NATIONAL QUALITY FORUM
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Meeting Summary

Measure Applications Partnership Coordinating Committee Education Meeting

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Coordinating Committee on August 9, 2021.

Welcome, Opening Remarks, and Agenda

Amy Moyer, Senior Director, NQF, welcomed participants to the MAP Education Meeting and thanked all participants for the time given to support the new Measure Set Review (MSR) initiative for MAP. Kathleen Giblin, Senior Vice President, NQF, joined Ms. Moyer in thanking MAP participants and provided opening remarks that highlighted the opportunity of the MSR pilot to holistically review the measure sets in federal programs and provide feedback to the U.S. Department of Health and Human Services (HHS) on measures that may no longer be providing value in those programs. Ms. Giblin noted the iterative nature of the MSR pilot that will evolve into a more robust process for the coming years and emphasized the opportunity to learn and improve through this initiative.

Following opening remarks, Ms. Moyer reviewed the meeting agenda and began roll call by introducing Coordinating Committee Co-Chairs Charles (Chip) Kahn III and Misty Roberts. Mr. Kahn and Ms. Roberts shared enthusiasm for the opportunity before the Coordinating Committee to review current measures not only for their fit for purpose, but to review programs as a whole, rather than in parts, and to provide strategic assessment of measures. Mr. Kahn and Ms. Roberts emphasized that the process for the pilot year is a starting point intended for future revision and noted that the process would shift in the future to a responsibility for individual MAP Workgroups.

Centers for Medicare & Medicaid Services (CMS) Presentation

Ms. Moyer turned the meeting over to Dr. Michelle Schreiber, Deputy Director for Quality and Value, Centers for Medicare & Medicaid Services (CMS). Dr. Schreiber thanked the Coordinating Committee, Co-Chairs, NQF and CMS staff, and measure developers for their combined efforts to engage with and support the MAP. Dr. Schreiber shared enthusiasm on behalf of CMS for the MSR process and the opportunity to receive broad stakeholder feedback on measures that may be strategically reviewed for removal and to comprehensively shape the direction of federal programs. Finally, Dr. Schreiber noted that the ultimate goals of MAP discussions were to inform beneficiaries, improve outcomes, and create accountability in the healthcare ecosystem.

Following these remarks, Dr. Schreiber presented an overview of CMS goals and ongoing work in quality measurement. CMS maintains a strong preference for measures with NQF endorsement, but not all measures currently in federal programs meet this preference. CMS aims to align measures across both programs and government agencies, including through work with Veterans Health Administration (VA) and the Department of Defense (DOD), while maintaining appropriate modifications for their relevant populations. Dr. Schreiber highlighted recent discussion around transitioning measure types, including process to outcome measures, transitions to digital measures that allow for the examination of rich electronic health record (EHR) data sets, and an increase in patient-reported outcomes measures and

patient-centered measures. These transitions align with the CMS Meaningful Measures plans which maintain a focus on patients and value-based care.

After reviewing the MAP evaluation criteria, Dr. Schreiber described a new Quality Measure Index tool being employed internally at CMS that provides a standardized look at measures during evaluation, which may be shared with the public in the future. Stakeholder engagement and public comment play critical roles in the evaluation of measures, and Dr. Schreiber noted that while the MAP serves as an advisory initiative only, it has become an essential process for gaining external input and giving voice to the wide variety of opinions across individuals and institutions.

Section 1890A of the Social Security Act first supported the establishment of a federal pre-rulemaking process for recommending measures into programs. In December of 2021, Congress authorized the consensus-based entity supporting this process to additionally weigh in on measures for removal. Dr. Schreiber shared the enthusiasm of CMS for this new opportunity to further shape federal programs and for the creation of a new MAP Health Equity Advisory Group to capture critical voices and considerations. CMS has released a request for information (RFI) on equity seeking input on issues such as stratification of data, race and ethnicity data collection, and how to best promote equity, which is a federal priority.

Dr. Schreiber provided a high-level overview of programs within the MAP initiative and noted that many had received extensions or flexibility in scoring over the past year due to the COVID-19 pandemic, but emphasized the need to continue public reporting so that beneficiaries can continue to make informed decisions. Dr. Schreiber reiterated the tremendous opportunity to receive additional input on measures in federal programs through the MSR process and to shape federal programs through a holistic approach.

Following her presentation, Dr. Schreiber opened up the floor for questions. The following topics were discussed:

- **Overlap between the MAP and Core Quality Measures Collaborative (CQMC) initiatives** – The CQMC initiative is a partnership between America's Health Insurance Plans (AHIP), CMS, and NQF that develops recommendations for measure sets for certain areas, including ambulatory services, accountable care organizations (ACOs), primary care, oncology, and now behavioral health and neurology. These are recommendations for best measures that payers may coalesce around, many of which may be part of the Merit-based Incentive Payment System (MIPS) program. Dr. Schreiber shared that CMS hopes to see convergence and future alignment between CQMC and MIPS program measures, but noted that currently, CQMC measures are often more claims-based, while CMS is moving towards digital measures.
- **Plans to link data from ambulatory surgical centers, emergency department (ED) visits, and hospitalizations** – Coordinating Committee members asked if there were future plans to link this data to provide a better grasp on safety events. Dr. Schreiber stated that the ability to collect this data is linked to having measures written to collect it. CMS cannot collect data and create measures subsequently, and so this data is dependent on how measures are written and tested.
- **Balancing different pieces of health equity measurement** – Coordinating Committee members noted the vast amount of activity happening in the field of health equity despite lack of agreement on metrics, and raised concerns about possibilities that risk adjustment can provide some organizations with exemption while potentially creating punitive results for organizations lacking resources. Dr. Schreiber acknowledged that at this time, there are not comprehensive data available on race and ethnicity, sexual orientation and gender identity, or language, which leads to the root question of what the standardized data elements for those data should be.

Without this information, it is difficult to stratify measures. Currently, CMS provides some information back to organizations, but included questions in the current RFI to seek input on providing confidential reports back to organizations and how the data should be stratified. Dr. Schreiber noted the need for better data and systems to ensure all parties collect and report this data, but acknowledged a desire for critical access hospitals and individual clinicians to also be able to succeed on this front despite smaller resources.

- **Challenges of including all perspectives in health equity quality measurement** – Coordinating Committee members commented that measures can affect numerous stakeholders, including patients, payers, etc., and that there may be a lack of accurate self-reported data. Dr. Schreiber acknowledged the complexity of these issues and the fears that patients may face in reporting demographic data, and emphasized the needs to better engage patients to overcome these challenges.
- **Home and community-based services (HCBS) core measure sets** – Coordinating Committee members commented that there are increasing expenditures in Medicaid HCBS, and that many individuals in that program have dual eligibility for Medicare and Medicaid. However, there is no HCBS core measures set, although it is under development. Dr. Schreiber agreed with this point and noted that Medicaid has recently surpassed Medicare in number of enrolled beneficiaries. HCBS is a critical part of Medicaid, and Medicaid core sets are published by states. CMS is looking to include HCBS in skilled nursing facility (SNF) programs, and Dr. Schreiber emphasized that it is important to begin considering how to treat Medicaid data and how to link providers to HCBS services.

Scope of Work and Timeline for the MSR Pilot

Ms. Moyer presented the condensed timeline for the pilot year of the MSR initiative, which will only be undertaken by the Coordinating Committee in its introductory year. The MSR initiative will be expanded to MAP Workgroups and Advisory Groups in 2022, building on feedback from the Coordinating Committee during its Strategic Meeting that will take place on September 15, 2021.

The process for MSR review will occur in several stages, leveraging existing processes where possible: 1) Coordinating Committee members will select 10 measures each that they feel should be considered for removal through a survey, 2) NQF staff will aggregate responses and 3) compile the top selections (up to 24) in a final list, and 4) Coordinating Committee members will discuss and provide feedback on the list of measures during the two-day MSR meetings. Ms. Moyer clarified that voting will not occur during the MSR meetings, and only qualitative input will be provided as recommendations to HHS.

Ms. Moyer shared additional plans for measure selection to ensure appropriate representation of stakeholders and programs and provided an overview of measure review criteria that Coordinating Committee members may use to help identify and consider measures for removal. Ms. Moyer emphasized that these criteria are a starting point that will evolve with input from Coordinating Committee members, and thanked Coordinating Committee members again for their participation in the difficult and condensed work laid out before them.

MAP Coordinating Committee Discussion

Coordinating Committee members asked a series of clarifying questions regarding the MSR process, including on how the Committee would be providing feedback to HHS and how many measures were to be reviewed during measure selection. Ms. Moyer clarified that feedback would not include voting during the MSR meetings for the pilot year, and that Coordinating Committee members were allowed to select any measures from the complete list of measures currently active in federal programs.

Coordinating Committee members expressed concern at the large number of measures included in that list on a condensed timeline and discussed options for narrowing the scope of the pilot measure selection, such as automatic inclusion of any measures without NQF endorsement. Coordinating Committee members were also concerned that out of such a large denominator, clear frontrunners for a final list may not emerge.

Dr. Schreiber offered the suggestion of focusing solely on programs that would have payment implications, but clarified that the Merit-based Incentive Payment System (MIPS) program would be too large of an ask to include in this pilot. Coordinating Committee members decided to narrow the scope of the MSR pilot to the following programs:

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

Coordinating Committee members noted that these programs were limited to the domain of the MAP Hospital Workgroup and raised the question of whether the Coordinating Committee would have sufficient experience and insight to review these programs without the inclusion of Hospital Workgroup Members. This may be particularly true for MAP stakeholder groups such as patients, who use Workgroup recommendations as a strong base for their review. Mr. Kahn clarified that the timeline for the pilot year did not allow for inclusion of individual MAP Workgroups, and Ms. Moyer informed the Coordinating Committee that after the pilot year, MAP Workgroups will take on their traditional role of completing initial reviews of measures to provide their expertise while the Coordinating Committee would resume its oversight role. Mr. Kahn also noted that the most important result of the pilot would be the ability to form a solidified process for the coming years.

Coordinating Committee members also debated the automatic inclusion of non-endorsed measures. Ms. Moyer noted that automatically including those measures for consideration would increase the number of measures to be reviewed during MSR meetings and potentially minimize discussion time for each measure. NQF staff recommend no more than 24 measures for discussion to ensure appropriate consideration of each. Ms. Roberts suggested simplifying the process by leaving non-endorsed measures in the list to be shared with Coordinating Committee members following the meeting and allowing members to broadly use the suggested criteria, including endorsement status, for review and measure selection.

To maintain a strategic perspective, Dr. Schreiber requested that Coordinating Committee members also consider categories of measures and opportunities to reduce measure burden, such as the use of composite measures or reduction in individual disease measures where appropriate. Through this approach, Coordinating Committee members may find that individual measures which pass given criteria may or may not fit from a holistic and programmatic view. Dr. Schreiber also clarified that certain measures may be statutorily included in programs.

Ms. Roberts, Mr. Kahn, and Ms. Moyer summarized the conclusions of the Coordinating Committee as follows: Coordinating Committee members will use the measure selection criteria as guidelines to select 10 measures for suggested removal out of the measures included in the ASCQR, HACRP, Hospital IQR Program, HRRP, VBP, and IPFQR programs. All measures in these programs will be included on the list for review, regardless of endorsement status.

Opportunity for Public Comment

No public comments were offered during the Education Meeting.

Next Steps

Ms. Udara Perera, Senior Manager, NQF, summarized next steps. Coordinating Committee members should select measures for the MSR meetings by Monday, August 16, 2021, following the guidance laid out during the Education Meeting. Coordinating Committee members were also asked to complete Disclosure of Interest (DOI) forms for the MAP initiative by Wednesday, August 18, 2021, and to reach out to NQF staff if they had not yet received calendar invitations to the MSR meetings on September 8-9, 2021. Coordinating Committee members noted that some would need to discuss the MSR process and decisions internally at their organizations before submitting their measure selections.