NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership Coordinating Committee In-Person Meeting

The National Quality Forum (NQF) convened a public in-person meeting for the Measure Applications Partnership (MAP) Coordinating Committee on January 15, 2020.

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

Sam Stolpe, NQF Senior Director, welcomed participants to the in-person meeting. MAP Coordinating Committee Co-chair, Chip Kahn, provided opening remarks. Dr. Stolpe then reviewed the following meeting objectives: to finalize recommendations to the Department of Health and Human Services (HHS) on Measures Under Consideration (MUCs) for use in federal programs for the clinician, hospital, and post-acute care/long-term care (PAC/LTC) settings, consider strategic issues that span all of the MAP Workgroups, and discuss potential improvements to the pre-rulemaking process

CMS Opening Remarks and Meaningful Measures Update

Michelle Schreiber, CMS QMVIG Group Director, offered opening remarks and presented on the Meaningful Measures Initiative. MAP provided feedback on the presentation and on proposed changes to the initiative.

MAP reviewed 19 priority areas within the Meaningful Measures Initiative and encouraged CMS to further narrow focus to the nation's highest priority areas. MAP encouraged CMS to include in its considerations how and why it is prioritizing certain areas over others, as well as the rationale for why changes occur within Meaningful Measures. MAP suggested that CMS clarify its thinking and share rationales for proposed changes in its approach.

MAP also applauded the cascading of measure accountability and stressed considering the patient first to allow for comparison of care providers on quality. MAP strongly emphasized the importance of capturing the patient voice through patient-reported outcomes, as well as a continued person-centered approach to measurement. MAP was concerned that many disparity and equity issues are still not being addressed, especially around access to care. Patient-reported outcomes in this area were thought to be particularly important. MAP also stressed the importance of care coordination, integrating payment and regulatory drivers to improve this aspect of care. MAP also supported CMS's efforts to improve maternal morbidity.

MAP noted that some measures are reverting to claims rather than electronic sources and called for improvement in data sourcing. MAP suggested that measures that draw on other electronic sources beyond the EHR should be considered, including the use of all-payer data.

Overview of Pre-Rulemaking Approach

Kate Buchanan, NQF Senior Project Manager, provided an overview of the three-step approach to pre-rulemaking, which includes program overview, review of current measures, and evaluation of Measures Under Consideration for what they would add to the program measure set. Ms. Buchanan then

reviewed the four decision categories that the Coordinating Committee members could vote on following the discussion of each measure.

Hospital Programs

Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program Measures

Mr. Kahn opened for public comment. No public comments were offered.

MUC2019-18 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure

MAP supported MUC2019-18 for rulemaking. A prior version of this measure is currently included in PCHQR and addresses the Meaningful Measure area of healthcare-associated infections. The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the spring 2019 CDP cycle. The measure is otherwise identical to the existing measure in PCHQR. MAP members noted the need to monitor the use of the measure in spinal cord injuries. MAP also noted the importance of comparing cancer hospitals to like hospitals given the differences in the patient populations. The Rural Health Workgroup noted that the 11 PPS-exempt cancer hospitals in the program are in urban centers, but rural patients often use them, and expressed support of MUC2019-18. MAP supported the continued use of this measure in PCHQR with the updated specifications.

MUC2019-19 National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure

MAP supported MUC2019-19 for rulemaking. MAP noted that MUC2019-19 is an updated version of the existing measure in PCHQR (NQF 0139). The risk-adjustment model for this measure was updated, and the measure was submitted and re-endorsed by the NQF Patient Safety Standing Committee in the spring 2019 CDP review cycle. MAP noted that this measure is also otherwise identical to the existing measure in PCHQR. MAP noted that CLABSIs are associated with significant morbidity, mortality, and costs. Patients in ICUs are at an increased risk for CLABSI because 48 percent of ICU patients have indwelling central venous catheters, accounting for 15 million central line days per year in U.S. MAP encouraged CMS and CDC to review if there are patient-specific traits that lead to higher rates of CLABSI within cancer hospitals. The Rural Health Workgroup also noted that the 11 cancer hospitals in the program are in urban centers, but rural patients often use them, and the Workgroup expressed support of MUC2019-19.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Measure

MUC2019-22 Follow-Up After Psychiatric Hospitalization

MAP conditionally supported MUC2019-22 for rulemaking pending NQF endorsement. MAP noted that this measure is an expansion of the existing NQF 0576 Inpatient Psychiatric Facility Quality Reporting Program Follow-Up After Hospitalization for Mental Illness measure, broadening the measure population to include patients hospitalized for drug and alcohol disorders as those patients also require follow-up care post-discharge. MAP noted the importance of robust care transitions for this expanded population but also identified several critical concerns with the proposed measure. MAP expressed concern that the numerator requires patients to pursue follow-up care and may not reflect whether follow-up care has been arranged by the hospital being measured; this was counterbalanced by other MAP members stating that hospitals can have an important role in ensuring patients keep their follow-up care appointments. MAP noted that the Stark Law may limit the ability for hospitals and care

managers to ensure necessary SUD treatment follow-up after hospitalization, given the limited number of SUD providers.

MAP members were also concerned that patients may not have access to appropriate SUD outpatient follow-up care. MAP was also concerned that the same evidence base for drug and alcohol disorders as was provided for other behavioral health conditions may not be present. Members noted the importance of telehealth follow-up as a critical tool and the importance of including these visit types in the measure. CMS noted that telehealth is currently billable in a limited fashion, only if it is submitted with a GT modifier. MAP was generally not satisfied with the current specifications and expressed concern that the measure could lead to unintended negative consequences for patients.

Finally, several members noted that the evidence base for this measure needs to be specific to the conditions of interest and argued that this expanded SUD population should be measured separately from the patients with mental illness. By examining the two populations separately, CMS would acknowledge the two different provider groups that the hospital would be coordinating with and also help to illuminate potential workforce challenges limiting follow-up care for patients seeking SUD treatment. The MAP Rural Health Workgroup viewed this measure as appropriate, as SUD and mental health issues impact many rural residents, but the Workgroup expressed concern about access to care, recommending telehealth follow-up as a potential solution, which would harmonize with the NCQA HEDIS measure.

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

MUC2019-64 Standardized Transfusion Ratio for Dialysis Facilities

MAP conditionally supported MUC2019-64 for rulemaking, pending NQF endorsement of the revised measure specifications. MAP noted that the measure is based on an endorsed measure (NQF 2979) that was implemented in ESRD QIP, but with some modifications to the specifications. MAP considered the updates to the measure to be both appropriate and necessary. MAP noted that this measure is for reporting purposes only and is not used for payment.

MAP noted that this updated and re-specified claims-based outcome measure has been submitted for endorsement consideration to the NQF Renal Standing Committee for the fall 2019 review cycle. MAP noted that in 2021, Medicare Advantage will include dialysis, which may affect which beneficiaries stay in their home to receive dialysis and which go to facilities.

Hospital Inpatient Quality Reporting (IQR) Program and Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs) Measures

MUC2019-114 Maternal Morbidity

MAP conditionally supported MUC2019-114 Maternal Morbidity for rulemaking. The conditions identified by MAP include adjusting the language of the attestation question to clarify that the hospital is expected both to attest to participation in a quality improvement initiative as well as to implement patient safety practices or bundles to address complications. MAP included an additional condition that CMS allow multihospital quality improvement collaborative participation, in addition to statewide or national collaboratives to account for programs sponsored by large health systems. Lastly, MAP added a condition that the Maternal Morbidity measure should go through the NQF endorsement process and receive endorsement. MAP underscored that maternal morbidity is increasing at an alarming rate in the U.S., nearly doubling in the last decade. With no quality measures that address maternal morbidity, MAP strongly supported CMS's attempts to address this healthcare crisis through measurement. MAP also recommended adding some information to the answer options to clarify what constitutes a "yes, no, or n/a" response.

MUC2019-26 Hospital Harm – Severe Hyperglycemia

MAP offered conditional support for MUC2019-26 Hospital Harm – Severe Hyperglycemia, pending NQF endorsement of the measure. IQR currently does not include a measure that assesses severe hyperglycemia events that are largely avoidable through proper glycemic monitoring and intervention. MAP expressed concern and encouraged CMS to consider the unintended consequence that this measure may lead to increases in hypoglycemia, which was regarded as a more serious issue. The Rural Health Workgroup noted that diabetes rates are high in rural settings, and the measure addresses a preventable patient safety issue that is relevant for rural populations. The Rural Health Workgroup expressed concern that if glucose levels are derived from laboratory data (rather than at point of care), they may be more difficult to obtain and/or incorporate into EHR systems in rural hospitals. They also were concerned that EHR systems in rural hospitals may not be as robust or current, making it more difficult to compute the measure (e.g., using RxNORM). Finally, MAP generally agreed that the measure did not carry any significant implementation burden.

Merit-Based Incentive Payment System (MIPS) Program Measures

Dr. Bruce Hall, Coordinating Committee co-chair, opened for public comment. No public comments were offered.

MUC2019-27 Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate

MAP conditionally supported MUC2019-27 for rulemaking. Support for this measure is pending removal and replacement of NQF 1789 in the MIPS program measure set with this measure, and NQF CDP Standing Committee review of reliability performance at the physician group level in spring 2020. MAP noted that this measure is a respecified version of the measure Risk-Adjusted Readmission Rate (RARR) of unplanned readmission within 30 days of hospital discharge for any conditions (NQF 1789), which was developed for patients 65 years of age and older using Medicare claims. MAP expressed concerns regarding the validity of the measure and that the attribution method may not be appropriate for groups of specialists. MAP urged CMS to carefully investigate the validity and the reliability of the measure's attribution method and adjust the model should it not prove reliable and valid.

MAP emphasized the importance of addressing unplanned readmissions and noted that physician groups can influence this outcome by supporting appropriate medication reconciliation at discharge, reducing infection risk, and ensuring proper outpatient follow-up. MAP suggested that this measure promotes a systems level approach by clinicians and suggested a future focus on especially high-risk conditions such as COPD and heart failure. MAP noted that the NQF All-Cause Admissions and Readmissions Standing Committee had requested additional information from the developer on reliability performance of this measure at various case sizes for the physician group level of analysis in the course of the Consensus Development Process (CDP).

MUC2019-28 Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

MAP supported MUC2019-28 for rulemaking. MAP noted that this measure can improve the quality of surgical care delivery and follow-up care for a common and costly surgical procedure performed for Medicare beneficiaries. MAP agreed that patient-reported outcomes performance measures related to TKA and THA would also be desirable but would be complementary to this measure. MUC2019-28 is endorsed as NQF 3493 and is a respecified version of Hospital-level Risk-Standardized Complication rate (RSCR) following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF 1550), which was developed for patients 65 years and older using Medicare claims. MAP noted

that NQF 1550 is currently being used in the CMS Hospital Inpatient Quality Reporting Program, though it underwent substantial respecification to allow for clinician and clinician group attribution. In adapting the hospital-level measure for MIPS-eligible clinicians, the same cohort of patients will be measured, but the outcomes will be attributed to a larger number of healthcare entities with a shared responsibility for delivery of high quality postsurgical care. The MAP Rural Health Workgroup noted that this measure will be limited to clinicians/clinician groups with at least 25 patients, and as such, the low case-volume issue will not come into play for rural providers. However, access to supportive services prior to surgery will be even more critical when these procedures are done in the outpatient setting, and access to such services may be more limited in rural areas.

MUC2019-66 Hemodialysis Vascular Access: Practitioner Level Long-Term Catheter Rate

MAP conditionally supported MUC2019-66 for rulemaking. As the measure has not been reviewed by an NQF CDP Standing Committee to determine the strength of the measure's reliability and validity, MAP's support is conditional upon NQF endorsement. MAP noted that the use of a long-term catheter has a higher observed mortality rate than the use of arteriovenous fistula, thus this measure has the potential to provide greater quality of care for patients by reducing the associated mortality and morbidity from long-term catheter use.

MAP noted that a modified version of this measure is currently being used in a CMS quality program—the End-Stage Renal Disease Quality Improvement Program (ESRD QIP). The measure is undergoing changes to allow specification for individual clinicians and clinician groups. While MAP questioned the ability of providers to move patients from catheters to fistulas, the measure developer noted that clinicians can influence this as evidenced by rate improvements after implementation of this measure in ESRD QIP. MAP expressed concern on the reliability of the measure and encouraged CMS to rigorously test the measure. The Rural Health Workgroup noted that kidney diseases are prevalent conditions in rural populations. They emphasized that rural patients on dialysis are older and have more comorbidities, and they voiced concern that these patients might be pressed to use a fistula, even when there is little benefit.

MUC2019-37 Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

MAP did not support MUC2019-37 for rulemaking in MIPS with potential for mitigation. The measure is a modified version of an existing NQF-endorsed measure (NQF 2888), last reviewed for endorsement in 2016. MAP noted that the newly developed measure differs from its predecessor in a few ways.

- Cohort: CMS added diabetes as a cohort-qualifying condition.
- Outcome: CMS narrowed the outcome to focus on admissions where risk can be reduced by providing high-quality ambulatory care, so that the measure can be used to assess ambulatory (rather than ACO-wide) care quality.
- Risk adjustment: CMS added social risk factors to the risk-adjustment model.

MAP noted several potential areas of mitigation for the measure: (1) The measure should apply to clinician groups, not to individual clinicians; (2) The measure should use a higher reliability threshold, (e.g., 0.7); (3) The measure developer should consider the NQF guidance on attribution and consider patient preference and selection as a method of attribution as those data become available; (4) The measure should undergo the NQF endorsement process. MAP suggested that rather than moving directly to this outcome measure, process measures that would get to the desired outcome might be an appropriate stepwise approach to increasing accountability. The MAP Rural Health Workgroup noted that chronic conditions included in this measure are prevalent in rural residents. However, the Rural

Health Workgroup does not believe this measure should be linked to payment for rural clinicians or clinician groups.

Medicare Shared Savings Program (SSP) Program Measures

MUC2019-37 Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

MAP conditionally supported MUC2019-37 MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions, pending NQF endorsement. MAP noted that with over 80 percent of adults over the age of 65 having MCCs, this measure has the potential to significantly improve the quality of care for the Medicare beneficiary population. MAP also noted that this measure carries a higher reliability score than the measure considered for MIPS, and MAP considered it still appropriate for the SSP program. MAP noted that ACOs in SSP focus on processes and interventions that reduce disease progression and undesirable sequalae that lead to hospital admission for Medicare patients with MCCs. Moreover, the accountability structure of an ACO allows for stronger oversight and care coordination to influence measure performance within the ACO system.

MAP identified several measure gaps within SSP: diagnostic efficiency, measures of cultural change, and additional measures of care coordination and hand-offs using eCQMs.

Medicare Parts C and D Star Ratings Program Measures

MUC2019-14 Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions

MAP conditionally supported MUC2019-14 for rulemaking, pending NQF endorsement. MAP noted the importance of the care coordination domain as a CMS priority. MAP observed that care coordination is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of healthcare services. This measure is an additional process measure to the Medicare Part C and D Star Ratings that lends itself to better care efficiencies and coordination for health plans and their beneficiaries. MAP also discussed the increase of utilization and costs associated with use of emergency departments for Medicare beneficiaries, particularly those with dual-eligible status and with a behavioral health diagnosis, both of which are much higher cost demographics. Coordinating the care of beneficiaries who use emergency services is an important component to ensuring that they also are receiving outpatient care and preventive services with the potential to mitigate disease progression that results in further unnecessary use of emergency facilities. The Rural Health Workgroup noted that the chronic conditions included in this measure are prevalent in rural residents, and that lack of access to care in rural areas may make performance on this measure more difficult for plans that cover rural residents. MAP was encouraged that telephone follow-up was included in this measure but encouraged CMS to ensure that the telephone follow-ups are meaningful to patients.

MUC2019-57 Use of Opioids at High Dosage in Persons without Cancer (OHD)

MAP supported for rulemaking MUC2019-57 Use of Opioids at High Dosage in Persons without Cancer (OHD). The measure has been endorsed by NQF at the health plan level as NQF 2940. MAP noted that this measure leads to health plans carefully considering the needs of patients at high doses, encouraging appropriate nonopioid pain management, providing appropriate personalized pain care plans, directly addressing OUD, and potentially tapering patients off of high dose opioid regimens. MAP noted that concerns have been raised that pressure from health plans to diminish prescribing could be associated with the unintended consequence of patients seeking illicitly obtained opioids or heroin. This may lead to changes in prescribing practices for clinicians to adhere to CDC prescribing guidelines that were

intended to serve as guidance and not as a strict mandate. The MAP Rural Health Workgroup agreed that opioid use is a relevant issue for rural residents, but expressed concern that without a balancing measure, there is a potential for patient harm due to forced tapering and the potential for seeking illicit drugs to treat pain. Rural residents have relatively less access to alternative pain treatment and other resources.

MUC2019-60 Use of Opioids from Multiple Providers in Persons without Cancer (OMP)

MAP supported for rulemaking. MUC2019-60 Use of Opioids from Multiple Providers in Persons without Cancer (OMP). MAP observed that the measure will encourage health plans to address pain management and OUD within their beneficiary population while avoiding unintended consequences associated with rapid decline of opioid dosages. This measure appropriately identifies either mismanaged pain or potential opioid seeking behavior. MAP noted that this measure is endorsed at the health plan level as NQF 2950. MAP noted that all three opioid measures are currently in use in the SSP Opioid Utilization Reports as well as in the Part D Overutilization Monitoring System. The MAP Rural Health Workgroup suggested that although this measure could promote use of drug monitoring programs in rural areas, on the whole, it may not be particularly applicable due to the relatively few pharmacies in rural areas.

MUC2019-61 Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)

MAP did not support for rulemaking MUC2019-61 Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP). MAP observed that this measure was endorsed in 2017 as NQF 2951. This measure was also seen as duplicative of the other two measures, with little added benefit to the program from the combined measure. MAP emphasized the need for parsimony in the measure set.

MUC2019-21 Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Dischargers, Patient Engagement and Medication Reconciliation Post-Discharge

MAP conditionally supported MUC2019-21 for rulemaking, pending NQF endorsement. MAP noted that this measure was also designated as a first-year measure for HEDIS 2018. MAP observed that Medicare beneficiaries are at particular risk during transitions of care because of higher comorbidities, declining cognitive function, and increased medication use. There is observed variance in performance among health plans on all four components of the measure. Further, evidence indicates that good care transitions and care coordination reduce healthcare costs and improve outcomes.

MAP also noted that the medication reconciliation postdischarge component of this measure is already included in the Star Ratings as an independent measure and has been since 2017. The measure developer (NCQA) indicated its intention to work with CMS to develop a plan to avoid the need for health plans to report on both measures. MAP expressed concern that this measure is not entirely electronic, but it was noted that alternative data sources are not available. The Rural Health Workgroup noted the importance of measures to assess transitions of care for rural residents but that the measure requires chart abstraction, which can be particularly burdensome for small rural providers. They also noted that a yes/no checkbox measure of medication reconciliation may not drive improvements in care quality. There was some concern with the medication reconciliation component, particularly given the lack of pharmacists in rural areas.

Post-Acute Care and Long-Term Care Programs

Mr. Kahn opened for public comment. No public comments were offered.

Home Health Quality Reporting Program

MUC2019-34 Home Health Within-Stay Potentially Preventable Hospitalization

MAP conditionally supported MUC2019-34 Home Health Within-Stay Potentially Preventable Hospitalization, pending NQF endorsement. CMS clarified that it intends to eventually replace related measures, NQF 0171 Acute Care Hospitalization During the First 60 Days of Home Health and NQF 0173 Emergency Department Use without Hospitalization During the First 60 Days of Home Health with the measure under consideration. MAP agreed that the measure adds value to the program measure set by adding an assessment of potentially preventable hospitalizations and observation stays that may occur at any point in the home health stay. No measure in the program currently provides this information.

The measure supports alignment for the measure focus area of admissions and readmissions across care settings and providers. There is variation in performance on this measure, and home health agencies have the ability to implement processes and interventions that can positively influence the measure results. The MAP Rural Health Workgroup noted that older and sicker patients reflected in rural populations often have issues with access to care. No public comments were received on this measure or on the HH QRP. MAP encouraged consideration of including Medicare Advantage patients in future iterations of the measure.

Hospice Quality Reporting Program

MUC2019-33 Hospice Visits in the Last Days of Life

MAP conditionally supported MUC2019-33 Hospice Visits in the Last Days of Life for rulemaking, pending NQF endorsement and removal of the existing hospice visit measures from the program. Generally, MAP agreed that collecting information about hospice staff visits will encourage hospices to visit patients and caregivers, provide services that will address their care needs, and improve quality of life during the patient's last days of life. MAP observed that currently, Hospice Visits When Death is Imminent, Measure 1 and Measure 2, address this quality objective in the Hospice QRP, but the measure under consideration performed better in validity and reliability testing, and has lower provider burden because it is reported using claims data.

MAP agreed that the goal of hospice is comfort. MAP encouraged that future iterations of this measure consider the quality of provider visits in addition to the quantity of visits. MAP members reviewed analysis from CMS demonstrating that not all types of provider visits correlate positively with Hospice CAHPS results. MAP examined the possible variations on the measure concept and generally agreed that the analysis supported the current proposed measure. The MAP Rural Health Workgroup noted concerns related to access to care in rural areas. Public comments expressed concern about overlap with the existing hospice visits measures. Commenters also had concerns with a hospice program's ability to accurately identify imminent death, and with only including some members of the interdisciplinary team in the visits captured in the measure. The commenters suggested examining other options for this measure concept such as different numbers of visits.

Future Direction of the Pre-Rulemaking Process

Dr. Hall facilitated discussion among the Committee on process improvements for the next cycle. Many members discussed the need for feedback on previous recommendations. Members want to know if developers modified measures based on MAP guidance, if the measure went through the NQF endorsement process, and if the federal government put the measure into the rule.

The Committee had several recommendations for the presentation of MAP materials. It noted that it would be helpful to see the conditions proposed for measures that received conditional support from the Workgroup outline on the PowerPoint slide deck. Additionally, members discussed whether it would be useful to have the Workgroup vote for each MUC on the slide as well. Some members thought that it would provide helpful context to see if the Workgroup was in agreement or if it was a close vote. Another member stated that there was a concern seeing the votes would lead the Committee to re-adjudicate Workgroup discussion.

One member noted that the MAP reviews both fully specified measures and measure concepts. The member recommended that MAP have criteria that do not cause fully specified measures to be held to a higher standard because there is more information available to Committee. Additionally, the member recommended alignment and harmonization with the Core Quality Measures Collaborative (CQMC).

Public Comment

Ms. Buchanan opened the web meeting to allow for public comment. The SNP Alliance offered a comment related to special needs plans and the potential impact of MUC19-14 Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions and MUC19-21 Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Discharges, Patient Engagement and Medication Reconciliation Post-Discharge. SNP Alliance expressed concern that many aspects of these measures are outside of the control of the plan, and that the timeframe, data source, and the notification (to whom, by whom, how, and when) are not appropriately applied.

Next Steps

Dr. Stolpe thanked the Committee and CMS for their participation. He stated that NQF staff will finalize the MUC recommendations based on the Committee review.