NATIONAL QUALITY FORUM

Welcome to Today's Meeting!

- Housekeeping reminders:
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - Please raise your hand and unmute yourself when called on
  - Please lower your hand and mute yourself following your question/comment
  - Please state your first and last name if you are a Call-In-User
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

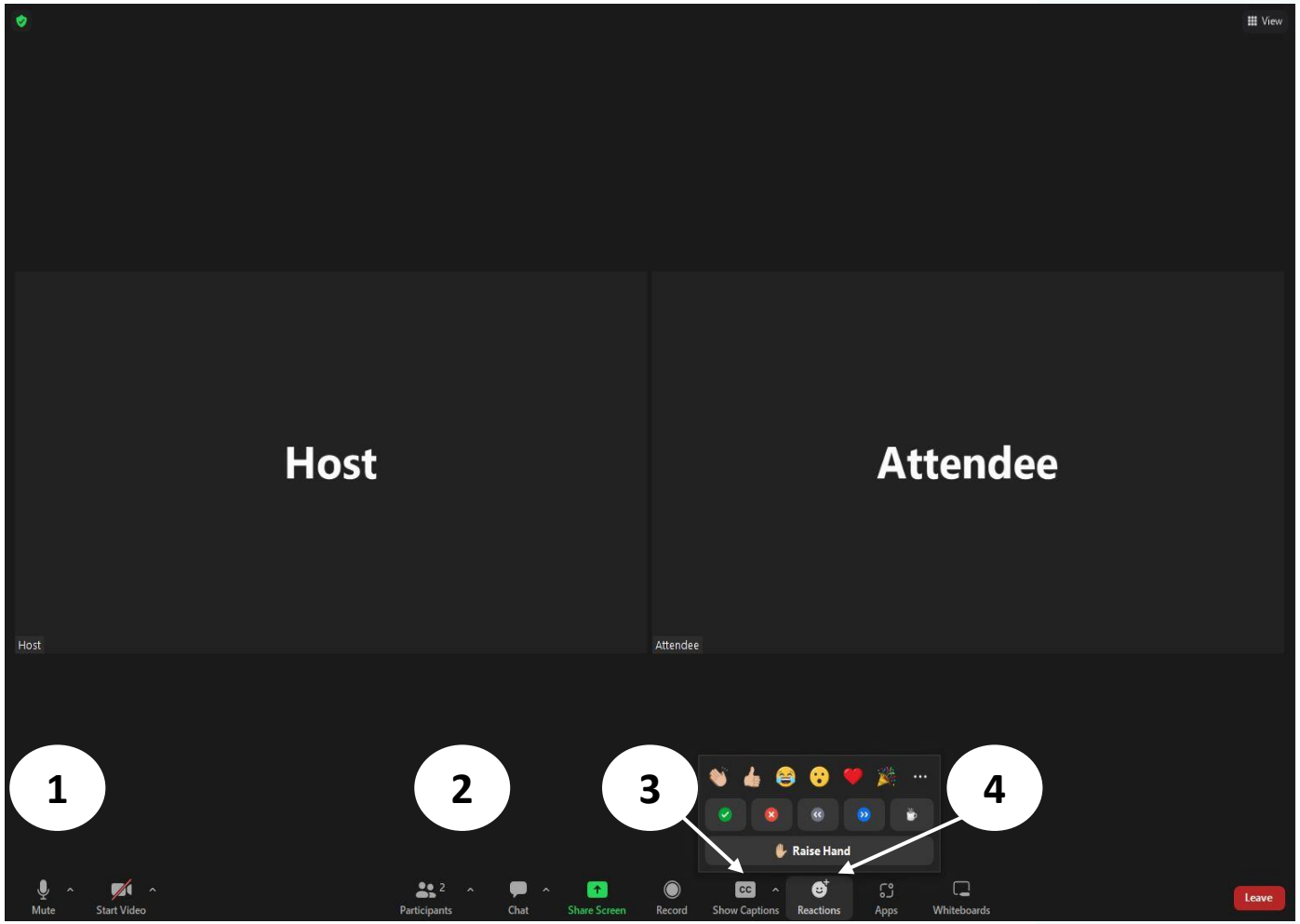
If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPcoordinatingcommittee@qualityforum.org.

NATIONAL QUALITY FORUM

Meeting Ground Rules

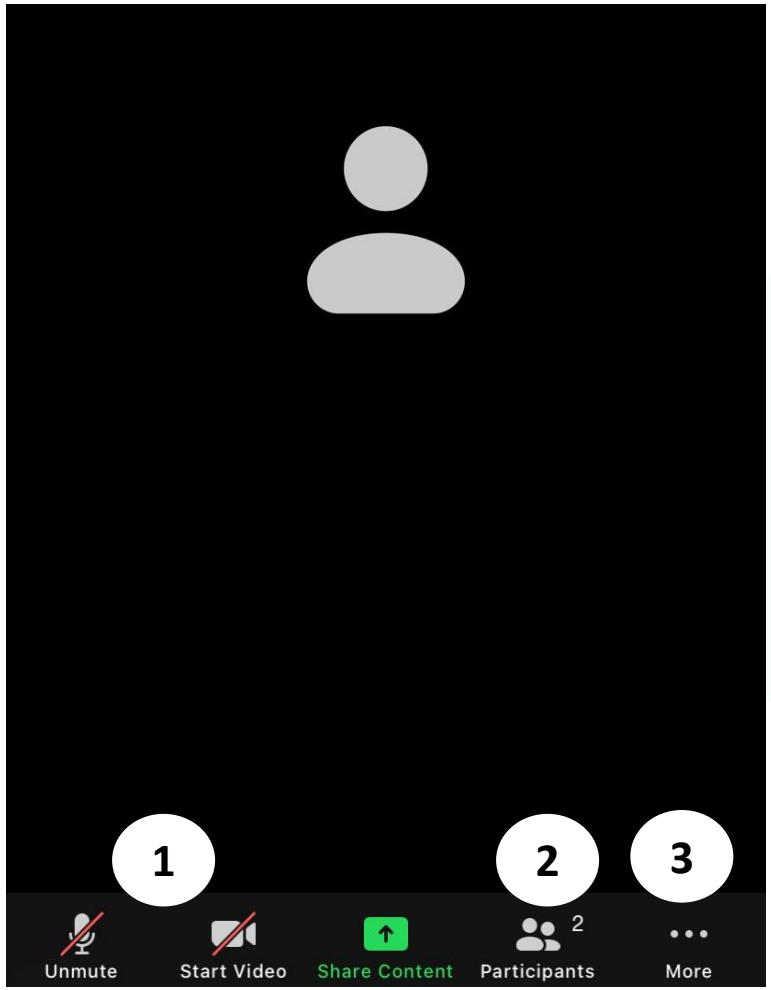
- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure selection criteria and guidance
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Using the Zoom Platform



1. Click the lower part of your screen to mute/unmute, start or pause video
2. Click on the participant or chat button to access the full participant list or the chat box
3. Click on show captions to enable closed captions
4. To raise your hand, select the raised hand function under the reactions tab

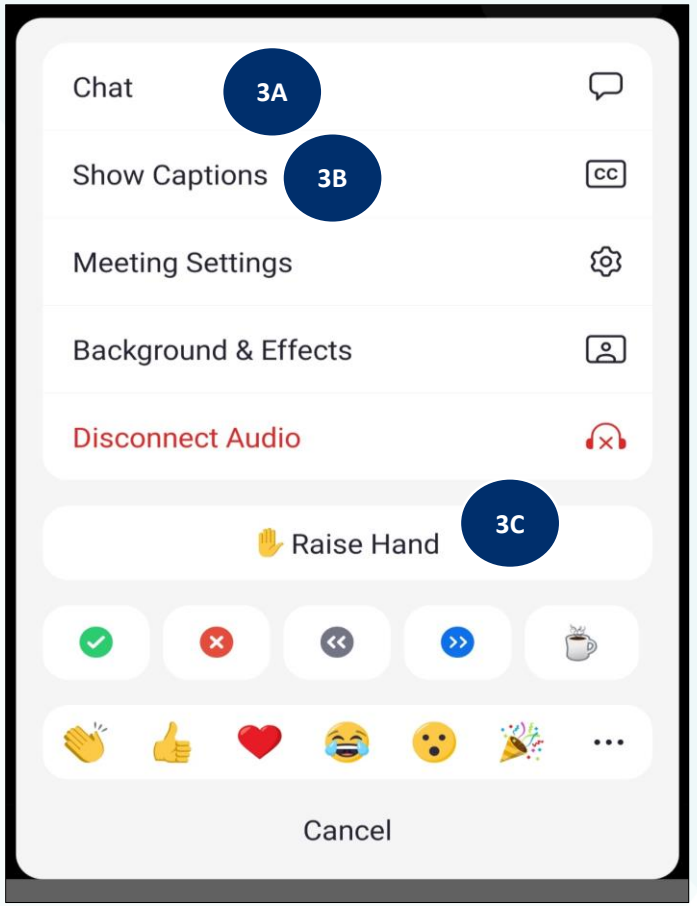
Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start or pause video

2. Click on the participant button to view the full participant list

3. Click on “more” button to (3A) view the chat box, (3B) show closed captions, or to (3C) raise your hand. To raise your hand, select the raised hand function under the reactions tab



NATIONAL QUALITY FORUM
Driving measurable health improvements together

https://www.qualityforum.org

Measure Applications Partnership (MAP)

MAP Coordinating Committee 2022-2023 Measures Under Consideration (MUC) Review Web Meeting – Day One

January 24, 2023

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003, Option Year 4

NATIONAL QUALITY FORUM

Agenda – Day One

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- Centers for Medicare & Medicaid Services (CMS) Opening Remarks
- Overview of Pre-Rulemaking Approach
- Review Cost Measures
- Break
- Review COVID-19 Measures
- Break

Agenda – Day One (continued)

- Review Cross-Setting Discharge Function Score Measures
- Review Geriatrics Measure
- Break
- Review Volume Measures
- Review Patient Activation Measure
- Preview of Day Two
- Adjourn

Welcome, Introductions, Disclosures of Interests, and Review of Meeting Objectives

Opening Remarks

Dana Gelb Safran, ScD

President and CEO, National Quality Forum (NQF)

Welcoming Remarks from Coordinating Committee Co-Chairs

Charles "Chip" Kahn, III, MPH
Federation of American Hospitals

Misty Roberts, RN, MSN, CPHQ, PMP
OneHome

NATIONAL QUALITY FORUM

Disclosures of Interest

- State your name, title, organization, brief bio, and acknowledge the disclosure(s) you listed in your DOI form if applicable
- Briefly note any of the following disclosures *relevant to the project*:
  - Engagement with project sponsors *(Centers for Medicare & Medicaid Services)*
  - Research funding, consulting/speaking fees, honoraria
  - Ownership interest
  - Relationships, activities, affiliations, or roles

Example: I'm Joan Smith, Chief Medical Officer of ABC Healthcare. I am also a Principal Investigator for a research project examining health disparities and health outcomes funded by XYZ Organization.

Coordinating Committee Membership

Coordinating Committee Co-Chairs: Charles Kahn, III, MPH; Misty Roberts, RN, MSN, CPHQ, PMP

Organizational Members (Voting)

- America's Health Insurance Plans
- American Academy of Hospice and Palliative Medicine
- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- American Medical Association
- American Nurses Association
- AmeriHealth Caritas
- Blue Cross Blue Shield Association
- Civitas Networks for Health
- Covered California
- HCA Healthcare
- Johnson & Johnson Health Care Systems, Inc.
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- OutCare Health
- Patient & Family Centered Care Partners, Inc.
- Patients for Patient Safety US
- Purchaser Business Group on Health

Coordinating Committee Membership (continued)

Individual Subject Matter Experts (Voting)

- Nishant Anand, MD, FACEP
- Dan Culica, MD, PhD
- Janice Tufte
- Lindsey Wisham, MPA

Federal Government Liaisons (Non-Voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Veteran Affairs (VA)
- Health Resources and Services Administration (HRSA)
- Office of the National Coordinator for Health Information Technology (ONC)

National Quality Forum MAP Team

- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Vice President
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
- **Ashlan Ruth, BS IE, PMP,** Project Manager
- **Susanne Young, MPH,** Senior Manager
- **Gus Zimmerman, MPP,** Analyst
- **Joelencia LeFlore, MPH,** Analyst
- **Magdelana Stinnett,** Analyst
- **Madeline Henry,** Associate

CMS Staff and Measure Contributors

- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), CCSQ, CMS
- **CMS Program and Measure Leads**
- **Measure Stewards and Developers**

Meeting Objectives

1. Finalize recommendations on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care (PAC/LTC) settings

CMS Opening Remarks

Opening Remarks

Michelle Schreiber, MD

Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS) and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG)

Welcome

A sincere **Thank You** for your participation.

Your goal today is to provide consensus recommendations to CMS regarding whether or not the measures presented should be used in various Value Based Quality Programs.

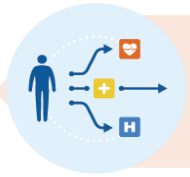
Measures in these programs help shape health system actions, support accountability and transparency, and are useful to patients/consumers.

Your recommendations are strongly considered in CMS deliberations about changes (measures removed/measures added) to these VBP programs.

While the final decision lies with CMS, your feedback is valuable and helps to represent those who will be impacted.

CMS National Quality Strategy Goals

Ensure best, safest, most effective care for all individuals



Improve quality & health outcomes across the care journey

Advance health equity & whole-person care

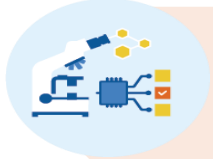
Target zero preventable harm

Engage individuals and communities as partners in their care

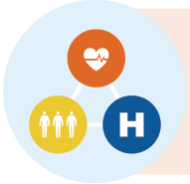
Enable a responsive, equitable, and resilient healthcare system

Enable a responsive and resilient healthcare system to improve quality

Accelerate and support the digital transition of health care



Promote innovation in science, analytics & technology



Align and coordinate quality across programs and care settings

National Quality Strategy Targets

Improve quality & health outcomes across the care journey	•Implement a universal set of impactful adult & pediatric measures across all CMS quality programs & across the care journey by 2026, benchmarked globally & stratified.
Advance health equity & whole-person care	•Implement a measurable equity component in every CMS quality program that encourages high quality care for underserved populations, beginning in 2022 with full implementation to follow in subsequent years.
Target zero preventable harm	•Improve safety metrics with a goal to return to pre-pandemic levels by 2025 & reducing harm by an additional 50% by 2030 through expanded safety metrics, targeted quality improvement & Conditions of Participation.
Engage individuals and communities as partners in their care	•Ensure individuals have a direct, significant & equitable contribution to how we evaluate quality & safety, and have the information needed to make the best health choices, with 25% of quality metrics being patient reported.
Accelerate and support the digital transition of health care	•Transition to all digital quality measures & achieve all-payer quality data collection by 2030 to reduce burden & make quality data rapidly available.
Enable a responsive and resilient healthcare system to improve quality	•Ensure support for healthcare workforce and systems and address workforce issues to reduce burnout and shortages to safeguard vital healthcare needs.
Promote innovation in science, analytics & technology	•Accelerate innovation in care delivery & incorporate technology enhancements to transform quality of care & advance value.
Align and coordinate quality across programs and care settings	•Promote standardized approaches to quality metrics, quality improvement initiatives, and VBP (and other) programs through use of universal measures set and aligned quality policies.

Strategic Priority Areas: Alignment for Measures and Program

CLINICAL	CROSS-CUTTING
Maternal Health	Equity
“Age Friendly” (Older Adult/Geriatrics)	Safety
Behavioral/Mental Health	Resilience
Diabetes	Interoperability/Digital Transformation
Cardiovascular, including Hypertension	Person Centered/CLAS
Kidney Care and Organ Transplantation	Alignment
Sickle Cell Disease	*
Wellness and Prevention	*
HIV and Hepatitis C	*
Cancer	*
Oral Health	*

* Indicates cell left intentionally blank

Considerations for Future Measure Priorities

As we continue filling priority gap areas in the CMS portfolio, measures should:

- Reflect areas of high impact where performance could lead to improvements of care for all individuals – especially in clinical priority or gap areas.
- Have no unintended consequences for rural communities/providers and no adverse impact on health equity
- Promote health equity by providing data which highlight areas of disparities or are suitable for stratification
- Be digitally specified (or “computable”), based on standardized data elements in USCDI
- Embody what is important to patients, including care aligned with goals and patient reported outcomes
- Promote safety

Alignment of Measures

Alignment is a key goal of the National Quality Strategy and Meaningful Measures Initiative. Wherever possible CMS aligns

- Within and across CMS programs
- Within and across other Federal programs
- Within and across other payers (Core Quality Measures Collaborative; Multi-payer Alignment workgroup of LAN)

Aligning measures will support a:

- Reduction of Burden
- Focus of provider attention on key clinical outcomes and metrics

Overview of Pre-Rulemaking Approach

MAP Coordinating Committee Charge

- Provide input to Department of Health and Human Services (HHS) on the coordination of performance measurement strategies and measure set review across public sector programs, across settings of care, and across public and private payers
- Set the strategic direction for MAP and ensure alignment among MAP Advisory Groups and setting-specific Workgroups
  - Clinician Workgroup
  - Hospital Workgroup
  - Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup
  - Rural Health Advisory Group
  - Health Equity Advisory Group
- Provide final approval of the recommendations developed by setting-specific Workgroups

MAP Decision Categories

NATIONAL QUALITY FORUM

2022-2023 MUC Decision Categories

- Support for Rulemaking
- Conditional Support for Rulemaking
- Do Not Support for Rulemaking with Potential for Mitigation
- Do Not Support for Rulemaking

2022-2023 MUC Decision Categories Descriptions

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation of the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied, and it meets assessments #1-6 of the MAP preliminary analysis algorithm. If the measure is in current use, it also meets assessment #7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments #1-3 but may need modifications. A designation of this decision category assumes at least one assessment from #4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.

2022-2023 MUC Decision Categories Descriptions (continued)

Decision Category	Definition	Evaluation Criteria
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such a modification would be considered a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments #1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment from #4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments #1-3.

Review of Voting Process and Meeting Procedure

Key Voting Principles

- **Quorum** is defined as **66 percent** of the voting members of the Workgroup and Committee present virtually for live voting to take place.
  - Quorum must be established prior to voting. The process to establish quorum is constituted of (1) taking roll call and (2) determining if a quorum is present. At this time, only if a member of the Committee questions the presence of a quorum is it necessary to reassess the presence of the quorum.
- If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.
- 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.
  - Abstentions do not count in the denominator.
- Every measure under consideration will receive a decision.

Procedure for Measures for Discussion

- **Step 1.** NQF staff will introduce the measure section and open the meeting for public comment on the measures in the section.
- **Step 2.** NQF staff will review the Workgroup decision for each measure under consideration (MUC).
  - NQF staff will summarize the Workgroup rationale and public comment on the Workgroup recommendation.
- **Step 3.** A CMS representative will present a brief overview and/or contextual background on the MUC.
- **Step 4.** Lead discussants will review and present their findings.
  - Lead discussants will state their own point of view, whether or not it is in agreement with the Workgroup recommendation or a divergent opinion.

Procedure for Measures for Discussion (continued)

- **Step 5.** A co-chair will open for discussion among the Coordinating Committee.
  - Coordinating Committee members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to the clarifying questions on the Workgroup decision.
- **Step 6.** The Coordinating Committee will vote on acceptance of the Workgroup decision.
  - After discussion ends, the co-chairs will open for a vote on accepting the Workgroup decision. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Coordinating Committee members vote to accept the Workgroup decision, then the Workgroup decision will become the MAP recommendation.
  - If less than 60% of the Workgroup votes to accept the Workgroup decision, discussion will continue on the measure.

Procedure for Measures for Discussion (continued 2)

- **Step 7.** Additional discussion and voting on the MUC will take place if less than 60% accept the Workgroup decision.
  - After discussion ends, the co-chairs will open the MUC for a vote.
  - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
  - If the co-chairs do not feel there is a consensus position to use to begin voting, the Coordinating Committee will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass, and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the Workgroup decision, the Workgroup decision will stand.

Procedure for Measures Pulled from Consent Calendar

- **Step 1.** NQF staff will introduce the measures pulled from the consent calendar and open the meeting for public comment.
- **Step 2.** NQF staff will present the measures pulled from the consent calendar.
- **Step 3.** The lead discussant or NQF staff will present their rationale for why they requested to pull the measure from the consent calendar.
- **Step 4.** A CMS representative will present a brief overview and/or contextual background on the MUC.
- **Step 5.** A co-chair will open for discussion among the Coordinating Committee.
- **Step 6.** The Coordinating Committee will vote on acceptance of the Workgroup decision.
- **Step 7.** Discussion and voting on the MUC will take place if less than 60% accept the Workgroup decision.

Procedure for Consent Calendar

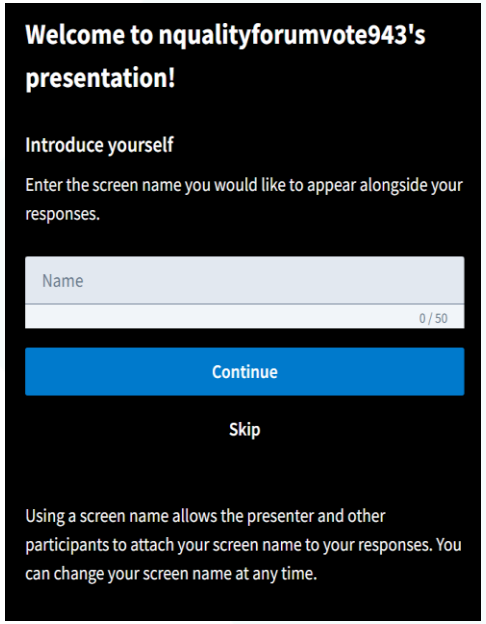
- **Step 1.** NQF staff will introduce the consent calendar section and open the meeting for public comment on the consent calendar measures.
- **Step 2.** NQF staff will present the measures on the consent calendar.
- **Step 3.** A co-chair will ask the Coordinating Committee for any clarifying questions or comments.

Decision Category or Meeting Procedure Questions?

Voting Test

Voting Via Desktop or Laptop Computer (Poll Everywhere)

- Click on the voting link that was emailed to you. You will see a wait message until voting begins.
- When voting opens, you will see the screen below. Enter your first and last name, then click "Continue" to access voting from the options that will appear on the screen.



- Please alert an NQF staff member if you are having difficulty with our electronic voting system.

Measures Under Consideration 2022-2023

Cost Measures

Public Comment for Cost Measures

- **MUC2022-101**: Depression *(MIPS)*
- **MUC2022-106**: Heart Failure *(MIPS)*
- **MUC2022-129**: Psychoses and Related Conditions *(MIPS)*

MUC2022-101: Depression

- **Description:** The Depression episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients receiving medical care to manage and treat depression. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician’s role in managing care during a Depression episode.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS

MUC2022-101: Depression
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement of the measure by a consensus-based entity (CBE).
  - MAP considered the appropriateness of the measure attribution methodology, Part D costs as part of the episode, and the risk adjustment model.
  - MAP acknowledged that the measure accounts for social determinants of health by including dual-eligible status in the risk adjustment model.
- **Public Comments Received**:
  - MUC List: 5
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-106: Heart Failure

- **Description:** The Heart Failure episode-based cost measure evaluates a clinicians or clinician groups risk-adjusted cost to Medicare for patients receiving medical care to manage and treat heart failure. This chronic condition measure includes the costs of services that are clinically related to the role of the attributed clinician in managing care during a Heart Failure episode.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS

MUC2022-106: Heart Failure
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement of the measure by a consensus-based entity (CBE).
  - MAP acknowledged concerns among members that guideline recommended care, in terms of devices and newer classes of medication therapy, have been shown to be of important clinical value for patients but do have cost implications.
  - MAP noted that the cost of this episode of care could be attributed to proceduralists who are responsible for high value interventions.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-129: Psychoses and Related Conditions

- **Description:** The Psychoses/Related Conditions episode-based cost measure represents the cost to Medicare for the items and services provided to a patient during an episode of care (episode). This measure evaluates a clinician's risk-adjusted cost to Medicare for patients who receive inpatient treatment for psychoses or related conditions during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician during the episode and up to 45 days after the trigger.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS

MUC2022-129: Psychoses and Related Conditions
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement of the measure by a consensus-based entity (CBE).
  - MAP considered how the availability of outpatient therapy impacts performance on this measure; however, the developer clarified that the availability of outpatient therapy does not influence measure performance.
  - MAP discussed the appropriateness of attribution methodology, but ultimately agreed with the value of the measure to this program set.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 4

Break – Day One

COVID-19 Measures

Public Comment for COVID-19 Measures

- **MUC2022-052**: Adult COVID-19 Vaccination Status *(MIPS)*
- **MUC2022-089**: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(IRF QRP)*
- **MUC2022-090**: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(HH QRP)*
- **MUC2022-091**: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(LTCH QRP)*
- **MUC2022-092**: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(SNF QRP)*

MUC2022-052: Adult COVID-19 Vaccination Status

- **Description:** Percentage of patients aged 18 years and older seen for a visit during the performance period who have ever completed or reported having ever completed a COVID-19 vaccination series and one booster dose
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS

MUC2022-052: Adult COVID-19 Vaccination Status
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - MAP discussed comments that there is regional variation in vaccine hesitancy and disparities in settings/patient populations that may lead to risk selection on this measure.
    - However, the Workgroup acknowledged that this measure is proposed for a program where clinicians choose which measures to report.
  - The Workgroup suggested that the developer consider future updates to the measure specification by defining vaccination as “up to date vaccination” to align with the most current guidelines.

MUC2022-052: Adult COVID-19 Vaccination Status
Workgroup and Public Comment Summary (continued)

- **Workgroup Rationale (continued)**:
  - Despite concerns raised during the measure developer's assessment of face validity with experts with the measure's ability to distinguish quality care, MAP generally agreed that the current measure and its specifications address a national public health emergency and should be supported for rulemaking.
  - MAP confirmed that the measure is fully developed, and measure testing methods/results were presented to the MAP.
- **Public Comments Received**:
  - MUC List: 8
  - Recommendations Spreadsheet: 5

MUC2022-089: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- **Description:** This one quarter measure reports the percentage of patients in an inpatient rehabilitation facility (IRF) who are up-to-date on their COVID-19 vaccinations per the Centers for Disease Control and Prevention's (CDC) latest guidance. The definition of up to date may change based on the CDC's latest guidance and can be found on the CDC webpage, "Stay Up to Date with Your COVID-19 Vaccines", at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html (last accessed 5/18/2022). This measure is based on data obtained through the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) discharge assessments during the selected quarter.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP

MUC2022-089: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Workgroup and Public Comment Summary

- **Program for Discussion**: IRF QRP
- **Workgroup Decision**: Do Not Support for Rulemaking
- **Workgroup Rationale**:
  - Although MAP agreed with the measure concept, there was concern with the 12-day average IRF length of stay and the potential impact of post-vaccine symptoms on a patient's therapy requirement.
  - MAP also questioned the process for the reporting of residents who refuse the vaccine, refuse to report, or those who are unable to report.
- **Public Comments Received**:
  - MUC List: 5
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- **Description:** The measure assesses the percent of home health patients that are up to date on their COVID-19 vaccinations as defined by CDC guidelines on current vaccination. Up to date as defined by CDC is outlined at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP

MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Workgroup and Public Comment Summary

- **Program for Discussion**: HH QRP
- **Workgroup Decision**: Do Not Support for Rulemaking
- **Workgroup Rationale**:
  - MAP supported the measure concept and noted the vulnerability of the elderly and disabled. However, MAP questioned the ability of home health providers to supply the vaccine to patients.
- **Public Comments Received**:
  - MUC List: 5
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-091: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- **Description:** This one-quarter measure reports the percentage of patients in a long-term care hospital (LTCH) who are up-to-date on their COVID-19 vaccinations per the Centers for Disease Control and Prevention's (CDC) latest guidance. The definition of up-to-date may change based on the CDC's latest guidance and can be found on the CDC webpage, "Stay Up to Date with Your COVID-19 Vaccines", at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html (last accessed 5/18/2022). This measure is based on data obtained through the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) discharge assessments during the selected quarter.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP

MUC2022-091: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Workgroup and Public Comment Summary

- **Program for Discussion**: LTCH QRP
- **Workgroup Decision**: Do Not Support for Rulemaking
- **Workgroup Rationale**:
  - MAP did not support the measure for the IRF QRP (MUC2022-089), nor the HH QRP (MUC2022-090).
- **Public Comments Received**:
  - MUC List: 3
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- **Description:** This one-quarter measure reports the percentage of patients in a Skilled Nursing Facility (SNF) who are up-to-date on their COVID-19 vaccinations per the Centers for Disease Control and Prevention's (CDC) latest guidance. The definition of up-to-date may change based on the CDC's latest guidance and can be found on the CDC webpage, "Stay Up to Date with Your COVID-19 Vaccines", at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html (last accessed 5/18/2022). This measure is based on data obtained through the Minimum Data Set (MDS) discharge assessments during the selected quarter.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP

MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
Workgroup and Public Comment Summary

- **Program for Discussion**: SNF QRP
- **Workgroup Decision**: Consensus Not Reached
  - **Preliminary Analysis Recommendation**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - Because MAP did not reach consensus, the recommendation is the NQF staff preliminary analysis recommendation, which is conditional support of the measure for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by a consensus-based entity (CBE).
  - MAP did not support the measure for the IRF QRP (MUC2022-089), nor for the HH QRP (MUC2022-090), nor the LTCH QRP (MUC2022-091).
- **Public Comments Received**:
  - MUC List: 7
  - Preliminary Recommendations Spreadsheet: 10

Afternoon Break – Day One

Cross-Setting Discharge Function Score Measures

Public Comment for Cross-Setting Discharge Function Score Measures

- **MUC2022-083**: Cross-Setting Discharge Function Score *(IRF QRP)*
- **MUC2022-085**: Cross-Setting Discharge Function Score *(HH QRP)*
- **MUC2022-086**: Cross-Setting Discharge Function Score *(SNF QRP, SNF VBP)*
- **MUC2022-087**: Cross-Setting Discharge Function Score *(LTCH QRP)*

MUC2022-083: Cross-Setting Discharge Function Score

- **Description:** This measure estimates the percentage of Inpatient Rehabilitation Facility (IRF) patients who meet or exceed an expected discharge function score.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP, SNF VBP

MUC2022-083: Cross-Setting Discharge Function Score
Workgroup and Public Comment Summary

- **Program for Discussion**: IRF QRP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE).
  - MAP questioned the assessment of self-care and mobility activities within a single performance score in the measure, noting the difficulty discerning a patient's issue and thus implementing an improvement plan.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 2

MUC2022-085: Cross-Setting Discharge Function Score

- **Description:** This measure estimates the percentage of Home Health (HH) Medicare patients who meet or exceed an expected discharge function score.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP, SNF VBP

MUC2022-085: Cross-Setting Discharge Function Score
Workgroup and Public Comment Summary

- **Program for Discussion**: HH QRP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE).
  - MAP discussed duplicative measures in HH QRP that could lead to potential patient selection bias.
- **Public Comments Received**:
  - MUC List: 5
  - Preliminary Recommendations Spreadsheet: 2

MUC2022-086: Cross-Setting Discharge Function Score

- **Description:** This measure estimates the percentage of Medicare Part A SNF stays that meet or exceed an expected discharge function score.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP, SNF VBP

MUC2022-086: Cross-Setting Discharge Function Score
Workgroup and Public Comment Summary

- **Program(s) for Discussion**: SNF QRP, SNF VBP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE).
  - While MAP generally supported the measure, there was discussion about measure redundancy within SNF QRP.
- **Public Comments Received**:
  - MUC List: SNF QRP – 3; SNF VBP – 2
  - Preliminary Recommendations Spreadsheet: SNF QRP – 3; SNF VBP – 3

MUC2022-087: Cross-Setting Discharge Function Score

- **Description:** This measure estimates the percentage of Long-Term Care Hospital (LTCH) patients who meet or exceed an expected discharge function score.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** HH QRP, IRF QRP, LTCH QRP, SNF QRP, SNF VBP

MUC2022-087: Cross-Setting Discharge Function Score
Workgroup and Public Comment Summary

- **Program for Discussion**: LTCH QRP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE).
- **Public Comments Received**:
  - MUC List: 1
  - Preliminary Recommendations Spreadsheet: 2

Geriatrics Measure

Public Comment for Geriatrics Measure

- **MUC2022-032**: Geriatrics Surgical Measure *(Hospital IQR)*

MUC2022-032: Geriatrics Surgical Measure

- **Description:** This programmatic measure assesses hospital commitment to improving surgical outcomes for patients greater than or equal to 65 years of age through patient-centered competencies aimed at achieving quality of care and safety for all older adult surgical patients. The measure will include 11 attestation-based questions across 7 domains representing a comprehensive framework required for optimal care of the older surgical patient. A hospital will receive a point for each domain where they attest to all items from at least one question (for a total of 7 points). Note that "patients" in all elements refers to surgical patients greater than or equal to 65 years of age at time of operation.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR

MUC2022-032: Geriatrics Surgical Measure
Workgroup and Public Comment Summary

- **Program for Discussion**: Hospital IQR
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE), and further work on paring down the elements included in the attestation, and presenting information about gaps for the components covered by the measure.
  - MAP supported the importance of a measure focused on older adults as a vulnerable population, and noted how attestation measures can help to build out the infrastructure for and direct attention to important topics. However, MAP members also expressed concern about the subjectiveness of attestation-based measures, with some noting a preference for outcome or process measures.
  - MAP also noted the overlap with MUC2022-112 Geriatrics Hospital Measure.
- **Public Comments Received**:
  - MUC List: 10
  - Preliminary Recommendations Spreadsheet: 4

Second Afternoon Break – Day One

Volume Measures

Public Comment for Volume Measures

- **MUC2022-028**: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) *(ASCQR)*
- **MUC2022-030**: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) *(Hospital OQR)*

MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7)

- **Description:** Structural measure of facility capacity collects surgical procedure volume data on selected categories of procedures frequently performed in the ASC setting Categories include: Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous, Respiratory, Skin, and Other
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** ASCQR

MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7)
Workgroup and Public Comment Summary

- **Program for Discussion:** ASCQR
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by a consensus-based entity (CBE).
  - MAP discussed how there are varying levels of evidence for the correlation between the volume of procedures and outcomes depending on the procedure, and how the strength of the correlation varies by procedure.
  - Some MAP members suggested limiting the measure to those procedures where volume has the strongest correlation with outcomes; however, they noted this would be a substantive change to the measure. Other MAP members did not support this change, as they thought the measure, as specified, could help to generate better data on the correlation between procedure volume and outcomes.

MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7)
Workgroup and Public Comment Summary (continued)

- **Workgroup Rationale (continued)**:
  - MAP members expressed differing views on the value of volume data to patients.
    - MAP members representing the patient perspective thought the measure would be useful to patients as they decide where to seek care, as one data point along with others (e.g., advice from providers).
    - Other MAP members expressed concern about the value of volume data for informing patient decisions without other context, and encouraged the use of outcome measures instead.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 2

MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26)

- **Description:** Structural measure of facility capacity collects surgical procedure volume data on selected categories of outpatient procedures frequently performed within the outpatient department (e.g., outpatient surgery, cath lab, endoscopy). Gastrointestinal, Eye, Nervous System, Musculoskeletal, Skin, Genitourinary, Cardiovascular, Respiratory, and Other
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital OQR

MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26)
Workgroup and Public Comment Summary

- **Program for Discussion**: Hospital OQR
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by a consensus-based entity (CBE).
  - MAP raised a concern that rural and critical access hospitals, which provide outpatient care and report measures for the Hospital OQR program, may have low volume. MAP recommended that this concern be considered during the endorsement process.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 4

Patient Activation Measure

Public Comment for Patient Activation Measure

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

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

- **Description:** The Patient Activation Measure (PAM) (Registered Trademark) is a 10- or 13- item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM performance measure (PAM-PM) is the change in score on the PAM from baseline to follow-up measurement. A positive change would mean the patient is gaining in their ability to manage their health. The measure is not disease specific but has been successfully used with a wide variety of chronic conditions, as well as with people with no medical diagnosis.
- **Level of Analysis:** Clinician - Individual; Clinician - Group; Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP, MIPS

MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months
Workgroup and Public Comment Summary

- **Program for Discussion:** ESRD QIP
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - A MAP member requested that the measure be specifically reviewed by the National Quality Forum's Renal Standing Committee.
  - Another MAP member expressed concern that the PAM is a universal tool and not built around a specific condition.
  - A MAP member requested review of data from the measure's use in a demonstration project before its implementation in the ESRD QIP.
- **Public Comments Received**:
  - MUC List: 9
  - Preliminary Recommendations Spreadsheet: 5

Preview of Day Two

THANK YOU.

NATIONAL QUALITY FORUM

https://www.qualityforum.org

Welcome to Today's Meeting! [2]

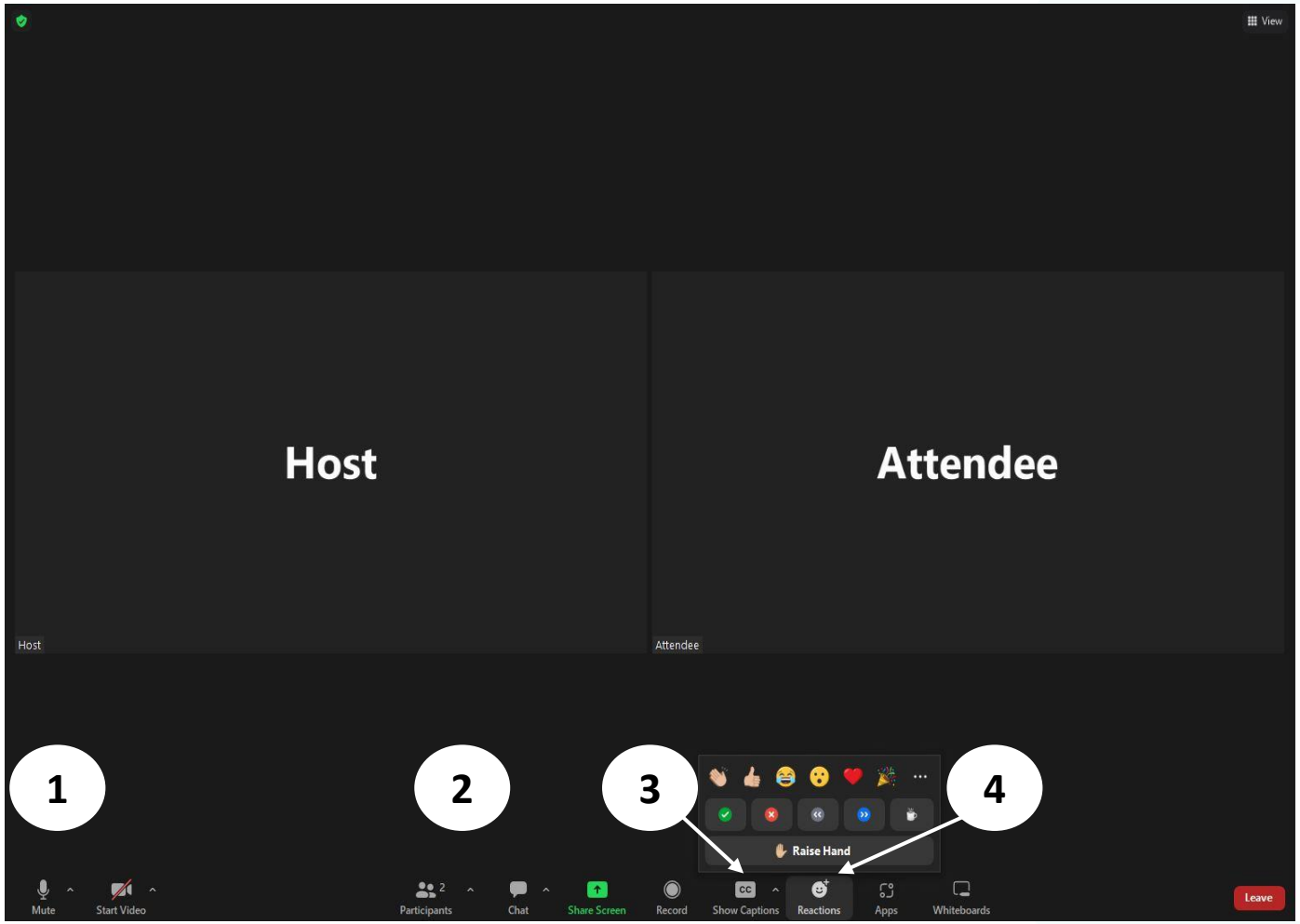
- Housekeeping reminders:
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - Please raise your hand and unmute yourself when called on
  - Please lower your hand and mute yourself following your question/comment
  - Please state your first and last name if you are a Call-In-User
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPcoordinatingcommittee@qualityforum.org.

Meeting Ground Rules[2]

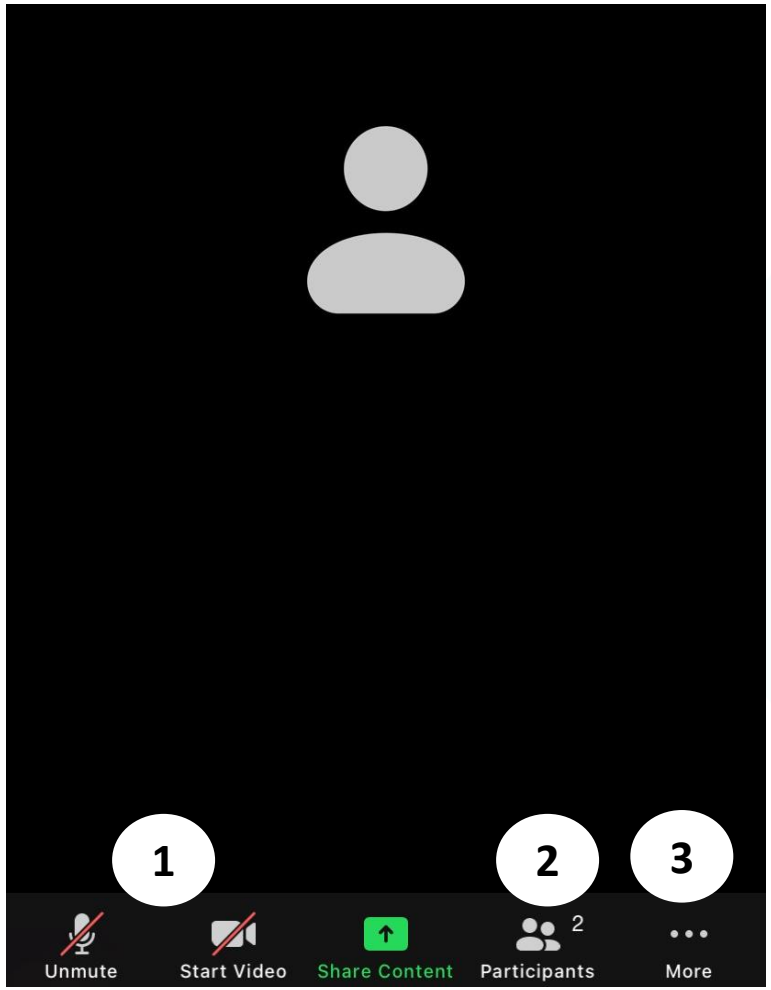
- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure selection criteria and guidance
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Using the Zoom Platform[2]



1. Click the lower part of your screen to mute/unmute, start or pause video
2. Click on the participant or chat button to access the full participant list or the chat box
3. Click on show captions to enable closed captions
4. To raise your hand, select the raised hand function under the reactions tab

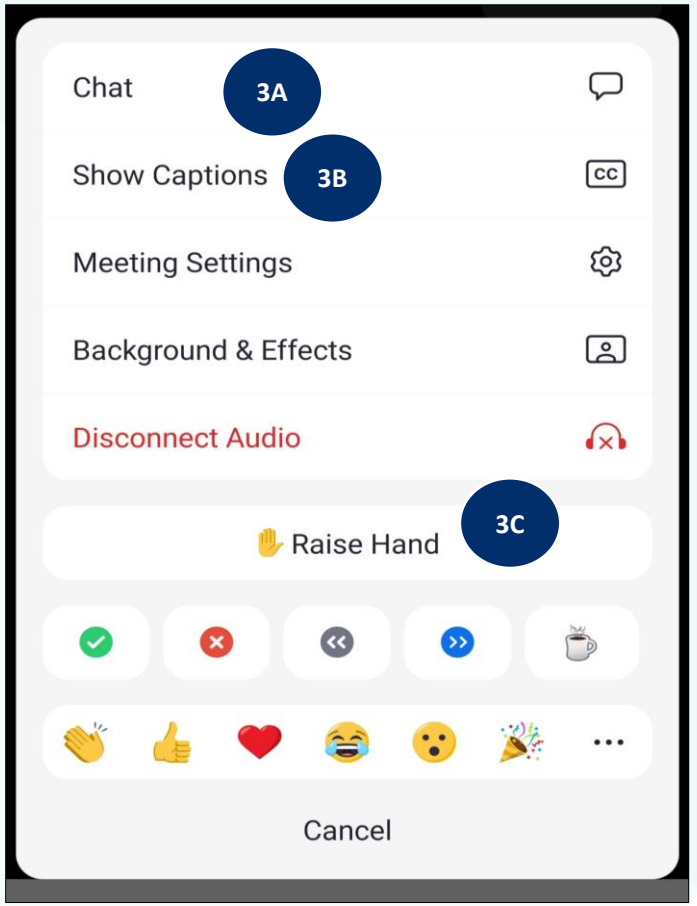
Using the Zoom Platform (Phone View)[2]



1. Click the lower part of your screen to mute/unmute, start or pause video

2. Click on the participant button to view the full participant list

3. Click on “more” button to (3A) view the chat box, (3B) show closed captions, or to (3C) raise your hand. To raise your hand, select the raised hand function under the reactions tab



NATIONAL QUALITY FORUM
Driving measurable health improvements together

https://www.qualityforum.org

Measure Applications Partnership (MAP)^2

MAP Coordinating Committee 2022-2023 Measures Under Consideration (MUC) Review Web Meeting – Day Two

January 25, 2023

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003, Option Year 4

Agenda – Day Two

- Welcome, Preview of Day Two, and Roll Call
- Review Social Determinants of Health and Disparities Measures
- Break
- Review Safety Measures
- Break
- Review Rural Emergency Hospital Quality Reporting Program Measures

Agenda – Day Two (continued)

- Review Measures Pulled from the Consent Calendar
- Break
- Review Measures on the Consent Calendar
- Gaps Discussion
- Opportunity for Public Comment
- Closing Remarks and Next Steps
- Adjourn

Coordinating Committee Membership[2]

Coordinating Committee Co-Chairs: Charles Kahn, III, MPH; Misty Roberts, RN, MSN, CPHQ, PMP

Organizational Members (Voting)

- America's Health Insurance Plans
- American Academy of Hospice and Palliative Medicine
- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- American Medical Association
- American Nurses Association
- AmeriHealth Caritas
- Blue Cross Blue Shield Association
- Civitas Networks for Health
- Covered California
- HCA Healthcare
- Johnson & Johnson Health Care Systems, Inc.
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- OutCare Health
- Patient & Family Centered Care Partners, Inc.
- Patients for Patient Safety US
- Purchaser Business Group on Health

Coordinating Committee Membership (continued)[2]

Individual Subject Matter Experts (Voting)

- Nishant Anand, MD, FACEP
- Dan Culica, MD, PhD
- Janice Tufte
- Lindsey Wisham, MPA

Federal Government Liaisons (Non-Voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Department of Veteran Affairs (VA)
- Health Resources and Services Administration (HRSA)
- Office of the National Coordinator for Health Information Technology (ONC)

National Quality Forum MAP Team[2]

- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Vice President
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
- **Ashlan Ruth, BS IE, PMP,** Project Manager
- **Susanne Young, MPH,** Senior Manager
- **Gus Zimmerman, MPP,** Analyst
- **Joelencia LeFlore, MPH,** Analyst
- **Magdelana Stinnett,** Analyst
- **Madeline Henry,** Associate

CMS Staff and Measure Contributors[2]

- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), CCSQ, CMS
- **CMS Program and Measure Leads**
- **Measure Stewards and Developers**

Review of Voting Process and Meeting Procedure – Day Two

Procedure for Measures for Discussion – Day Two

- **Step 1.** NQF staff will introduce the measure section and open the meeting for public comment on the measures in the section.
- **Step 2.** NQF staff will review the Workgroup decision for each measure under consideration (MUC).
  - NQF staff will summarize the Workgroup rationale and public comment on the Workgroup recommendation.
- **Step 3.** A CMS representative will present a brief overview and/or contextual background on the MUC.
- **Step 4.** Lead discussants will review and present their findings.
  - Lead discussants will state their own point of view, whether or not it is in agreement with the Workgroup recommendation or a divergent opinion.

Procedure for Measures for Discussion – Day Two (continued)

- **Step 5.** A co-chair will open for discussion among the Coordinating Committee.
  - Coordinating Committee members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to the clarifying questions on the Workgroup decision.
- **Step 6.** The Coordinating Committee will vote on acceptance of the Workgroup decision.
  - After discussion ends, the co-chairs will open for a vote on accepting the Workgroup decision. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Coordinating Committee members vote to accept the Workgroup decision, then the Workgroup decision will become the MAP recommendation.
  - If less than 60% of the Workgroup votes to accept the Workgroup decision, discussion will continue on the measure.

Procedure for Measures for Discussion – Day Two (continued 2)

- **Step 7.** Additional discussion and voting on the MUC will take place if less than 60% accept the Workgroup decision.
  - After discussion ends, the co-chairs will open the MUC for a vote.
  - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
  - If the co-chairs do not feel there is a consensus position to use to begin voting, the Coordinating Committee will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass, and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the Workgroup decision, the Workgroup decision will stand.

Procedure for Measures Pulled from Consent Calendar – Day Two

- **Step 1.** NQF staff will introduce the measures pulled from the consent calendar and open the meeting for public comment.
- **Step 2.** NQF staff will present the measures pulled from the consent calendar.
- **Step 3.** The lead discussant or NQF staff will present their rationale for why they requested to pull the measure from the consent calendar.
- **Step 4.** A CMS representative will present a brief overview and/or contextual background on the MUC.
- **Step 5.** A co-chair will open for discussion among the Coordinating Committee.
  - A co-chair will ask the Coordinating Committee for any clarifying questions or comments based on the lead discussant's rationale.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to the clarifying questions on the Workgroup decision.

Procedure for Measures Pulled from Consent Calendar – Day Two (continued)

- **Step 6.** The Coordinating Committee will vote on acceptance of the Workgroup decision.
  - After discussion ends, the co-chairs will open for a vote on accepting the Workgroup decision. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Coordinating Committee members vote to accept the Workgroup decision, then the Workgroup decision will become the MAP recommendation.
  - If less than 60% of the Workgroup votes to accept the Workgroup decision, discussion will continue on the measure.

Procedure for Measures Pulled from Consent Calendar – Day Two (continued 2)

- **Step 7.** Discussion and voting on the MUC will take place if less than 60% accept the Workgroup decision.
  - After discussion ends, the co-chairs will open the MUC for a vote.
  - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
  - If the co-chairs do not feel there is a consensus position to use to begin voting, the Coordinating Committee will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass, and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the Workgroup decision, the Workgroup decision will stand.

Procedure for Consent Calendar – Day Two

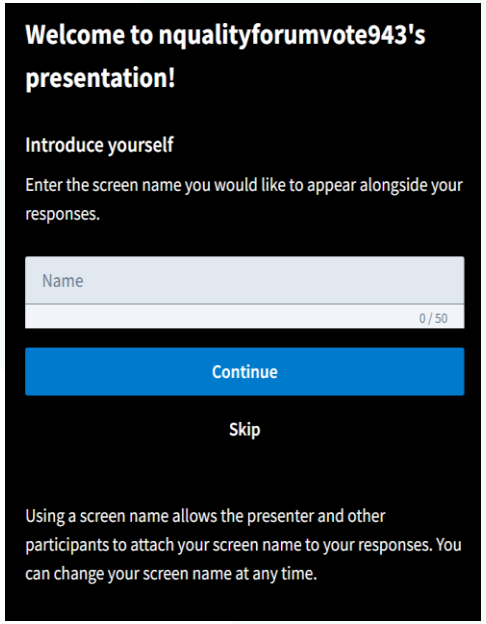
- **Step 1.** NQF staff will introduce the consent calendar section and open the meeting for public comment on the consent calendar measures.
- **Step 2.** NQF staff will present the measures on the consent calendar.
- **Step 3.** A co-chair will ask the Coordinating Committee for any clarifying questions or comments.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to the clarifying questions on the Workgroup decision.

Voting Process or Meeting Procedure Questions?

Voting Test – Day Two

Voting Via Desktop or Laptop Computer (Poll Everywhere)[2]

- Click on the voting link that was emailed to you. You will see a wait message until voting begins.
- When voting opens, you will see the screen below. Enter your first and last name, then click "Continue" to access voting from the options that will appear on the screen.



- Please alert an NQF staff member if you are having difficulty with our electronic voting system.

Measures Under Consideration – Day Two

Social Determinants of Health (SDOH) and Disparities Measures

Public Comment for SDOH and Disparities Measures

- **MUC2022-050**: Screen Positive Rate for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-058**: Hospital Disparity Index (HDI) *(Hospital IQR)*

MUC2022-050: Screen Positive Rate for Social Drivers of Health

- **Description:** The Screen Positive Rate for Social Drivers of Health is a structural measure that provides information on the percent of patients admitted for an inpatient facility stay or that have received established care in the case of dialysis facilities, and who are 18 years or older on the date of admission or date of established care in the case of dialysis facilities, were screened for all five HSRNs, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** ESRD QIP, IPFQR, PCHQRP

MUC2022-050: Screen Positive Rate for Social Drivers of Health
Workgroup and Public Comment Summary

- **Program for Discussion**: ESRD QIP, IPFQRP, PCHQRP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending endorsement by a consensus-based entity (CBE) to address reliability and validity concerns, attentiveness to how results are shared and contextualized for public reporting, and encouragement for CMS to examine any differences in reported rates by reporting process (to assess whether they are the same or different across hospitals).
  - MAP supported the importance of the measure for identifying facilities that may need more resources and for quality improvement purposes and thought the measure could encourage facilities to engage with their communities.
  - However, other MAP members had concerns that the measure does not reflect quality of care, but rather a facility's patient population mix, and that consumers could misunderstand how to interpret the measure's results when publicly reported.

MUC2022-050: Screen Positive Rate for Social Drivers of Health
Workgroup and Public Comment Summary (continued)

- **Workgroup Rationale (continued)**:
  - MAP members encouraged presentation of the results in a way that provides context for consumers.
- **Public Comments Received**:
  - MUC List: ESRD QIP – 6; IPF QRP – 4; PCHQRP – 2
  - Preliminary Recommendations Spreadsheet: ESRD QIP – 20; IPF QRP – 20; PCHQRP – 17

MUC2022-058: Hospital Disparity Index (HDI)

- **Description:** The HDI is a prototype method for a single score that summarizes several measurements of disparity in care at a hospital. This score will summarize existing results of the Centers for Medicare and Medicaid Services (CMS) Disparity Methods (stratified measure results) across a range of measures and social and demographic risk factors, to provide more accessible information about variations in healthcare disparity across hospitals.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR

MUC2022-058: Hospital Disparity Index (HDI)
Workgroup and Public Comment Summary

- **Program for Discussion**: Hospital IQR
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, including testing with low volume hospitals which do not have all seven readmission rates calculated and may have small numbers of the targeted groups, and endorsement by a consensus-based entity (CBE).
  - MAP expressed concerns that the measure title may be misleading, as the measure is a composite of readmissions measures only, and recommended renaming the measure to focus on readmissions. Some MAP members also expressed concern with only focusing on readmission measures.

MUC2022-058: Hospital Disparity Index (HDI)
Workgroup and Public Comment Summary (continued)

- **Workgroup Rationale (continued)**:
  - While MAP supported the intent of the measure – to identify and reduce disparities – some MAP members asked that CMS provide confidential reports of the composite measure score to hospitals before making the reports publicly available.
  - MAP also discussed the importance of seeking patient feedback on the composite measure, and suggested as the measure evolves, that the measure developer involve patients in reviewing the measure.
- **Public Comments Received**:
  - MUC List: 5
  - Preliminary Recommendations Spreadsheet: 7

Break – Day Two

Safety Measures

Public Comment for Safety Measures

- **MUC2022-035**: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) *(SNF VBP)*
- **MUC2022-082**: Severe Sepsis and Septic Shock: Management Bundle *(HVBP)*

MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)

- **Description:** This one-year measure reports the percentage of long-stay residents in a nursing home who have experienced one or more falls resulting in major injury (defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) reported in the look-back period no more than 275 days before the target assessment. The long-stay nursing home population is defined as residents who have received 101 or more cumulative days of nursing home care by the end of the target assessment period. This measure uses data obtained through the Minimum Data Set (MDS) 3.0 OBRA, PPS, and/or discharge assessments during the selected quarter(s).
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** SNF VBP

MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)
Workgroup and Public Comment Summary

- **Program for Discussion**: SNF VBP
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - While MAP expressed general support for the measure, MAP discussed the use of a long-stay measure to improve resident care within a VBP program.
  - MAP discussed the 275 days look back period and the length of time a fall event would stay on a facility record.
- **Public Comments Received**:
  - MUC List: 6
  - Preliminary Recommendations Spreadsheet: 8

MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle

- **Description:** This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first three interventions should occur within three hours of presentation of severe sepsis, while the remaining interventions are expected to occur within six hours of presentation of septic shock.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HVBP

MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle
Workgroup and Public Comment Summary

- **Program for Discussion**: HVBP
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending clarity being provided about the differences between the measure specifications reviewed by MAP and the current measure specifications.
    - The measure has been updated since the MUC submission and MAP therefore, reviewed an older version of the specification.
    - The developer clarified that the measure specifications reviewed by MAP reflect the latest clinical guidelines and align with the specifications submitted to the CBE for endorsement review, but do contain smaller updates related to the guidance for certain portions of the measure.

MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle
Workgroup and Public Comment Summary (continued)

- **Workgroup Rationale (continued)**:
  - Some MAP members were in strong support of the measure as it is closely linked to improved outcomes and demonstrates a performance gap. Others noted concern about the burden associated with chart abstraction and the need for hospitals to frequently update their data collection methods to align with the changing requirements of the measure.
  - Some MAP members also expressed concern about the measure leading to a potential unintended consequence of antibiotic overuse.
- **Public Comments Received**:
  - MUC List: 13
  - Preliminary Recommendations Spreadsheet: 9

Afternoon Break – Day Two

Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures

Public Comment for REHQRP Measures

- **MUC2022-039**: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients *(REHQRP)*
- **MUC2022-066**: Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy *(REHQRP)*

MUC2022-039: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients

- **Description:** Median time from ED arrival to time of departure from the ED for patients discharged from the ED. The measure is calculated using chart abstracted data, on a rolling quarterly basis, and is publicly reported in aggregate for one calendar year. The measure has been publicly reported since 2013 as part of the ED Throughput measure set of the CMS Hospital Outpatient Quality Reporting (OQR) Program.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** REHQRP

MUC2022-039: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients
Workgroup and Public Comment Summary

- **Program for Discussion**: REHQRP
- **Workgroup Decision:** Do Not Support for Rulemaking
- **Workgroup Rationale:**
  - MAP agreed that publicly reporting ED wait times could have potential negative unintended consequences, as patients may avoid EDs with longer wait times, even when patients need urgent care.
  - A MAP member asked whether data collected as part of the Medicare Beneficiary Quality Improvement Project (MBQIP) could provide insight into how rural hospitals may perform on the measure.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 4

MUC2022-066: Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy

- **Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a colonoscopy procedure performed at a Rural Emergency Hospital among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** REHQRP

MUC2022-066: Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy
Workgroup and Public Comment Summary

- **Program for Discussion**: REHQRP
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - MAP questioned whether rural emergency hospitals would have enough cases to report the measure and some members questioned whether MUC2022-066 and MUC2022-067 could be combined.
    - » CMS responded that this would require development of a new measure.
  - Other MAP members observed that colonoscopies may be more common in rural emergency hospitals than other types of procedures or surgeries and supported the importance of this measure for patients in rural settings.
- **Public Comments Received**:
  - MUC List: 3
  - Preliminary Recommendations Spreadsheet: 2

Measures Pulled from the Consent Calendar

Public Comment for Measures Pulled from the Consent Calendar

- **MUC2022-098:** Connection to Community Service Provider *(MIPS)*
- **MUC2022-111:** Resolution of At Least 1 Health-Related Social Need *(MIPS)*
- **MUC2022-055:** Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure *(Hospital IQR)*
- **MUC2022-057:** Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure *(Hospital IQR)*

MUC2022-098: Connection to Community Service Provider

- **Description:** Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** MIPS

MUC2022-098: Connection to Community Service Provider
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a consensus-based entity (CBE).
  - MAP acknowledged several challenges with implementing a measure of this type, including a range of capacity to serve patients with HRSNs when there is a range of community services available, and potential costs from EHR vendors to implement the measure.
    - However, MAP supported this measure noting that it identifies needs among patients which can affect their overall health in future years, especially in the prevention of chronic diseases.
    - MAP also noted that community clinics attempt to address the social needs of their patients, and this measure provides an opportunity for physicians to take an active role of documenting the needs in the community as this collection of data will be useful for federal, state, and local officials to close gaps in care.

MUC2022-098: Connection to Community Service Provider
Workgroup and Public Comment Summary (continued)

- **Public Comments Received**:
  - MUC List: 12
  - Preliminary Recommendations Spreadsheet: 23

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

- **Description:** Percent of patients 18 years or older who screen positive for one or more of the following HRSNs: food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety; and report that at least 1 of their HRSNs was resolved within 12 months after screening.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** MIPS

MUC2022-111: Resolution of At Least 1 Health-Related Social Need
Workgroup and Public Comment Summary

- **Program for Discussion**: MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking
- **Workgroup Rationale**:
  - MAP conditionally supported the measure for rulemaking pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a consensus-based entity (CBE).
  - MAP noted that relying on self-reported data to determine if an HRSN was resolved may be challenging, and MAP recommended that patient or caregiver perspectives should be incorporated in final measure face validity testing. However, MAP was broadly supportive of the measure.
- **Public Comments Received**:
  - MUC List: 8
  - Preliminary Recommendations Spreadsheet: 24

MUC2022-055: Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure

- **Description:** Hospital-level, risk-standardized readmission rate (RSRR) of all-cause 30-day unplanned readmission after admission for any eligible condition within 30 days of hospital discharge. The measure, based on NQF #2879, uses enrollment data, inpatient claims, and electronic health record data. Hospitals receive a single summary RSRR, derived from the volume-weighted results of five specialty cohorts. Conditionally supported by the MAP pending NQF endorsement and currently in the IQR Program (voluntary reporting 7/1/2021, mandatory reporting beginning 7/1/2023). This MUC submission expands the cohort from Medicare fee-for-service (FFS) patients to include Medicare Advantage patients age 65 & older.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR

MUC2022-055: Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure
Workgroup and Public Comment Summary

- **Program for Discussion**: Hospital IQR
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - MAP expressed appreciation for the inclusion of Medicare Advantage beneficiaries in the measure and expressed overall support for the measure.
- **Public Comments Received**:
  - MUC List: 4
  - Preliminary Recommendations Spreadsheet: 3

MUC2022-057: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure

- **Description:** Hospital-level, risk-standardized 30-day all-cause mortality rate (RSMR) for Medicare fee-for-service (FFS) and Medicare Advantage (MA) patients (65 to 94). The measure, based on NQF #3502, uses enrollment data, inpatient claims, and electronic health data to identify 30-day all-cause mortality outcome, and adjust for comorbidities based on the ICD-10 diagnosis/procedure codes and clinical risk factors from electronic health data for the measure score calculation. This measure, previously conditionally supported for use in IQR and planned for use by CMS for voluntary reporting in IQR, is being expanded to include Medicare Advantage patients in addition to FFS patients in the cohort.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR

MUC2022-057: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure
Workgroup and Public Comment Summary

- **Program for Discussion**: Hospital IQR
- **Workgroup Decision**: Support for Rulemaking
- **Workgroup Rationale**:
  - MAP expressed support for the measure and noted agreement that mortality is a meaningful outcome to patients and providers. MAP expressed agreement with the addition of Medicare Advantage patients to the measure.
- **Public Comments Received**:
  - MUC List: 3
  - Preliminary Recommendations Spreadsheet: 3

Second Afternoon Break- Day Two

Consent Calendar Measures

Public Comment for Consent Calendar Measures

- Please refer to the end of the agenda or slide number 176 for the list of measures
- Please keep comments to 2 minutes or less
- Please reference the MUC ID or measure title when providing comments

Consent Calendar Measures: End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Workgroup Recommendation: Support for Rulemaking**
  - **MUC2022-079**: Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities
- **Workgroup Recommendation: Do Not Support for Rulemaking with Potential for Mitigation**
  - **MUC2022-075**: Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR)
  - **MUC2022-076**: Standardized Fistula Rate for Incident Patients

Consent Calendar Measures: Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-078**: Psychiatric Inpatient Experience Measurement

Consent Calendar Measures: Hospital Inpatient Quality Reporting Program (Hospital IQR)

- **Workgroup Recommendation: Support for Rulemaking**
  - **MUC2022-018:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient)
- **Workgroup Recommendation: Do Not Support for Rulemaking with Potential for Mitigation**
  - **MUC2022-112:** Geriatrics Hospital Measure

Consent Calendar Measures: Hospital Outpatient Quality Reporting Program (Hospital OQR)

- **Workgroup Recommendation: Support for Rulemaking**
  - **MUC2022-020:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient)

Consent Calendar Measures: Merit-based Incentive Payment System (MIPS)

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

- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-014**: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
  - **MUC2022-048**: Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument
  - **MUC2022-063**: Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)
  - **MUC2022-065:** Preventive Care and Wellness (composite) *(MIPS)*
  - **MUC2022-097:** Low Back Pain

Consent Calendar Measures: MIPS (continued)

- **Workgroup Recommendation: Conditional Support for Rulemaking (continued)**
  - **MUC2022-100**: Emergency Medicine
  - **MUC2022-114**: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy
  - **MUC2022-115**: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
  - **MUC2022-116**: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
  - **MUC2022-122**: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder
  - **MUC2022-127**: Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk
  - **MUC2022-131**: Reduction in Suicidal Ideation or Behavior Symptoms

Consent Calendar Measures: MIPS (continued 2)

- **Workgroup Recommendation: Do Not Support for Rulemaking with Potential for Mitigation**
  - **MUC2022-060**: First Year Standardized Waitlist Ratio (FYSWR)

Consent Calendar Measures: Part C and D Star Ratings [Medicare]

- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-043**: Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans

Consent Calendar Measure: Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)

- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-120**: Documentation of Goals of Care Discussions Among Cancer Patients

Consent Calendar Measures: Rural Emergency Hospital Quality Reporting Program (REHQRP)

- **Workgroup Recommendation: Support for Rulemaking**
  - **MUC2022-067**: Risk-standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-081**: Abdomen Computed Tomography (CT) Use of Contrast Material

Consent Calendar Measures: Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-099**: Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure
  - **MUC2022-113:** Number of Hospitalizations per 1,000 Long-Stay Resident Days
  - **MUC2022-126:** Total Nursing Staff Turnover

Consent Calendar Measures: Cross-Program

- **Workgroup Recommendation: Support for Rulemaking**
  - **MUC2022-026:** Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting *(ASCQR, Hospital OQR)*
  - **MUC2022-125:** Gains in Patient Activation Measure (PAM) Scores at 12 Months *(MIPS)*
    - *Note: The measure submitted for ESRD QIP is not on the consent calendar and will be discussed during the meeting.*
- **Workgroup Recommendation: Conditional Support for Rulemaking**
  - **MUC2022-024**: Hospital Harm - Acute Kidney Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
  - **MUC2022-027**: Facility Commitment to Health Equity *(ESRD QIP, IPFQR, PCHQRP)*
  - **MUC2022-053**: Screening for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
  - **MUC2022-064**: Hospital Harm - Pressure Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
  - **MUC2022-084:** COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) (2022 revision) *(ASCQR, ESRD QIP, Hospital IQR, Hospital OQR, IPFQR, IRF QRP, PCHQRP, LTCH QRP, SNF QRP)*

Coordinating Committee Clarifying Questions and Comments on the Consent Calendar

*** Please reference the MUC ID or measure title when asking questions or providing comments**

Gaps Discussion

Opportunity for Public Comment

Next Steps

Timeline of Upcoming Activities

- **Recommendations Spreadsheet Published**
  - By February 1, 2023

MAP Resources

- CMS' 2022 MUC List Needs and Priorities Document
  - 2022 Needs and Priorities (PDF)
- CMS' Pre-Rulemaking Overview
  - CMS Pre-Rulemaking webpage
- MAP Member Guidebook
  - Member Guidebook (PDF)
- Measure Applications Partnership Overview
  - National Quality Forum webpage

MAP Contact Information

- Coordinating Committee project page: Coordinating Committee webpage
  - Email: MAPcoordinatingcommittee@qualityforum.org

Closing Remarks

THANK YOU!

NATIONAL QUALITY FORUM

https://www.qualityforum.org

Appendix

Consent Calendar Measure List

Consent Calendar Measure List: MUC ID, Measure Title, and Program

- **MUC2022-075:** Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) *(ESRD QIP)*
- **MUC2022-076:** Standardized Fistula Rate for Incident Patients *(ESRD QIP)*
- **MUC2022-079:** Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities *(ESRD QIP)*
- **MUC2022-078:** Psychiatric Inpatient Experience Measurement *(IPFQR)*
- **MUC2022-018:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) *(Hospital IQR)*
- **MUC2022-112:** Geriatrics Hospital Measure *(Hospital IQR)*
- **MUC2022-007:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) *(MIPS)*
- **MUC2022-014:** Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood *(MIPS)*
- **MUC2022-048:** Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument *(MIPS)*
- **MUC2022-060:** First Year Standardized Waitlist Ratio (FYSWR) *(MIPS)*
- **MUC2022-063:** Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) *(MIPS)*
- **MUC2022-065:** Preventive Care and Wellness (composite) *(MIPS)*
- **MUC2022-097:** Low Back Pain *(MIPS)*
- **MUC2022-100:** Emergency Medicine *(MIPS)*
- **MUC2022-114:** Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy *(MIPS)*
- **MUC2022-115:** Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up *(MIPS)*
- **MUC2022-116:** Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up *(MIPS)*
- **MUC2022-122:** Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder *(MIPS)*
- **MUC2022-127:** Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk *(MIPS)*
- **MUC2022-131:** Reduction in Suicidal Ideation or Behavior Symptoms *(MIPS)*
- **MUC2022-043:** Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans *(Part C and D Star Ratings [Medicare])*
- **MUC2022-120:** Documentation of Goals of Care Discussions Among Cancer Patients *(PCHQRP)*
- **MUC2022-067:** Risk-standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery *(REHQRP)*
- **MUC2022-081:** Abdomen Computed Tomography (CT) Use of Contrast Material *(REHQRP)*
- **MUC2022-099:** Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure *(SNF VBP)*
- **MUC2022-113:** Number of Hospitalizations per 1,000 Long-Stay Resident Days *(SNF VBP)*
- **MUC2022-126:** Total Nursing Staff Turnover *(SNF VBP)*
- **MUC2022-024:** Hospital Harm - Acute Kidney Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-026:** Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting *(ASCQR, Hospital OQR)*
- **MUC2022-027:** Facility Commitment to Health Equity *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-053:** Screening for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-064:** Hospital Harm - Pressure Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-084:** COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) (2022 revision) *(ASCQR, Hospital IQR, Hospital OQR, IPFQR, PCHQRP, ESRD QIP, IRF QRP, LTCH QRP, PCHQRP, SNF QRP)*
- **MUC2022-020:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) *(HOQR)*
- **MUC2022-125:** Gains in Patient Activation Measure (PAM) Scores at 12 Months *(MIPS)*
  - *Note: The measure submitted for ESRD QIP is not on the consent calendar and will be discussed during the meeting.*

Consent Calendar Measure Specifications

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

- **Description:** This electronic clinical quality measure (eCQM) provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of eligible CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision**: Support for Rulemaking

MUC2022-014: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

- **Description:** The percentage of top-box responses among patients aged 18 years and older who had an ambulatory palliative care visit and report feeling heard and understood by their palliative care provider and team within 2 months (60 days) of the ambulatory palliative care visit.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-018: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient)

- **Description:** This electronic clinical quality measure (eCQM) provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of eligible CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient hospital care settings are eligible.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **Workgroup Decision:** Support for Rulemaking

MUC2022-020: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient)

- **Description:** This electronic clinical quality measure (eCQM) provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of eligible CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in hospital outpatient care settings (including emergency settings) are eligible.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** Yes
- **Program(s) submitted to:** Hospital OQR
- **Workgroup Decision:** Support for Rulemaking

MUC2022-024: Hospital Harm - Acute Kidney Injury

- **Description**: The proportion of inpatient hospitalizations for patients 18 years of age or older who have an acute kidney injury (stage 2 or greater) that occurred during the encounter as evidenced by a substantial increase in serum creatinine value, or by the initiation of kidney dialysis (continuous renal replacement therapy [CRRT], hemodialysis or peritoneal dialysis).
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR, Medicare Promoting Interoperability Program
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-026: Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting

- **Description:** The measure will estimate a facility-level risk-standardized improvement rate for patient-reported outcomes (PROs) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit (SCB) improvement will be measured by the change in score on the joint-specific patient-reported outcome measure (PROM) instruments, measuring hip or knee pain and functioning, from the preoperative assessment (data collected 90 to 0 days before surgery) to the postoperative assessment (data collected 275 to 425 days following surgery).
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ASCQR, Hospital OQR
- **Workgroup Decision:** Support for Rulemaking

MUC2022-027: Facility Commitment to Health Equity

- **Description:** This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Facilities will receive one point each for attesting to five different domains of commitment to advancing health equity for a total of five points.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP, IPFQR, PCHQRP
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-043: Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans

- **Description:** This measure assesses the percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the measurement year.
- **Level of Analysis:** Health Plan
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** Part C & D Star Ratings [Medicare]
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-048 Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument

- **Description:** This measure determines the percentage of pregnant or postpartum patients at a clinic who received a CVD risk assessment with a standardized instrument, such as the CVD risk assessment algorithm developed by the California Maternal Quality Care Collaborative (CMQCC). Aim is that 100 percent of eligible pregnant/postpartum patients undergo CVD risk assessment using a standardized tool. Every patient should be assessed for CVD risk at least once during the and, as needed, additional times when symptoms present during the pregnancy postpartum period. The measure can be calculated on a quarterly or annual basis.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-053: Screening for Social Drivers of Health

- **Description:** The Screening for Social Drivers of Health measure assesses the total number of patients, aged 18 years and older, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during an inpatient facility stay, or during established care in the case of dialysis facilities. The measure cohort includes patients who are admitted to an inpatient facility or who have established care in the case of dialysis facilities and are 18 years or older on the date of admission or on the date of established care in the case of dialysis facilities.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP; IPFQR; PCHQRP
- **Workgroup Decision:** Conditional Support for Rulemaking

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

- **Description:** The FYSWR measure tracks the number of incident patients in a practitioner (inclusive of physicians and advanced practice providers) group who are under the age of 75 and were listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis. For this measure, patients are assigned to the practitioner group based on the National Provider Identifier (NPI)/Unique Physician Identifier Number (UPIN) information entered on the CMS Medical Evidence 2728 form.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Do Not Support for Rulemaking with Potential for Mitigation

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

- **Description:** This measure tracks the percentage of patients in each dialysis practitioner group practice who were on the kidney or kidney-pancreas transplant waitlist (all patients or patients in active status). Results are averaged across patients prevalent on the last day of each month during the reporting year. The proposed measure is a directly standardized percentage, which is adjusted for covariates (e.g. age and risk factors).
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **NQF Recommendation:** Conditional Support for Rulemaking

MUC2022-064: Hospital Harm - Pressure Injury

- **Description:** The proportion of inpatient hospitalizations for patients 18 years of age or older at the start of the encounter, who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR, Medicare Promoting Interoperability Program
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-065: Preventive Care and Wellness (composite)

- **Description:** Percentage of patients who received age- and sex-appropriate preventive screenings and wellness services. This measure is a denominator-weighted composite of seven component measures that are based on recommendations for preventive care by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), American Association of Clinical Endocrinology (AACE), and American College of Endocrinology (ACE). Please refer to the 2022_MUC List Data_MIPS_PCW_Composite_CompositeCalculationAttachment_FINAL_05_09-22.docx attachment for more information on the exact composite calculation process.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision**: Conditional Support for Rulemaking

MUC2022-067: Risk-standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery

- **Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of an outpatient surgical procedure performed at a Rural Emergency Hospital among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** REHQRP
- **Workgroup Decision:** Support for Rulemaking

MUC2022-075: Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR)

- **Description:** The standardized modality switch ratio (SMoSR) is defined to be the ratio of numbers of observed modality switches (from in-center to home dialysis- peritoneal or home hemodialysis) that occur for adult incident ESRD dialysis patients treated at a particular facility, to the number of modality switches (from in-center to home dialysis- peritoneal or home hemodialysis) that would be expected given the characteristics of the dialysis facility's patients and the national norm of dialysis facilities. The measure includes only the first durable switch that is defined as lasting 30 continues days or longer.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) Submitted to:** ESRD QIP
- **Workgroup Decision:** Do Not Support for Rulemaking with Potential for Mitigation

MUC2022-076: Standardized Fistula Rate for Incident Patients

- **Description:** The Standardized Fistula Rate (SFR) for Incident Patients is based on the prior SFR (NQF #2977) that included both incident and prevalent patients. This measure was initially endorsed in 2016, but as part of measure maintenance review by the NQF Standing Committee in 2020, concerns were raised about the strength of evidence supporting the prior measure. Namely, recent updates to the KDOQI guidelines downgraded the evidence supporting fistula as the preferred access type and instead focus on catheter avoidance and developing an individualized ESKD Life plan.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) Submitted to:** ESRD QIP
- **Workgroup Decision:** Do Not Support for Rulemaking with Potential for Mitigation

MUC2022-078: Psychiatric Inpatient Experience Measurement

- **Description:** The measure is a 23-item five-point Likert scale (i.e., "strongly agree, agree, neutral, disagree, strongly disagree" as well as a "does not apply" option) survey to assess the experience of patients who have received inpatient psychiatric services. The survey measures four key domains of patient experience for inpatient psychiatric care settings, including Relationship with the Treatment Team, Nursing Presence, Treatment Effectiveness, and the Healing Environment.
- **Level of Analysis:** Facility; Other: Hospital Units
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** IPFQR
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-079: Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities

- **Description:** The Standardized Emergency Department Encounter Ratio is defined to be the ratio of the observed number of emergency department (ED) encounters that occur for adult Medicare ESRD dialysis patients treated at a particular facility to the number of encounters that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. Note that in this document an emergency department encounter always refers to an outpatient encounter that does not end in a hospital admission. This measure is calculated as a ratio but can also be expressed as a rate.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP
- **Workgroup Decision:** Support for Rulemaking

MUC2022-081: Abdomen Computed Tomography (CT) Use of Contrast Material

- **Description:** This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both).
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** REHQRP
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-084: COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) (2022 revision)

- **Description:** Percentage of healthcare personnel who are considered up to date with recommended COVID-19 vaccines.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ASCQR, ESRD QIP, Hospital IQR, Hospital OQR, IPFQR, IRF QRP, PCHQRP, LTCH QRP, SNF QRP
- **NQF Recommendation:** Conditional Support for Rulemaking

MUC2022-097: Low Back Pain

- **Description:** The Low Back Pain episode-based cost measure evaluates risk adjusted cost to Medicare of a clinician or clinician group for patients receiving ongoing medical care to manage and treat low back pain. This chronic condition measure includes the costs of services that are clinically related to the role of the attributed clinician in managing care during a Low Back Pain episode.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-099: Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure

- **Description:** This measure estimates the risk-standardized rate of unplanned, potentially preventable readmissions that occur during SNF stays among Medicare fee-for-service [FFS] beneficiaries. This measure applies two substantive refinements to the original measure (described in detail with the numerator and denominator), which was submitted and published to the MUC list in 2015 and finalized in the fiscal year (FY) 2017 SNF PPS final rule for use in the SNF VBP program in 2016. The measure is calculated in an identical manner using the following formula: (risk-adjusted numerator/risk-adjusted denominator)*national observed rate. The measure is calculated using two years of Medicare FFS claims data.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** SNF VBP
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-100: Emergency Medicine

- **Description:** The Emergency Medicine episode-based cost measure evaluates a clinician's risk-adjusted cost to Medicare for patients who have an emergency department (ED) visit during the performance period. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This measure includes costs of Part A and B services during each episode from the start of the ED visit that opens, or triggers the episode through 14 days after the trigger, excluding a defined list of services for each ED visit type that are unrelated to the ED care.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-112: Geriatrics Hospital Measure

- **Description:** This structural measure assesses hospital commitment to improving outcomes for patients greater than or equal to 65 years of age through patient-centered competencies aimed at achieving quality of care and safety for all older patients. The measure will include 14 attestation-based questions across 8 domains representing a comprehensive framework required for optimal care of older patients admitted to the hospital or being evaluated in the emergency department. A hospital will receive a point for each domain where they attest to at least one corresponding statement (for a total of 8 points). For each item, attestation of all elements is required to qualify for the measure numerator.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **Workgroup Decision**: Do Not Support for Rulemaking with Potential for Mitigation

MUC2022-113: Number of Hospitalizations per 1,000 Long-Stay Resident Days

- **Description:** The number of unplanned hospitalizations (including observation stays) for long-stay residents per 1,000 long-stay resident days. For this measure, long-stay resident days are all days after the resident's 100th cumulative day in the nursing home.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** SNF VBP
- **Workgroup Decision**: Conditional Support for Rulemaking

MUC2022-114: Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy

- **Description:** Percentage of patients without a diagnosis of glaucoma who had an intravitreal or periocular corticosteroid injection (e.g., triamcinolone, preservative-free triamcinolone, dexamethasone, dexamethasone intravitreal implant, or fluocinolone intravitreal implant) who, within seven (7) weeks following the date of injection, are screened for elevated intraocular pressure (IOP) with tonometry with documented IOP =<25 mm Hg for injected eye OR if the IOP was >25 mm Hg, a plan of care was documented.
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-115: Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up

- **Description:** Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 8 weeks
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-116: Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up

- **Description:** Percentage of patients with a diagnosis of acute posterior vitreous detachment (PVD) and acute vitreous hemorrhage in either eye who were appropriately evaluated during the initial exam and were re-evaluated no later than 2 weeks
- **Level of Analysis:** Clinician – Individual
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-120: Documentation of Goals of Care Discussions Among Cancer Patients

- **Description:** Measuring documentation of goals of care discussions is a critical step toward achieving the outcome of goal concordant care. Oncologists are responsible for ensuring documentation of these discussions. Documentation of goals in structured fields prompts discussions, enhances their quality and efficiency, and promotes accessibility. This measure assesses goals of care discussion documentation among patients with cancer who die while receiving care at the reporting hospital. In this process measure, reported annually, hospitals will report the percent of cancer patients who died during the reporting period and had the patient's goals of care documented prior to death.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** PCHQRP
- **Workgroup Decision:** Conditional Support for Rulemaking

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

- **Description:** The percentage of individuals aged 18 and older with a mental and/or substance use disorder who demonstrated improvement or maintenance of functioning based on results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) or Sheehan Disability Index (SDS) 30 to 180 days after an index assessment.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

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

- **Description:** The Patient Activation Measure (PAM) (Registered Trademark) is a 10- or 13- item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM performance measure (PAM-PM) is the change in score on the PAM from baseline to follow-up measurement. A positive change would mean the patient is gaining in their ability to manage their health. The measure is not disease specific but has been successfully used with a wide variety of chronic conditions, as well as with people with no medical diagnosis.
- **Level of Analysis:** Clinician – Individual; Clinician – Group; Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** MIPS, ESRD QIP
- **Workgroup Decision:** Support for Rulemaking

MUC2022-126: Total Nursing Staff Turnover

- **Description:** The percent of nursing staff that stop working in a facility within a given year.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** SNF VBP
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-127 Initiation, Review, And/Or Update to Suicide Safety Plan for Individuals With Suicidal Thoughts, Behavior, or Suicide Risk

- **Description:** This measure assesses the percentage of adult aged 18 and older with suicidal ideation or behavior symptoms (based on results of a standardized assessment tool) or increased suicide risk (based on the clinician's evaluation) for whom a suicide safety plan is initiated, reviewed, and/or updated in collaboration between the patient and their clinician.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MUC2022-131: Reduction in Suicidal Ideation or Behavior Symptoms

- **Description:** The percentage of individuals aged 18 and older with a mental and/or substance us disorder who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale 'Screen Version' or 'Since Last Visit' (CSSRS), within 120 days after an index assessment.
- **Level of Analysis:** Clinician – Individual; Clinician – Group
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** MIPS
- **Workgroup Decision:** Conditional Support for Rulemaking

MAP Implementation Results

2019-2020 MUC Recommendations

Support for Rulemaking (5 Measures)
Finalized Into Rulemaking
• 06064-C-MIPS: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)*
Not Finalized Into Rulemaking
• 06077-C-PARTD: Use of Opioids at High Dosage in Persons without Cancer (OHD)
• 06076-C-PARTD: Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
• 01364-C-PCHQR: National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure*
• 01475-C-PCHQR: National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

NATIONAL QUALITY FORUM

2019-2020 MUC Recommendations (continued-1)

Conditional Support for Rulemaking (11 Measures)
Finalized Into Rulemaking
• 06154-C-HIQR: Maternal Morbidity • 06141-E-HIQR: Hospital Harm – Severe Hyperglycemia* • 06166-C-MIPS: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate • 06062-C-MIPS: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups • 06159-C-PARTC: Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Discharges, Patient Engagement and Medication Reconciliation Post-Discharge • 06156-C-PARTC: Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions • 06111-C-HQR: Hospice Visits in the Last Days of Life (HVLDL)* • MUC19-64: Standardized Transfusion Ratio for Dialysis Facilities* • 06161-C-HHQR: Home Health Within-Stay Potentially Preventable Hospitalization Measure
Not Finalized Into Rulemaking
• 02816-C-MSSP: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* • MUC19-22: Follow-Up After Psychiatric Hospitalization

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

2019-2020 MUC Recommendations (continued-2)

Do Not Support for Rulemaking with Potential for Mitigation (1 Measure)
Not Finalized Into Rulemaking
• MUC19-37: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions; in the Medicare Shared Savings Program, the score would be at the MIPS provider (or provider group) level.
Do Not Support for Rulemaking (1 Measure)
Not Finalized Into Rulemaking
• 06078-C-PARTD: Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)
Removed from Consideration (2 Measures)
Not Finalized Into Rulemaking
• 05858-C-MIPS: Emergency Department Utilization (EDU)
• 05859-C-MIPS: Acute Hospital Utilization (AHU)

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

2020-2021 MUC Recommendations

Support for Rulemaking (2 Measures)
Finalized Into Rulemaking
• 07047-C-HIQR: Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty: Hospital-Level Performance Measure* • 01013-C-ESRDQIP: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

2020-2021 MUC Recommendations (continued-1)

Conditional Support for Rulemaking (16 Measures)
Finalized Into Rulemaking
• 06114-C-SNFQRP: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization • 12735-C-HOQR: Breast Cancer Screening Recall Rates • 06090-E-HIQR: Global Malnutrition Composite Score* • 06090-C-PI: Global Malnutrition Composite Score* • 08060-C-HQR: Hospice Care Index • 08061-C-MIPS: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) • 08062-C-IRFQR: COVID–19 Vaccination Coverage among Healthcare Personnel • 08062-C-LTCHQR: COVID–19 Vaccination Coverage among Healthcare Personnel • 08062-C-SNFQRP: COVID–19 Vaccination Coverage among Healthcare Personnel • 08062-C-ASCQR: COVID–19 Vaccination Coverage among Healthcare Personnel • 08062-C-HOQR: COVID–19 Vaccination Coverage among Healthcare Personnel* • 08062-C-IPFQR: COVID–19 Vaccination Coverage among Healthcare Personnel • 08062-C-PCHQR: COVID-19 Vaccination Coverage among Healthcare Personnel • 08062-C-HIQR: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel* • 08062-C-IRFQR: COVID–19 Vaccination Coverage among Healthcare Personnel • 08051-E-HOQR: ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM)*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

2020-2021 MUC Recommendations (continued-2)

Conditional Support for Rulemaking (5 Measures)
Not Finalized Into Rulemaking
• 08058-C-MIPS: Melanoma Resection Episode-Based Cost Measure • MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions • MUC20-0045: SARS-CoV-2 Vaccination by Clinicians • 08064-C-ESRDQIP: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities • 08056-C-MIPS: Colon and Rectal Resection Episode-Based Cost Measure

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

2020-2021 MUC Recommendations (continued-3)

Do Not Support for Rulemaking with Potential for Mitigation (6 Measures)
Not Finalized into Rulemaking
• 08055-C-MIPS: Asthma/Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure • 08057-C-MIPS: Diabetes Episode-Based Cost Measure • 08059-C-MIPS: Sepsis Episode-Based Cost Measure • 06162-C-MIPS: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System • 06167-C-MIPS: Intervention for Prediabetes • 05726-C-MIPS: Preventive Care and Wellness (composite)

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

Review of Measures Under Consideration (MUCs) by MAP Advisory Groups

MAP Health Equity Advisory Group Charge

- Provide input to the MAP Workgroups and Coordinating Committee during the pre-rulemaking process on measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Identify health disparity gaps in measurement
- Provide input to reduce health differences closely linked with social, economic, or environmental disadvantages

Health Equity Advisory Group Review of MUCs

- The Health Equity Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on:
  - Risk adjustment and measure use (public reporting versus internal use) as potential health equity issues
  - The need for stratified reporting of measures to identify and address health disparities
  - The need for measures to be actionable for providers
  - Whether "checklist" measures (i.e., attestation measures) initiate meaningful changes to quality of care
  - Workflow and data collection/reporting burden for smaller, rural, and safety net providers
  - Workforce capacity (i.e., staffing shortages)

MAP Rural Health Advisory Group Charge

- To provide input on measurement issues to MAP Workgroups and Coordinating Committee during the pre-rulemaking process and to provide rural perspectives on the selection of quality measures in MAP
- Identify rural-relevant gaps in measurement
- To provide input to help address priority rural health issues, including the challenge of low case-volume and access

Rural Health Advisory Group Review of MUCs

- The Rural Health Advisory Group reviewed all the MUCs and provided feedback to the setting-specific Workgroups on:
  - Low patient volume impacting measure reporting and stratification
  - Limited resources and barriers to accessing care (e.g., transportation, broadband access for telehealth services) in rural communities
  - The fragmentation of care in rural settings (i.e., decreased availability of post-acute care and rehabilitation services)
  - Workflow and data collection/reporting burden for smaller, rural, and safety net providers
  - Workforce capacity (i.e., staffing shortages, locum staff)

Overview of MAP PAC/LTC Workgroup and CMS Programs

MAP PAC/LTC [Post-Acute Care/Long-Term Care] Workgroup Charge

- To provide recommendations on matters related to the selection and coordination of measures for post-acute care (PAC) and long-term care (LTC) programs

NATIONAL QUALITY FORUM

PAC/LTC Programs

Home Health Quality Reporting Program (HH QRP)

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

Home Health Quality Reporting Program (HH QRP)

- **Program Type:** Pay for Reporting & Public Reporting
- **Incentive Structure:** Section 484.225(i) of Part 42 of the Code of Federal Regulations (C.F.R.) provides that HHAs that meet the quality data reporting requirements are eligible to receive the full home health (HH) market basket percentage increase. HHAs that do not meet the reporting requirements are subject to a two (2%) percentage point reduction to the HH market basket increase.
- **Program Goals:** Alignment with the mission of the National Academy of Medicine (NAM) which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient centeredness, safety, and timeliness.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** IRFs that fail to submit data will have their applicable IRF Prospective Payment System (PPS) payment update reduced by 2%.
- **Program Goals:** Address the rehabilitation needs of the individual including improved functional status and achievement of successful return to the community post-discharge.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

- **Program Type**: Pay for reporting and public reporting
- **Incentive Structure**: LTCHs that fail to submit data will have their applicable annual payment update (APU) reduced by 2%.
- **Program Goals:** Furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days).

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

- **Program Type:** Pay for reporting and public reporting
- **Incentive Structure:** SNFs that do not submit the required quality data will have their annual payment update reduced by 2%.
- **Program Goal:** Increase transparency so that patients are able to make informed choices.

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

- **Program Type:** Value-Based Purchasing
- **Incentive Structure:** The SNF VBP Program awards incentive payments to SNFs based on a single all-cause readmission measure (SNF 30-Day All-Cause Readmission Measure; NQF #2510), as mandated by Protecting Access to Medicare Act (PAMA) of 2014. SNFs' performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score and the National SNF performance during the baseline period to calculate an achievement score. The higher of the achievement and improvement scores becomes the SNF's performance score. The Consolidate Appropriation Act (CAA) of 2021 expanded the model to include up to 9 new measures and a validation process for the measures. CMS finalized the first additional measures in the FY 2023 rule.
- **Program Goals:** Transforming how care is paid for, moving increasingly towards rewarding better value, outcomes, and innovations instead of merely volume, and linking payments to performance on a single readmission measure.

MAP Hospital Workgroup Charge and CMS Programs

MAP Hospital Workgroup Charge

- To provide recommendations on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals

MAP Hospital Workgroup Programs

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (Hospital IQR)
- Hospital Outpatient Quality Reporting Program (Hospital OQR)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) (Medicare Promoting Interoperability Program)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)
- Rural Emergency Hospital Quality Reporting Program (REHQRP)

  (New in 2023)

Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- **Program Type:** Quality Payment Program & Public Reporting
- **Incentive Structure:** Ambulatory Surgical Centers (ASCs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the ASC Fee Schedule (ASCFS) for not meeting program requirements
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about ASC quality so they can make informed choices about their care.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goals:** Improve the quality of dialysis care and produce better outcomes for beneficiaries

Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goals:** Encourage hospitals to reduce HACs through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

Hospital Inpatient Quality Reporting Program (Hospital IQR)

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

Hospital Outpatient Quality Reporting Program (Hospital OQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals outpatient departments (HOPDs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about HOPD quality so they can make informed choices about their care.

Hospital Value-Based Purchasing Program (HVBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2.0% of base operating DRG is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments
- **Program Goals:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update
- **Program Goals:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices

Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) (Medicare Promoting Interoperability Program)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goals:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)

- **Program Type:** Quality Reporting
- **Incentive Structure:** PCHQR is a voluntary reporting program. Data are reporting on Provider Data Catalog (PDC)
- **Program Goals:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

Rural Emergency Hospital Quality Reporting Program (REHQRP)

- **Program Type:** Quality Reporting
- **Incentive Structure:** Provider reporting and public display of data required per statute
- **Program Goals:** Public reporting of quality data for consumer use and to inform quality improvement efforts

Overview of MAP Clinician Workgroup and CMS Programs

MAP Clinician Workgroup Charge

- To provide recommendations on issues related to measures that would impact clinicians, particularly in the office setting

NATIONAL QUALITY FORUM

Clinician Programs

Merit-based Incentive Payment System (MIPS) Program

Medicare Part C and D Star Ratings

Merit-based Incentive Payment System (MIPS)

- **Program Type:** Quality Payment Program (QPP)
- **Incentive Structure:**
  - Pay-for-performance.
  - There are four connected performance categories that affect a clinician's payment adjustment. Each performance category is scored independently and has a specific weight.
  - The MIPS performance categories and finalized 2023 weights are the following:
    - Quality (30%);
    - Promoting Interoperability (25%);
    - Improvement Activities (15%); and
    - Cost (30%).
  - The final score (100%) based on the four performance categories will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians.
- **Program Goals:**
  - Improve quality of patient care and outcomes for Medicare fee-for-service (FFS).
  - Reward clinicians for innovative patient care.
  - Drive fundamental movement toward value in healthcare.

Medicare Part C and D Star Ratings

- **Program Type:** Quality Payment Program & Public Reporting
- **Incentive Structure:**
  - Medicare Advantage: Public reporting and quality bonus payments (QBP)
  - Stand-alone Prescription Drug Plans: Public reporting
- **Program Goals:**
  - Provide information about plan quality and performance indicators to beneficiaries to help them make informed plan choices
  - Incentivize high performing plans (Part C)
  - The April 2018 final rule (CMS-4282-F) initially codified the methodology for the Part C and D Star Ratings