care settings present measurement challenges in rural areas. Some procedures (e.g., total hip arthroplasties/total knee arthroplasties [THA/TKA]) are increasingly likely to be handled via outpatient/ambulatory services; therefore, measures limited to inpatient care may be subject to low case-volume challenges. Nonetheless, rural areas are still unlikely to have stand-alone ambulatory surgical centers (ASCs).

- To better capture the attribution of care in rural settings, measures should include nonphysician practitioners (e.g., physician assistants, nurse specialists), who play a more prominent role in rural areas.

The Rural Health Advisory Group also discussed rural-specific considerations for COVID-19 measures (e.g., high degree of vaccine hesitancy in rural areas), as well as the continued challenge of low case-volumes for many performance measures used in rural areas.

4.4.1.2 Clinician Workgroup Recommendations

4.4.1.2.1 Key Themes From the Clinician Workgroup Review

Themes that emerged within the MAP Clinician Workgroup related to COVID-19, cost measures, and the burden of measures include the following:

- The proposed Coronavirus 2 (CoV-2) Vaccination measure represents a promising effort to advance measurement for an evolving national pandemic. Collecting information on severe acute respiratory syndrome (SARS)-CoV-2 vaccination coverage and providing feedback to clinicians would facilitate benchmarking and quality improvement.
- While CMS is required by the MACRA of 2015 to implement cost measures within the MIPS program, there is concern related to explicit connections between cost and quality for measures that CMS is considering for MIPS. While the need to use appropriately correlated cost and quality measures together to assess health system efficiency is well established, there is currently no clear consensus among stakeholders on precisely how to do so.
- The move toward public-private payer alignment to decrease burden needs to be balanced with allowing for pockets of measurement innovation moving the quality enterprise forward. There is some resistance to PRO-PMs because they are more burdensome to collect. MAP encouraged CMS to provide support and infrastructure to ease the burden of data collection for PRO-PMs.

The measures reviewed by the Clinician Workgroup and its discussions support CMS' efforts to use outcome measures and PROs and to align measures across private and public entities. In addition, deliberations on the COVID-19 measures are critical to remaining current with the evolving environment and changing needs brought about by the pandemic. This continues to remain relevant as the pandemic has continued and as vaccines have become more available to clinicians and the public.

4.4.1.3 MAP Hospital Recommendations

4.4.1.3.1 Key Themes From the Hospital Workgroup Review

Key themes from the Hospital Workgroup pre-rulemaking review process related to COVID-19 vaccination monitoring for healthcare personnel, the use of composite measures, and care coordination include the following:

- COVID-19 measures can help patients understand the extent to which healthcare systems at the facility level are vaccinating their personnel and extending a measure of protection for their safety as well.
- Composite measures provide a comprehensive view of how a given provider is performing on a series of measures. Individual components of certain measures should not always be equally weighted.

- Care coordination across and among all providers helps to enable the most effective team-based care for patients. The ability to manage care and services has a direct impact on patient and caregiver burden and on patient readmissions.

The Hospital Workgroup's activities align with objectives to achieve seamless care coordination, wellness, and prevention and to use the highest value and highest-impact measures. The inclusion of COVID-19 measures is also critical to maintaining a timely response to a still-evolving pandemic.

4.4.1.4 MAP PAC/LTC Workgroup Recommendations

4.4.1.4.1 Key Themes From the PAC/LTC Workgroup Review

During the pre-rulemaking process, themes that emerged within the PAC/LTC Workgroup related to COVID-19 and care coordination include the following:

- Collecting recognized information on SARS-CoV-2 vaccination coverage among healthcare personnel and providing feedback to skilled nursing facilities (SNFs) will allow facilities to benchmark coverage rates and improve coverage in their respective facilities. Reducing the rates of COVID-19 in healthcare personnel will reduce transmission among patients and instances of staff shortages due to illness.
- Sharing information across care settings and throughout the entire care team promotes shared accountability for the quality of patient care. This sharing ensures that all clinicians on the care team have up-to-date and accurate information. Moreover, this information is necessary to provide safe, high quality care.
- Care coordination is vital to safe and effective care transitions for all patients. Coordination across and among all providers helps to enable the most effective team-based care for patients. Measuring care coordination beyond facility stays, including a referral to effective services after the stay, is important. Managing care and all the services after discharge has a direct impact on patient and caregiver burden and patient readmissions.

The high-impact measures reviewed during the MAP pre-rulemaking cycle and the emerging themes both align with the objective to create alignment across several programs. Specifically, these measures address the following CMS MM 2.0 Framework areas: safety and seamless care coordination.

4.5 MAP Option Period 3 (March 2021 – September 2022)

4.5.1 MSR Pilot

As described in the *Overview* section of this document, Subtitle A – Section 102 of the Consolidated Appropriations Act of 2020 granted the CBE 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. In 2021, NQF collaborated with CMS and the MAP Coordinating Committee to define a process for this review process called MSR. The initial cycle focused on developing a process for review and creating criteria for evaluating measures within federal programs. The process was implemented on a pilot basis in 2021 with measures considered only by the MAP Coordinating Committee.

In order to have a feasible goal during the pilot, Coordinating Committee members decided to focus the pilot on five selected hospital programs rather than the complete list of 20 programs for which MAP reviews measures. The specific hospital programs considered were as follows:

- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing (VBP) Program
- Hospital Inpatient Quality Reporting (Hospital IQR) Program

Coordinating Committee members selected up to 10 measures from the approximately 40 measures within these programs to recommend for discussion during the Coordinating Committee MSR meeting. The MAP Coordinating Committee ultimately reviewed 22 measures. The Coordinating Committee also provided feedback on the MSR pilot and suggested modifications to the criteria and processes for future iterations. The MAP recommendations for the 2021 MSR pilot are described below in Table 7.

Table 7. 2021 MSR Pilot Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Hospital Workgroup	Ambulatory Surgical Center Quality Reporting (ASCQR)	3	Support for Retaining
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	3	Support for Retaining
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	1	Support for Removal
Hospital Workgroup	Hospital Readmissions Reduction (HRR) Program	3	Support for Retaining
Hospital Workgroup	Hospital Value-Based Purchasing Program (VBP)	1	Support for Retaining
Hospital Workgroup	Hospital Value-Based Purchasing Program (VBP)	1	Support for Removal
Hospital Workgroup	Inpatient Rehabilitation Quality Reporting (IRFQR)	2	Support for Retaining
Hospital Workgroup	Inpatient Rehabilitation Quality Reporting (IRFQR)	8	Support for Removal

4.5.2 MAP Pre-rulemaking Recommendations

For the 2021–2022 MUC cycle, MAP made recommendations on 44 MUCs for 13 federal programs, including several cross-setting measures considered for multiple programs, resulting int 29 unique measures. The MAP recommendations for the 2021–2022 cycle are described below in Table 8.

Table 8. 2021–2022 MAP Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	1	Support for Rulemaking
Clinician Workgroup	MIPS	8	Conditional Support for Rulemaking
Clinician Workgroup	MIPS	1	Do Not Support for Rulemaking With Potential for Mitigation
Clinician Workgroup	Medicare Part C and D Star Ratings	1	Support for Rulemaking
Clinician Workgroup	Medicare Part C and D Star Ratings	2	Conditional Support for Rulemaking
Hospital Workgroup	Medicare Promoting Interoperability Programs for Hospitals	1	Support for Rulemaking
Hospital Workgroup	Medicare Promoting Interoperability Programs for Hospitals	3	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Value-Based Purchasing Program (VBP)	1	Support for Rulemaking
Hospital Workgroup	Hospital Value-Based Purchasing Program (VBP)	1	Conditional Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	3	Support for Rulemaking
Hospital Workgroup	Hospital Inpatient Quality Reporting (IQR) Program	8	Conditional Support for Rulemaking
Hospital Workgroup	Hospital-Acquired Condition Reduction Program (HACRP)	2	Conditional Support for Rulemaking
Hospital Workgroup	Prospective Payment system (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	3	Conditional Support for Rulemaking
Hospital Workgroup	End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	1	Do Not Support for Rulemaking

Workgroup	CMS Program	Number of Measures	Recommendation
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program	2	Support for Rulemaking
PAC/LTC Workgroup	Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program	2	Conditional Support for Rulemaking
PAC/LTC Workgroup	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	1	Support for Rulemaking
PAC/LTC Workgroup	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Inpatient Rehabilitation Quality Reporting Program (IRF QRP)	1	Conditional Support for Rulemaking
PAC/LTC Workgroup	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	1	Conditional Support for Rulemaking

4.5.2.1 Health Equity Advisory Group

NQF convened a new advisory group during the 2021–2022 MAP cycle: the MAP Health Equity Advisory Group. This new group will provide input on the MUCs, with measurement issues related to health disparities and critical access hospitals in mind. The aim of the Health Equity Advisory Group is to reduce health disparities closely linked with SDOH, such as social, economic, or environmental disadvantages. NQF received over 150 nominations for a seat on this advisory group. Of those nominations received, NQF selected 27 organizations and individuals, as well as five federal liaisons. This group is composed of stakeholders with expertise in heath disparities and quality measurement. This includes experience with topics such as quality of care related to age, sex, income, race, ethnicity, disability, literacy, sexual orientation, gender identity, geographic location, and the intersection of these factors.

4.5.2.2 Overarching Themes From 2021–2022 MAP Review Meetings

Throughout the 2021–2022 MAP cycle, overarching themes emerged from the workgroup, advisory group, and Coordinating Committee meetings. Measure alignment, health equity, risk adjustment, and PROs were common discussion topics heard throughout the cycle, not only from members, but also from public comments.

4.5.2.2.1 Improving measure alignment

MAP workgroup and Coordinating Committee members expressed a desire to evaluate measure performance across programs. The rates of performance across programs at the clinician level versus the accountable care organization (ACO) level were of particular interest. The MAP PAC/LTC Workgroup echoed the need for information transfers and not just within the silos of care settings (e.g., hospital to SNF). In the MAP Hospital Workgroup, CMS highlighted the

promotion of program alignment with the incorporation of digital measures into the Medicare Promoting Interoperability Program for Hospitals.

4.5.2.2.2 Measures for health equity that inspire action

Leveraging quality measures to promote equity is one of the five goals within the CMS Quality Measurement Action Plan. This cycle's addition of the MAP Health Equity Advisory Group further emphasizes the importance of this voice within the MUC process. All workgroups expressed enthusiasm for the focus on health equity in the 2021 MUC List. Workgroup members also encouraged CMS to consider measures for health equity that show strong connections to outcomes or that would ensure action by accountable entities.

The Health Equity Advisory Group agreed that equity needs to be considered throughout the process of measurement development rather than evaluated only at the end of testing and development. It noted that improving health equity will be an iterative process, and decisions should be made with the understanding that measures may need to be fine-tuned over time.

4.5.2.2.3 Risk adjustment and stratification of measures

The MAP workgroup and advisory group members emphasized the need for measures that include risk adjustment and stratification. They also expressed a need for clarification from CMS regarding the standardization of collection and meaningful use of data for stratification and the importance of sending results of this information back to facilities.

The Health Equity Advisory Group had a robust discussion involving the stratification of measures. It shared potential categories of stratification, including age, sex, race, ethnicity, English proficiency, gender identity, sexual orientation, visit type, insurance, disability, markers of economic disparities, rurality, and setting type. The Health Equity Advisory Group agreed that the goal is not to stratify all measures by all categories, but to stratify where appropriate. It also cautioned that stratification is a critical tool for investigating disparities; nonetheless, further thought is required regarding the incorporation of stratified results into payment programs.

4.5.2.2.4 Patient-reported outcome measures

The MAP workgroup and advisory group members commented on the need for person-centered and person-reported goals. They also agreed with the importance of the family/caregiver perspective and patient experience. The MAP PAC/LTC Workgroup noted the definition of quality is different for each individual, and unless that definition is integrated into measurement, individual needs will not be met. Additionally, the Health Equity Advisory Group highlighted the need for translation and validation of PRO-PM tools to minimize concerns regarding language, culture, and response bias. The consumer and caregiver voices are the foundation for CMS' Meaningful Measures 2.0 initiative, which helps to steer quality measures that drive value-based care.

4.5.2.3 Themes From the Clinician Workgroup

4.5.2.3.1 Alignment of the Shared Savings Program with the Alternative Payment Model Performance Pathway

The MAP Clinician Workgroup expressed concern for unintended consequences by reporting on all-payer data in the Medicare SSP, particularly for Federally Qualified Health Centers (FQHCs) or

those that care for a disproportionately disadvantaged population. The workgroup noted that social driver measures would fit well within the SSP.

4.5.2.4 Themes From the Hospital Workgroup

4.5.2.4.1 Implementation of measures into the Hospital Inpatient Quality Reporting Program before use within the Hospital Value-Based Purchasing Program

The MAP Hospital Workgroup and CMS clarified that by virtue of a statutory requirement, any measure intended for the VBP Program must first be implemented for at least one year in the Hospital IQR Program. MAP noted that since older versions of the measures are currently implemented in federal programs, it may be helpful for hospitals to receive communications to clarify why performance changes may occur in the future.

4.5.2.5 Themes From the PAC/LTC Workgroup

4.5.2.5.1 Infection control

Healthcare-associated infections (HAIs) continue to be one of CMS' high priorities for future measure consideration across multiple programs and settings. The topic of infection was discussed throughout the MAP cycle, with attention to the infection measures presented across multiple programs and settings. The MAP PAC/LTC Workgroup noted that the COVID-19 pandemic uncovered an underpreparedness and lack of resources related to infection control. The workgroup indicated that infection control resources and focus are currently being addressed, specifically for nursing homes; however, these resources have a limited time frame. The workgroup agreed with the need to align ongoing measurement that reflects overall infection control performance. Safety is a building block within CMS' Meaningful Measures 2.0 initiative.

4.5.2.6 2022 MSR

For the 2022 MSR, MAP made recommendations on 32 measures under review for six CMS quality reporting and VBP programs covering ambulatory, acute, and PAC/LTC settings. The MAP recommendations for the 2022 MSR are described below in Table 9.

Table 9. 2022 MSR Draft Recommendations

Workgroup	CMS Program	Number of Measures	Recommendation
Clinician Workgroup	Merit-Based Incentive Payment System (MIPS)	2	Support for Retaining
Clinician Workgroup	MIPS	3	Conditional Support for Retaining
Clinician Workgroup	MIPS	2	Conditional Support for Removal
Clinician Workgroup	Medicare Shared Savings Program (SSP)	2	Support for Retaining
Hospital Workgroup	Hospital Outpatient Quality Reporting	5	Consensus not reached due to lack of quorum
Hospital Workgroup	Ambulatory Surgical Center Quality Reporting (ASCQR)	1	Support for Retaining
Hospital Workgroup	ASCQR	1	Conditional Support for Retaining

Workgroup	CMS Program	Number of Measures	Recommendation
Hospital Workgroup	Prospective Payment system (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	1	Conditional Support for Retaining
Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup	Home Health Quality Reporting Program (HH QRP)	1	Support for Retaining
PAC/LTC	HH QRP	6	Conditional Support for Retaining
PAC/LTC	HH QRP	1	Conditional Support for Removal
PAC/LTC	HH QRP	2	Support for Removal

Key themes from the 2022 MSR will be included in the Final Recommendations Report, which will be published in late September 2022.

5. Obstacles Overcome and Lessons Learned

In addition to the process evolutions described in this document, NQF continually revised its operational approach to maximize efficiencies and expand and improve stakeholder engagement. Throughout each Option Period, NQF reviewed both internally and with CMS strategic improvements and lessons learned. Notable moments over the last five years include the following:

- Delays to the MUC List during the 2020–2021 cycle
    - The COVID-19 pandemic caused a delay to the publication of the MUC List during Option Period 2. NQF worked with CMS to develop multiple contingency plans to maintain the integrity of the process to the extent possible while meeting statutory deadlines. Through these combined efforts, the MAP team successfully submitted the Recommendations Spreadsheet on time.
- Implementation of the MUC List Review during the holiday corridor
    - Due to statutory limitations, the MUC List is published no later than December 1 of each year, with final recommendations to the Secretary due no later than February 1 of the following year. This timeline requires detailed communication with stakeholders and dedicated project staff to execute a series of all-day meetings during a busy holiday season. Preparation for these meetings begins early-to-mid fall, pending the availability of public information required to inform review meetings, which often leads to a significant amount of effort in a short amount of time. Through continued partnership with CMS and evolution of the process, NQF has successfully navigated these constraints year over year.
- Measures addressing critical topics
    - MAP faces an ongoing challenge of balancing the desire to recommend high quality, vetted measures into federal programs and the need to include measures addressing high-priority topic areas or conditions. Measures on the MUC List in any year may or may not have completed testing and development and may or may not have undergone a CBE endorsement process. While the focus of the MAP initiative is to identify suitable measures to address gaps and needs in federal programs, MAP members are reluctant to recommend measures that are not of proven quality, are not completely specified, or whose specifications may not be ideal. This conflicts with the desire to include measures addressing critical and time-sensitive healthcare issues, such as measures for COVID-19

vaccination that emerged in the 2021 cycle before completing testing and development. NQF was challenged with giving MAP the opportunity to provide feedback on these critical measures earlier in the development process. NQF continues to partner with CMS Program and Measure Leads and measure developers to provide MAP members with the best and most up-to-date information possible each year to ensure that MAP members make informed, balanced decisions about the appropriateness of each measure for inclusion in federal programs.

- New Measure Set Review process
    - NQF was tasked with developing both a pilot and full MSR process in Option Period 3. As with any pilot, the process continued to evolve and improve. Through the hard work of the staff and in partnership with CMS, NQF successfully implemented both the pilot and first full MSR cycle.
- Project management expansion
    - In January 2020, NQF launched the use of a standard project management approach aligned with the Project Management Institute's Project Management Body of Knowledge (PMBOK®) project performance domains: Development Approach & Life Cycle, Planning, Project Work, Delivery, and Measurement, Navigating Uncertainty, Stakeholder, and Team, which involved the addition of certified project managers.
    - This project management expansion included a transition to more sophisticated project management software, which allowed for more efficient management of deliverables, team assignments, and long-term planning.
- Report structure evolution
    - The final deliverables for the MAP team have evolved over the course of the last five years. Initially, NQF published a single report for each workgroup (i.e., Clinician, PAC/LTC, and Hospital). These reports were first posted for public comment and then published on the NQF website. Starting in Option Year 2, NQF combined the workgroup (including the Rural Health Advisory Group, with the Health Equity Advisory Group added in 2021) recommendations into two separate deliverables: the Recommendations Spreadsheet and Final Recommendations Report. Creation of the Recommendations Spreadsheet allowed for a streamlined submission of recommendations to the Secretary following all advisory, workgroup, and Coordinating Committee Review meetings. Publishing the Recommendations Report after the statutory deadline allows for greater detail, insight, and analysis of all recommendations.
- PA process development
    - The MAP team has worked to develop the PA process extensively over the last five years. Through multiple iterations, the MAP team has taken a basic fact sheet and transformed it into the most important NQF tool/analysis for MUC List deliberations. It codifies the MAP decision-making process, and supplies the data used by the workgroups/advisory groups to make their decisions. It also helps to identify measures that could generate lengthy discussions prior to the MAP deliberations to assist CMS and its contractors in preparing for the issues that are likely to plague specific MUCs.

NQF is proud to lead this important work with continued, focused effort and recognition of the impact it has on healthcare quality. This work could not be completed without the invaluable contributions of volunteer stakeholders and engagement of the public, and NQF applauds all who have been and continue to be involved.

6. Appendix

Below is a list of MAP reports by MUC or MSR cycle and the links to those reports.

2017–2018 MUC Cycle

- 2017–2018 Preliminary Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86759
- 2017–2018 Spreadsheet of Final Recommendations to HHS and CMS: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=86972
- MAP 2018 Considerations for Implementing Measures in Federal Programs – PAC-LTC: https://www.qualityforum.org/Publications/2018/02/MAP_2018_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx
- MAP 2018 Considerations for Implementing Measures Final Report – Hospitals: https://www.qualityforum.org/Publications/2018/02/MAP_2018_Considerations_for_Implementing_Measures_Final_Report_-_Hospitals.aspx
- MAP 2018 Considerations for Implementing Measures in Federal Programs – Clinicians: https://www.qualityforum.org/Publications/2018/03/MAP_2018_Considerations_for_Implementing_Measures_in_Federal_Programs_-_Clinicians.aspx

2018–2019 MUC Cycle

- 2018–2019 Preliminary Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89075
- 2018–2019 MAP Final Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89244
- MAP 2019 Considerations for Implementing Measures Final Report – PAC/LTC: https://www.qualityforum.org/Publications/2019/02/MAP_2019_Considerations_for_Implementing_Measures_Final_Report_-_PAC-LTC.aspx
- MAP 2019 Considerations for Implementing Measures Final Report – Clinicians: https://www.qualityforum.org/Publications/2019/03/MAP_Clinicians_2019_Considerations_for_Implementing_Measures_Final_Report.aspx
- MAP 2019 Considerations for Implementing Measures Final Report – Hospitals: https://www.qualityforum.org/Publications/2019/02/MAP_2019_Considerations_for_Implementing_Measures_Final_Report_-_Hospitals.aspx

2019–2020 MUC Cycle

- 2019–2020 MAP Preliminary Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=91734
- 2019–2020 MAP Final Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=91911
- MAP 2020 Considerations for Implementing Measures Final Report – Hospitals: https://www.qualityforum.org/Publications/2020/02/MAP_2020_Considerations_for_Implementing_Measures_Final_Report_-_Hospitals.aspx
- MAP 2020 Considerations for Implementing Measures Final Report – Clinician: https://www.qualityforum.org/Publications/2020/03/MAP_2020_Considerations_for_Implementing_Measures_Final_Report_-_Clinician.aspx

- MAP 2020 Considerations for Implementing Measures Final Report – PAC/LTC: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=92586

2020–2021 MUC Cycle

- 2020–2021 MAP Preliminary Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94589
- 2020–2021 MAP Final Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94650
- 2020–2021 MAP Considerations for Implementing Measures Final Report – Clinicians, Hospitals, PAC/LTC: https://www.qualityforum.org/Publications/2021/03/MAP_2020-2021_Considerations_for_Implementing_Measures_Final_Report_-_Clinicians,_Hospitals,_and_PAC-LTC.aspx

2021–2022 MUC Cycle

- 2021–2022 MAP Preliminary Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96688
- 2021–2022 MAP Final Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96698
- 2021–2022 MAP Considerations for Implementing Measures Final Report – Clinicians, Hospitals, and PAC/LTC: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96821

2021 MSR Pilot

- 2021–2022 MAP Final Recommendations Spreadsheet: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96152
- 2021–2022 MAP Considerations for Measure Set Removal in Federal Programs – Final Report: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=96238