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

Meeting Summary
February 13, 2023

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-T0003, Option Year 4.

Contents

Meeting Summary

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

The National Quality Forum (NQF) convened a two-day, public web meeting for members of the Measure Applications Partnership (MAP) Coordinating Committee on January 24, and January 25, 2023. The purpose of the meeting was to finalize recommendations on measures for use in federal programs for the clinician, hospital, and post-acute care/long-term care (PAC/LTC) settings. There were 250 attendees at this meeting, including MAP members, NQF staff, government representatives, measure developers and stewards, and members of the public.

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

Jenna Williams-Bader, senior director, NQF, welcomed participants to day one of the Coordinating Committee 2022-2023 Measures Under Consideration (MUC) Review Meeting and reviewed housekeeping reminders and the day one agenda.

Ms. Williams-Bader invited Dr. Dana Gelb Safran, president and CEO, NQF, to provide opening remarks. Dr. Safran welcomed participants to the Coordinating Committee 2022-2023 MUC Review Meeting. Dr. Safran stated that NQF is honored to partner with the Centers for Medicare & Medicaid Services (CMS) to convene the Measure Applications Partnership (MAP) and provide input on performance measures being considered for use in public reporting and performance-based payment programs. Dr. Safran highlighted that MAP's work will impact the lives of patients and families across the nation. Dr. Safran emphasized that MAP brings together a unique multistakeholder group representing a diverse array of voices, ensuring that the federal government receives varied and thoughtful input as measures are considered for final rulemaking. Dr. Safran thanked committee members, MAP co-chairs, federal liaisons, CMS colleagues, measure developers, and members of the public for their participation in the MAP process.

Ms. Williams-Bader invited the Coordinating Committee co-chairs, Charles "Chip" Kahn, III, and Misty Roberts, to provide opening remarks. Mr. Kahn thanked MAP members, NQF staff, and CMS colleagues for their contributions to making this year's MUC cycle a success. Ms. Roberts echoed Mr. Kahn's comments, expressed looking forward to the meeting over the next two days, and emphasized that the Coordinating Committee should draw upon the previous work carried out by the Advisory Groups and Workgroups in December.

Dr. Tricia Elliott, vice president, NQF, facilitated introductions and disclosures of interest (DOIs) from members of the MAP Coordinating Committee. Of the 21 organizational members, 18 attended the meeting. In addition, there were two co-chairs, and four subject matter experts (SMEs), totaling 24 members. The minimum quorum required for voting was 18 members. Two MAP members disclosed they have more than 10 thousand dollars in stock with a healthcare entity. These two disclosures were deemed not to be a direct conflict, therefore not a recusal from measure voting. A MAP member disclosed they are employed by an organization that manufactures a coronavirus disease 2019 (COVID-19) vaccine and the organization has assets in the cost measures area. The MAP member indicated they

would recuse themselves during the discussion of and voting for the cost measures (MUC2022-101, -106, and -129) and the COVID-19 measures (MUC2022-052, -089, -090, -091, and -092). A MAP member disclosed they are employed by an organization that contributed to the development of MUC2022-032 and indicated they would recuse themselves from discussion of this measure. A MAP member disclosed participation in the measure developer's technical expert panel (TEP) for MUC2022-101 and MUC2022-106; however, this disclosure was deemed not to be a direct conflict and therefore, not a recusal from voting. Dr. Elliott also introduced the nonvoting federal government liaisons. See Appendix A for detailed attendance. Dr. Elliott reminded MAP that conflicts of interest may be declared during the meeting, and any undisclosed conflicts of interest or biased conduct can be reported to the co-chairs or NQF staff.

Ms. Williams-Bader recognized the NQF team and the Centers for Medicare & Medicaid Services (CMS) staff supporting the MAP Coordinating Committee activities. Ms. Williams-Bader also recognized the CMS program and measure leads, and the measure stewards and developers. Ms. Williams-Bader then reviewed the meeting objective for day one which was to finalize recommendations on measures for use in federal programs for the clinician, hospital, and PAC/LTC settings.

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for CMS and Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG), welcomed participants to the meeting and thanked NQF staff and MAP members for their participation. Dr. Schreiber emphasized the importance of public comment as CMS considers measures for use in Medicare quality programs. Dr. Schreiber shared CMS' national quality strategy goals, national quality strategy targets, and strategic priority areas for measure and program alignment. Dr. Schreiber reviewed future measure priorities and the importance of measure alignment.

Overview of the 2022-2023 Pre-Rulemaking Approach

Ms. Williams-Bader shared that the charge of the MAP Coordinating Committee is to (1) provide input to the 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; (2) set the strategic direction for MAP and ensure alignment among MAP Advisory Groups and setting-specific Workgroups; and (3) provide final approval of the recommendations developed by the setting-specific Workgroups.

Ms. Williams-Bader continued by reviewing the MAP decision categories:

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

Ms. Williams-Bader explained that MAP Workgroups must reach a decision about every MUC and each decision is accompanied by one or more statements of rationale that explain why each decision was reached.

Ms. Williams-Bader reviewed the MAP key voting principles. Ms. Williams-Bader highlighted that quorum is defined as 66 percent of the voting members of the Coordinating Committee present virtually for live voting to take place and quorum must be established prior to voting. Ms. Williams-Bader

explained that if MAP does not establish a quorum 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. Ms. Williams-Bader noted that every MUC will receive a decision. Ms. Williams-Bader shared the meeting procedures for the measures for discussion, the measures pulled from the consent calendar, and measures on the consent calendar.

Ms. Williams-Bader opened the floor for questions. At this time, one question and three comments were raised. A MAP member asked whether public comment would occur prior to voting. Ms. Williams-Bader responded that there will be an opportunity for public comment at the beginning of each measure section.

A MAP member expressed frustration that their request to pull a measure from the consent calendar was not granted. Two other MAP members echoed this comment. Ms. Williams-Bader acknowledged these concerns and clarified that Coordinating Committee members must present a clear and compelling rationale in order to pull a measure from the consent calendar for discussion. Ms. Williams-Bader noted while it was initially anticipated that Coordinating Committee members could pull measures for discussion, not all requests could be accommodated due to time constraints imposed by the large number of measures under consideration during this year's MUC cycle. As a result, Ms. Williams-Bader explained that more stringent criteria needed to be applied to requests for pulling measures. Ms. Williams-Bader also noted that MAP members would have an opportunity to comment on measures on the consent calendar during the meeting on day two.

Measures Under Consideration

Cost Measures

Ms. Williams-Bader introduced the cost measures under discussion:

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

Public Comment

Ms. Williams-Bader turned to Mr. Kahn to open the meeting for public comment. Mr. Kahn provided instructions to the meeting attendees on the public commenting process before opening the meeting for public comment. At this time, three comments were raised.

The first commenter noted the Coordinating Committee's prior cost measure discussions, namely concerns with care stinting. The commentor further noted the issue with cost measures is any value with therapies beyond the measurement period will be a lost value. The commenter stated there are innovative therapies that have an upfront cost but will result in a long-term benefit that exceeds the measurement period as is the case for these three cost measures. The commenter urged CMS to conduct careful reviews of evolving standards of care including innovative therapies that may have long-term economic and therapeutic benefits not captured within a measurement period.

The second commenter expressed concerns for the cost measures related to mental health (MUC2022-101 and MUC2022-129). The commenter stated good care may not necessarily cost less, and good care will impact the overall cost of care as the previous commenter stated. The commenter noted cost savings are achieved over time and costs related to mental health appear in other ways such as societal

costs. The commenter stated cost savings usually appear downstream through improved health and reduction in comorbidities, and the measures as currently constructed do not have a way to capture downstream savings. The commenter further stated there may be unintended consequences such as negative impacts on inpatient settings which are already under resourced. The commenter noted the need to review the long-term impacts of cost measures.

Ms. Williams-Bader read a statement for measures MUC2022-101 and MUC2022-129 from a commenter who was unable to attend the meeting. The commenter noted participation on the clinical expert panels that developed the two measures. The commenter noted the panel addressed all feedback from those of patients, clinicians, and the public. The commenter further noted that the panel shortened the episode window of MUC2022-129 to 45 days to ease the burden on clinicians, even though the data supports a longer episode window. The commenter stated the panel supports the measures for rulemaking as the benefits outweigh the burden including, the importance of mental health, the data demonstrates the cost of healthcare for depression and psychoses is generally predictable and improving outcomes does not occur overnight.

MUC2022-101: Depression (MIPS)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking. Ms. Williams-Bader stated the Workgroup considered the appropriateness of the measure attribution methodology, the Part D medication costs as part of the episode, and the risk adjustment model. Ms. Williams-Bader also stated the Workgroup acknowledged that the measure accounts for social determinants of health by including dual-eligible status in the risk adjustment model. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received four public comments on the preliminary recommendation – two comments were in support of the measure with certain conditions and two were not in support. Ms. Williams-Bader indicated those who did not recommend the measure expressed concern that the measure does not accurately attribute cost to clinicians about the impact of cost associated with Part D drugs and stated that further testing was needed to assess the reliability of the measure. Ms. Williams-Bader stated another commenter expressed concern that the measure may incentivize providers to focus on short-term costs rather than evidence-based care and several comments noted the lack of risk adjustment for social risk factors. Ms. Williams-Bader further stated other comments agreed that cost measures are critical for understanding the value of care and supported the measure contingent on endorsement from a consensus-based entity to assess the measure's reliability and validity.

Ms. Williams-Bader turned to CMS for further clarification on the measure. Dr. Schreiber reminded the Coordinating Committee there is a statutory mandate for the Merit-based Payment System (MIPS) to include cost measures. Dr. Schreiber noted CMS "put a lot of work" into these measures. A CMS representative noted this measure has the potential to be impactful as depression is a common condition and mental health is an agency priority. The CMS representative further noted there are currently no cost measures in MIPS that address mental or behavioral health. The CMS representative stated this measure has the potential to enhance the optimizing chronic disease management MIPS Value Pathway (MVPs) which was finalized for use in the CY 2023 performance period. The CMS representative further noted depression is the leading cause of psychiatric hospitalizations in older adults and can exacerbate comorbidities.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant

noted full support for the cost measures. The lead discussant acknowledged the concerns of access that came from the Health Equity Advisory Group and Rural Health Advisory Group discussions. The lead discussant noted that cost is a key driver for access and advancing these measures overall supports accountability. The lead discussant noted the long-standing use of cost measures related to physical health. The lead discussant further noted they were struck by the comment about the change in the episode window for MUC2022-129 and questioned whether CMS should keep the original window if they are providing the data calculation.

Another lead discussant agreed with the prior discussant's comments. The lead discussant noted the measure needs to be reviewed and endorsed before it is adopted into rulemaking. The lead discussant questioned the use of the measure at the individual physician level. The lead discussant noted the challenge to gather information with cost measures to differentiate care among physicians and its relationship to the measure's validity. The lead discussant further noted the measure's potential application at the group level even with the methodological issues of cost measures but expressed concern with the measure's use at the individual physician level.

Mr. Kahn opened the floor for MAP members to discuss the measures. A MAP member noted it was clear by the voting in which this measure did not reach the threshold for the consent agenda and the public comments that there is a lack of agreement. The MAP member expressed concern with the potential to further fracture the fragile mental health system and remove resources that will strain the number of inpatient beds. The MAP member noted most depression patients are not seen in the emergency department, nor are they admitted to the hospital for care. The MAP member questioned whether this measure is capturing the most severe cases of depression. The MAP member stated there are outstanding issues with this measure and recommended not moving forward with the measure.

Another MAP member spoke from the patient and family perspective. The MAP member stated it was a "slippery area" when the cost dynamic is a factor in clinical decision making. The MAP member noted the desire for clinicians to make their best judgement utilizing shared decision making with patients and families, and using evidence based clinical outcomes. The MAP member acknowledged the statutory requirement, but further expressed concern with all three cost measures.

Another MAP member stated support for cost measures and the desire for high quality healthcare. The MAP member, however, questioned the ability to differentiate between physician level and group level care.

Mr. Kahn invited the measure developer to respond to questions and comments on the measure. The measure developer noted that although the measure did not meet the 80 percent threshold for the consent calendar, the recommendation received 75 percent of the Clinician Workgroup vote. The developer noted there was a substantial amount of consensus among the group developing the measure through field testing. The developer stated care stinting is something they assess across all cost measures. The developer noted the concern of care stinting would manifest as a strong negative correlation between better performance on the cost measure and performance on quality measures. The developer noted they did not see that result with the seven or eight measures they were able to test. The developer further noted the only statistically significant correlation was with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) health status and functional status measure and that was a positive correlation. The developer explained that the measure's performance by design is driven by hospital admission, emergency room (ER) visits, and other complications from treatment. The developer noted the best performers on the measure are those clinicians with fewer hospital admissions and ER visits so that addresses the concern about access and availability. The developer

responded to the question about the ability to distinguish good from poor performance. The developer stated at the group level the mean reliability of the measure was 0.87 at an episode case minimum of 20 and 0.91 at an episode case minimum of 30. The developer further stated at the individual clinician level the mean reliability was 0.8 for a case minimum of 20 and 0.85 for a case minimum of 30. The developer acknowledged there are some clinician groups performing better than others. The developer stated an important context was most clinicians in MIPS report as groups and in recent years more than 90 percent of MIPS participants report in groups. The developer noted the measure does address social risk factors through risk adjustment. The developer further noted that testing demonstrated there was no evidence to support the concern that the measure was biased against more complex patients – the predictive ratios were stable around 1.0 and were consistent across the deciles of patients.

A CMS representative responded to a comment about the measure's reliability. The CMS representative noted that NQF and MAP do not set any reliability standards, but the MIPS applicable mean reliability and statute is set at 0.4.

A lead discussant added that the Clinician Workgroup documentation indicated the distribution of performance for rural hospitals and non-rural hospital areas was similar, even across census regions. A MAP member posed a question to CMS about why the measure was being presented to MAP before being endorsed as there are many questions about validity and reliability, which is not the responsibility of MAP to assess. The MAP member noted the measure does not appear to be ready for rulemaking. The MAP member further noted there are other cost measures already meeting the statutory requirement for MIPS. Dr. Schreiber responded that the 50 percent requirement mandated by statute for [Medicare] Part A and B spending has yet to be met. Dr. Schreiber noted the validity and reliability is quite good. Dr. Schreiber further noted there is no mandate that MIPS measures be endorsed, but it is a goal CMS works towards.

A MAP member commented there is huge variation in how depression is treated based on the three sub-categories of depression: mild, moderate, and severe. The MAP member questioned how all of that is taken into account within the measure. The measure developer stated there was robust discussion among the technical expert panel (TEP). The developer noted the measure is currently separated into subgroups of those patients with psychotic features and those patients without psychotic features. The developer noted each subgroup has a robust risk adjustment model which considers approximately 79 comorbidities. The developer further noted, after the risk adjustment, the subgroups look very similar which indicates confidence with the adjustment. The MAP member questioned the developer about the treatment regardless of the risk, such as in the case of major depression. The developer noted that during measure development the question about severity and differing treatment was one of discussion. The developer further noted comparison in the measure is implicitly only made "like to like" as much as possible. The developer acknowledged there are clinical differences in treatment patterns within groups of patients. The developer noted that expected costs in the model track observed costs which means there is no bias against particular subgroups of patients. Mr. Kahn expressed concern that the discussions were going beyond the scope of the Coordinating Committee. Mr. Kahn acknowledged comments by a MAP member that these in-depth discussions are the work of the setting-specific Workgroups and the endorsement process.

Mr. Kahn asked for clarification on the conditions of the recommendation. Ms. Williams-Bader confirmed the Workgroup recommendation was "Conditional Support for Rulemaking" pending consensus-based entity (CBE) endorsement. Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-

101. Voting results were as follows: Yes – 16, No – 7, and percentage voting Yes – 70 percent. Full voting results are available in Appendix D.

MUC2022-106: Heart Failure (MIPS)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking pending endorsement of the measure by a CBE. Ms. Williams-Bader stated that the Workgroup acknowledged concerns among members that guideline recommended care, in terms of devices and never classes of medication therapy, have been shown to be of important clinical value for patients but do have cost implications. Ms. Williams-Bader further stated that the Workgroup noted the cost of this episode of care could be attributed to proceduralists who are responsible for high value interventions. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received four public comments on the preliminary recommendation – two comments were in support of the measure under certain conditions and two were not in support of the measure. Ms. Williams-Bader noted those who did not recommend the measure expressed validity concerns regarding the risk-adjustment model as it appears to rely on claims data, which cannot capture severity of illness, and does not include social risk factors, and whether attribution at the clinician level is appropriate. Ms. Williams-Bader further noted there were concerns raised that the measure may disincentivize the provision of evidence-based care and exacerbate disparities. Ms. Williams-Bader stated other comments agreed that cost measures were critical for understanding the value of care and supported the measure contingent on endorsement from a CBE to assess the measure's reliability and validity.

Ms. Williams-Bader turned to CMS for further clarification on the measure. A CMS representative stated that the measure will be impactful as heart failure is a common and costly condition among Medicare patients. The CMS representative noted studies have demonstrated that heart failure is one of the leading causes of hospitalizations and readmissions in the United States. The CMS representative noted there are currently no cost measures in MIPS that focus on heart failure and this measure has the potential to enhance the MVP on cardiovascular care that was modified in 2023 by more directly assessing the cost of managing heart failure.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant stated agreement with the Workgroup recommendation and noted costs can be driven by differences in quality. The lead discussant acknowledged the concerns submitted through public comments and agreed with the need to be mindful of care stinting in particular. The lead discussant further noted the condition of endorsement by a CBE would provide the forum to ensure the measure includes an appropriate attribution methodology and review risk adjustment concerns.

Another lead discussant noted the measure reflects an area of high impact and that heart failure is a key driver of cost in the population. The lead discussant stated appreciation for the episode-based cost measure as it allows for focused improvement and actionable efforts on a narrowed clinical area. The lead discussant acknowledged the comments and noted the risk adjustment methodology is adequate, but agreed the inclusion of clinical data could improve the risk adjustment by telling a more complete patient story. The lead discussant noted the concerns about care stinting for fear of increased short term cost increases and inequitable access to care. The lead discussant further noted the question about who controls cost but stated that those concerns do not outweigh the benefits of the measure. The lead discussant agreed with the "Conditional Support for Rulemaking" and concurred that endorsement

would be a good place to address some of the outstanding questions about the measure.

Another lead discussant applauded CMS for taking on heart failure especially when it pertains to cost because of the clinical variation. The lead discussant stressed the need for risk adjustment to consider social determinants of health as they factor significantly into care. The lead discussant noted that testing assessed whether higher cost services would have an adverse impact, but there was a limited amount of therapeutics reviewed. The lead discussant noted there are therapeutics coming down the pipeline beneficial to patients that increase the cost only in the short term but are not used due to cost implications. The lead discussant agreed with "Conditional Support for Rulemaking" for the measure, but strongly noted the need to figure out a way to not deprive patients of leading-edge care that may only increase short term costs.

Ms. Williams-Bader reminded the Coordinating Committee of the measure developer's supplemental information sent by NQF staff for reference. Mr. Kahn opened the floor for MAP members to discuss the measures. A MAP member posed a question about how the measure is operationalized. The MAP member gave a specific example about a heart failure patient, the potential use of an expensive SGLT2 [sodium-glucose Cotransporter-2 inhibitor] medication, and a potential disagreement between the cardiologist and primary care physician about the medication use. The MAP member asked who would be held accountable for the cost. A physician who led the workgroup during measure development responded that the measure aims to attribute it to the physician who has a significant existing relationship with the patient. The MAP member responded that both the primary care physician and the cardiologist may have this relationship. The MAP member noted this was the concern with the use of the measure at the individual physician level. Mr. Kahn asked if both the primary care physician and the cardiologist would be measured, or just one. The measure developer stated that during development there were discussions about attribution, noting in this example it would be possible for both to be attributed in the episode and both be measured. The developer further noted it would be determined by evidence in the physician claims. The measure developer explained the measure's attribution criteria includes the history of a clinician seeing a patient, and the display of a Part D billing pattern or a drug billing pattern that suggests management of drugs related to heart failure.

A lead discussant asked how it is ensured that clinicians are not going to be disincentivized from performing appropriate care even if there is a cost. The lead discussant acknowledged emergency department and inpatient care as costs that can be avoided but expressed concern for potential therapeutics that can improve quality and functional life. The measure developer responded there was testing on therapeutics that was shared in the supplemental information and noted improved outcomes with particular treatments. The developer noted three cost categories, outpatient major procedures, ambulatory minor procedures, and laboratory/pathology tests, all had negative coefficients indicating that an increase in any of these categories translates to a decrease in downstream adverse events. The lead discussant asked if the total cost would be lower along with the downstream cost. The developer did not have that testing available, but noted the key drivers of performance on cost measures are inpatient admission costs.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-106 pending CBE endorsement. Voting results were as follows: Yes – 18, No – 3, and percentage voting Yes – 86 percent. Full voting results are available in Appendix D.

MUC2022-129: Psychoses and Related Conditions (MIPS)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking pending endorsement of the measure by a CBE. Ms. Williams-Bader stated that the Workgroup considered how the availability of outpatient therapy impacts performance on the measure; however, the developer clarified that the availability of outpatient therapy does not influence measure performance. Ms. Williams-Bader further stated the Workgroup discussed the appropriateness of attribution methodology, but ultimately agreed with the value of the measure to this program set. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received four public comments on the preliminary recommendation – two comments were in support of the measure under certain conditions and two were not in support of the measure. Ms. Williams-Bader noted those who did not recommend the measure expressed concern that the measure does not accurately attribute cost to clinicians and stated that further testing is needed to assess the reliability of the measure. Ms. Williams-Bader noted additional concerns were raised that the measure holds inpatient psychiatrists accountable for costs that occur after the patient is discharged, and that it may have negative unintended consequences on the provision of mental and behavioral healthcare services and the vulnerable patient population seeking these services. Ms. Williams-Bader further noted other comments agreed that cost measures are critical for understanding the value of care and supported the measure contingent on endorsement from a CBE to assess its reliability and validity, and an evaluation for including appropriate risk adjustment for social risk factors.

Ms. Williams-Bader turned to CMS for further clarification on the measure. A CMS representative noted that psychosis is one of the most common reasons for inpatient stays, thus the measure has a strong potential to be impactful on Medicare spending. The CMS representative indicated the measure is an updated version of a measure reviewed by MAP several years ago and there has been work done to address the concerns raised by MAP, namely around what clinicians in an inpatient setting can do after a patient is discharged. The CMS representative noted key changes included shortening the episode window from 90 to 45 days, excluding episodes for specific scenarios where there is less ability to influence events such as involuntary holds, and adding a risk adjuster for facility type to account for differences between IPPS [inpatient prospective payment system] hospitals and IPF [inpatient psychiatric facility] hospitals.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant agreed with concerns about the measure having unintended consequences and noted its need for further development and field testing. The lead discussant noted the need for clarity on what it would mean given the wide range of costs that would be incurred by patients during inpatient stays after a diagnosis. The lead discussant further noted that the attribution methodology is not clear as there are consultation costs in addition to hospital costs. The lead discussant stated there needs to be more field testing to move this measure forward. The lead discussant also stated from the patient and family perspective there needs to be a balance between quality and cost when developing cost measures.

Another lead discussant noted concerns with the measure. The lead discussant noted that the measure is ambitious as it tries to address preventive care, acute care, and post-acute care. The lead discussant further noted the difficulty with the measure as there are transitional care issues and stated they did not support the measure.

Another lead discussant stated the developers addressed some of the issues raised by MAP in the 2019

review. The lead discussant agreed with the recommendation of "Conditional Support for Rulemaking" based on the condition of endorsement.

Mr. Kahn opened the floor for MAP members to discuss the measure. A MAP member noted geographic variation would further challenge the measure, especially if there are no real resources or outpatient services in the area. The MAP member further noted the measure may have negative consequences and produce further strain on the availability of inpatient beds for patients. The MAP member stated they did not support the measure.

The measure developer noted the overall rationale for the measure was to address concerns regarding the extent to which clinicians and the inpatient setting can influence what happens for mental health treatment after an inpatient stay. The developer noted their response to those concerns was reducing the episode window from 90 days to 45 days to align it with quality measures that are already present in CMS programs. The developer noted during testing there were patient interviews and focus groups that indicated a patient received no follow up post initial discharge until there was a rehospitalization. The developer noted those comments were salient and that a way to address constraints is to engage care coordination that can reduce the incidence of hospital readmissions.

Another measure developer noted the measure as one of the most tested measures submitted. The developer stated that testing results indicated the main driver of performance in the measure was the high cost of readmissions. The developer noted that for psychosis patients currently there is close to a 25 percent readmission rate for the inpatient setting and as a whole a 15 percent readmission rate. The developer further noted the measure's reliability is very high, close to 0.9 at the 30 episode case minimum and 0.83 at the 20 episode minimum.

Mr. Kahn asked if there were any other comments or questions from the Coordinating Committee. The measure developer responded to a question from a MAP member regarding risk adjustment, noting there is risk adjustment for IPPS hospitals and IPF hospitals.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-129 pending endorsement by a CBE. Voting results were as follows: Yes – 17, No – 5, and percentage voting Yes – 77 percent. Full voting results are available in Appendix D.

COVID-19 Measures

Ms. Williams-Bader introduced the COVID-19 measures under consideration:

- **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)*

Public Comment

Ms. Williams-Bader turned to Ms. Roberts to open the floor to allow for public comment. Ms. Roberts reminded the meeting attendees of the public commenting process before opening the floor for public comment. No public comments were offered.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup supported the measure for rulemaking. Ms. Williams-Bader explained that the Workgroup suggested the developer consider future updates to the measure specification by defining vaccination as "up to date vaccination" to align with the most current guidelines; however, the Workgroup generally agreed that the current measure and its specifications address a national public health emergency and should be supported for rulemaking. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received five public comments on the preliminary recommendation – three comments supported the measure under certain conditions and two did not support the measure. Ms. Williams-Bader said those who did not support the measure appreciated the measure concept but expressed concerns that the receipt of COVID-19 vaccination is outside the clinician's locus of control and the measure may unfairly penalize providers, particularly because of vaccine hesitancy and variations by geographic region. Ms. Williams-Bader said that those who supported the measure commented that the measure will add value to MIPS and have a positive impact on public health; however, one commenter noted the measure should be stratified to identify disparities in COVID-19 vaccination and others expressed concerns about vaccine hesitancy and clinician access to vaccine information.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber remarked the measure is important for patients to understand regional differences in COVID-19 vaccination rates. Dr. Schreiber emphasized that allergy is the only contradiction included in the measure, which is designed to encourage discussions between patients and providers. A CMS representative added that there are currently no measures in the MIPS program that assess COVID-19 vaccination for patients. A Centers for Disease Control and Prevention (CDC) representative underscored the importance of COVID-19 vaccination.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant noted the evolving nature of COVID-19 vaccine guidance and expressed concern that the measure is not aligned with current evidence. The lead discussant commented that the CDC is responsible for educating the public about public health issues, such as those related to COVID-19, and expressed that clinicians should not be held solely responsible for whether a patient chooses to receive a COVID-19 vaccine. The lead discussant also said it is unfair to compare clinicians across geographic regions due to regional differences in vaccine hesitancy. Dr. Schreiber responded that the measure will be modified in accordance with current COVID-19 vaccine guidance and said that the measure is currently up to date. Dr. Schreiber added that clinicians can influence individual patient behavior and noted the measure is voluntary.

Another lead discussant expressed support for the measure and noted that a multitude of factors impact vaccine uptake, including political influences and social drivers of health. In light of this, the lead discussant asked that CMS consider expanding the exclusions in the measure.

Another lead discussant remarked that the measure addresses an urgent public health issue and expressed reassurance that the measure can be voluntarily selected by clinicians. The lead discussant highlighted the measure relies on data from various sources (e.g., state immunization registries, retail pharmacy records) and expressed concern that incomplete data could affect performance on this measure.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member appreciated

that the measure is voluntary and underscored the importance of physician counseling for vaccine uptake. Another MAP member appreciated the elective nature of the measure, but questioned what incentives are in place for clinicians to report this data.

A MAP member expressed support for the measure but recommended that CMS consider expanding exemptions in the measure. Another MAP member asked CMS to clarify why patient refusal was not included as an exclusion. Dr. Schreiber responded that the purpose of the measure is to assess performance on COVID-19 vaccine uptake. Dr. Schreiber explained that allowing exceptions for patient refusal would not accurately reflect uptake rate. A MAP member commented that the stated purpose of the measure is not aligned with the purpose of the MIPS program. Another MAP member commented that it may be useful to capture data on patient refusal.

A MAP member agreed that the measure concept is important, but questioned whether the measure drives quality improvement or provides valuable information to patients. The MAP member noted the difficulty of changing patients' attitudes toward COVID-19 vaccination and commented that the measure will not drive quality improvement because only those clinicians with high rates of vaccination coverage will choose to report. The MAP member said that clinicians could instead report on another more meaningful measure, citing this as the opportunity cost associated with the measure. A MAP member expressed agreement with the previous MAP member's comment. Another MAP member expressed concern that the measure will not improve quality of care and should not be added to an "already overflowing list of measures." Another MAP member expressed agreement with the previous MAP member's comment.

A MAP member asked CMS to comment on the process for modifying a measure's specifications. Dr. Schreiber responded that the specifications of a measure can be readily changed but the measure must then be reviewed as part of the MUC cycle. A MAP member commented that certain changes to a measure's specifications may trigger different scoring rules.

A MAP member said that they would support a measure that assesses the receipt of a COVID-19 booster because this rate remains low relative to receipt of an initial COVID-19 vaccine series, thereby offering greater potential for improvement. Another MAP member expressed concern that the measure is not specified to account for updated CDC guidance and said that the measure is not ready for use.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Support for Rulemaking," for MUC2022-052. Voting results were as follows: Yes – 9, No – 13, and percentage voting Yes – 41 percent. The Coordinating Committee did not reach consensus and discussion continued on the measure.

A MAP member suggested a potential mitigation strategy for the measure that includes: (1) modification of the measure specifications to align with current CDC guidance; and (2) expansion of vaccine exemptions.

A MAP member acknowledged the importance of COVID-19 vaccination but said the measure is not appropriate for the MIPS program. The MAP member explained that because MIPS allows clinicians to select which measures they report, the measure will not achieve its intended purpose to provide valuable information to patients and providers about COVID-19 vaccine uptake. Another MAP member remarked that the measure is not ready to move forward at this time. Mr. Kahn suggested moving forward with a vote of, "Do Not Support for Rulemaking" for MUC2022-052.

Ms. Roberts moved the Coordinating Committee to vote "Do Not Support for Rulemaking" for

MUC2022-052. Voting results were as follows: Yes – 16, No – 5, and percentage voting Yes – 76 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup did not support the measure for rulemaking. Ms. Williams-Bader explained that although the Workgroup agreed with the measure concept, concerns were raised regarding the inpatient rehabilitation facility (IRF) length of stay, and the potential impact of post-vaccine symptoms on a patient's therapy requirement. Ms. Williams-Bader continued by explaining that the Workgroup also questioned the process for the reporting of residents who refuse the vaccine, refuse to report, or those who are unable to report. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received four public comments on the preliminary recommendation – one comment supported the measure under certain conditions and three did not support the measure. Ms. Williams-Bader said that although commenters strongly supported efforts to increase COVID-19 vaccination, multiple concerns were raised about the measure. Ms. Williams-Bader outlined these concerns, which included whether the measure concept is appropriate for use in post-acute care settings where care is delivered episodically; that the receipt of COVID-19 vaccination is outside the clinician's locus of control and the measure may unfairly penalize providers, particularly if patients decline the vaccine after educational efforts; whether reporting is feasible and immunization data is readily available; and, that the measure should be tested and receive endorsement by a CBE prior to use. Lastly, Ms. Williams-Bader said that a commenter supporting the measure under certain conditions encouraged consideration of exclusions, particularly for contraindication.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative explained that the measure was developed with input from patients, families, caregivers, and advocates, who felt that a raw vaccination coverage rate among patients would be valuable when choosing a facility for themselves or their loved ones. The CMS representative said the measure has the potential to prevent the spread of COVID-19 to high-risk populations and increase COVID-19 vaccination coverage among PAC patients. The CMS representative remarked that the measure will allow CMS and PAC providers to monitor COVID-19 vaccination data at the beneficiary-level, thereby improving outreach and education with specific patient populations, and allowing for stratification by key demographic characteristics. The CMS representative noted this information is not currently available for PAC settings. Dr. Schreiber added that the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) is a pay-for-reporting program that does not penalize providers for performance, only for failure to report.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant expressed disagreement with the concerns raised by the Workgroup regarding the potential for receipt of a COVID-19 vaccine to increase a patient's length of stay and expressed support for the measure. The lead discussant also noted the measure does not include exclusions for medical reasons whereas such exclusions exist for influenza vaccine measures and suggested that CMS consider this exclusion.

In response to comments made by the previous lead discussant, another lead discussant explained that some patients who receive the COVID-19 vaccine in PAC/LTC settings may have a prolonged stay, which may disincentivize providers from vaccinating. The lead discussant also expressed concern that the measure could lead to selection bias and cautioned that pay-for-reporting measures can transition to pay-for-performance measures. The lead discussant expressed agreement with the Workgroup's

decision of "Do Not Support for Rulemaking."

Another lead discussant echoed previous concerns raised about the evolving nature of COVID-19 vaccine guidance and facilities' access to immunization data. Dr. Schreiber responded that the measure specifications include "up to date" definitions that will evolve in accordance with CDC guidelines.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member expressed support for the measure, as well as for the others in this measure suite (MUC2022-090, -091, and -092). The MAP member suggested that CMS should consider collecting data on whether the receipt of a COVID-19 vaccine leads to increased length of stay or increased hospitalization among PAC/LTC residents. Another MAP member expressed agreement and said that CMS should monitor for unintended consequences related to patients' access to post-acute care. A CMS representative responded that CMS routinely monitors all measures, including for unintended consequences, and will take appropriate action when warranted.

Dr. Schreiber said CMS believes that vaccination of PAC/LTC facility residents is important to prevent the individual from developing severe COVID-19, in addition to preventing the spread of COVID-19 to healthcare personnel and patients. A MAP member expressed agreement and said that the measure would provide valuable information to patients and family caregivers when choosing a facility. A MAP member expressed support for the measure and commented that clinicians should consider exceptions to vaccination on a per case basis.

A MAP member commented that COVID-19 vaccines are not administered in-house and that PAC/LTC facilities do not typically maintain an on-the-shelf vaccine supply. Dr. Schreiber responded that CMS does not require facilities to maintain an on-the-shelf vaccine supply. A CMS representative added that facilities are not required to administer the COVID-19 vaccine and can instead arrange for the patient to receive the vaccine elsewhere, such as at a community pharmacy.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Do Not Support for Rulemaking," for MUC2022-089. Voting results were as follows: Yes – 11, No – 9, and percentage voting Yes – 55 percent. The Coordinating Committee did not reach consensus and discussion continued on the measure.

Ms. Roberts suggested the Coordinating Committee consider the decision category of, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-089. A MAP member suggested a potential mitigation strategy for the measure that includes: (1) endorsement of the measure by a CBE; (2) validation of the IRF data collection tool; and (3) an exploration of adding medical exemptions to the measure.

Ms. Roberts moved the Coordinating Committee to vote, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-089. Voting results were as follows: Yes – 17, No – 4, and percentage voting Yes – 81 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader briefly reviewed the measure, noting that the Workgroup did not support the measure for rulemaking and NQF received four public comments on the preliminary recommendation which were similar to those submitted for MUC2022-089, -091, and -092.

Ms. Williams-Bader asked if the lead discussants had additional comments for MUC2022-090 that differed from those already provided for MUC2022-089. A lead discussant expressed concerns about the

feasibility of vaccine storage and administration in the home health (HH) setting. A CMS representative responded that HH agencies generally do not administer the COVID-19 vaccine but can encourage patients to receive their vaccine elsewhere, such as at their provider's office or a retail pharmacy. The CMS representative also said that CMS believes collecting vaccination coverage data adds value to the Home Health Quality Reporting Program (HH QRP).

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member added that the wasting of vaccine doses is not unique to the HH setting and that there are ongoing efforts to distribute single-dose vials in order to reduce waste.

Ms. Roberts moved the Coordinating Committee to vote, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-090, with the same mitigation strategy as MUC2022-089. The potential mitigation strategy for MUC2022-090 includes: (1) endorsement of the measure by a CBE; (2) validation of the HH data collection tool; and (3) an exploration of adding medical exemptions to the measure. Voting results were as follows: Yes – 19, No – 1, and percentage voting yes – 95 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader briefly reviewed the measure, noting that the Workgroup did not support the measure for rulemaking and NQF received four public comments on the preliminary recommendation which were similar to those submitted for MUC2022-089, -090 and -092.

Ms. Williams-Bader asked if the lead discussants had additional comments for MUC2022-091 that differed from those already provided for MUC2022-089. No additional comments were offered.

Ms. Roberts opened the floor for MAP members to discuss the measure, asking that the discussion be limited to comments that had not been previously raised during the discussion of MUC2022-089. No additional comments were offered.

Ms. Roberts moved the Coordinating Committee to vote, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-091, with the same mitigation strategy as MUC2022-089. The potential mitigation strategy for MUC2022-091 includes: (1) endorsement of the measure by a CBE; (2) validation of the LTCH data collection tool; and (3) an exploration of adding medical exemptions to the measure. Voting results were as follows: Yes – 18, No – 2, and percentage voting yes – 90 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader briefly reviewed the measure, noting because the Workgroup did not reach consensus, the recommendation is the NQF staff preliminary analysis recommendation of "Conditional Support for Rulemaking" pending testing data indicating the measure is reliable and valid, and endorsement by a CBE. Ms. Williams-Bader shared NQF received 10 public comments on the preliminary recommendation, of which one conditionally supported the measure and eight did not support the measure. Ms. Williams-Bader said that in addition to the previous concerns expressed in comments received for MUC2022-089, -090, and -091, additional concerns were raised that the measure is duplicative of an existing reporting requirement for skilled nursing facilities (SNFs) and that the measure does not accurately reflect the SNF patient population. Ms. Williams-Bader shared that the comment supporting the measure under certain conditions encouraged CMS to consider expanding exclusions included in the measure, particularly for contraindication.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative responded that if this measure were finalized into rulemaking, CMS has the ability to forgo the current National Healthcare Safety Network (NHSN) reporting requirement. The CMS representative noted however, that the data captured by the NHSN reporting requirement differs from that which would be collected by this measure. The CMS representative explained that whereas the NHSN data is facility level and captures all nursing home residents, the measure collects individual-level data specific to SNF patients.

Ms. Williams-Bader asked if the lead discussants had additional comments for MUC2022-092 that differed from those already provided for MUC2022-089. A lead discussant echoed concerns about the duplicative nature of the measure. No additional comments were offered.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member asked CMS to outline the process to remove the NHSN reporting requirement. A CMS representative responded that because the NHSN reporting requirement runs through 2024 and this measure would not be used for reporting for several years, the NHSN reporting requirement would remain for the foreseeable future.

Ms. Roberts moved the Coordinating Committee to vote, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-092, with the same mitigation strategy as MUC2022-089. The potential mitigation strategy for MUC2022-092 includes: (1) endorsement of the measure by a CBE; (2) validation of the SNF data collection tool; and (3) an exploration of adding medical exemptions to the measure. Voting results were as follows: Yes – 19, No – 1, and percentage voting yes – 95 percent. Full voting results are available in Appendix D.

Cross-Setting Discharge Function Score Measures

Ms. Williams-Bader introduced the cross-setting discharge function score measures under consideration:

- **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)*

Public Comment

Ms. Williams-Bader turned to Mr. Kahn to open the meeting for public comment. Mr. Kahn reminded the meeting attendees of the public commenting process before opening the meeting for public comment. At this time, one comment was raised.

The commenter noted potential issues related to the endorsement process and that these measures would be competing with existing measures, especially for SNF QRP and IRF QRP. The commenter noted due to the competing measures it would be difficult for inpatient rehabilitation facilities as well as skilled nursing facilities to administer or understand measure results. The commenter further noted the existing self-care and mobility measures are publicly reported so this would create a situation in which providers would need to understand which was more important for them to perform well on, the new function score measure or the existing measures. The commenter noted concern with the recommendation of conditional support and suggested the Coordinating Committee consider a different category such as "Do Not Support for Rulemaking with Potential for Mitigation" so that any issues can be corrected resulting from having competing measures.

MUC2022-083: Cross-Setting Discharge Function Score (IRF QRP)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking, pending endorsement by a CBE. Ms. Williams-Bader stated that the Workgroup 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. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received two public comments on the preliminary recommendation – one comment supported the measure under certain conditions and one did not support the measure. Ms. Williams-Bader noted one commenter recognized the importance of the measure concept but questioned the utility of the measure as "cross-setting" considering the different patient populations served by the various post-acute care settings. Ms. Williams-Bader further noted this commenter also questioned whether testing of the measure demonstrated that this measure produces statistically meaningful information that is useful and encouraged endorsement by a CBE. Ms. Williams-Bader stated a commenter suggested that CMS work with stakeholders to ensure that the measure specifications support patient autonomy.

Ms. Williams-Bader turned to CMS for further clarification on the measure. Dr. Schreiber noted these cross-setting measures were developed to satisfy the IMPACT Act that mandated reporting of post-acute care measures using standardized patient assessment instruments. Dr. Schreiber noted the measures are based on meeting a predicted discharge score, noting these are not new concepts to the post-acute care settings and are currently used in both the IRF and SNF quality reporting programs. Dr. Schreiber stated if these measures appear to be duplicative, CMS can remove other measures so that measures are aligned within programs. Dr. Schreiber noted the measures in all four post-acute care settings report the percentage of patients or residents who meet or exceed an expected discharge function and the expected, or predicted function estimate, also accounts for patient demographics and clinical characteristics. A CMS representative noted this type of functional outcome measure was chosen in consultation with the TEP to capture a wide array of patients. The CMS representative stated the new and salient details include: (1) the measures are cross-setting using the same standardized patient assessment items aligned across all four post-acute care settings, (2) the measures use a parsimonious set of assessment items applicable to a wide range of post-acute care patients and encompass both mobility status and self-care, (3) the measures use an improved method for estimation of item scores when missing due to patients not assessed for an item, and (4) the measures have strong scientific acceptability as demonstrated by excellent reliability and good validity results. The CMS representative noted these measures will add an important and succinct way of addressing provider quality across the post-acute care settings.

Ms. Williams-Bader invited lead discussants to provide comments on the measures. A lead discussant who represented the patient and family perspective noted the desire for a single focus on function that applies to multiple settings, particularly these settings where frequently the same patients transition among these settings. The lead discussant stated support of the measure's improvements and enhancements, noting if there is duplication CMS should remove the old measures. The lead discussant noted that the technical reports documented the piloting and testing of the measures.

Another lead discussant noted enthusiasm for this suite of measures that use an existing standardized data collection tool that could produce results across the continuum of care. The lead discussant suggested an additional condition for CMS to review the suite of measures to evaluate any duplicative

measures. The lead discussant asked for clarification that the measure is a percentage of an expected discharge function score and not that the measure estimates the percentage. A CMS representative confirmed that the measure is a percentage of an expected score.

Mr. Kahn opened the floor for MAP members to discuss the measure. Ms. Williams-Bader reminded the Coordinating Committee there was an additional condition suggested by a lead discussant earlier in the discussion. Mr. Kahn asked the lead discussant to restate the condition. The lead discussant stated that CMS would evaluate the entirety of the measures within each program to evaluate the appropriate time to remove duplicate measures. Ms. Roberts noted an assumption that CMS reviews measures automatically and questioned whether that needed to be stated as a condition. A CMS representative confirmed that the whole suite of measures is considered during rulemaking, considering removal in addition to adding measures. The lead discussant agreed the additional condition was not needed.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-083 pending endorsement by a CBE. Voting results were as follows: Yes – 20, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

MUC2022-085: Cross-Setting Discharge Function Score (HH QRP)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking, pending endorsement by a CBE. Ms. Williams-Bader noted the Workgroup discussed duplicative measures in HH QRP that could lead to potential patient selection bias. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received two public comments on the preliminary recommendation – one comment supported the measure under certain conditions and one did not support the measure. Ms. Williams-Bader noted the two comments were the same as the ones submitted for the previous measure (MUC2022-083).

Ms. Williams-Bader turned to CMS for further clarification on the measure. A CMS representative noted this home health measure takes into account patients whose goals are maintenance or those who are not expected to improve in their functional outcome, noting this is an improvement over the existing program measures.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant noted their comments applied across all care settings. Another lead discussant noted nothing specific to add for this care setting.

Mr. Kahn opened the floor for MAP members to discuss the measure. There was no additional discussion among the Coordinating Committee.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-085 pending endorsement by a CBE. Voting results were as follows: Yes – 20, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

MUC2022-086: Cross-Setting Discharge Function Score (SNF QRP, SNF VBP)

Ms. Williams-Bader provided an overview of the measure, noting there will be separate votes for the two programs. Ms. Williams-Bader noted the Workgroup conditionally supported the measure for rulemaking in both programs, pending endorsement by a CBE. Ms. Williams-Bader noted that while the

Workgroup generally supported the measure, there was discussion about measure redundancy within SNF QRP. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted on the preliminary recommendation, NQF received three public comments for SNF QRP and three public comments for SNF VBP. Ms. Williams-Bader noted one commenter supported the measure under certain conditions for both programs and two commenters did not support for either program. Ms. Williams-Bader further noted that the concerns raised for these programs were the same as the ones raised for prior programs.

Ms. Williams-Bader turned to CMS for further clarification on the measure. A CMS representative noted, as previously stated, that CMS would be examining all existing function measures in the SNF QRP to evaluate which to remove at the same time as adding measures.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. There were no further comments by the lead discussants for the measure.

Mr. Kahn opened the floor for MAP members to discuss the measure. There was no further discussion among the Coordinating Committee.

Mr. Kahn asked for clarification about voting on the two programs and the potential to carry over votes. Ms. Williams-Bader clarified that the first vote would be for SNF QRP and following the vote Mr. Kahn could ask if there are any objections to carrying the vote forward.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-086 in SNF QRP pending endorsement by a CBE. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

Mr. Kahn asked if there were any objections to carrying the vote forward to SNF VBP. There were no objections stated. Ms. Williams-Bader confirmed the votes for SNF QRP would be carried forward, "Conditional Support for Rulemaking" for MUC2022-086 SNF VBP pending endorsement by a CBE. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

MUC2022-087: Cross-Setting Discharge Function Score (LTCH QRP)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking, pending endorsement by a CBE. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received two public comments on the preliminary recommendation – one comment supported the measure, and one did not. Ms. Williams-Bader further noted that the concerns raised for this program were the same as concerns raised for prior programs.

Ms. Williams-Bader turned to CMS for further clarification on the measure. There were no additional comments from CMS regarding the measure.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. There were no additional comments from lead discussants regarding the measure.

Mr. Kahn opened the floor for MAP members to discuss the measure. There was no additional discussion among the Coordinating Committee.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-087 pending endorsement by a CBE. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

Geriatrics Measure

Ms. Williams-Bader introduced the geriatrics measure under consideration:

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

Public Comment

Ms. Williams-Bader turned to Ms. Roberts to open the meeting for public comment. Ms. Roberts reminded the meeting attendees of the public commenting process before opening the meeting for public comment. At this time, no public comments were offered.

MUC2022-032: Geriatrics Surgical Measure (Hospital IQR)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking pending endorsement by a CBE, further work on paring down the elements included in the attestation and presenting information about gaps for the components covered by the measure. Ms. Williams-Bader noted the Workgroup supported the importance of a measure focused on older adults as a vulnerable population and commented on how attestation measures can help to build out the infrastructure for and direct attention to important topics. Ms. Williams-Bader noted, however, the Workgroup also expressed concern about the subjectiveness of attestation-based measures, with some noting a preference for outcome or process measures. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted NQF received four public comments on the preliminary recommendation – two comments supported the measure under certain conditions and two did not support the measure. Ms. Williams-Bader stated those who agreed with the Workgroup's initial decision of "Conditional Support for Rulemaking" commented that the measure should receive endorsement from a CBE prior to use to ensure its reliability and validity. Ms. Williams-Bader stated concerns were raised about the measure's data collection burden, and suggestions were made for CMS to explore the integration of this measure with the Geriatrics Hospital Measure (MUC2022-112). Ms. Williams-Bader noted those who did not support the measure expressed concerns about a lack of evidence demonstrating that the measure leads to improvements in care and that there is a gap in care. Ms. Williams-Bader noted additional concerns were raised that existing measures more accurately capture surgical quality, the burden of this measure outweighs the potential benefit, and the attestations are unclear.

Ms. Williams-Bader turned to CMS for further clarification on the measure. Dr. Schreiber noted this is one of two measures submitted for consideration, both attestation measures. Dr. Schreiber noted MAP's discussion over the years regarding the pros and cons of structural measures. Dr. Schreiber stated CMS does think structural measures establish the basic expectations of facilities and have led to changes in care. Dr. Schreiber noted that geriatrics or age friendly care is another important area, especially for Medicare. Dr. Schreiber further noted that these measures are based on the age friendly care initiatives by the Institute for Healthcare Improvement (IHI). A CMS representative noted the seven domains of care include identifying goals of care, medication management, cognition and delirium, function and mobility, social determinants of health, care transition, and ensuring high quality care for high-risk patients.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant stated strong support for the measure, noting submission for endorsement would be a good condition. The lead discussant noted there are measures for other populations such as pediatrics, but surprisingly there are very few measures for the most vulnerable population in the healthcare system. The lead discussant noted that structural measures do have real impact and hospitals use structural measures as a checklist for how to improve and show change over time. The lead discussant noted that attestation measures sometimes are not considered as reliable as other forms, but when combined with verifications they can be highly reliable. The lead discussant commended CMS for taking this step for this critical population. The lead discussant noted they requested to pull MUC2022-112 from the consent calendar, but NQF staff declined to pull the measure.

Another lead discussant agreed with the importance of the measure but questioned the method and whether there needs to be accreditation for hospitals instead. The lead discussant noted concern that surgical issues are time sensitive and questioned how much the hospital can address the seven domains.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member disclosed a past chair position with the American Society of Anesthesiologists Brain Health Initiative which strongly advocates for a review of cognition and delirium screening, which is domain three of the measure. The MAP member noted this is an important measure.

Another MAP member noted this is a critical area to consider in terms of the population but questioned the number of attribution measures offered by CMS. The MAP member noted the measure is a check box list, however there is evidence that attestation measures can work. The MAP member urged CMS, as they bring these measures forward, to provide the evidence to accompany the measures.

A MAP member expressed excitement to see geriatrics measures on the list and agreed with prior comments about the lack of these measures. The MAP member agreed with the prior commenter about the measure being "check box" but noted that sometimes "check box" measures are what is needed.

Ms. Roberts asked how Hospital IQR measures are used in the program. Dr. Schreiber confirmed the Hospital IQR measures are pay for reporting and frequently new hospital measures are pay for reporting for a year or two before being moved to pay for performance. Dr. Schreiber noted Hospital IQR measures are publicly reported.

Ms. Roberts asked if there were any other comments from the Coordinating Committee. A MAP member noted that the developer presented literature to support the association between structures and clinical outcomes. The MAP member noted this does not mean the association is perfect, but this was addressed at the Workgroup level.

The measure developer stated appreciation of the comments from the Coordinating Committee. The developer noted receiving requests from payer groups and patient advocate groups about how to identify good geriatric surgical care. The measure developer further noted that geriatricians have shared that surgeons need to elicit care goals from the patient and not just assume those goals. The developer stated this may ultimately be how to evaluate quality by adhering to the patient's goals for the procedure. The developer noted when evaluating outcomes from their registry, the National Surgical Quality Improvement Program (NSQIP), the elderly have unwarranted, high complications and unsafe care. The developer further noted a deep dive into outcomes revealed that they stem from what makes up this measure including, goal setting, medications, cognition and delirium, function and mobility. The developer stated, when evaluating hospitals and hospital level surgeries, it is the structural things that

are not in place. The developer noted that structural and processes strategies have improved outcomes, such as in trauma hospitals. The developer stated the data indicates implementing more outcome measures is probably not the right strategy in this setting.

A MAP member responded with appreciation for the measure developer's comments. The MAP member offered a suggestion to measure patient goal attainment. Another MAP member asked if surgery was assessed from the geriatrician or the primary care physician perspective and not only the hospital. The measure developer responded that preoperative, intraoperative, postoperative and post-discharge are all within the measure. The developer noted the first phase, preoperative and the transition to home, are the key parts that are missing in care right now.

A MAP member noted with regard to process and outcome measures in patient safety, sometimes there is a need for a process measure. The MAP member further noted that unless there are active screenings for delirium, delirium will not be found. The MAP member stated delirium is virtually never reported in claims data because it is not looked for, so this is where there needs to be a process measure to avoid the poor outcome.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-032 pending endorsement by a CBE. Voting results were as follows: Yes – 21, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

Volume Measures

Ms. Williams-Bader introduced the volume measures under consideration:

- **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*)

Public Comment

Ms. Williams-Bader turned to Mr. Kahn to open the meeting for public comment. Mr. Kahn reminded the meeting attendees of the public commenting process before opening the meeting for public comment. No public comments were offered.

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

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup conditionally supported the measure pending testing indicating the measure is reliable and valid, and endorsement by a CBE. Ms. Williams-Bader explained that the Workgroup 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. Ms. Williams-Bader said that Workgroup members expressed differing views on the value of volume data to patients. Ms. Williams-Bader noted that the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted that NQF received two public comments on the preliminary recommendation – one comment supported the measure under certain conditions, and one did not support the measure. Ms. Williams-Bader said that those who did not support the measure expressed concerns that there is a lack of evidence to support the measure concept and commented that the measure has not been tested

or endorsed by a CBE. Ms. Williams-Bader noted additional concerns were raised that volume measures are inconsistent with the goals of CMS' Meaningful Measures 2.0 framework. Ms. Williams-Bader noted that those who agreed with MAP's conditional support of the measure said that the implementation of a volume metric could provide valuable insights about quality and support consumer choice. Ms. Williams-Bader noted, however, that commenters suggested development of a new measure that could provide more granular information on volume by procedure rather than type of clinician and encouraged CMS to explore ways to develop complementary measures of patient outcomes, including patient-reported outcome-based performance measures (PRO-PMs), that could pair with a volume measure to provide a complete picture of quality at a given facility.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber explained that as procedures move from the inpatient setting to ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs), CMS is eager to expand measures for use in these settings. Dr. Schreiber continued that for certain procedures, evidence demonstrates that higher volumes are correlated with better outcomes; as a result, the measure informs consumer choice and allows organizations to track volumes. A CMS representative noted that the measure, formerly ASC-7, as well as the accompanying HOPD measure, formerly OP-26, were removed in 2018 due to burden outweighing the benefits of the measures. The CMS representative explained that while studies suggest that larger facilities' surgical procedure volumes alone do not lead to better outcomes, higher volumes may be associated with better outcomes due to those facilities having characteristics that improve care, such as more effective teams or superior systems, and programs to identify and address complications.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant commented that the relationship between volume and quality varies by procedure type and expressed that this could be difficult to explain to patients. The lead discussant expressed agreement with the concerns raised by the Workgroup that there are varying levels of evidence for the correlation between the volume of procedures and outcomes depending on the procedure. The lead discussant said the measure is imperfect but addresses an important need – in particular, for small volume providers where outcomes are often difficult to assess.

A lead discussant applauded CMS for introducing the measure, noting that there are few structural measures such as this included in the measure set. The lead discussant remarked that one merit of the measure is its alignment with MUC2022-030.

Mr. Kahn opened the floor for MAP members to discuss the measure. A MAP member commented that volume is affected by a myriad of factors and questioned the usefulness of the measure to patients.

A MAP member expressed that there is need for the measure, especially as the ASC industry continues to grow. The MAP member said the measure would provide important information to the public. Another MAP member expressed agreement. A third MAP member remarked that the value of the data provided by the measure is that low volume providers are typically those with the poorest outcomes. A fourth MAP member agreed, stating that performance tends to level off once a certain proficiency level is attained. The MAP member said this measure will be useful for identifying this proficiency level.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-028. Ms. Williams-Bader reminded the Coordinating Committee that the Workgroup conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 21, No – 1, and percentage voting Yes – 95 percent. Full voting

results are available in Appendix D.

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

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup conditionally supported the measure pending testing indicating the measure is reliable and valid, and endorsement by a CBE. Ms. Williams-Bader explained that the Workgroup raised a concern that rural and critical access hospitals, which provide outpatient care and report measures for the Hospital Outpatient Quality Reporting Program (Hospital OQR), may have low volume, and MAP recommended that this concern be considered during the endorsement process. Ms. Williams-Bader noted that the measure has not yet been submitted endorsement.

Ms. Williams-Bader noted that NQF received four public comments on the preliminary recommendation – one comment supported the measure under certain conditions and three did not support the measure. Ms. Williams-Bader explained that those who did not support the measure expressed concerns that there is a lack of evidence to support the measure concept and commented that the measure has not been tested or endorsed by a CBE. Ms. Williams-Bader said that additional concerns were raised that volume measures are inconsistent with the goals of CMS' Meaningful Measures 2.0 framework and fail to provide patients and clinicians with meaningful information regarding quality. Ms. Williams-Bader also noted that a previous version of the measure, OP-26, was removed by CMS in 2018 due in part to the reporting burden imposed on providers. Ms. Williams-Bader noted those who agreed with MAP's conditional support of the measure said that the implementation of a volume metric could provide valuable insights about quality and support consumer choice. Ms. Williams-Bader noted, however, that commenters suggested development of a new measure that could provide more granular information on volume by procedure rather than type of clinician and encouraged CMS to explore ways to develop complementary measures of patient outcomes, including PRO-PMs, that could pair with a volume measure to provide a complete picture of quality at a given facility.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative noted the measure's similarities to MUC2022-028 and reiterated the comments previously provided by CMS for MUC2022-028.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant remarked that while the original measure, OP-26, was previously removed from the program due to measure burden, this should no longer be an issue due to widespread use of electronic health records (EHRs) and electronic data extraction. The lead discussant reiterated that the measure will be useful as surgical procedures move from inpatient settings to ASCs and HOPDs, and expressed support for the measure.

A lead discussant suggested that CMS consider expanding their testing of the measure from Medicare fee-for-service to include all payer claims data. The lead discussant also agreed with the previous lead discussant that the measure's reporting burden is low.

A lead discussant said that the Workgroup's concern regarding low volumes at rural and critical access hospitals did not resonate with them. The lead discussant explained that patients should be aware of which facilities have low volumes in order to make an informed decision on where to seek care.

Mr. Kahn opened the floor for MAP members to discuss the measure, asking that the discussion be limited to comments that had not been previously raised during the discussion of MUC2022-028. Mr.

Kahn raised a previous comment about the saliency of low procedure volumes among patients in rural communities and remarked that patients often do not have a choice of where they seek care. A MAP member acknowledged this but reiterated that MAP should work to ensure that patients have as much choice as possible. Mr. Kahn expressed agreement.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-030. Ms. Williams-Bader reminded the Coordinating Committee that the Workgroup conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 20, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

Patient Activation Measure

Ms. Williams-Bader introduced the patient activation measure under consideration:

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

Public Comment

Ms. Williams-Bader turned to Ms. Roberts to open the meeting for public comment. Ms. Roberts reminded the meeting attendees of the public commenting process before opening the meeting for public comment. At this time, one comment was raised.

A commenter shared their personal experience with the patient activation measure (PAM) as a kidney transplant recipient, noting it would have been useful during their transition from pediatric to adult care. The commenter said that the PAM allows patients, caregivers, and providers to identify areas where additional support may be needed and those areas where the patient is confident in managing their care. The commenter added that the PAM is easy to use and distribute, and provided an example of a teammate who used the PAM to identify a patient who was not confident making healthcare appointments. By identifying this lack of confidence, the teammate was able to help the patient.

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

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup supported the measure for rulemaking. Ms. Williams-Bader noted, however, that several Workgroup members raised concerns. Ms. Williams-Bader said that a Workgroup member requested that the measure be specifically reviewed by the NQF Renal Standing Committee, while another Workgroup member expressed concern that the PAM is a universal tool and not built around a specific condition. Additionally, Ms. Williams-Bader said that a Workgroup member requested review of data from the measure's use in a demonstration project before its implementation in the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). Ms. Williams-Bader noted that the measure is endorsed.

Ms. Williams-Bader said that NQF received five public comments on the preliminary recommendation – two comments supported the measure and three supported the measure under certain conditions. Ms. Williams-Bader explained that those who agreed with MAP's recommendation of "Support for Rulemaking" commented that PRO-PMs offer the potential to engage patients in their own care, improve outcomes, and support consumer choice. Ms. Williams-Bader continued that others suggested MAP change its recommendation to "Conditional Support for Rulemaking," pending assessment of the measure's methodologic and psychometric properties by the NQF Scientific Methods Panel (SMP), review by NQF's Renal Standing Committee, and NQF endorsement maintenance review to allow for consideration of forthcoming evidence from the Kidney Care Choices (KCC) model. Lastly, Ms. Williams-

Bader cited concerns were raised about the feasibility of measure implementation and the potential burden imposed by the measure's use of a proprietary instrument.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber commented that CMS is excited to introduce measures such as the MUC that take into consideration the patient's point of view. A CMS representative commented that the measure is currently in use in the KCC model. The CMS representative explained that the intention for the ESRD QIP is to report the aggregate in differences in score between baseline and follow-up PAM scores, as is being reported in the KCC model. The CMS representative underscored the importance of empowering patients with end-stage kidney disease on dialysis to take an active role in their healthcare management and decision-making; this is particularly critical for adolescent and young adult patients who are preparing to transition from pediatric to adult care. Lastly, the CMS representative clarified that a free version of the survey instrument will be publicly available online and will include translations of the survey and automated scoring. The CMS representative shared a link to the survey instrument.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant expressed support for the measure, remarking that it centers the patient voice and is actionable for providers. The lead discussant added that there is strong evidence demonstrating that the measure promotes patient engagement and reduces costs. The lead discussant expressed that the measure also has the potential to advance health equity.

Another lead discussant noted their delight to seeing MUC2022-125 proposed for rulemaking and noted that the measure is endorsed at the clinician group level, but not at the facility level. For this reason, the lead discussant asked that the Coordinating Committee conditionally support the measure. The lead discussant also expressed concern that the NQF endorsement process has changed since the measure was initially endorsed and encouraged the Coordinating Committee to exercise caution when considering the measure's score-level reliability and validity assessments.

Another lead discussant shared that MUC2022-125 is a great measure to put forward and noted they were impressed with the number of public comments received for the measure. The lead discussant also remarked that among the public comments, those representing the patient and caregiver perspective tended to support the measure, while several notable organizations did not support it.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member asked whether the PAM instrument is endorsed. A CMS representative responded that the measure is endorsed. A MAP member clarified that the measure is endorsed at the clinician group level, but not at the facility level, which is the level of analysis proposed for MUC2022-125 for use in the ESRD QIP.

A MAP member emphasized the importance of personal choice, shared decision making, and self-determination for patients, all of which the measure promotes. In reference to another MAP member's concern that the PAM is not condition specific, the MAP member stated that in the disability and mental health communities there is movement away from condition-specific measures toward universal measures.

A MAP member expressed disagreement with the comment from a Workgroup member who requested that the measure be reviewed by NQF's Renal Standing Committee. The MAP member said that while members of the Renal Standing Committee should be invited to review the measure and weigh in during the endorsement process, the measure should remain under the purview of the Patient Experience and Function Standing Committee. Another MAP member expressed agreement with the previous MAP

member's comment.

A MAP member shared their personal experience with using the PAM at their organization within a group of high-risk patients, stating that the measure promotes patient engagement and prioritizes the needs of the patient. The MAP member said that in their experience, the measure was valid and reliable both at the individual clinician and clinician group levels. The MAP member asked the measure developer to clarify whether the measure is reliable and valid at the facility level of analysis. The measure developer responded that although they have not yet been submitted to NQF, the data demonstrate that the measure is reliable and valid at the facility level.

A MAP member suggested that the Coordinating Committee move toward a vote of, "Conditional Support for Rulemaking," pending endorsement of the measure at the facility level of analysis by a CBE. Another MAP member expressed agreement with this suggestion.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Support for Rulemaking," for MUC2022-125. Voting results were as follows: Yes –8, No – 13, and percentage voting Yes – 38 percent. The Coordinating Committee did not reach consensus and discussion continued on the measure.

Ms. Roberts moved the Coordinating Committee to vote, "Conditional Support for Rulemaking," for MUC2022-125 pending endorsement at the facility level of analysis by a CBE. Voting results were as follows: Yes – 22, No – 0, and percentage voting Yes – 100 percent. Full voting results are in Appendix D.

Preview of Day Two

Ms. Williams-Bader thanked Coordinating Committee members for their engagement throughout the meeting and provided a preview of day two.

Adjourn

Ms. Williams-Bader closed the meeting.

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

Welcome, Preview of Day Two, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the MAP Coordinating Committee MUC Review Meeting, thanked participants for their attendance, and reviewed the ground rules and the day two agenda. There were 315 attendees at this meeting, including MAP members, NQF staff, government representatives, measure developers and stewards, and members of the public.

Ms. Williams-Bader turned the meeting to Dr. Elliott for a roll call of the Coordinating Committee membership. Of the 21 organizational members, 19 attended the meeting. In addition, there were two co-chairs, and four subject matter experts (SMEs), totaling 25 members. The minimum quorum required for voting was 18 members. See Appendix B for detailed attendance.

Ms. Williams-Bader briefly reviewed the voting procedure for the measures for discussion and provided an overview of the voting procedure for the measures pulled from the consent calendar. Ms. Williams-Bader paused for questions about the voting process or meeting procedure. At this time, one question was raised. A MAP member asked for clarification regarding the use of the consent calendar and the process used to create the consent calendar. Ms. Williams-Bader responded that due to time constraints and competing priorities, no strategic meeting was held this year for MAP to discuss the consent calendar process. However, Ms. Williams-Bader noted that an email was sent to MAP members to solicit feedback on the proposed consent calendar process. The MAP member responded that the consent calendar is only successful if members have confidence in the process. Another MAP member expressed agreement with the previous MAP member's comment.

Measures Under Consideration

Social Determinants of Health (SDOH) and Disparities Measures

Ms. Williams-Bader introduced the social determinants of health (SDOH) and disparities measures under consideration:

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

Public Comment

Ms. Roberts opened the floor to allow for public comment. At this time, six comments were raised, all of which were supportive of MUC2022-050.

A commenter expressed excitement to see the inclusion of SDOH measures on the MUC List and verbalized support for both measures. The commenter said that because these measures are cross-cutting, they help to provide context to other measures.

A commenter expressed strong support for MUC2022-050 and noted that there are no other SDOH measures under consideration for these programs. The commenter noted that MUC2022-050 was tested over a five-year period among 2 million patients across 644 patients as part of the Centers for Medicare & Medicaid Services Innovation Center (CMMI) Accountable Health Communities (AHC)

model.

A commenter expressed that MUC2022-050 is well tested and said that the measure will provide meaningful information to patients and providers. The commenter also emphasized that CMS has standardized the five SDOH domains included in MUC2022-050 as part of the AHC model. The commenter urged CMS to adopt MUC2022-050, as well as the three additional SDOH measures under consideration this MUC cycle (MUC2022-053, -098, and -111), to minimize burden on providers and patients.

A commenter said that MUC2022-050 and MUC2022-058 were adopted for use in North Carolina's Medicaid program and proved important for galvanizing alignment across the public and private health sectors. The commenter expressed support for both measures.

A commenter remarked that given the disproportionate and profound impact of social drivers of health on communities of color, it is imperative that CMS enact the SDOH measures under consideration to achieve racial equity and equitable health outcomes. The commenter underscored that social drivers of health impact which healthcare options are available to patients and said that the opportunity to screen patients for social needs will ensure that they receive access to community resources. The commenter expressed that these SDOH measures will invigorate clinicians, patients, and communities to move toward health.

A commenter urged CMS to adopt MUC2022-050, as well as the three additional SDOH measures under consideration this MUC cycle (MUC2022-053, -098, and -111). The commenter expressed that MUC2022-050 provides an opportunity for the healthcare system to understand what people need to be healthy and to achieve equity. The commenter said that the data captured by the measure are needed to justify modifications to staff roles and clinic workflows, and to have recognition of patients' unmet social needs by federal quality reporting and value-based programs. The commenter also said that the measure may reduce clinician burnout and financial risk for providers who care for patients with greater social needs.

MUC2022-050: Screen Positive Rate for Social Drivers of Health (ESRD QIP)

Ms. Williams-Bader noted that the measure is under consideration for three programs and provided a general overview applicable to all three programs. Ms. Williams-Bader said that the Workgroup conditionally supported the measure for rulemaking pending endorsement by a 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). Ms. Williams-Bader said that the Workgroup supported the importance of the measure for identifying facilities that may need more resources for quality improvement purposes and thought the measure could encourage facilities to engage with their communities. However, Ms. Williams-Bader noted that other Workgroup 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. Ms. Williams-Bader said that Workgroup members encouraged the presentation of results in a way that provides context for consumers.

Ms. Williams-Bader noted that on the preliminary recommendation, NQF received 20 public comments for the ESRD QIP, 20 public comments for the IPFQR, and 17 public comments for the PCHQRP, for a total of 57 comments. Because remarks were similar across all three programs, Ms. Williams-Bader combined the public comments when summarizing them. Ms. Williams-Bader noted that among the 57

comments, 42 supported the measure, 11 supported the measure under certain conditions, and four did not support the measure. Ms. Williams-Bader said that those who supported the measure commented that the measure fills an important measurement gap, and will promote health equity and quality improvement efforts. Ms. Williams-Bader continued by saying that comments also expressed that the measure may reduce clinician burnout and financial risk for providers who care for patients with greater social needs. Ms. Williams-Bader noted, however, that several concerns were raised about the measure, including the lack of specificity or standardization around numerator and denominator definitions; the measure's reliability, validity, and use of risk adjustment; and the impact of geographical differences may have on the measure and its administrative feasibility. Ms. Williams-Bader also noted an additional concern was expressed that the measure does not reflect quality, but rather a facility's patient population; in turn, the measure may negatively impact safety net providers and disincentivize the provision of care to patients from underserved communities. Lastly, Ms. Williams-Bader noted that the measure has not yet been submitted for endorsement.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber reminded the Coordinating Committee that MUC2022-050 – as well as MUC2022-053 which was not discussed by the Coordinating Committee as it was on the consent calendar – were introduced during the 2021-2022 MUC cycle and were finalized into rulemaking for the Hospital IQR program. Dr. Schreiber noted that MUC2022-058 is a newly introduced measure. Dr. Schreiber explained that MUC2022-050, -053, -058, -098, and -111 constitute a measure suite designed to promote equity, a key priority for CMS. Dr. Schreiber emphasized that CMS is committed to using the levers of value-based programs to support equity. A CMS representative explained that while MUC2022-050 is a structural measure, it is a step forward in addressing health inequities and patient-centered care. The CMS representative noted that the measure addresses a performance gap, as data indicate that 84 percent of physician offices do not screen for all five health-related social needs (HRSNs) included in the measure, even though 30 percent of patients would screen positive for one or more HRSNs.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant said that their organization supports the measure concept but highlighted the need for standardization of instruments used to gauge quality of care. The lead discussant cautioned that the measure could be scored in a way that is not meaningful or leads to inequities if clinicians are disincentivized from caring for certain patients. The lead discussant also questioned what it means to "screen positive for social drivers of health," and asked whether a high rate is considered positive or negative.

Another lead discussant expressed that the data captured by the measure will allow physicians and patients to engage in shared decision making. The lead discussant expressed privacy concerns and said that the information collected by the measure could be used against patients; however, the lead discussant remarked that if used in the correct manner, the measure could help direct resources to vulnerable communities. The lead discussant verbalized support for the measure, as did the third and final lead discussant.

Ms. Roberts opened the floor for MAP members to discuss the measures. A MAP member asked the measure developer to clarify why the measure does not take into account the patient's ability to afford care. The measure developer responded that the original measure was based on CMMI's AHC model, which screened 2 million beneficiaries and employed an expert review and TEP to standardize the domains included in MUC2022-050. The measure developer noted that MUC2022-050 aligns and overlaps with other measures, such as the Hospital IQR version of the measure that was previously finalized for rulemaking, and that measure alignment efforts are ongoing. A second MAP member

commented that MUC2022-050 should be harmonized with similar Healthcare Effectiveness Data and Information Set (HEDIS) measures to promote alignment across the healthcare system.

A MAP member asked whether MUC2022-050 has been tested. The measure developer responded that the tool from the AHC model has been tested but the measure itself has not been tested in the care settings proposed by the measure. The MAP member acknowledged that the measure concept is important but questioned whether the measure will promote equity and improve quality, noting the need for evidence.

A MAP member expressed frustration that other MAP members expressed hesitation about implementing the measure. The MAP member said that there is no "perfect" measure, and that change is incremental. The MAP member said that the Coordinating Committee should focus on whether the measure addresses an important issue in a reliable way and promotes health equity. The MAP member expressed enthusiastic support for the measure. Another MAP member expressed agreement with the previous MAP member's comments and said that the measure is the first step to linking social needs with healthcare. Several MAP members agreed that the measure provides a starting point for ultimately improving quality of care.

A MAP member asked whether there is data showing that patients do not answer the survey truthfully. Another MAP member expressed agreement, saying that some patients may not answer truthfully for fear of potential repercussions. A third MAP member expressed agreement with the previous comments and questioned the actionability of the measure for providers, especially if patients are not willing or able to disclose their unmet HRSNs. The MAP member also questioned what the implications are for the reporting of the measure. A CMS representative responded that the measure is intended to foster an open dialogue between providers and patients, and clarified that a higher percentage of patients screening positive for social drivers of health is indicative of higher HRSNs for a patient population, thus allowing for the allocation of resources for these communities. The CMS representative added that the ESRD QIP is a pay-for-performance program, while the IPFQR and PCHQRP are pay-for-reporting programs.

A MAP member acknowledged the importance of the measure but questioned whether the data captured by the measure will help clinicians in providing quality care to patients. The MAP member cited a lack of testing data, and emphasized that if data from the measure are used for accountability or public reporting purposes, the measure could have negative unintended consequences on patients. The MAP member said that the measure is "flawed" and that MUC2022-050 appears to be a "check box" measure.

A MAP member recognized the importance of screening for social drivers of health and reporting those data to CMS. The MAP member said that the measure could be used for value-based payment programs to support providers practicing in communities with high rates of social needs. However, the MAP member said that MUC2022-050 is not a quality or performance measure, and that public reporting of the measure may be misleading to patients. The MAP member noted that the measure does not require the use of a particular data collection instrument, meaning that performance cannot be accurately assessed.

Another MAP member echoed the previous MAP member's comments and highlighted the importance of the data captured by the measure. However, the MAP member cautioned that the measure should not be used in a pay-for-performance program, such as the ESRD QIP, because the measure is indicative of the clinician's patient population and not their performance. The MAP member asked for clarification

from CMS as to why the measure is proposed for the ESRD QIP. Dr. Schreiber responded that the goal of the measure is to direct resources toward patient populations that have high screen positive rates of social drivers of health. The MAP member acknowledged this rationale but said that this does not align with the nature of the ESRD QIP as a pay-for-performance program.

A MAP member questioned whether the measure reflects the quality of care provided. Dr. Schreiber responded that quality care cannot exist without equity, and that the measure is intended to bring attention and resources to communities demonstrating high social needs according to the measure. A second MAP member acknowledged the importance of the measure concept but remarked that the measure is not appropriate for payment programs. A third MAP member clarified that they support the measure but not for programs that publicly report performance, such as the ESRD QIP, as this could negatively impact providers who practice in under resourced communities. A fourth MAP member expressed agreement with the previous MAP member's comment.

A MAP member said that the measure provides an opportunity to uncover information about a patient's life, which can help drive improvements in quality. The MAP member said that asking questions and collecting data will have a positive impact on patients. The MAP member expressed strong support for the measure. Three additional MAP members expressed agreement with the previous MAP member's comments.

A MAP member questioned the actionability of the measure for providers (i.e., what do providers do once the data are collected?). Another MAP member asked whether a clinician's actions could affect performance on the measure. Dr. Schreiber responded that clinicians and facilities can implement interventions to reduce the screen positive rate for their patient population, such as transportation arrangements. In response, the MAP member asked whether the measure should assess a change in screen positive rate for social drivers of health rather than a direct rate.

A MAP member said that the measure provides actionable information on areas for improvement and acknowledged concerns about a clinician's locus of control. The MAP member shared their personal experience, saying they have seen providers successfully implement instruments like the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) to address patients' HRSNs. A CDC representative added that these data will help clinicians better engage with community partners that can help address these findings.

Despite the "imperfections" of the measure, a MAP member expressed support for the measure and noted the importance of CMS to capture data on social drivers of health.

Ms. Roberts suggested that the Coordinating Committee move to vote on acceptance of the Workgroup's recommendation, "Conditional Support for Rulemaking," and outlined the conditions: (1) endorsement by a CBE to address reliability and validity concerns, (2) attentiveness to how results are shared and contextualized for public reporting, and (3) examination of any differences in reported rates by reporting process.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-050 for the ESRD QIP. Voting results were as follows: Yes – 18, No – 6, and percentage voting Yes – 75 percent. Full voting results are available in Appendix D.

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

Ms. Roberts asked if any Coordinating Committee members objected to carrying over the vote from

MUC2022-050 for the ESRD QIP to the IPFQR. A MAP member said that they would change their vote if the Coordinating Committee were to take a vote for the IPFQR but said that their vote would not change the results. The MAP member said that they had no objection to carrying the vote over. No objections were raised, and the vote was carried over. Voting results were as follows: Yes – 18, No – 6, and percentage voting Yes – 75 percent. Full voting results are in Appendix D.

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

Ms. Roberts asked if any Coordinating Committee members objected to carrying over the vote from MUC2022-050 for the ESRD QIP to the PCHQRP. No objections were raised, and the vote was carried over. Voting results were as follows: Yes – 18, No – 6, and percentage voting Yes – 75 percent. Full voting results are in Appendix D.

MUC2022-058: Hospital Disparity Index (HDI) (Hospital IQR)

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup conditionally supported the measure for rulemaking pending testing indicating the measure is reliable and valid, including testing with low volume hospitals that do not have all seven readmission rates calculated and may have small numbers of the targeted groups, and endorsement by a CBE. Ms. Williams-Bader explained that the Workgroup expressed concerns that the measure may be misleading, as the measure is a composite of readmission measures only and recommended renaming the measure to focus on readmissions. Ms. Williams-Bader said that some Workgroup members also expressed concern with only focusing on readmission measures. Ms. Williams-Bader noted that while the Workgroup supported the intent of the measure – to identify and reduce disparities – some Workgroup members asked that CMS provide confidential reports of the composite measure score to hospitals prior to making the reports publicly available. Ms. Williams-Bader said that the Workgroup 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. Ms. Williams-Bader noted that the measure has not yet been submitted for endorsement.

Ms. Williams-Bader noted that NQF received seven public comments on the preliminary recommendation – one supported the measure under certain conditions and six did not support the measure. Ms. Williams-Bader said that those who did not support the measure expressed multiple concerns, including those related to the measure's reliability and validity; the potential to double count events, as the measure overlaps with condition-specific and all-cause readmission rate measures; and the methodology used to impute race and ethnicity data. Ms. Williams-Bader said that some commented that the name of the measure is misleading, and if publicly reported, the measure would not be easily understood by consumers. Ms. Williams-Bader noted that those who conditionally supported the measure raised concern that the measure may penalize safety net providers and recommended that the measure receive endorsement from a CBE prior to use.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative explained that MUC2022-058 is a prototype for a composite measure of existing measures in use in the Hospital IQR; currently, CMS stratifies and confidentially reports each of the individual measures to facilities. The CMS representative said that the composite measure is designed to evaluate equity gaps and disparities across the inpatient population, and will provide more accessible information about variation in healthcare disparities across hospitals.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant noted that the measure includes seven readmission measures, and fails to provide a comprehensive

assessment of quality of care. The lead discussant asked that the measure be renamed to the "Hospital Readmission Disparity Index," as the current name could mislead consumers. The lead discussant questioned whether there is sufficient evidence to support the premise that readmission alone can serve as an indication of disparities in care and suggested that other measures in the Hospital IQR are likely better indicators. Lastly, the lead discussant expressed concern that the measure uses Medicare Bayesian Improved Surname Geocoding (MBISG 1.0) to impute race and ethnicity data. The lead discussant explained that this methodology makes assumptions and is inferior to the gold standard, self-reported data.

Another lead discussant echoed previous comments that were made during the discussion of MUC2022-050, noted the need for changing the measure's title, and questioned the actionability and downstream impacts of the measure.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member asked whether MAP had ever proposed that a measure title be changed and requested more information on this process. Ms. Roberts responded that in her experience, this was the first instance of MAP suggesting a name change for a measure.

A MAP member again questioned why MBISG 1.0 was used to impute race and ethnicity data. Dr. Schreiber acknowledged the MAP member's concern and noted that the Office of Minority Health (OMH) uses MBISG 1.0 in the Health Equity Summary Score (HESS). Dr. Schreiber said that the data imputed by MBISG 1.0 is highly correlated with self-reported data. The measure developer added that this method has several advantages, including that it does not directly assign individuals to a single race or ethnicity. The provider said that MBISG 1.0 can provide important information about racial and ethnic disparities while minimizing risk.

A MAP member noted that the measure only considers readmissions and asked whether CMS has examined other measures to identify disparities. The measure developer noted that the goal of the measure is to be actionable for providers and make individual measure scores available. The developer noted that there are substantial disparities both within and across hospitals. The developer explained that a strength of the measure is that it accounts for disparities within groups in a hospital, as well as overall risk-standardized readmission rates; this ensures that small disparities between groups of patients will not simply result from poor quality of care for all patients at a single facility. The developer said that the measure allows hospitals to identify quality issues at their facility and compare themselves against other providers.

A MAP member asked whether CMS would request MAP to review this measure at a future date, noting that MUC2022-058 is a prototype. Dr. Schreiber responded that CMS plans to develop hospital disparity index (HDI) measures across programs and that they will be presented to MAP.

A MAP member asked whether the measure penalizes providers whose patient populations have greater social needs, such as safety net providers. Dr. Schreiber responded that the measure will actually help safety net providers by identifying those hospitals that are performing well.

Ms. Roberts suggested that the Coordinating Committee move to vote on acceptance of the Workgroup recommendation of, "Conditional Support 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 CBE, and suggested that the Coordinating Committee add a third condition related to changing the measure title.

Ms. Roberts raised a previously suggested name, "Hospital Readmission Disparity Index" and asked whether there were any objections. No objections were offered.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-058. Voting results were as follows: Yes – 20, No – 2, and percentage voting Yes – 91 percent. Full voting results are available in Appendix D.

Safety Measures

Ms. Williams-Bader introduced the safety measures under consideration:

- **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*)

Public Comment

Ms. Williams-Bader turned to Mr. Kahn to open the meeting for public comment. Mr. Kahn provided instructions to the meeting attendees on the public commenting process before opening the meeting for public comment. At this time, one comment was raised.

The commenter noted they are a board member of an organization that represents both patients and family members of sepsis victims, along with a large cadre of healthcare professionals. The commenter stated that the key question was whether compliance with SEP-1 [severe sepsis and septic shock management bundle] measure should become a value-based payment metric. The commenter noted there are four studies that looked at sepsis mortality before and after the inception of SEP-1 indicating no beneficial effect. The commentor, however, noted that those studies did not address the effectiveness of the recommended bundles and can only do so if there is widespread uptake of those bundles. The commenter stated that the bundles were completed in approximately only 40 percent of cases, and three of the four studies did not determine the extent to which the bundles were in use prior to October 2015. The commenter stated that CMS' own study did evaluate whether the use of the bundle was effective and indicated at all levels of severity and at all deciles of receiving bundled care, the bundles reduced mortality. The commenter further stated that the four studies indicated reduced mortality would only be possible with adherence and near universal compliance, and that is what value-based payment is intended to provide. The commenter stated their organization's support of the SEP-1 measure and its addition to the value-based payment programs.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup supported the measure for rulemaking. Ms. Williams-Bader stated that while the Workgroup expressed general support for the measure, the Workgroup discussed the use of a long-stay measure to improve resident care within a value-based purchasing (VBP) program. Ms. Williams-Bader noted that the Workgroup also discussed the 275 days look back period and the length of time a fall event would stay on a facility record.

Ms. Williams-Bader noted NQF received eight public comments on the preliminary recommendation – two supported the measure under certain conditions and five did not support the measure. Ms. Williams-Bader noted one comment supporting the measure under certain conditions commented that the measure should first be implemented in the SNF QRP which currently includes a short-stay version

of the measure. Ms. Williams-Bader stated those who did not support the measure raised concerns that this long-stay measure is inappropriate for SNF VBP, which focuses on short stays, and noted there is a short-stay version of the measure in SNF QRP already. Ms. Williams-Bader noted additional concerns were raised that the look back period should be shortened to incentivize improvement and that the measure should be limited to major bone fractures. Ms. Williams-Bader noted the measure was endorsed.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative noted the measure is endorsed and most recently maintained NQF's endorsement during the patient safety spring 2021 cycle. The CMS representative indicated that CMS is considering adding the measure to SNF VBP to fill a gap in patient safety quality measures and during a patient and caregiver SNF VBP focus group it was noted as an important criterion for evaluating quality of care. The CMS representative stated that injurious falls are the leading care of disability and death among nursing home residents and are therefore considered to be never events. The CMS representative stated that adding a long-stay measure to the program would best represent the quality of care provided to all nursing home residents as approximately 94 percent of all long-term care facilities (LTCFs) are certified as both SNFs and nursing homes, with the majority of residents Medicaid or Medicare beneficiaries regardless of payer coverage. The CMS representative noted nursing homes can use the measure to identify specific resident characteristics, known risk factors, and available interventions to reduce the incidence of falls, ultimately improving patient care and safety.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant asked for clarification on the Workgroup vote. Ms. Jenna-Williams noted the "Support for Rulemaking" decision was the Workgroup's first vote. The lead discussant stated this is a valuable measure, but the discussion should focus on the comments raised by public commenters and others about the measure's use in a VBP program. The lead discussant reviewed that the VBP program adjusts Medicare payment up to two percent for short stay post-acute care fee-for-service residents, but this measure is for residents who have stayed in the nursing home longer than 100 days, no longer on Medicare and either private pay, Medicaid, or using other payment sources. The lead discussant noted the 275 days look back period was of concern as this is a payment adjustment program. The lead discussant noted concern with the long look back period in which three quarters of a year could count against a facility, even if there were quality improvements. The lead discussant stated another concern was the SNF VBP program is designed to measure outcome, adjusting for services delivered under a [Medicare] Part A stay, and this is a measure for long-stay benefits. The lead discussant also stated concern with the lack of risk adjustment to the measure. Lastly, the lead discussant stated the Workgroup's discussion focused on the value and importance of the measure, but it does not make sense to support the measure for the VBP program.

Another lead discussant expressed support for the measure as it covers a vulnerable population. The lead discussant noted the need to consider other payers and how CMS impacts and can drive the private payer sector of the market. The first lead discussant acknowledged and agreed that falls are important but noted that CMS already has a short-stay measure in use, and it is reported. The lead discussant questioned whether a long-stay measure should be incorporated into a Medicare payment program.

Mr. Kahn opened the floor for MAP members to discuss the measure. A MAP member asked whether resident falls that result in a major injury are reported, irrespective of payment status. Dr. Schreiber responded that falls are to be reported. A lead discussant responded with CMS' review process post fall including, a potential on-site review and if quality care problems are found it could result in a citation, a

fine, or even a denial of payment and admissions. The MAP member stated they did not fully understand the difference between long-stay and short-stay, and if a fall is already being reported there is a life cycle that follows the fall. Mr. Kahn asked the lead discussant to elaborate on their interpretation of the Workgroup discussion. The lead discussant noted the Workgroup focused their discussion on the importance of the measure. The lead discussant acknowledged the importance of the measure but questioned the measure's appropriateness for rulemaking for a short stay. Dr. Schreiber noted Congress authorized the expansion of the SNF VBP up to ten measures and does allow measures for long-stay residents, noting careful review with the Office of General Counsel. Dr. Schreiber further noted the vast majority of SNF facilities are both short- and long-stay facilities. Dr. Schreiber emphasized the importance of the measure and the need for the measure to be linked to payment as well as reporting. A CMS representative noted approximately 80 percent of long-stay residents are Medicare beneficiaries. The CMS representative further noted the short-stay falls measure is topped out and not NQF-endorsed. Lastly, the CMS representative stated after looking at risk factors for risk adjustment during modeling, there were none found to be statistically significant.

A MAP member noted CMS already answered the question about risk adjustment but added that even though there is variation, this population is homogeneous from facility to facility. The MAP member asked for explanation from the lead discussant on the concern with a 275-days look back period. The MAP member stated the thought was there needs to be enough events to occur over time to be able to compare facilities. The lead discussant responded that the look back period was originally added to help with the stability of the measure as falls with [major] injuries are relatively infrequent. The lead discussant reiterated the question regarding whether a long-stay population goes into a short-stay program, noting the program was designed around a Medicare fee-for-service program. Mr. Kahn noted with hospitals and readmissions, there is no control of what happens after a discharge and many readmissions are due to what happens after, and not in, the hospital. The lead discussant responded that there is wide variation in the number of post-acute care admissions among facilities; some have maybe 75 and others 200 to 300 a year, and payment is adjusted for the care of long-stay patients. A MAP member agreed with the lead discussant's concern but asked if the care for long-stay residents is a proxy for the care of short-stay patients. The lead discussant agreed protocols cross over and staff cross over, but the relationship between short-stay and long-stay outcomes across all measures have not crossed over.

A MAP member asked for clarification that if there is a fall with major injury, if the patient will end up in the hospital, which then would be paid for by Medicare. Dr. Schreiber responded with agreement of the comment.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Support for Rulemaking," for MUC2022-035. Voting results were as follows: Yes – 19, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle (HVBP)

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking pending clarity being provided about the differences between the measure specifications reviewed by the Workgroup and the current measure specifications. Ms. Williams-Bader noted the measure has been updated since the MUC submission and therefore the Workgroup reviewed an older version of the specification. Ms. Williams-Bader further noted that the measure developer clarified that the measure specification reviewed by the Workgroup reflects the latest clinical guidelines and aligns with the specification submitted to the CBE for endorsement review,

but it does contain smaller updates related to the guidance for certain portions of the measure. Ms. Williams-Bader stated some Workgroup members were in strong support of the measure as it is closely linked to improved outcomes and demonstrates a performance gap. However, Ms. Williams-Bader also stated 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. Lastly, Ms. Williams-Bader stated some Workgroup members also expressed concern about the measure leading to a potential unintended consequence of antibiotic overuse. Ms. Williams-Bader noted the measure was endorsed.

Ms. Williams-Bader noted NQF received nine public comments on the preliminary recommendation – one supported the measure under certain conditions and eight did not support the measure. Ms. Williams-Bader stated concerns were raised that the measure does not reflect current clinical practice guidelines and it is difficult for the measure to keep aligned with the changing evidence, that there is evidence indicating the measure does not lead to improved outcomes, and that the measure may incentivize antibiotic overuse.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber stated the measure has been in the Hospital IQR program for numerous years and is now proposed for HVBP. Dr. Schreiber noted there is evidence that using the [SEP-1] steps in the program have led to decreased mortality due to sepsis. Dr. Schreiber further noted sepsis is one of the leading causes of mortality in hospitals and the measure should be moved to a payment program so that hospitals are held accountable. Dr. Schreiber stated that the measure is consistent with the most recent clinical guidelines. Dr. Schreiber noted that CMS, in conjunction with CDC, are working on an outcome measure that will not be ready for another few years, which means it would be an additional few years before it reached a payment program. Dr. Schreiber further noted, due to the length of time before a revised measure would reach a payment program, and the importance of the sepsis measure being linked to performance and payment, CMS is proposing the measure for HVBP. A CMS representative further noted CMS is considering the measure for HVBP to create a stronger incentive for high quality sepsis care and to improve safety. The CMS representative stated that SEP-1 meets the requirements of adoption into the VBP program as it has been in the Hospital IQR for numerous years and has been publicly reported for over one year.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant stated strong support for the measure as sepsis is the leading cause of death and the leading cost driver in hospitals. The lead discussant expressed that any delay in sepsis care can cause mortality. The lead discussant stated, although antibiotic overuse is a big campaign for their organization, sepsis care is not the time to worry about antibiotic use. The lead discussant further stated the measure has a significant impact not only on patient mortality, but also patient suffering.

Another lead discussant noted this is a complex measure, but healthcare is complex, and sepsis has evolved over the years. The lead discussant likened sepsis to heart failure 20 years ago when it was the infancy of how and what providers did for heart failure. The lead discussant noted there is more data on sepsis, and it is possible to see the impact this data has on patients and families. The lead discussant stated they were struck by the public comment regarding the difficulty of chart abstraction and the time to find the data in their system. The lead discussant stressed that the EMR [electronic medical record] and EHR cannot dictate how to treat and care for patients. In response to an earlier comment from Dr. Schreiber, the lead discussant stated if measures will be used across pediatric and adult populations in Medicare and Medicaid programs by the year 2026, then there is a need to be forward-thinking

regarding sepsis. The lead discussant further stated sepsis is an issue in the pediatric population where there are high mortality and morbidity rates. The lead discussant shared a personal experience about the loss of a young family member to sepsis. The lead discussant stated they have seen where sepsis has come from, and noted "what is paid for is what gets acted upon" in organizations.

Mr. Kahn opened the floor for MAP members to discuss the measure. A MAP member agreed that the cost of data abstraction, when talking about one of the leading causes of death, is a cost to everyone including insurers. The MAP member noted most hospitals in the United Kingdom (UK) will spend a significant amount of money employing nurses to do chart abstraction on sepsis due to its importance. The MAP member also noted as an intensivist, if there is good antibiotic stewardship, patients should almost immediately be reviewed to see if the appropriate antibiotic is being used and stopped if it is not a sepsis diagnosis.

A MAP member noted their close following of the measure, noting there have been multiple studies that have assessed the individual components of the measure, indicating they were not associated with better outcomes. The MAP member read a recent editorial from the *Journal of the American Medical Association (JAMA)* noting the impact of SEP-1 across hundreds of hospitals including, increased broad-spectrum antibiotic use and the lack of lowered mortality rates. The MAP member acknowledged they are not an expert on sepsis, but they do discuss with experts in the field, who all oppose the SEP-1 measure. The MAP member noted that the measure has dramatically increased screening, so sepsis is being detected earlier and any mortality benefit is probably coming from that. The MAP member stated the wording about potential unintended consequences is not potential, but definite. The MAP member further stated one of the large studies found a 25 percent increase in antibiotics for methicillin-resistant *Staphylococcus aureus* (MRSA) and a 45 percent increase in antibiotics for *Pseudomonas aeruginosa*. The MAP member noted that even though the measure is endorsed, there needs to be another review of the measure and the current evidence.

Another MAP member noted the evidence is always going to change, and it is hard to determine what is the best evidence. The MAP member further noted that individuals will critique the bundle, but it is not a new bundle and at this time it is the best bundle related to sepsis care. The MAP member shared their clinical experience observing the poor outcomes of patients who are delayed antibiotics or fluid. The MAP member acknowledged unintended consequences but agreed with the prior MAP member with regards to a good antibiotic stewardship program that evaluates and stops antibiotics when possible. The MAP member stated full support for the measure.

The measure developer noted that the question is whether the sepsis measure is appropriate for the VBP program. The developer responded to the MAP member's *JAMA* editorial reference, noting the four large studies did not evaluate antimicrobial appropriateness and one of the studies pointed to that as a limitation. The measure developer noted those studies assessed increased antibiotic use but did not evaluate whether that was inappropriate utilization or not. The developer further noted that some of the studies also indicated increased identification of sepsis cases and one would expect increased antibiotic usage with increased identification of cases. The developer stated that none of the studies demonstrated any adverse events associated with the increased antibiotic usage. The developer stated that one study observed a decrease in mortality during the pre-SEP-1 implementation period at the same time as the increase in antibiotic usage, and that the mortality decrease continued after SEP-1 implementation at a slower pace. The developer referenced another article from 2022 that assessed 1.5 million patients and the impact of the measure on time from sepsis diagnosis to antibiotic administration. The developer stated that the study indicated the time shortened and there was no

significant increase in antibiotic utilization. The developer further stated the study reported an observed decrease in hospital mortality and a decrease in 30-day mortality.

A MAP member noted the measure went through a protracted process with NQF including an appeal last year, noting the NQF Appeals Board reviewed the studies and recommended continued endorsement of SEP-1. The MAP member further noted this does not suggest that the measure will always be perfect and there is a need to routinely review the science.

Dr. Schreiber reiterated the comments made by the previous MAP member, noting the NQF Appeals Board supported the measure. Dr. Schreiber noted this is the best sepsis bundle, noting implementing sepsis bundles does lead to better outcomes and decreased mortality. Dr. Schreiber acknowledged the lead discussant who shared a personal experience with sepsis and expressed sympathy for the suffering of those patients with sepsis.

Mr. Kahn asked the measure developer about the area of AI [artificial intelligence] and its future impact on measuring patient information. The developer noted they conduct quarterly literature reviews to identify changes in technology and how that can be incorporated into measures. The developer noted that changes do occur, and the "Conditional Support for Rulemaking" was due to the most recent version of the measure not being available at the time it was submitted to the MUC List. A MAP member commented, in terms of AI, the biggest benefit will most likely be better identification of sepsis in patients. The MAP member noted that it will help with the use of antibiotics, noting the need for more specific alerting systems to prevent unnecessary antibiotic use. The measure developer noted it would be beneficial if a better biomarker is developed for identifying patients with severe sepsis, noting it does not exist right now.

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-082 pending clarity being provided about the differences between the measure specifications reviewed by MAP and the current measure specifications. Voting results were as follows: Yes – 21, No – 2, and percentage voting Yes – 91 percent. Full voting results are available in Appendix D.

Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures

Ms. Williams-Bader introduced the Rural Emergency Hospital Quality Reporting Program (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)*

Public Comment

Ms. Roberts opened the floor to allow for public comment. No public comments were offered.

MUC2022-039: Median Time from emergency department (ED) Arrival to ED Departure for Discharged ED Patients (REHQRP)

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup did not support the measure for rulemaking. Ms. Williams-Bader said that the Workgroup agreed that publicly reporting emergency department (ED) wait times could have potential negative unintended consequences, as patients may avoid EDs with longer wait times, even when patients need urgent care. Ms. Williams-

Bader continued that a Workgroup 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. Ms. Williams-Bader noted that the endorsement of the measure was previously removed.

Ms. Williams-Bader noted that NQF received four public comments on the preliminary recommendation – all four did not support the measure. Ms. Williams-Bader remarked that concerns were raised about a lack of evidence to support the measure concept and that the measure is not a reflection of quality, but of patient, provider, or market characteristics; as a result, the measure may be misleading to consumers if publicly reported. Ms. Williams-Bader noted that unintended consequences were also raised, including that universal application of the measure may disadvantage poorly resourced hospitals.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. Dr. Schreiber explained that some critical access and rural hospitals will convert to rural emergency hospitals (REHs) under the newly established REHQRP. Dr. Schreiber remarked that critical access and rural hospitals often struggle to remain open due to low patient volumes and the purpose of the REHQRP is to reimburse providers at a rate that incentivizes them to remain open. Dr. Schreiber noted that facilities that gain the REH designation will no longer provide inpatient care and instead, will focus on the provision of ambulatory and emergency care; as a result, CMS is eager to implement this measure into the program. Dr. Schreiber noted that the measure is currently in use in the Hospital OQR (as OP-18) and explained that because longer ED wait times may result in negative unintended consequences for patients, CMS views wait times as indicators of quality. A CMS representative highlighted that the measure includes four separate data elements for (1) patients without a psychiatric principal diagnosis; (2) patients who can be treated at the ED and return to their place of residence including LTC facilities; (3) patients with a psychiatric principal diagnosis who require mental health services; and (4) patients that are transferred from the ED to an acute care emergency hospital for inpatient treatment. The CMS representative noted that these four elements will be used for measure stratification, but not public reporting.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. A lead discussant commented that OP-18 used in the Hospital OQR has led to marginal improvements in wait times over 10 years and noted that the measure is not endorsed by a CBE. The lead discussant acknowledged the previous concern raised by a public commenter about psychiatric patients often requiring longer ED stays but said that the measure's stratification appears to address this issue. The lead discussant also asked CMS to clarify whether the REHQRP is a pay-for-performance program. Dr. Schreiber clarified that the REHQRP is a pay-for-reporting program.

Another lead discussant applauded CMS for prioritizing rural health but noted that OP-18 was previously recommended for removal by MAP from the Hospital OQR due to a lack of evidence that the measure advances quality improvement efforts. The lead discussant questioned if this measure would provide meaningful information to providers on how to improve quality. The lead discussant raised previous discussions by the Workgroup about the impact of patient acuity mix on ED wait times and asked CMS to address this concern. Dr. Schreiber responded that while OP-18 has shown little improvement in ED wait times, it has demonstrated substantial variation in wait times among facilities. Dr. Schreiber explained that this measure, MUC2022-039, is important to the REHQRP because ambulatory care is the focus of REHs. Dr. Schreiber said that a benefit of the measure is that it has already been in use in the Hospital OQR. A Health Resources and Services Administration (HRSA) representative added that measuring ED use provides important information on a community's health and the local care delivery system, thereby

serving as potential markers for access and health status.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member commented that in their experience, there appears to be an increasing use of the ED among patients who are not able to visit their provider for a same-day appointment. The MAP member expressed concern that ED wait times may be longer as a result.

A MAP member expressed support for the measure concept but questioned whether ED wait times are the most pressing issue for rural hospitals. The MAP member noted that rural providers often need to obtain consultations, which can be time consuming. The MAP member raised concern that by overly focusing on ED wait times, the measure could negatively impact other priorities – namely, the provision of care to patients. However, the MAP member acknowledged that ED wait times remain important because patients with prolonged wait times may leave without being seen.

A MAP member commented that wait times can vary due to patient mix and are reflective of the community and their needs. The MAP member remarked that the measure incentivizes clinicians to admit patients who cannot be seen immediately. The MAP member expressed that the measure disincentivizes clinicians from keeping a watchful eye on patients and providing them with the appropriate level of care.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Do Not Support for Rulemaking," for MUC2022-039. Voting results were as follows: Yes – 18, No – 2, and percentage voting Yes – 90 percent. Full voting results are in Appendix D.

MUC2022-066: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (REHQRP)

Ms. Williams-Bader provided an overview of the measure, noting that the Workgroup questioned whether REHs would have enough cases to report it. Ms. Williams-Bader said that some Workgroup members questioned whether MUC2022-066 and MUC2022-067 should be combined; per CMS, this would require development of a new measure. Ms. Williams-Bader continued that other Workgroup members observed that colonoscopies may be more common in REHs than other types of procedures or surgeries and supported the importance of this measure for patients in rural settings. Ms. Williams-Bader noted that the measure is endorsed.

Ms. Williams-Bader said that NQF received two public comments on the preliminary recommendation – both supported the measure. Ms. Williams-Bader remarked, however, that one comment stated that the utility of the measure is unclear because it is unknown whether facilities that gain the new REH designation will have adequate volumes to calculate performance; if they have sufficient volume, the commenter supports the measure.

Ms. Williams-Bader turned the meeting over to CMS for further clarification on the measure. A CMS representative explained that the measure is in use in the Hospital OQR where it has been publicly reported since 2017, and that the measure received NQF endorsement in 2020. The CMS representative said that the measure fills a gap in the REHQRP by promoting effective communication and care coordination for low-risk colonoscopies. The CMS representative emphasized that it is important for patients living in rural areas to have access to high-quality healthcare services.

Ms. Williams-Bader invited lead discussants to provide comments on the measure. The lead discussant expressed support for the measure and the Workgroup's recommendation of, "Support for Rulemaking," noting the measure will allow patients to make informed choices of where to seek care.

The lead discussant acknowledged the concerns about low volumes given the emerging nature of the REHQRP but said this was insufficient for not moving forward with the measure.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member recognized the importance of the measure but questioned what qualifies as a "high" rate of complication after outpatient colonoscopy. The developer responded that data from the HOPD setting indicate that the average complication rate is 16 percent and ranges from 11 to 24 percent. Two MAP members remarked that this rate appears exceptionally high for low-risk colonoscopies. Later, the developer clarified that measure testing data indicate that among 4,034 facilities, the risk-standardized hospital visit rate after outpatient colonoscopy ranges from 11.67 to 24.27 per 1,000 colonoscopies (median = 16.38).

Another MAP member commented that the measure is important for obtaining "good" data on colonoscopies performed in rural settings and underscored the importance of reviewing outcomes for these procedures.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Support for Rulemaking," for MUC2022-066. Voting results were as follows: Yes – 18, No – 1, and percentage voting Yes – 95 percent. Full voting results are in Appendix D.

Measures Pulled from Consent Calendar

Ms. Williams-Bader introduced the section for measures pulled from the consent calendar and described the process in which these measures were pulled for discussion. Ms. Williams-Bader noted measures discussed until this point in the meeting had less than 80 percent of the Workgroup voting for the same decision category or did not achieve consensus at the Workgroup. Ms. Williams-Bader explained in order to determine if others should be pulled, NQF staff asked Coordinating Committee members if they would like to request to pull any measures during the public comment on the Workgroup's preliminary recommendations. Ms. Williams-Bader further explained that NQF staff also reviewed public comments on the preliminary recommendations to determine if any new information was received through public comment that was not available or discussed during the Workgroup's measure Review Meeting, which was conflicting to the Workgroup's recommendation. Ms. Williams-Bader noted after receiving requests from Committee members and after reviewing public comment, NQF decided to pull a smaller number of measures in order to give the Committee ample time to discuss the measures for discussion. NQF reviewed the Committee member requests for those where NQF thought new information was presented that was not available or discussed during the Workgroup's measure Review Meeting, which was conflicting to the Workgroup's recommendation. This resulted in NQF staff pulling four measures from the consent calendar – two due to Committee member request and two due to public comment.

- **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)*

Public Comment

Ms. Williams-Bader turned to Mr. Kahn to open the meeting for public comment. Mr. Kahn reminded the meeting attendees of the public commenting process before opening the meeting for public

comment. At this time, 10 comments were raised.

A commenter expressed strong support for MUC2022-098 and -111. The commenter noted these are the only SDOH measures under consideration for clinician programs this cycle. The commenter shared their personal experience implementing a screening, referral, and follow-up process in their urban clinic that helped families meet basic needs such as housing, food, and utilities. The commenter noted that colleagues were astonished by the unmet needs identified by patients and families who they had been seeing for years. The commenter stated that it is known that populations of color disproportionately experience these social and structural drivers of health. The commenter noted both measures have been implemented and tested in CMMI's AHC model. The commenter further noted that many clinical practices have experience connecting patients to services and following up to determine if patients have received resources, even though it is not required. The commenter said it is not surprising that clinicians are generally reluctant to screen for something without having a plan for addressing the identified issue. The commenter acknowledged that integrating this measure may not be easy for many clinicians, but it is possible and is essential to patient health.

A commenter noted the importance of hearing the voice of physicians, noting the issue of provider burnout. The commenter said when North Carolina transitioned to managed Medicaid in 2021 they were able to screen a high number of participants for social needs, noting it helped providers triage and connect participants to services. The commenter noted the first piece of triage is understanding that if a patient is without food, without a home, or under threat of violence, the other core medical measures will fall flat. The commenter further noted that connecting a patient to community resources allows the clinician to focus on medical care.

A commenter stated support for MUC2022-098 and -111, noting the importance of the measures for moving towards a more equitable system for healthcare delivery. The commenter said they are treating patients daily who are at risk and vulnerable, noting food insecurity, housing instability, and lack of transportation. The commenter stated the lack of measuring or incentivizing health systems to allocate additional resources towards these obstacles puts patients in a position where they cannot help themselves or improve their health.

A commenter stated they are part of the foundation which submitted the two original drivers of health measures for the Hospital IQR program and MIPS last year. The commenter referenced their comments from earlier in the day stating strong support for MUC2022-055, -098 and -111, noting reinforcement by many of the commenters during the meeting. The commenter noted the original two measures were a stake in the ground to begin to measure an issue that needed to be improved and the measures discussed at the meeting build on that and begin to seek not only leverage points in the healthcare system, but also novel solutions to solving these issues. The commenter stated in 2021 their organization surveyed over 1,000 physicians and more than 60 percent supported asking patients about drivers of health.

A commenter voiced support for MUC2022-098 and -111, noting social drivers have a sizable impact on health and healthcare cost. The commenter noted the need to build models that care for patients' physical, mental, and social needs both in the clinic and home community. The commenter urged the MAP to recognize the SDOH screening measure and the screen positive rate, which will allow clinicians to connect their patients to community-based social resources. The commenter noted the need for alignment as CMS has implemented the measures in the Hospital IQR program. The commenter stated that the person-level SDOH data will help generate important data that will help improve the healthcare system. The commenter noted they see these social impacts every day, the impact they have on health,

and how they drive health outcomes and cost. The commenter stated as a practicing pediatrician they see children who have social needs that cause hospitalizations, noting that is bad not only for the children and families, but also the healthcare system.

A commenter expressed support for MUC2022-098 and -111. The commenter stated as a physician not a day goes by where they do not take into account social risks and care management such as transportation, medication, and diet. The commenter noted it is critical to know this information to inform future policy and improve population health in this country.

A commenter noted support for MUC2022-098 and -111. The commenter shared their experience implementing screenings for food insecurity in private practices, and echoed an earlier comment that the results of such screenings are surprising to colleagues. The commenter noted measuring these items, standardizing these items, incentivizing them while keeping them optional is what ends up streamlining the process. The commenter noted streamlining makes it easier to fit the measures into a busy practice workflow.

A commenter noted their rural clinic is the last resort for most patients that have low or no income, food insecurity and housing instability. The commenter stated that patient care, surgery, and treatments are affected by homelessness, lack of transportation, or length of transportation, noting support of the SDOH measures discussed in the section.

A commenter echoed support for MUC2022-098 and -111. The commenter stated they worked in South Boston, noting it as one of the birth places of the community health center movement where addressing social needs and the root cause of health is part of the movement. The commenter further noted that not screening, assessing, or doing something about those needs means a patient's quality of care cannot be improved. The commenter stated setting up incentives for screening without ensuring connections to resources, may incentivize unethical screening for social needs. The commenter noted there are already frameworks with depression remission and response metrics that "push full cycle." The commenter echoed earlier statements that food insecurity is probably one of the highest screening rates, but also one of the quickest wins.

A commenter noted that advancing health equity and addressing social drivers of health requires changing how and what is measured in healthcare. The commenter expressed strong support for the adoption of the standardized SDOH measures. The commenter noted that without measurements of social factors, how these factors promote or harm health is invisible, in particular with negative consequences for communities of color. The commenter noted that during both last year's and this year's MUC cycle, the MAP Advisory Groups, Workgroups, and Coordinating Committee members who reviewed the SDOH screening measures emphasized the importance of linking the screening measures to connecting patients to SDOH resources. The commenter also noted during the public comment period last year stakeholders called upon CMS to enact SDOH navigation and resource measures alongside the screening measures. The commenter urged the Committee to focus its conversation on the empirical data from the five-year CMS AHC pilot from which these two measures are directly derived to ensure an evidence-based conversation.

Mr. Kahn thanked the commenters for their input and turned the meeting to Ms. Williams-Bader to introduce the first measure.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally

supported the measure for rulemaking pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a CBE. Ms. Williams-Bader stated the Workgroup acknowledged several challenges with implementing a measure of this type, including a range of capacity to serve patients with health-related social needs (HRSNs) when there is a range of community services available, and potential costs from EHR vendors to implement the measure. Ms. Williams-Bader stated the Workgroup 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. Ms. Williams-Bader further stated the Workgroup noted that community clinics attempt to address the social needs of their patients, and the measure provides an opportunity for physicians to take an active role in 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. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement. Ms. Williams-Bader noted NQF received 23 public comments on the preliminary recommendation.

Ms. Williams-Bader invited the lead discussant to provide their rationale for requesting to pull the measure from the consent calendar. The lead discussant stated they fully support the intent of the measure, but their concern was whether the measure could be implemented on a broader scale than in one state or the CMMI model. The lead discussant noted the lack of rigor behind the measure specifications and testing, as compared to other MIPS measures or measures proposed for MIPS during this pre-rulemaking cycle. The lead discussant stated last year MAP reviewed two similar measures (screening for social risk factors and screening positive for social risk factors) with similar recommendation conditions. The lead discussant further stated both measures are now in CMS programs without MAP's recommended conditions, noting it remains unclear how CMS plans to address the issues. The lead discussant noted the issues include: (1) lack of information about the measure's reliability, validity, and feasibility; (2) inclusion of social needs domains that have not been standardized; and (3) lack of standardization regarding survey instruments. The lead discussant noted that continuing to ignore these important factors, especially when physicians are now asked to address and resolve social risk factors, may lead to unintended consequences. The lead discussant noted the need to study and compare the use of multiple survey tools for screening of the same domains within and across social risk measures. The lead discussant stated it is unknown whether patients would screen positive or negative for the same social risk factor depending on the tool the physician or medical practice uses, noting how misleading this information could be for patients and physicians who are supposed to engage in quality improvement. The lead discussant stated further detail is needed on what satisfies the intervention requirement, and the activities or referrals need to be widely available within a region or community and demonstrated to be effective for an individual. The lead discussant noted that there is an assumption that what was done in a CMMI model will work within MIPS, but the structure and incentives to participate were different, noting the CMMI model included community-level participation.

Ms. Williams-Bader turned the meeting over to CMS for contextual comments. Dr. Schreiber answered questions regarding MIPS and how the measure might be applicable for MIPS. Dr. Schreiber noted if clinicians are eligible, they need to report in MIPS, but they have a wide choice of measures to report. Dr. Schreiber then noted most clinicians report though a large practice, usually a multi-specialty practice, and this would certainly be an option under consideration for the MIPS value pathways. A CMS representative noted that these measures are seen as a steppingstone in being able to address heath equity, noting this is a priority within the administration. The CMS representative acknowledged there may be challenges within a community, or even a provider setting, to address all the needs of a patient. The CMS representative further noted that in order to start addressing health equity needs there needs to be a starting point.

Ms. Williams-Bader noted there were several comments about the measure and if it was moved into MVPs whether it would need to come back through MAP. Dr. Schreiber stated that currently MVPs are being posted publicly for public review and comments. Dr. Schreiber further stated MIPS measures come to MAP for discussion and measures that would be proposed in the MVPs are those measures that would have already been though MAP. Dr. Schreiber noted it is premature to talk about a foundation level in MVPs.

Mr. Kahn opened the floor for MAP members to discuss the measure. A MAP member noted this discussion is similar to one earlier in the meeting about whether a measure is appropriate for the program but that this is an elective measure within MIPS.

The lead discussant suggested a potential condition of knowing more information and detail on what satisfies the intervention requirement, activities, or referrals. The lead discussant noted in the past CMS has allowed for broad interpretation of measure specifications and after the fact distributed further guidance that disagreed with the initial interpretation negatively impacting scores. The measure developer responded that the measure is about connection to a community service provider and the measure specification offers a detailed description. The developer explained it includes reporting from the patient or community service provider that the patient was connected to the provider.

A MAP member noted that to effectively address social drivers of health, there needs to be an effective connection with community-based organizations. The MAP member noted the large number of commenters, specifically physicians, making public comments in support of the measure. The MAP member stated the need for linkage and connection with community providers in order to effectively respond to the social drivers of health.

A MAP member noted the importance of the measure and suggested maintaining the focus that the Committee review the measure's fit for purpose. The MAP member noted the lack of consistent screening tools might affect the validity of the measure but would presumably be resolved when the measure goes under endorsement review. The MAP member noted support for the measure with the rationale that was offered by the Workgroup for "Conditional Support for Rulemaking."

Mr. Kahn moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-098 pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a CBE. Voting results were as follows: Yes – 18, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

A MAP member asked for clarification on how these conditional supports are operationalized in terms of conditions related to NQF endorsement. Dr. Schreiber noted that endorsement is always CMS' intent with as many measures as possible. Ms. Williams-Bader noted there are MAP implementation results in the slide deck appendices.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup conditionally supported the measure for rulemaking pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a CBE. Ms. Williams-Bader noted the Workgroup stated 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. Ms. Williams-Bader further noted the Workgroup was broadly supportive of the measure. Ms. Williams-Bader noted the measure has not yet been submitted for endorsement.

Ms. Williams-Bader invited the lead discussant to provide their rationale for requesting to pull the measure from the consent calendar. The lead discussant stated the unique factor with this measure compared to the prior measure is the resolution timeframe. The lead discussant noted the measure as currently drafted has insufficient specificity and from a data collection standpoint is subjectively written. The lead discussant explained that the measure assumes the social need will remain resolved throughout 12 months, but likely a patient may have a social need resolved earlier in the year but subsequently requires additional assistance for the social need or a new intervention. The lead discussant noted conversations with those on the frontline working on equity issues stated the need to study what is an acceptable timeframe for resolution, noting it may be based on locality or the specific social need and for some patients, psychiatric patients for instance, may be more challenging to resolve. The lead discussant further noted the desire to hear from CMS on how they plan to address the conditions that have been placed on the social screening measure.

Ms. Williams-Bader turned the meeting over to CMS for contextual comments. The CMS representative noted this is the beginning stage of how to address health equity. The measure developer noted this measure was psychometrically evaluated and compared favorably to other screening tools used in the health centers (HCs), which is what these two measures are based on. The developer noted the feasibility from the developer's own experience with over 150 community health centers that have screened over 1.6 million patients in the last five years and the HC model had over 1 million beneficiaries screened. Mr. Kahn stated concern that individual physician offices are not equivalent to a community health center, which are well designed for referring patients to community services. Mr. Kahn noted that physicians have choices in MIPS, but there are limited choices, and they will need to accept some of these measures to report. The measure developer responded that these measures have been tested in hospital settings and hundreds of non-community health center clinics, as well.

A MAP member asked the measure developer about how resolution is defined, whether it is progress towards resolution or a scale. The measure developer noted this is a patient-reported measure based on the patient's definition of resolution or the community service provider's definition who reports on the patient's behalf.

A CMS representative noted agreement on the importance of the topic. The CMS representative noted over time programs have evolved from using process measures to more outcome measures, noting there will continue to be better measures. The CMS representative reminded the Committee that in addition to the 198 MIPS measures, there are 150 QCDR [qualified clinical data registry] measures, so there are many measures that clinicians can choose to report.

Mr. Kahn noted that the 80 percent or more of the Workgroup voted for the recommendation, and moved the Coordinating Committee to vote on acceptance of the Workgroup recommendation, "Conditional Support for Rulemaking," for MUC2022-111 pending testing indicating the measure is reliable, valid, and feasible, and endorsement by a CBE. Voting results were as follows: Yes – 18, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup supported the measure for rulemaking. Ms. Williams-Bader noted the Workgroup expressed appreciation for the inclusion of Medicare Advantage beneficiaries in the measure and expressed overall support for the measure. Ms. Williams-Bader noted the measure was endorsed.

Ms. Williams-Bader stated this measure was pulled due to public comment. Ms. Williams-Bader noted that NQF received three public comments – one comment was in support of the measure and two were in support under certain conditions. Ms. Williams-Bader stated those who supported the measure under certain conditions requested that the measure receive endorsement by a CBE to ensure its reliability and validity with the inclusion of Medicare Advantage patients. Ms. Williams-Bader further stated the Workgroup also raised concern regarding the underlying accuracy of Medicare Advantage data.

Ms. Williams-Bader stated NQF staff pulled the measure because of the first concern – that the measure has not been endorsed with Medicare Advantage data, which impacts the denominator and numerator, and is a new data source for the measure. Ms. Williams-Bader noted this is considered a substantive enough change where the measure would need an endorsement review.

Ms. Williams-Bader turned the meeting over to CMS for contextual comments. Dr. Schreiber noted this is a measure many are familiar with, and the addition of Medicare Advantage data will make this a more robust measure.

Mr. Kahn stated the key question for the Coordinating Committee is whether to add the request that CMS seek endorsement from the CBE. Mr. Kahn asked for feedback from the Committee. A MAP member asked if the measure developer had any additional information to share around the concern related to the quality of Medicare Advantage data. The developer noted there were two years of testing before proposing adding the Medicare Advantage data. The developer reported they compared inpatient hospital Medicare admission claims and Medicare Advantage claims, noting the extensive testing did not indicate substantial changes. The developer further noted these measures are due for NQF maintenance endorsement in 2024 and scheduled for implementation in 2026.

A MAP member acknowledged it was good that the measures were going through maintenance but noted the need for MAP to be consistent with recommendations. The MAP member stated if the measure is not endorsed with the Medicare Advantage data, it should be a conditional support recommendation. Another MAP member agreed with the prior comment on consistency.

Mr. Kahn moved the Coordinating Committee to vote, "Conditional Support for Rulemaking," for MUC2022-055 pending endorsement by a CBE. Voting results were as follows: Yes – 18, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix D.

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

Ms. Williams-Bader provided an overview of the measure, noting the Workgroup supported the measure for rulemaking. Ms. Williams-Bader noted the Workgroup expressed support for the measure and noted agreement that mortality is a meaningful outcome to patients and providers. Ms. Williams-Bader further noted the Workgroup expressed agreement with the addition of Medicare Advantage patients to the measure. Ms. Williams-Bader noted the measure was endorsed.

Ms. Williams-Bader stated this measure was pulled due to public comment. Ms. Williams-Bader noted NQF received three public comments – one comment was in support of the measure and two were in support under certain conditions. Ms. Williams-Bader stated the comments were similar to the previous measure with those who supported the measure under certain conditions requesting that the measure receive endorsement by a CBE to ensure its reliability and validity with the inclusion of Medicare Advantage patients. Ms. Williams-Bader further stated the Workgroup also raised concern regarding the underlying accuracy of Medicare Advantage data.

Ms. Williams-Bader stated NQF staff pulled the measure because of the first concern – that the measure has not been endorsed with Medicare Advantage data, which impacts the denominator and numerator, and is a new data source for the measure. Ms. Williams-Bader noted this is considered a substantive enough change where the measure would need an endorsement review.

Ms. Williams-Bader turned the meeting over to CMS for contextual comments and CMS invited the measure developer to speak. The developer noted the data is the same as the hospital-wide readmission measure except for the outcome, which is obtained from beneficiary files, noting it is easier to obtain the mortality outcomes.

Mr. Kahn moved the Coordinating Committee to vote on the recommendation, "Conditional Support for Rulemaking," for MUC2022-057 pending endorsement by a CBE. Voting results were as follows: Yes – 19, No – 0, and percentage voting Yes – 100 percent. Full voting results are available in Appendix D.

Consent Calendar Measures

Ms. Williams-Bader introduced the consent calendar measures (see Appendix C).

Public Comment

Ms. Williams-Bader opened the floor to allow for public comment. At this time, one comment was raised. A commenter expressed excitement that the Coordinating Committee voted to conditionally support MUC2022-032. The commenter asked CMS to consider implementing MUC2022-112 alongside MUC2022-032, noting that the measures are very similar and taken together, will have a positive impact on the care of older adults.

Discussion of Consent Calendar Measures

Mr. Kahn opened the floor for MAP members to ask clarifying questions and offer comments on the consent calendar measures. MAP members raised comments and questions regarding MUC2022-007, -018, -020, -065, -112, -113, -125, and -126.

MUC2022-007: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) (MIPS); MUC2022-018: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) (Hospital IQR); MUC2022-020: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) (Hospital OQR)

A MAP member said that their request to pull MUC2022-007, -018 and -020 for discussion was not accommodated. The MAP member noted that the Workgroup voted to support the measures for rulemaking and that the measures are endorsed. However, the MAP member cited two concerns that were not addressed by the Workgroup nor during the endorsement process. The first concern cited by the MAP member was that the collection of data elements for these measures is reliant on proprietary software developed by the measure developer. The MAP member said that the developer has not described the feasibility of integrating this proprietary software into information technology (IT) systems and expressed concerns about administrative burden. The MAP member said that their second concern centers on validity due to a lack of documentation shared about the testing performed for the proprietary software which derives data elements for the measure. A second MAP member agreed that the use of proprietary software is problematic if the Coordinating Committee were to recommend the measure for rulemaking, noting that this appears to be the case since the measures cannot be pulled for

discussion.

The measure developer responded that the measure was tested across 16 hospitals and a large system of outpatient radiology centers. The developer explained that all data were assembled and demonstrated high accuracy, validity, and reproducibility. The developer continued by saying that measure burden was assessed using surveys, which found that the measure burden was comparable to that of other measures. The developer explained that the proprietary software was developed out of necessity, as electronic clinical quality measures (eCQMs) cannot access radiology data, which is stored as pixels or in a standardized radiation dose structured report (RDSR). Dr. Schreiber added that the use of the proprietary software was discussed by the Workgroup and that it will be made available free of charge.

MUC2022-065: Preventive Care and Wellness (composite) (MIPS); MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months (MIPS)

A MAP member said that their request to pull MUC2022-065 and MUC2022-125 for discussion was not accommodated. The MAP member raised an issue with MUC2022-065 because it is a composite measure. The MAP member did not elaborate further, but said that concerns about composite measures have previously been discussed at other NQF subcommittee meetings.

The MAP member said that MUC2022-125 is "highly problematic," stating that evidence demonstrates that general internal medicine patients tend to be sicker than other patients, a point which is also acknowledged by the measure developer. For this reason, the MAP member expressed concern that the measure will result in lower scores among internists relative to other clinicians.

MUC2022-112: Geriatrics Hospital Measure (Hospital IQR)

A MAP member said that their request to pull MUC2022-112 for discussion was not accommodated. The MAP member said that because the Workgroup voted "Do Not Support for Rulemaking with Potential for Mitigation," the measure warranted further discussion by the Coordinating Committee. The MAP member noted that the Coordinating Committee had voted to conditionally support a similar measure, MUC2022-032. For these reasons, the MAP member said that they would like the measure to be discussed by the Coordinating Committee. Another MAP member expressed agreement with the previous MAP member's comments.

A MAP member said that by not pulling MUC2022-112 for discussion, the Coordinating Committee is abdicating its responsibility to ensure that the Workgroups apply the decision categories consistently across all MUCs. Another MAP member expressed agreement with this comment.

MUC2022-113: Number of Hospitalizations per 1,000 Long-Stay Resident Days (SNF VBP); MUC2022-126: Total Nursing Staff Turnover (SNF VBP)

A MAP member said that their request to pull MUC2022-113 and -126 for discussion was not accommodated. The MAP member raised that there is already a short-stay version of the measure, as well as a preventable hospitalization measure, in use in the SNF VBP and wondered whether this third proposed measure is necessary. Additionally, the MAP member noted that the SNF VBP is designed to assess short-stay patients, meaning that this long-stay measure is not appropriate for the program. The MAP member said that measures which are not time-sensitive are required to be implemented in the SNF QRP first and receive endorsement by a CBE prior to implementation in the SNF VBP. For this reason, the MAP member said that the measure is not ready for rulemaking. The MAP member said that they wished to raise these concerns as they were not discussed by the Workgroup to an appreciable extent.

The MAP member noted that NQF received seven comments on the preliminary recommendation for MUC2022-126 which did not support the measure and cited concerns that turnover has been especially high during the COVID-19 pandemic and the timing of the measure is inappropriate for use in a VBP. The MAP member noted that the measure is already publicly reported as part of the Medicare Five-Star Quality Rating System. The MAP member said that measures which are not time-sensitive are required to be implemented in the SNF QRP first and receive endorsement by a CBE prior to implementation in the SNF VBP. The MAP member said that they wished to raise these concerns as they were not discussed by the Workgroup to an appreciable extent.

Discussion of Consent Calendar Process

After discussion of specific measures on the consent calendar, Ms. Roberts invited comments from MAP on the consent calendar process. A MAP member expressed that there is a need to examine the consent calendar process. Another MAP member expressed concern that MAP may put forth a recommendation to CMS without having had the opportunity to discuss the measure in depth. Ms. Williams-Bader acknowledged this concern and explained that Coordinating Committee members are unable to pull measures from the consent calendar for discussion during the meeting due to time constraints and logistical issues (i.e., measure developers or stewards may not be in attendance to address concerns or questions raised by the Coordinating Committee). Two MAP members expressed that the Coordinating Committee's discussion is more important to CMS than the recommendations themselves.

Despite the concerns raised about the consent calendar process, including the inability to pull measures for discussion, several MAP members verbalized that MAP should not change the process during the meeting. Instead, several MAP members agreed that these process concerns should be considered in the planning for future Coordinating Committee meetings. A MAP member acknowledged the concerns raised about changing the consent calendar process during the meeting but requested that the Coordinating Committee move to discuss and vote on MUC2022-112.

Dr. Schreiber thanked NQF for organizing the Coordinating Committee meetings and working to accommodate the large volume of measures under consideration for the 2022-2023 cycle. Dr. Schreiber said that CMS prioritizes MAP's discussions and public comments over the voting results when considering measures for rulemaking.

Ms. Roberts asked Ms. Williams-Bader to clarify the process for pulling measures for discussion. Ms. Williams-Bader reviewed the criteria for pulling measures from the consent calendar, including that a measure may be pulled if new information provided during the second public comment period was not available to the Workgroup, or was not already discussed by the Workgroup. Ms. Williams-Bader said that this criterion was applied to the rationales provided by the Coordinating Committee members who requested to pull measures for discussion. Ms. Williams-Bader explained that due to the volume of measures, not all requests for measures to be pulled from the consent calendar for discussion could be accommodated. Mr. Kahn raised that the criteria to pull measures for discussion were reviewed and agreed to by the co-chairs. Mr. Kahn reiterated that the volume of measures did not allow for accommodation of all requests to pull measures and said that NQF and the co-chairs will incorporate this feedback into planning for future Coordinating Committee meetings.

A MAP member expressed that the rationale for pulling MUC2022-112 for discussion, as requested by another MAP member, is that the Workgroup did not apply the decision categories consistently between MUC2022-032 and MUC2022-112. Another MAP member expressed agreement and said that MUC2022-112 should be put to a vote by the Coordinating Committee.

Mr. Kahn asked whether the Coordinating Committee needs to vote on approval of the consent calendar. Ms. Williams-Bader responded that it was not planned for the Coordinating Committee to vote on the consent calendar. A MAP member expressed that the consent calendar should be put to a vote by the Coordinating Committee. Another MAP member agreed and said that a consent calendar requires a vote from the Coordinating Committee.

Ms. Williams-Bader and the co-chairs convened a private conference to discuss the next steps for the meeting.

Vote on Consent Calendar

After a short break, Ms. Williams-Bader reconvened the meeting and said that the Coordinating Committee would vote on acceptance of the consent calendar, noting that MUC2022-112 would be pulled from the consent calendar and not included in the consent calendar vote, at the request of the MAP members who raised concerns that the decision categories were not applied consistently between MUC2022-032 and -112.

Ms. Williams-Bader turned the meeting over to the co-chairs. Ms. Roberts asked if there are any objections to the proposal outlined by Ms. Williams-Bader. No objections were raised.

Ms. Roberts moved the Coordinating Committee to vote on acceptance of the consent calendar except MUC2022-112. Voting results were as follows: Yes – 19, No – 1, and percentage voting Yes – 95 percent.

Additional Measure Pulled from Consent Calendar

Ms. Roberts moved the Coordinating Committee to discuss MUC2022-112.

MUC2022-112: Geriatrics Hospital Measure (Hospital IQR)

Ms. Williams-Bader provided a brief overview of the measure, noting that the Workgroup did not support the measure for rulemaking with potential for mitigation. Ms. Williams-Bader explained that the Workgroup's proposed mitigation strategy was a consideration for combining MUC2022-112 and MUC2022-032 into a measure that is less burdensome and crosswalking the measures to be clear about where they align and where there are differences. Ms. Williams-Bader remarked that the Workgroup discussed the overlap between MUC2022-112 and MUC2022-032, and noted that hospitals, particularly ones in rural settings, may find it burdensome to report both measures. Ms. Williams-Bader said MAP members urged the developer to consider how to combine the two measures, or to focus on just one measure. Ms. Williams-Bader noted that NQF received four public comments on the preliminary recommendation for MUC2022-112 – none of which supported the measure.

Ms. Roberts asked Ms. Williams-Bader to remind the Coordinating Committee of the Committee's vote on MUC2022-032 at yesterday's meeting. Ms. Williams-Bader responded that the Coordinating Committee unanimously voted to accept the Workgroup's recommendation of "Conditional Support for Rulemaking" pending endorsement by a CBE, further work to pare down the elements included in the attestation, and the presentation of information about gaps for the components covered by the measure.

Ms. Williams-Bader turned the meeting to the MAP member who requested to pull MUC2022-112 from the consent calendar to provide their rationale for their request. The MAP member said that geriatric patients are overrepresented among hospital admissions and discharges, and highlighted the vulnerability of this population. The MAP member said that there are few accountability measures

specific to the provision of care for geriatric patients and expressed that this measure, as well as MUC2022-032, fill an important measurement gap. The MAP member suggested that the Coordinating Committee vote to conditionally support the measure contingent on the same conditions put forth by the Coordinating Committee for MUC2022-032.

Ms. Williams-Bader turned the meeting over to CMS to provide further clarification on the measure. Dr. Schreiber remarked that this is a structural measure that supports a frail and vulnerable population with complex conditions. Dr. Schreiber introduced the measure developer who said that they would address any questions or concerns raised by the Coordinating Committee.

Ms. Roberts opened the floor for MAP members to discuss the measure. A MAP member expressed that the measure concept is important and asked whether "Conditional Support for Rulemaking" is appropriate if the Coordinating Committee were to suggest substantive changes to MUC2022-112, such as recommending CMS to pare down the measure. Ms. Williams-Bader clarified that "Conditional Support for Rulemaking" would be appropriate since this recommendation does not provide specific detail on how the measure should be pared down.

A MAP member noted the high degree of similarity between the domains included in MUC2022-112 and MUC2022-032. The MAP member said that it was unclear why the Workgroup conditionally supported MUC2022-032 but did not support MUC2022-112. The measure developer responded that the two measures were developed together and explained that the Workgroup chose to conditionally support MUC2022-032 because it includes fewer domains than MUC2022-112 and thus, would impose a lesser burden. The measure developer said that as a result, the Workgroup voted "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-112 and recommended that MUC2022-032 and MUC2022-112 be combined into a single measure.

A MAP member expressed support for MUC2022-112 and said that should the measures be combined, it is important that the domains that address the unique needs of geriatric surgical patients be retained.

A MAP member emphasized the importance of consistency as MAP members discuss and vote on measures. The MAP member recognized the importance of the measure concept and said that structural measures like MUC2022-112 have a profound impact on the geriatric patient population. The MAP member expressed support for the measure.

A MAP member expressed concern that the domains included in the measure are not consistent with the recommendations put forth by the U.S. Preventive Services Taskforce (USPSTF). Additionally, the MAP member expressed hesitation around re-voting and potentially overturning the Workgroup's recommendation, noting that the Workgroup had the opportunity to engage in a more detailed discussion of the measure. The measure developer said that the Workgroup engaged in a detailed discussion and their main concern was the burden of the measure.

A MAP member expressed that MUC2022-112 promotes safe and effective care for older patients. The MAP member remarked that the individual domains in the measure are evidence-based.

A MAP member questioned why the Workgroup did not vote "Do Not Support for Rulemaking with Potential for Mitigation" for both MUC2022-032 and MUC2022-112 given their recommendation to combine the two measures. Ms. Williams-Bader said her impression was that the Workgroup supported both measures in concept, but due to the order in which the measures were discussed, only voted to conditionally support MUC2022-032 because it was discussed first at the Workgroup meeting; the Workgroup voted, "Do Not Support for Rulemaking with Potential for Mitigation" for MUC2022-112

because the inclusion of both measures would be too burdensome. Another MAP member stressed the importance of parsimony and expressed that inclusion of both measures in the Hospital IQR would be redundant.

Ms. Roberts suggested that the Coordinating Committee move to vote on acceptance of the Workgroup's recommendation "Do Not Support for Rulemaking with Potential for Mitigation" and outlined the Workgroup's proposed mitigation strategy to combine MUC2022-112 and MUC2022-032 into a measure that is less burdensome and crosswalk the measures to be clear about where they align and where there are differences. Voting results were as follows: Yes – 11, No – 10, and percentage voting Yes – 52 percent. The Coordinating Committee did not reach consensus and discussion continued on the measure.

Ms. Roberts asked whether the Coordinating Committee should vote on another decision category or if it should simply be noted that the Coordinating Committee did not reach consensus on acceptance of the Workgroup recommendation. Mr. Kahn said that the Coordinating Committee should vote on another decision category. Ms. Roberts proposed that the Coordinating Committee move forward with a vote of "Conditional Support for Rulemaking" with the same conditions outlined for MUC2022-032 (i.e., endorsement by a CBE, further work to pare down the elements included in the attestation, and the presentation of information about gaps for the components covered by the measure). Voting results were as follows: Yes – 13, No – 8, and percentage voting Yes – 62 percent. Full voting results are available in Appendix D.

Additional Process Considerations

Mr. Kahn acknowledged the consent calendar process concerns that were raised during the meeting. Mr. Kahn suggested that NQF staff and the co-chairs develop and propose a series of consent calendar process changes to the Coordinating Committee members.

A MAP member said that they were "uncomfortable" overturning the Workgroup's recommendation with a slim majority. The MAP member again stressed the importance of revisiting the consent calendar process. Another MAP member asked for changes on how measures are pulled from the consent calendar for discussion and suggested that perhaps multiple MAP members should request to discuss a measure for it to be pulled from the consent calendar. A third member expressed agreement with the previous MAP member's comment.

A MAP member underscored the Coordinating Committee's role in ensuring that the Workgroups apply the MUC decision categories consistently, and suggested that this be included as a criterion used to pull measures from the consent calendar for discussion.

A MAP member questioned how the Coordinating Committee can make meetings more efficient. The MAP member expressed that much of the meeting is spent on immaterial discussion of the importance of measures when the Coordinating Committee's charge is to assess the appropriateness of measures for rulemaking given the intended purpose of the program for which the measures are proposed. The MAP member also noted that most measures reviewed by MAP and finalized for rulemaking are not endorsed by a CBE. The MAP member expressed concerns that such measures are "skirting" the endorsement process and suggested that the Coordinating Committee more stringently evaluate measures under consideration for which there is not an urgent need. Another MAP member expressed agreement with the previous member's comments.

A MAP member noted feeling "turned off" when concerns raised about measures under consideration

for MIPS were met with reminders that measures included in this program are voluntary (i.e., clinicians select which measures they report). The MAP member questioned the importance of such measures if clinicians can simply choose not to report them.

A MAP member suggested that perhaps there should be two separate processes for measures under consideration for pay-for-performance versus pay-for-reporting programs.

Discussion of Gaps

Due to time constraints, the Coordinating Committee did not have an opportunity to discuss gaps.

Opportunity for Public Comment

Ms. Williams-Bader opened the floor to allow for public comment. No comments were offered.

Next Steps and Closing Remarks

Ms. Williams-Bader summarized next steps and said that the final MAP recommendations spreadsheet will be published by February 1, 2023. Ms. Williams-Bader invited the Coordinating Committee co-chairs and Dr. Schreiber to provide closing remarks.

Mr. Kahn suggested a plan for NQF staff and Coordinating Committee co-chairs to develop and propose consent calendar process changes to Coordinating Committee members. Mr. Kahn thanked Coordinating Committee members, NQF staff, CMS staff, and measure developers and stewards for their contributions. Ms. Roberts echoed Mr. Kahn's comment and thanked attendees for their patience and flexibility. Dr. Schreiber thanked the co-chairs and Coordinating Committee members for their thoughtful contributions, noting that MAP's discussion is the most important to CMS staff and contractors. Dr. Schreiber also thanked NQF staff. Ms. Williams-Bader echoed previous comments and thanked attendees for their participation.

Adjourn

Ms. Williams-Bader closed the meeting.

Appendix A: MAP Coordinating Committee Attendance – Day One

The following members of the MAP Coordinating Committee were in attendance on day one of the meeting on January 24, 2023:

Co-chairs

- Charles "Chip" Kahn, III, MPH
- Misty Roberts, RN, MSN, CPHQ, PMP

Organizational Members

- America's Health Insurance Plans
- 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
- HCA Healthcare
- Johnson & Johnson Health Care Systems, Inc.
- The Joint Commission
- The Leapfrog Group
- National Patient Advocate Foundation
- OutCare Health
- Patient & Family Centered Care Partners, Inc.
- Patients for Patient Safety US (PFPS US)
- Purchaser Business Group on Health

Individual Subject Matter Experts

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

Federal 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)

Appendix B: MAP Coordinating Committee Attendance – Day Two

The following members of the MAP Coordinating Committee were in attendance on day two of the meeting on January 25, 2023:

Co-chairs

- Charles "Chip" Kahn, III, MPH
- Misty Roberts, RN, MSN, CPHQ, PMP

Organizational Members

- America's Health Insurance Plans
- 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
- 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 (PFPS US)
- Purchaser Business Group on Health

Individual Subject Matter Experts

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

Federal 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)

Appendix C: Consent Calendar Measures

End Stage Renal Disease Quality Incentive Program (ERSD 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

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
    - *Note: During the meeting MUC2022-112 was pulled from the consent calendar for discussion and voting. Full voting results are available in* Appendix D.

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)

Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

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

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)
  - **MUC2022-097**: Low Back Pain
  - **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
- **Workgroup Recommendation: Do Not Support with Potential for Mitigation**
    - **MUC2022-060**: First Year Standardized Waitlist Ratio (FYSWR)

Part C & D Star Ratings [Medicare]

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

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

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

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

Cross-Program Measures

- **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 was not on the consent calendar and was 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, Hospital IQR, Hospital OQR, IPFQR, PCHQRP, ESRD QIP, IRF QRP, LTCH QRP, SNF QRP)*

Appendix D: Full Voting Results

Some MAP members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained for the entirety of the meeting.

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7)	Ambulatory Surgical Center Quality Reporting Program (ASCQR)	21 (95)	1 (5)	22 (100)	Conditional Support for Rulemaking
MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26)	Hospital Outpatient Reporting Program (Hospital OQR)	20 (95)	1 (5)	21 (100)	Conditional Support for Rulemaking
MUC2022-032: Geriatrics Surgical Measure	Hospital Inpatient Quality Reporting Program (Hospital IQR)	21 (100)	0 (0)	21 (100)	Conditional Support for Rulemaking
MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)	19 (95)	1 (5)	20 (100)	Support for Rulemaking
MUC2022-039: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients	Rural Emergency Hospital Quality Reporting Program (REHQRP)	18 (90)	2 (10)	20 (100)	Do Not Support for Rulemaking
MUC2022-050: Screen Positive Rate for Social Drivers of Health	End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	18 (75)	6 (25)	24 (100)	Conditional Support for Rulemaking

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-050: Screen Positive Rate for Social Drivers of Health	Inpatient Psychiatric Facility Quality Reporting Program (IPFQRP)	18 (75)	6 (25)	24 (100)	Conditional Support for Rulemaking
MUC2022-050: Screen Positive Rate for Social Drivers of Health	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)	18 (75)	6 (25)	24 (100)	Conditional Support for Rulemaking
MUC2022-052: Adult COVID-19 Vaccination Status	Merit-based Incentive Payment System (MIPS)	9 (41) 16 (76)	13 (59) 5 (24)	22 (100) 21 (100)	Support for Rulemaking Do Not Support for Rulemaking
MUC2022-055: Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure	Hospital IQR	18 (95)	1 (5)	19 (100)	Conditional Support for Rulemaking
MUC2022-057: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure	Hospital IQR	19 (100)	0 (0)	19 (100)	Conditional Support for Rulemaking
MUC2022-058: Hospital Disparity Index (HDI)	Hospital IQR	20 (91)	2 (9)	22 (100)	Conditional Support for Rulemaking
MUC2022-066: Facility 7-Day Risk-Standardized Hospital Visit Rate After Outpatient Colonoscopy	REHQRP	18 (95)	1 (5)	19 (100)	Support for Rulemaking
MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle	Hospital Value-Based Purchasing Program (HVBP)	21 (91)	2 (9)	23 (100)	Conditional Support for Rulemaking

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-083: Cross-Setting Discharge Function Score	Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)	20 (100)	0 (0)	20 (100)	Conditional Support for Rulemaking
MUC2022-085: Cross-Setting Discharge Function Score	Home Health Quality Reporting Program (HH QRP)	20 (95)	1 (5)	21 (100)	Conditional Support for Rulemaking
MUC2022-086: Cross-Setting Discharge Function Score	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	21 (100)	0 (0)	21 (100)	Conditional Support for Rulemaking
MUC2022-086: Cross-Setting Discharge Function Score	SNF VBP	21 (100)	0 (0)	21 (100)	Conditional Support for Rulemaking
MUC2022-087: Cross-Setting Discharge Function Score	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	21 (100)	0 (0)	21 (100)	Conditional Support for Rulemaking
MUC2022-089: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	IRF QRP	11 (55) 17 (81)	9 (45) 4 (19)	20 (100) 21 (100)	Do Not Support for Rulemaking Do Not Support for Rulemaking with Potential for Mitigation
MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are up to Date	HH QRP	19 (95)	1 (5)	20 (100)	Do Not Support for Rulemaking with Potential for Mitigation
MUC2022-091: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	LTCH QRP	18 (90)	2 (10)	20 (100)	Do Not Support for Rulemaking with Potential for Mitigation
MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	SNF QRP	19 (95)	1 (5)	20 (100)	Do Not Support for Rulemaking with Potential for Mitigation

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-098: Connection to Community Service Provider	MIPS	18 (95)	1 (5)	19 (100)	Conditional Support for Rulemaking
MUC2022-101: Depression	MIPS	16 (70)	7 (30)	23 (100)	Conditional Support for Rulemaking
MUC2022-106: Heart Failure	MIPS	18 (86)	3 (14)	21 (100)	Conditional Support for Rulemaking
MUC2022-111: Resolution of At Least 1 Health-Related Social Need	MIPS	18 (95)	1 (5)	19 (100)	Conditional Support for Rulemaking
MUC2022-112: Geriatrics Hospital Measure*	Hospital IQR	11 (52) 13 (62)	10 (48) 8 (38)	21 (100) 21 (100)	Do Not Support for Rulemaking with Potential for Mitigation Conditional Support for Rulemaking
MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months	ESRD QIP	8 (38) 22 (100)	13 (62) 0 (0)	21 (100) 22 (100)	Support for Rulemaking Conditional Support for Rulemaking
MUC2022-129: Psychoses and Related Conditions	MIPS	17 (77)	5 (23)	22 (100)	Conditional Support for Rulemaking

**During the meeting MUC2022-112 was pulled from the consent calendar for discussion and voting.*