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Measure Applications Partnership (MAP) Coordinating Committee: 2022 Measure Set Review Meeting

Meeting Summary
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Meeting Summary

Measure Applications Partnership (MAP) Coordinating Committee 2022 Measure Set Review (MSR) Meeting – Day One

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Coordinating Committee on August 24, 2022, and August 25, 2022. The purpose of the meeting was to finalize recommendations for the 2022 Measure Set Review (MSR) of measures selected for potential removal from federal programs for clinician, hospital, and post-acute care/long-term care (PAC/LTC) settings. There were 124 attendees at this meeting including MAP Coordinating Committee members, NQF staff, government representatives, and members of the public.

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

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP Coordinating Committee 2022 MSR meeting and thanked those participants for their attendance. Ms. Williams-Bader reviewed housekeeping reminders, meeting ground rules, and the meeting agenda for day one. Ms. Williams-Bader noted the pilot of a consent calendar during day two. Ms. Williams-Bader noted that Coordinating Committee members will have the opportunity to pull additional measures for discussion from the consent calendar during the consent calendar section on day two. Ms. Williams-Bader then invited Dr. Dana Gelb Safran, president and CEO, NQF, to provide opening remarks to the meeting participants.

Dr. Safran welcomed participants to the MAP Coordinating Committee 2022 MSR meeting. Dr. Safran noted NQF's honor to be partnered with CMS on the MSR process and this year's expansion from the pilot to the three setting specific Workgroups and two Advisory Groups. Dr. Safran stated the meeting will focus on the Coordinating Committee's finalization of recommendations for potential measure removal from federal programs. Dr. Safran noted the use of the consent calendar and its focus to create efficiencies within the Coordinating Committee meeting. Dr. Safran thanked Committee members, federal liaisons, program leads, members of the public, and provided a special thanks to the Coordinating Committee co-chairs, Chip Kahn and Misty Roberts.

Ms. Williams-Bader introduced co-chairs Chip Kahn and Misty Roberts to provide opening remarks to the meeting attendees. Mr. Kahn welcomed Coordinating Committee members participating in the meeting. Mr. Kahn noted this was the second year of the MSR process, that the process will continue to evolve, and the co-chairs look forward to Committee input on the process. Mr. Kahn noted the importance of quorum for meetings that require voting. Ms. Roberts provided additional thanks to the Coordinating Committee members and expressed excitement about the next two days. Ms. Roberts echoed Mr. Kahn's statement about the continued evolution of the MSR process. Ms. Roberts also noted the use of a consent calendar and its ability to streamline the process within the meeting.

Ms. Williams-Bader reviewed the disclosures of interest (DOI) process and then introduced Gus Zimmerman, analyst, NQF, to facilitate roll call and the DOI review. Of the 18 Coordinating Committee organizational members, 16 attended the meeting. In addition, there were two co-chairs and three subject matter experts, totaling 21 voting members. The minimum quorum number to allow for in-meeting voting was 16 members. One Committee member disclosed employment with the National Committee for Quality Assurance, a steward of several measures, including 05837-E-MIPS. This

Committee member recused themselves from voting on the measure. The full attendance details are available in Appendix A. Mr. Zimmerman concluded roll call by introducing the nonvoting federal government liaisons in attendance. Ms. Williams-Bader reminded the Committee of the importance of quorum during the meeting and asked Committee members to inform NQF staff if they need to step away from the meeting. Ms. Williams-Bader also noted there are Workgroup co-chairs who will join the meeting to provide information about the setting-specific Workgroup measure discussions.

Ms. Williams-Bader recognized the NQF team and CMS staff supporting the MSR meeting activities. Ms. Williams-Bader then reviewed the meeting objectives:

1. Review the 2022 MSR process and measure review criteria
2. Finalize recommendations on measures selected for potential removal from federal programs for clinician, hospital, and post-acute care/long-term care settings
3. Seek feedback from the Coordinating Committee on the MSR process.

CMS Opening Remarks

Dr. Michelle Schreiber, deputy director of the Centers for Clinical Standards & Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS) and the group director for the Quality Measurement and Value-Based Incentives Group (QMVIG) provided a welcome on behalf of CMS. Dr. Schreiber noted there has been a robust discussion in the first five MSR meetings and that the details of those discussions help inform CMS' work. Dr. Schreiber thanked the Committee members, the co-chairs, and the NQF staff. Dr. Schreiber noted there are several individuals from CMS on the phone and thanked them for their attendance. Dr. Schreiber introduced a new medical officer to the CMS Division of Quality Measurement, Dr. Stephanie Clark, who will join future MAP calls. Dr. Clark introduced herself, thanked the Committee for the invitation to join the meeting, and noted looking forward to being a part of the MAP work.

Review of MSR Process and Measure Review Criteria

Susanne Young, manager, NQF, reviewed the MSR process and measure review criteria. Ms. Young started with an overview of the four-step process for the 2022 MSR. Those steps included prioritize, survey, prepare, and discuss. Ms. Young noted the first three steps were completed and the Coordinating Committee's meeting is a conclusion of the fourth step, discuss, in which Coordinating Committee members will discuss and vote to accept Workgroup recommendations. Ms. Young also noted the final MSR Recommendations Report will be published in early fall and is one factor in CMS measure evaluation.

Ms. Young presented the 2022 MSR measure review criteria of which there are 10 criteria. Ms. Young noted these criteria were adjusted after the pilot and there is anticipation the criteria will continue to evolve as the Committee gains experience with the MSR process. Ms. Young further noted there will be an opportunity for Committee feedback on the MSR process toward the end of the meeting on day two. Ms. Young reviewed the four MSR decision categories: support for retaining, conditional support for retaining, conditional support for removal, and support for removal.

Ms. Young reviewed the Coordinating Committee key voting principles. Ms. Young noted quorum means that at least sixty-six percent of the voting members are present for live voting to take place. Ms. Young also noted a consensus threshold is set at sixty percent of voting, and every measure under review for MSR will receive a decision category.

Ms. Young continued with an overview of the process for days one and two of the Committee meeting. For measures not on the consent calendar the process will begin with a measure introduction, followed by an overview from the Workgroup representative of the Workgroup decision and Workgroup rationale, and measure findings from lead discussants. Next, a co-chair will facilitate Committee discussion of the measure under review. After discussion, the Coordinating Committee will vote on acceptance of the Workgroup recommendation and NQF staff will tally the votes. If less than sixty percent of the Committee members vote to accept the Workgroup's decision, the Committee will vote on a new decision category. If no decision category reaches consensus, the measure will be assigned the recommendation "support for retaining." For measures on the consent calendar, a co-chair will ask Committee members if they would like to pull any measures from the consent calendar. Next, NQF staff will present the measures on the consent calendar and corresponding decision categories. A co-chair will ask if there are any objections to the consent calendar and if there are no objections, the consent calendar decision categories will become the Coordinating Committee's recommendations. Ms. Young noted if there are measures pulled from the consent calendar, the process will continue as dictated by the non-consent calendar measure steps.

Ms. Young opened the meeting for any questions on the MSR process and no questions were presented. Next, Ms. Young facilitated a test question with the Committee utilizing the voting platform and then passed the meeting back to Ms. Williams-Bader.

MSR Recommendations for the Hospital Outpatient Quality Reporting (Hospital OQR) Program

Ms. Williams-Bader noted there were two hospital programs with measures not on the consent calendar, the Hospital OQR program and the Ambulatory Surgical Center Quality Reporting (ASCQR) program. Ms. Williams-Bader introduced the first program to be discussed with measures not on the consent calendar, the Hospital OQR program.

Opportunity for Public Comment on MSR Recommendations for the Hospital OQR Program

Ms. Roberts opened the meeting for public comment on the five Hospital OQR program measures not on the consent calendar. No public comments were presented during this commenting section.

Discussion of the Measure Set Review Recommendations for the Hospital OQR Program

Ms. Williams-Bader explained that for the five Hospital OQR program measures there will be a vote on a decision category and not an acceptance of the Workgroup decision. Ms. Williams-Bader noted this was due to the lack of quorum during the Hospital Workgroup MSR meeting and the electronic survey distributed post meeting. Ms. Williams-Bader noted the Hospital Workgroup members were asked what decision category they would like to start with during the Workgroup meeting and that was shared with the Coordinating Committee in the meeting materials.

00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain

Ms. Williams-Bader introduced the measure and reviewed the measure information including the description, endorsement status, and selection count for MSR nomination by Workgroup and Advisory Group members. Ms. Williams-Bader noted this measure information was provided to the Coordinating Committee as there was not a Workgroup recommendation. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. Dr. Schreiber noted this measure's focus was utilization and quality. Dr. Schreiber stated the measure was trying to avoid MRI utilization for patients when conservative therapies had not been tried first.

Ms. Roberts and Ms. Williams-Bader turned to the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative noted the Workgroup agreed to start with the decision category of "support for removal" based on two factors: 1) NQF's measure endorsement committee not choosing to reindorse the measure in 2016, and 2) MAP's prior discussion of the measure in 2018. The Hospital Workgroup representative further stated there were Workgroup comments noting that the measure may have served a purpose when it was first adopted in 2009 but given the advancement in time and loss of endorsement it may be time for the measure to be removed. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

One of the Committee members asked if there was a formal process for when a Workgroup does not meet quorum. Dr. Tricia Elliott, senior managing director, NQF, noted lack of quorum has not occurred in recent history, so it was determined to bring the measure to the Coordinating Committee to move forward with discussion and voting. The Committee member also asked if it was known what stakeholders were present at the Hospital Workgroup discussion, in particular whether purchasers and consumers were involved.

Ms. Williams-Bader further explained NQF's follow-up email process post-Hospital Workgroup meeting and NQF's attempt to meet quorum through an off-line electronic vote. A co-chair asked if this was something that needs to be brought back to the Workgroup to establish a process going forward or whether this was an isolated incident. Ms. Williams-Bader noted the novelty of the summer timeline and the new MSR process timeline, in general, for MAP members. The other co-chair noted the necessity to move forward with the information presented to the Coordinating Committee and decide on the recommendations for the measures. Several Committee members agreed with the co-chair's statement. One Committee member noted there was polling during the Rural Health Advisory Group and Health Equity Advisory Group meetings. Ms. Williams-Bader clarified the polling conducted during the Advisory Group meetings did not require quorum. One Committee member asked if the Coordinating Committee could vote to send the measures back to the Hospital Workgroup and a co-chair confirmed sending the measures back was not an option.

The Committee member who requested to know the stakeholders who were present for the Workgroup meeting circled back to the question. Ms. Williams-Bader announced the list of Hospital Workgroup members in attendance from the meeting summary. Ms. Williams-Bader noted the list contained members who attended any portion of the meeting, and the summary did not reference who was in attendance for each specific measure discuss.

A lead discussant asked about the survey respondent section on the measure summary sheet and whether these were public respondents. Ms. Williams-Bader clarified the survey respondent section was in reference to the initial survey in which Workgroup and Advisory Group members nominated measures for discussion for the MSR process. The lead discussant also noted a public comment by the Blue Cross Blue Shield Association that indicated support for retaining the measure in the program with certain conditions and asked if a representative from the Blue Cross Blue Shield Association could clarify the comment. A Committee member from the Blue Cross Blue Shield Association responded that the Blue Cross Blue Shield Association wanted to ensure the measure did not lead to escalated use of MRIs. The Committee member further stated the measure may have issues with the use of claims data and whether that indicated appropriate measure use as some interventions would not make it into claims data. The Committee member noted they had concerns about removing the measure, but further noted there may be a better measure.

Another lead discussant asked CMS to speak to the concerns regarding validity and the exclusions to determine the use of conservative therapies. This lead discussant noted the performance data was stable and asked whether the measure was measuring what it intended to measure. A CMS program lead noted significant practice variation does exist with imaging including X-ray, computerized tomography, MRI, bone scan and ultrasound, and such use does have cost implications. The lead discussant noted it becomes difficult when a measure loses endorsement to have insight into how the measure is refined and changed, and the impact on the validity testing of the change. The lead discussant further stated there may need to be a different data source in the future.

A Committee member asked for more information about what variation was observed in the measure. A co-chair also asked for clarification on the variation and whether variation was in the performance data or types of imaging. The CMS program lead noted the data was reported in the Hospital Workgroup meeting. The measure developer further noted there was newer data for the current performance period. The developer stated among facilities that meet the known case count the performance data was 29.9 percent to 62.2 percent with a median of 45 percent. The developer noted there was still variation and opportunities for improvement. A Committee member asked for clarification about what 60 percent was measuring. The developer clarified that the percentage refers to those MRIs performed for which no antecedent conservative therapy was performed in the 60 days preceding the MRI. The Committee member commented that number appeared high. Another Committee member responded that the measure data has not moved since 2016. The Committee member further noted although there was variation, there has not been even incremental improvement. Dr. Schreiber reiterated the measure was showing variation. Dr. Schreiber stated it may not be the measure but more a fundamental issue that the country may not be advancing with conservative therapy for low back pain prior to MRI. Dr. Schreiber noted that it may be a question of whether the measure be removed or to refocus effort on something else such as quality improvement work.

A Committee member commented on the use of this measure in their value-purchasing work and observed geographic variation, specifically better rates in Northern California compared to Southern California. The Committee member noted the lack of improvement was not justification for removing the measure but addressing underlying issues such as financial concerns or through broader alternative payment models. The Committee member also observed a high volume of advanced imaging leads to referrals for inappropriate surgery, specifically low back fusion. The Committee member commented that a key issue was to think about the macro impact from a population perspective. A Committee member noted agreement that this may be an area for quality improvement on a national level. The Committee member noted measure review criterion number seven was performance does not substantially differentiate between high and low performers and commented data was shown that the measure does differentiate.

A co-chair questioned whether this measure informed individuals to change provider behavior. A Committee member noted it would be helpful to know if consumers or purchasers have used this measure to drive change. Another Committee member responded that this measure was used to observe those individuals who made imaging referrals and looked at the imaging variations within those referrals. A co-chair noted the lack of information regarding the use of the measure and the difficulty in making a decision on this measure. The other co-chair noted agreement with a prior comment regarding measure removal having the same thoughtfulness as measure inclusion. An Advisory Group member noted this measure was actively used in United Healthcare and was used to identify differentiation in providers. This Advisory Group member agreed the measure was not perfect but stated depending on how the health plan responds to the measure it has initiated change.

A co-chair asked for clarification on what type of federal program the Hospital OQR program was, and Dr. Schreiber confirmed it was pay for reporting. Ms. Roberts noted the Hospital Workgroup wanted to start with "support for removal" but she was hearing mixed comments from the Committee members on a decision category. There was discussion from the co-chairs about where to start the vote and it was decided to start with "support for removal."

Ms. Roberts moved the Committee to vote "support for removal" for measure 00140-C-HOQR. Voting results were as follows: Yes – 6, No – 14. Consensus was not reached, and Committee discussion continued.

Ms. Roberts suggested "conditional support for removal" but noted she did not have conditions to add. Ms. Williams-Bader clarified the decision category the condition for "conditional support for removal" is a better measure covering the topic. A co-chair suggested the Committee stop voting at this point as the measure was already in the program and the removal vote did not pass. There was discussion among Committee members in agreement with the co-chair's comment. Ms. Williams-Bader clarified that the default decision category was "support for retaining" if the Committee did not reach consensus, but without a vote NQF would need to think about how to communicate the recommendation to the public and CMS. Ms. Williams-Bader noted at this point there was no consensus, and the statement would be a default to "support for retaining." A Committee member noted there was a difference between consensus and not voting on the measure. This Committee member suggested voting for clarity in the public record. Another Committee member asked what the conditions would be for "conditional support for retaining." This Committee member suggested a condition to include feedback from stakeholders. Ms. Williams-Bader asked for clarification about the condition as conditions are usually something to change about the measure. The Committee member further suggested endorsement as a condition as that would include stakeholder input. Ms. Roberts agreed with the condition of endorsement. One Committee member suggested "conditional support for removal." Ms. Roberts noted hearing different feedback from the Committee, but since "support for removal" did not pass, suggested voting in category order. A Committee member noted the Committee already voted no to "support for removal" so the vote should go into the retention categories.

Ms. Roberts moved the Committee to vote "conditional support for retaining," for measure 00140-C-HOQR with the condition of consensus-based entity (CBE) endorsement. Voting results were as follows: Yes – 18, No – 2. Complete voting results are in Appendix B.

00922-C-HOQR: Left Without Being Seen

Ms. Williams-Bader introduced the measure and reviewed the measure information including the description, endorsement status, and selection count for MSR nomination by Workgroup and Advisory Group members. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. The CMS lead noted this measure was implemented in the program in 2012. The CMS lead stated the performance of this measure may be an issue and could be an indication of the health system or the availability of the care and not the quality of care at the emergency department. The CMS lead noted an emergency department's performance issue could be inefficient patient flow or inefficient community resources leading to increased patient wait times. The CMS lead noted the measure was publicly reported and used to calculate overall star ratings. The CMS lead further noted facilities receive reports so those facilities can review performance and compare outcomes to peers.

Ms. Roberts turned to the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative noted the Workgroup agreed to start with the decision category of "support for removal" after a brief discussion that was focused mostly on the removed endorsement. The Hospital Workgroup representative also noted Workgroup members

commented on the granularity of the measure and questioned what was driving the differences, whether it was the hospital practice or broader factors like workforce challenges. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

A lead discussant noted there were no public comments. Another lead discussant noted the Rural Health Advisory Group supported removing the measure, although there were a small number of members in attendance. The lead discussant further noted 15 of the 17 Health Equity Advisory Group members supported retaining the measure. The lead discussant agreed with the CMS lead that many underserved communities utilize the emergency room as a primary care location of service. The lead discussant stated this was a measure that was important to communities with mental illness, substance abuse, and underserved who lack access to care.

Another lead discussant stated being impacted by the Health Equity Advisory Group's poll and shared those concerns about how health access affects care. The lead discussant further stated the Health Equity Advisory Group wanted more granularity from the measure to make it more useful. The lead discussant noted this measure would be more useful if it was known why individuals were leaving the emergency room.

A co-chair asked whether the measure was endorsed, and it was confirmed the measure lost endorsement. A lead discussant further stated the measure not only lost endorsement, but it does not have a steward. A co-chair stated the difficulty in adjudicating a measure without endorsement.

A Committee member agreed with the co-chair about the importance of measure endorsement within the Measures Under Consideration (MUC) process. The Committee member further stated when discussing recommendations of measures for removal it was slightly different than the MUC process and the use of a measure should be reviewed. The Committee member noted if a measure was being used effectively and demonstrating improvement, those are considerations that should go into the recommendation.

A Committee member noted the Health Equity Advisory Group's support of the measure, but further stated the measure could be used the opposite way. The Committee member noted if a patient has checked in to an emergency room multiple times and left without being seen, it could be punitive towards the patient in some situations.

A lead discussant asked for clarification regarding the requirement of endorsed measures in the program. The CMS program lead confirmed the Hospital OQR program statutorily does not require measure endorsement.

A Committee member agreed with endorsement in a perfect world but noted there may be situations where measures are not endorsed yet utilized in federal programs. The CMS lead noted there may be other factors in the endorsement process such as financial resources. A co-chair asked for clarification about the measure steward. A Committee member noted from the documentation it appeared the prior steward was not interested in moving forward with continued endorsement. A co-chair noted the need to stand by endorsement as it provides a thorough review of measures.

A measure developer who maintains the measure for CMS noted the hospital system that created the measure and originally took the measure through endorsement opted not to maintain the measure when it was time for re-endorsement. The developer noted the national performance rate was about two percent of patients left without being seen. The developer further noted when looking at performance rates, out of 3,624 hospitals, 504 report a "left without being seen" rate of two percent or more. The developer stated there was not much variation in performance and that was where the

measure has been sitting for many years. The developer further stated that the hospitals with higher "left without being seen" rates are those hospitals with low sample sizes.

A Committee member questioned whether it was worth the effort to calculate the measure if the performance was high and unvarying. The measure developer noted that when a patient leaves without being seen the record was flagged and the hospital submits the total number of records flagged. Another Committee member circled back to a co-chair's comment about the Committee's history of seeking measures that are endorsed. The Committee member noted that measure endorsement was a factor, but it may not be the determining factor for a recommendation. A co-chair noted this discussion was about measures that have been in use for a long time. The co-chair further stated endorsement should be a strong criterion. The Committee member responded that endorsement was important but was not the only criteria.

A Committee member asked for clarification about the role of the measure developer who maintains the measure. Dr. Schreiber confirmed CMS was the current measure steward. The measure developer stated in their role they provided literature reviews on the measure and answered questions from reporting hospitals. A Committee member noted this measure has moved the needle and improved patient care in the past, but there is no current variation. The Committee member further noted it was critically important to replace this measure with another with an equity lens.

Ms. Roberts posed a question to CMS regarding the value to keeping this measure in the program. The CMS program lead noted the measure was publicly reported, so facilities receive reports with data that can be used for improvement. Dr. Schreiber further noted retention in the program included accountability of the emergency department. Dr. Schreiber stated the measure may reflect a patient's lack of access or a feeling they are not being attended to within the emergency department. Dr. Schreiber stated two percent may be a small percentage, but it was still many patients. The CMS lead further stated this measure will assist CMS with information about why those patients are leaving the emergency department. A Committee member asked whether removing the measure removes the opportunity for CMS to have that information. Dr. Schreiber noted CMS is working towards stratifying measures around equity and directionally this may be one of those measures. The Committee member asked whether there was an opportunity to modify the measure. Ms. Roberts confirmed the Committee could ask for a modification but asked without a measure steward who would do the modification. Dr. Schreiber confirmed CMS would make the modifications. A Committee member noted for individuals without a medical record, demographics are not collected at emergency department check-in. A Committee member asked if this measure included demographic data that would allow stratification. Dr. Schreiber confirmed CMS does not have the demographic data.

Ms. Roberts moved the Committee to vote, "support for removal," for measure 00922-C-HOQR. Voting results were as follows: Yes – 12, No – 7. Complete voting results are in Appendix B.

Next Steps – Day One

Ms. Roberts asked about the process for day two of the meeting as there were three additional Hospital OQR program measures to discuss that were not completed during day one of the meeting. Ms. Williams-Bader noted there was a buffer in day two of the meeting during the discussion of measures pulled from the consent calendar. Ms. Williams-Bader asked if any Committee members planned to pull any additional measures from the consent calendar. A Committee member suggested the three Hospital OQR program measures be pushed to the end of day two of the meeting and if time did not allow for review that those be sent back to the Workgroup. A co-chair noted that was not possible in the timeline. Ms. Williams-Bader confirmed it was not possible and again asked if any Committee members planned

to pull any measures from the consent calendar. A few Committee members indicated they would request to pull measures from the consent calendar but did not give a specific number. The co-chairs suggested the NQF staff determine the timeframe for day two of the meeting and the co-chairs would adhere to the schedule.

Ms. Williams-Bader thanked Committee members for their participation on day one and adjourned the meeting.

Measure Applications Partnership (MAP) Coordinating Committee 2022 Measure Set Review (MSR) Meeting – Day Two

Welcome, Summary of Day One, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the MAP Coordinating Committee 2022 MSR meeting, thanked participants for their attendance, and reviewed the ground rules and agenda for day two. Ms. Williams-Bader provided a summary of the proceedings of day one in which there was substantial discussion on two of the Hospital OQR measures. Ms. Williams-Bader informed the participants that the discussion would continue on three more of those measures, with information to be provided from co-chairs of the Hospital Workgroup. Ms. Williams-Bader also provided a refresher on the 2022 MSR measure review criteria to ensure that the criteria are the foundation for the discussions of day two. Ms. Williams-Bader explained that the measure review criteria are the reason why a measure would be recommended for removal from a program and asked that participants please refer to these criteria when requesting that a measure be discussed from the consent calendar. Ms. Williams-Bader also reviewed the MSR decision categories and reminded participants that the MAP focuses on measures that are in use in federal programs. Ms. Williams-Bader asked whether there were any questions from Committee members. A Committee member thanked Ms. Williams-Bader for the overview and questioned whether the review of measures would occur only for federal programs or if the Committee would need to review measures holistically and not just for federal programs. A co-chair replied that the considerations of the MAP are for federal programs only and that the MAP recommendation does not equate to the measure not being used in other settings. The Committee member shared that if a measure is removed from CMS, in most cases it would not be available to stakeholders in the public to use the data. Dr. Schreiber clarified that this is correct because CMS is the data collector and other stakeholders use this data. Ms. Williams-Bader clarified that the discussion that participants should have at the meeting is whether the measures being discussed are the ones that should be used, of those that are available, for the topics that are being covering during the meeting's discussion. The Committee members had a discussion around the purpose of the MAP, the effective use of measures and whether they are being used effectively by key stakeholders.

Ms. Williams-Bader turned the meeting over to Mr. Zimmerman for a roll call of Coordinating Committee membership. The attendance details are available in Appendix A. Ms. Williams-Bader reminded Coordinating Committee members that quorum is important for the day and asked them to let NQF staff know if members need to step away from the meeting.

MSR Recommendations for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program

Ms. Williams-Bader introduced the ASCQR program and turned it over to Ms. Roberts to lead the discussion.

Opportunity for Public Comment on MSR Recommendations for the ASCQR Program

Ms. Roberts opened the meeting for public comment on the one ASCQR program measure not on the consent calendar. A member of the public shared that they represented the measure developer, and the measure developer does not think it is feasible for ambulatory surgery centers (ASCs) to follow up after 90 days and stated that the measure is not applicable to that setting of care. In response, a Committee

member sought to clarify whether the time that is examined by the measure is within 90 days, not after 90 days. The measure developer noted that the title of the measure is within 90 days.

Discussion of the Measure Set Review Recommendations for the ASCQR Program

01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

Ms. Williams-Bader introduced the measure and reviewed the Workgroup recommendation. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. Dr. Schreiber noted that this an important measure, is a measure of functional status, and shared that ASCs are responsible for the care that they provide at their facilities. The measure developer added that there are facility, state and national level data for sites and noted a drop in states reporting this data in relation to the pandemic. The measure developer continued that ASCs in 33 states are reporting this data and numbers were higher prior to this public health emergency.

Ms. Roberts asked the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative shared that many in the Workgroup were not eager to see the measure removed from the program because it is a patient reported outcome, but there are challenges with the practical recording of the data. The representative noted that there was re-tooling of the measure, so there is a desire to use the new survey instrument. The representative shared that this measure of visual function needs to align with others across programs, so maintaining this measure in some form in the program would be appropriate. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

Ms. Roberts called upon the lead discussants for comments. A lead discussant noted that the measure meets multiple criteria for removal, with the largest being the third criterion. The discussant felt that there is opportunity for improvement for some providers and noted a median of 100 and mean of 96 and a significant skew to the left. The discussant shared that the burden of collection seems to be a continuing issue. The discussant reviewed that the measure was endorsed in 2011 but endorsement was removed in 2018 pending approval of a better measure. The discussant noted that it is a great measure for MIPS where doctors can report it voluntarily, but ASC does not think it belongs in their program.

A Committee member shared that it is important to have this measure in the program and thought that there are opportunities to improve the number of ASCs that are reporting the measure. The Committee member disagreed with some of the perceptions in comments around seniors not wanting to respond to surveys, as they had firsthand seen otherwise. The Committee member continued that seniors are sometimes the highest respondents to surveys and there are ways to ensure responses from wide parts of the population.

Another Committee member noted the possibility of digitizing the instrument so that the information can be shared and mentioned that considering health equity is very important. The measure developer clarified that different versions of the survey have a different number of questions. A Committee member voiced strong support for this measure because they felt that collection of this data should be standard practice and not be considered as collection burden as it is fundamentally finding out whether a facility gets the outcome that they need. The Committee member also noted that CMS can do better with collecting this data and noted that CMS' particular role is essential because there are not many ASC measures and there are even fewer that are patient reported. A Committee member questioned how many ASCs are complying as it is voluntary. Dr. Schreiber responded that there are a relatively small number of ASCs that are reporting this data and CMS is looking into making it mandatory.

Ms. Roberts recommended that the Coordinating Committee move forward with voting to support the Workgroup recommendation as the Coordinating Committee recommendation. The recommendation is "conditional support for retaining" based on the conditions of a new survey instrument and aligning surveys. Voting results were as follows: Yes – 16, No – 3. Complete voting results are in Appendix B.

MSR Recommendations for the Medicare Shared Savings Program (MSSP)

Ms. Williams-Bader introduced the MSSP and turned it over to Mr. Kahn to lead the discussion.

Opportunity for Public Comment on MSR Recommendations for MSSP

Mr. Kahn opened the meeting for public comment on the one MSSP measure not on the consent calendar. No public comments were received.

Discussion of the Measure Set Review Recommendations for MSSP

00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Ms. Williams-Bader introduced the measure and reviewed the Workgroup recommendation. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. Dr. Schreiber noted that this is an important measure because of how common depression is and how much it affects other conditions. Dr. Schreiber turned it over to a CMS representative who highlighted elements of how the measure is reported, one is through web interface and the other is an electronic clinical quality measure (eCQM). The CMS lead noted that the web interface measure is available through 2024 and is within the Core Quality Measures Collaborative (CQMC). The CMS lead highlighted that there is a performance gap in screening for depression and a follow-up plan. The measure developer shared that the measure was previously NQF endorsed, reiterated that this is an important measure, and stated that there is 95percent reporting on this measure.

Ms. Williams-Bader provided the Clinician Workgroup rationale on the recommendation. Ms. Williams-Bader shared that the Workgroup thought removing the measure would create a gap in the program because there is only one other clinical measure in MSSP, however this measure makes it difficult to determine whether a patient not meeting this measure is due to them not being screened or not having a follow-up plan. Ms. Williams-Bader also shared that documentation is difficult and noted concern from the Rural Health Advisory Group about not being able to refer patients who screen positively. For complete details from the Clinician Workgroup meeting, please refer to the meeting summary (PDF).

Ms. Williams-Bader handed it over to Mr. Kahn for lead discussant comments. A lead discussant shared that they are currently using this measure, are looking at how to stratify by demographic data as this is a key measure, and they agree with the Workgroup's recommendation to support for retaining. CMS noted that this measure is a web interface version.

A Committee member commented that this is an important measure. The Committee member wondered what happens when a patient is comorbid and where patients that are already under care fit in. The Committee member also asked whether the population is patients that are in a specific panel or whether it is anyone that is seen in a particular year. Dr. Schreiber responded that the web interface measure is only for patients that are attributed to the accountable care organization (ACO). Another Committee member noted that CQMC supports this measure and both primary care and behavioral health support this on CQMC. The Committee member also stated that they understand the importance of clinical depression. Another Committee member voiced support for retaining this measure because they stated that there is a mental health crisis in the country, so it is important to hear from patients and families all the time. The Committee member agreed that rural communities are under-resourced

but stated that this measure needs to be provided to the community to move the measurement forward.

Mr. Kahn recommended that the Coordinating Committee move forward with voting to support the Workgroup recommendation as the Coordinating Committee recommendation. The recommendation is "support for retaining." Voting results were as follows: Yes – 17, No – 2. Complete voting results are in Appendix B.

MSR Recommendations for the Consent Calendar

Opportunity for Public Comment on MSR Recommendations for the Consent Calendar

Mr. Kahn opened the meeting for public comment on the MSR recommendations for measures on the consent calendar. Ms. Williams-Bader noted that two measures were pulled from the consent calendar prior to the meeting and that this public comment is an opportunity to comment on those two measures. No public comments were received.

Discussion of the Measure Set Review Recommendations for the Consent Calendar

Ms. Williams-Bader reviewed the process discussion around the consent calendar. Ms. Williams-Bader reiterated that the measures on the consent calendar received between 80-100 percent consensus from the Workgroup. No questions were offered around the process. Ms. Williams-Bader continued to review the measures and Workgroup decisions for the measures on the consent calendar.

A Committee member noted that they had questions and concerns about two of the measures in home health, inquired about the current recommendations and requested that there be clarification about the Workgroup recommendation for these measures. The Committee member expressed concern about removing 03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) and 05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function and sought clarification about the Workgroup's recommendations. The PAC/LTC Workgroup representative clarified that 03493 received a "conditional support for removal" recommendation and shared that the Workgroup expressed that this measure is an important concept, but the Workgroup was hoping for a different measure that addresses limitations of this measure. The Workgroup representative noted this measure comes from a different long-term care (LTC) system and the context for home care is different, so the desire is for a measure to be specific to home care and consider unintended consequences. The Committee member shared that they are concerned about the message of NQF recommending removing a measure around falls and noted that almost any measure has concerns and gaps. Ms. Williams-Bader clarified that the recommendation is "conditional support for removal" and it is MAP recommending removal, not NQF. The PAC/LTC Workgroup representative noted that the reason for recommending removal of 05853 is because it is topped out and is a mandated measure for CMS. The Committee member noted that an alternative is to retain the measure until a more appropriate measure is put into place but stated that they are fine with the Workgroup recommendation for "conditional support for removal."

Another Committee member shared that they would like to pull 01246-C-MSSP: Controlling High Blood Pressure (non-eCQM) from the consent calendar because of the operationalization of the measure and stated that strict blood pressure control for the whole population does not work. The Committee member continued that the age range needs to have stratification accounted for and the most recent blood pressure reading is not the reality, as there needs to be a range and account for what is occurring at home as well. The Committee member noted that risk adjustment has not been considered and felt

that this is pushing for bad clinical care. The Committee member stated that they want the measure to be removed and agree with the Workgroup recommendation of "conditional support for retaining." Ms. Williams-Bader clarified that there are conditions attached to the recommendation.

The Committee member also requested to pull the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure from the consent calendar. They requested this because it is known that some portions of the measure have led to unnecessary treatment that have harmed patients, the biggest one being opioid treatment. The Committee member continued that the other issue with the measure is that most or all patients participate in the survey data so it is not possible to go with the small minority that participate that can lead to change, and the friendliness of a clinician's front desk staff is not something that all clinicians can control. Another member disagreed with the comments that were made by the previous Committee member and voiced that they fully support the CAHPS measure.

A Committee member agreed that the other Committee member raised good points on pulling the above measures. Mr. Kahn asked the Committee whether they would like to pull the two measures and several Coordinating Committee members agreed that they should be pulled. One Committee member noted that both the eCQM and non-eCQM versions of Controlling High Blood Pressure measure should be discussed. The Committee members agreed. The following three measures were pulled from the consent calendar: 01246-C-MSSP: Controlling High Blood Pressure; CMS eCQM ID: CMS165v10: Controlling High Blood Pressure; and Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey. No Committee members objected to the Workgroup recommendations for the other measures on the consent calendar.

MSR Recommendations for the Hospital Outpatient Quality Reporting (Hospital OQR) Program (Continued)

Discussion of the Measure Set Review Recommendations for the Hospital OQR Program

Ms. Williams-Bader announced that the Committee would continue the discussion around the three Hospital OQR measures that were not discussed during day one of the meeting.

00930-C-HOQR: Median time for ED Arrival to ED Departure for Discharged ED Patients

Ms. Williams-Bader introduced first measure and reviewed the measure information including the description, endorsement status, and selection count for MSR nomination by Workgroup and Advisory Group members. Ms. Williams-Bader noted this measure information was provided to the Coordinating Committee as there was not a Workgroup recommendation. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. The CMS lead clarified that the measure was not submitted for re-endorsement because it requires specification and algorithm changes related to abstraction of the data elements. The CMS lead shared that the measure collects data on overall rate and has been publicly reported since 2013. The CMS lead also shared that the rationale for this measure is that this is an indicator of hospital quality of care and leads to improved clinical outcomes.

Ms. Williams-Bader turned to the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative shared that there was a wide range of conversation on this measure at the Workgroup meeting because this information is important for patients to see and to understand what their experience in the hospital looks like upon admission. The Hospital Workgroup representative shared that the Workgroup chose to start with a recommendation of "conditional support for removal" because the measure lost NQF endorsement, it has been in the

program for some time but there does not seem to change in the rates that are publicly reported. The Workgroup representative reported Workgroup conversation around the lack of risk adjustment and the fear that the measure does not adequately account for differences in patient type and facilities. The Hospital Workgroup representative noted that the Workgroup would like to see a better measure than this one. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

Mr. Kahn called upon the lead discussants for comments. A lead discussant noted that there were no public comments on this measure and stated that they would recommend support for removal. The lead discussant stated that performance skews far to the right and there is no change over a period of ten years, and questioned whether this measure is measuring what it is targeted to measure. Mr. Kahn thanked the lead discussant and opened it up for Coordinating Committee discussion.

A Committee member had a question about what measures exist around emergency room performance because many low-income urban areas use the emergency room as a location for primary care. The Committee member noted concern about the potential removal of this measure along with 00922-C-HOQR: Left Without Being Seen from day one. The CMS lead noted that if both are removed then no measures relating to the emergency department would be left in the program. Mr. Kahn asked CMS whether they have looked for other measures given the deficits of these two emergency department measures. The CMS lead responded that there is nothing on the horizon. The CMS lead shared that there are measures around stroke care, time to percutaneous coronary intervention (PCI), and other clinical timing measures that are used by The Joint Commission (TJC). The CMS lead noted that they have a ST-elevation myocardial infarction (STEMI) eCQM that will be replacing two chart abstraction measures. A Committee member noted that if a patient must see a specialist over the weekend, it could take a long time. Another Committee member shared that there are different average times for high volume emergency departments, medium volume emergency departments, and low volume emergency departments.

Mr. Kahn moved to vote for "conditional support for removal" with the condition of CBE endorsement. Voting results were as follows: Yes – 16, No – 3. Complete voting results are in Appendix B.

02599-C-HOQR: Abdomen Computed Tomography (CT) – Use of Contrast Material

Ms. Williams-Bader introduced the measure and reviewed the measure information including the description, endorsement status, and selection count for MSR nomination by Workgroup and Advisory Group members. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. The CMS program lead noted that this measure is calculated over a one-year window and is a claims-based measure, so facilities are not burdened with data collection. The CMS lead shared that the measure assesses high quality and efficient care and prevents unnecessary exposure to contrast materials. The CMS lead also shared that it is an inverse measure and is not topped out and noted that 3,336 facilities are currently reporting this measure.

Mr. Kahn turned to the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative shared that there was concern among the Workgroup members around lack of endorsement for the measure and how long it has been in the program. The Workgroup representative noted that the Workgroup agreed to start with a recommendation of "conditional support for retaining." For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

Mr. Kahn called upon the lead discussants for comments. A lead discussant shared that hearing the above information has been helpful but noted they are concerned about whether the measure is topped

out. The lead discussant stated it seems reasonable to have conditional support for retaining the measure. Another lead discussant commented on the documented disparities in measure performance leading them to support retaining as the recommendation. No additional comments were offered from the Committee.

Mr. Kahn moved to vote for "conditional support for retaining" with the condition of CBE endorsement. Voting results were as follows: Yes – 19, No – 1. Complete voting results are in Appendix B.

02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery

Ms. Williams-Bader introduced the measure and reviewed the measure information including the description, endorsement status, and selection count for MSR nomination by Workgroup and Advisory Group members. Ms. Williams-Bader invited the CMS program lead to provide contextual comments about the measure. The CMS program lead noted adverse events that occur after outpatient surgery can result in an unanticipated hospital visit. The CMS lead highlighted that the measure is not considered to be topped out, shared that there are a total of 4,690 facilities reporting on this measure, and noted that the measure is endorsed.

Mr. Kahn and Ms. Williams-Bader turned to the Hospital Workgroup representative to provide background on the Workgroup discussion. The Hospital Workgroup representative noted that there was confusion by the Workgroup on the endorsement status and most of the Workgroup members were in support of retaining the measure. The Hospital Workgroup representative shared that the Workgroup had a conversation about the need for performance measures around social risk. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

Mr. Kahn called upon the lead discussants for comments. A lead discussant shared that they would strongly support this measure as CMS is best positioned to collect data on it and it is hard for others to collect this information. The lead discussant continued that it is very important for purchasers to be able to track this information and highlighted that 70 percent of surgeries are performed in these settings. The lead discussant also noted that this measure is important for consumers. Another lead discussant noted that this is an important measure and shared that this information needs to be tracked and kept over time. Ms. Williams-Bader asked CMS to clarify whether the version of this measure in the HOQR program is endorsed. The CMS program lead verified that it is endorsed.

Mr. Kahn moved to vote for "support for retaining" as the first vote as the measure is endorsed. Voting results were as follows: Yes – 20, No – 1. Full voting results can be accessed in Appendix B.

Measures Pulled from the Consent Calendar

Discussion and Recommendations of Measures Pulled from the Consent Calendar

Ms. Williams-Bader introduced the section for measures pulled from the consent calendar. Ms. Williams-Bader reminded the Committee there are two groups of measures that will be reviewed during this section. The first two measures were pulled by Committee members prior to the meeting and the other three measures were pulled by Committee members earlier in the day's meeting.

02936-C-ASCQR: Normothermia Outcome

Ms. Williams-Bader introduced the measure and turned the meeting over to Ms. Roberts. Ms. Roberts invited the CMS program lead to provide contextual comments about the measure. The CMS lead noted this measure assessed the percentage of patients who have undergone surgery who obtain normothermia deemed as 96.8 degrees Fahrenheit post-surgery. The CMS lead further noted this was an ASC Quality Collaboration (ASC QC) measure. The CMS lead acknowledged there was concern about

the measure only addressing hypothermia rather than hyperthermia. For complete details from the Hospital Workgroup meeting, please refer to the meeting summary (PDF).

Ms. Roberts turned to the lead discussant to present their rationale for requesting to pull the measure and findings from their review of the measure. The lead discussant noted that as patients age a large percentage have a lower body temperature between 94- and 98.6-degrees Fahrenheit. The lead discussant noted concern with the measure only referencing hypothermia and not hyperthermia, as emergencies can happen to patients during both. The lead discussant further noted the Hospital Workgroup discussed this measure was a standard of care. The lead discussant stated the measure performance was 95.11 in 2020 and questioned whether this measure was topped out. The CMS lead confirmed hyperthermia was not addressed in this measure. The CMS lead noted hyperthermia does occur but occurs much more rarely than hypothermia. The CMS lead stated the literature reports at least 20 percent of patients may experience hypothermia, and hypothermia was linked to a greater risk of complications. The CMS program lead acknowledged hyperthermia may need to be considered and they would bring this to the attention of the measure developer. The CMS program lead noted the measure steward tested this measure within a group of ambulatory surgical centers and the measure used a stringent standard for temperature. The CMS lead also noted the performance was relatively high, but there were still outliers with room for improvement.

A Committee member noted that anesthesia decreases body temperature and maintaining normal temperature was a good part of patient care. The Committee member further noted it is important that some centers are not providing this care, and this is an important measure in anesthesia quality. This Committee member stated hyperthermia during anesthesia can be a medical emergency but was a different situation than maintenance of normothermia for high-quality care. The CMS lead acknowledged there may need to be hyperthermia exclusions in the measure, or the specifications may need to be reexamined. The CMS lead noted they will take the discussion notes to the measure developer.

Ms. Roberts moved the Committee to vote on acceptance of the Workgroup decision "support for retaining" for measure 02936-C-ASCQR. Voting results were as follows: Yes – 17, No – 1. Complete voting results are in Appendix B.

05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report

Ms. Williams-Bader introduced the measure and invited the CMS program lead to provide contextual comments about the measure. The CMS lead noted this measure meets MIPS objectives and is a high priority measure. The CMS lead further noted the measure is not topped out, it shows room for improvement, and is a digital quality measure. The CMS lead stated the MIPS program offers different collection types based on clinician or group preference, therefore this measure does not penalize those who do not utilize an electronic health record. For complete details from the Clinician Workgroup meeting, please refer to the meeting summary (PDF).

Ms. Roberts turned to the lead discussant to present their rationale for requesting to pull the measure and findings from their review of the measure. The lead discussant noted the intent of the measure was to provide seamless care coordination. The lead discussant noted concerns including no way to know if the report was read, the measure does not hold the specialist responsible for closing the loop, and the measure assesses a one-way operation. The lead discussant referenced MSR measure review criterion number three and stated MAP did not support the measure for the Medicare and Medicaid EHR Incentive Program in 2011/2012, nor Physician Compare in 2013/2014, nor the Physician Feedback/Value-Based Payment Modifier Program in 2013/2014. The lead discussant referenced MSR measure review criterion number four and stated the measure only has raw data with no validity or

reliability data. The lead discussant acknowledged the measure was an important concept but noted there are practical problems. The lead discussant described practical problems with the measure including there may be situations where the referred patient's issue is resolved before being seen or there may be an extended waiting period of months before the patient sees the specialist. The lead discussant noted the operationalization of the measure can be a challenge for some electronic health systems.

Ms. Roberts asked if CMS had any further comments based on the lead discussant's findings. A CMS measure lead noted this measure does not need to be reported and there are 200 other measures to choose from within MIPS. The CMS lead stated the measure concept is critical to good care and can impose cost to the health care system if not addressed. The CMS lead further stated the measure may not be perfect, but the concept is too important to remove.

Ms. Roberts opened the meeting for Committee discussion. The lead discussant agreed fundamentally this measure was good but commented not everything needs to be measured to provide good clinical care. The lead discussant asked CMS whether the loop should be measured for both physicians. The CMS measure lead did not disagree but noted there are situations that can happen between the initiation of the referral and the specialist seeing the patient. The CMS lead noted the specialist may not know about the referral and therefore would not know if the patient chose not to follow through with the referral.

A Committee member agreed with the CMS lead's comments and agreed care coordination is essential to good care. The Committee member noted the Workgroup recommendations for measures on the consent calendar achieved at least an 80 percent consensus. Another Committee member agreed with the prior Committee member's comments. The Committee member stated one of the biggest weaknesses in the health system was this hand off.

Another Committee member asked for clarification about the measure's endorsement. The CMS program lead confirmed this measure was not endorsed. The CMS lead further noted per statute MIPS does not require endorsement if the measure is evidence based. The Committee member agreed with the lead discussant's concern regarding the measure's intended use and noted the measure may not be useful for consumers.

The lead discussant noted, according to the developer's documentation, there was no evidence cited for this measure. The lead discussant reiterated that clinically and conceptually the measure makes sense, but there was no evidence noted.

A Committee member asked if there are any other measures that capture the referral process. A CMS lead noted there are a few other measures that address communication with a specialty clinician providing care including (1) Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care and (2) Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older. The CMS lead further noted this measure is unique in that it assesses the complete communication loop. The Committee member noted this was a critical area when it comes to patient safety.

Ms. Roberts moved the Committee to vote on acceptance of the Workgroup decision, "support for retaining," for measure 05826-E-MIPS. Voting results were as follows: Yes – 18, No – 3. Complete voting results are in Appendix B.

Ms. Williams-Bader noted the next three measures were those measures pulled from the consent calendar earlier in the day's meeting.

01246-C-MSSP: Controlling High Blood Pressure

Ms. Williams-Bader introduced the measure. For complete details from the Clinician Workgroup meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader summarized the points raised by the lead discussant during the consent calendar section of the meeting. Ms. Williams-Bader noted the lead discussant's concerns with strict control across a whole population, lack of stratification particularly for older adults, use of the most recent blood pressure, and lack of risk adjustment. Ms. Williams-Bader also noted the lead discussant's preference to measure a blood pressure range and to include measurements at home. Ms. Williams-Bader further noted the lead discussant was concerned that these issues with the measure have been raised for some time, but there have not been changes to the measure.

A co-chair turned to CMS for any further comments. The CMS program lead noted the measure is a high priority measure and an intermediate outcome measure. The CMS lead further noted within MIPS there was a performance gap with room for improvement. A CMS measure lead stated the measure allows for at-home blood pressure readings to be included as long as the clinician was using those readings and documenting them in the record. The CMS lead noted the at-home blood pressure readings may have been the change made to the measure that took it out of alignment with the original NQF endorsed measure.

The lead discussant noted 65 years and older was where hypertension leads to bigger problems. A co-chair asked if this measure was endorsed, and the CMS lead confirmed that the changes to the measure specification changed the status to not endorsed. The co-chair asked if CMS will seek endorsement. A CMS measure lead noted this the measure is not stewarded by CMS, so it is not CMS' place to take the measure through endorsement.

A Committee member agreed the lead discussant raised important issues. This Committee member further noted this was an important measure and suggested adding endorsement to the condition to retaining this measure.

A Committee member who also represented the measure steward confirmed the measure was a HEDIS [Healthcare Effectiveness Data and Information Set] measure that was specified for the MIPS program, and the parent measure allowed for home-based blood pressure readings. A CMS lead noted the reason NQF endorsement was removed for the MIPS program was due to the number of encounters required for the denominator eligibilities – the NQF version requires multiple encounters, and the MIPS version only looks for one encounter.

The lead discussant suggested adding endorsement to the condition list. The co-chair asked about the measure steward's process for endorsement. The Committee member and representative from the measure steward noted that when their organization brings a measure for endorsement they try to bring all the implementation versions of the measure. The co-chair noted the endorsement issue would not be resolved at this meeting. The co-chair and Ms. Williams-Bader confirmed that the next measure on the agenda was the same measure in eCQM format.

The co-chair suggested pairing this measure and the eCQM version of the measure with a "conditional support for retaining" recommendation, with the condition of CBE endorsement. The lead discussant agreed with the suggestion. A Committee member asked for clarification whether both measures are not currently endorsed and the CMS program lead confirmed both versions of the measure are not endorsed.

Ms. Williams-Bader stated separate votes will be conducted for the two measures. Ms. Williams-Bader further asked if the Committee was comfortable with the stated conditions in the rationale and wanted to add CBE endorsement. The co-chair asked for any objections to the stated conditions with the addition of CBE endorsement. The lead discussant agreed with the suggestion.

The CMS program lead noted this measure was a web-interface measure and scheduled to sunset from MSSP starting with the 2025 performance period. The co-chair proposed to move forward with the proposed decision category and conditions. A Committee member asked for clarification whether at-home blood pressure readings were already added to the measure specification. A CMS lead clarified that the only readings not included were readings from manual blood pressure cuffs. Ms. Williams-Bader asked for clarification whether the Committee wanted to keep all three conditions and add endorsement as a condition.

Mr. Kahn moved the Committee to vote on acceptance of the Workgroup decision, "conditional support for retaining," for measure 01246-C-MSSP with the conditions being, (1) having multiple encounters, (2) change the last reading requirement to an average or a therapeutic window, (3) allow ambulatory or at-home blood pressure readings to be included, and the additional (4) CBE endorsement. Voting results were as follows: Yes – 20, No – 1. Complete voting results are in Appendix B.

CMS eCQM ID: CMS165v10: Controlling High Blood Pressure

Mr. Kahn moved the Committee to vote on acceptance of the Workgroup decision, "conditional support for retaining," for measure CMS eCQM ID: CMS165v10 with the conditions being, (1) having multiple encounters, (2) change the last reading requirement to an average or a therapeutic window, (3) allow ambulatory or at-home blood pressure readings to be included, and the additional (4) CBE endorsement. Voting results were as follows: Yes – 18, No – 1. Complete voting results are in Appendix B.

Ms. Williams-Bader noted a Committee member indicated earlier in the meeting there was a registry version of the measure in MSSP, but there was not a separate vote at the Workgroup meeting. Ms. Williams-Bader stated if the Committee agree, any comments for the eCQM can be applied and documented for the registry version of the measure. Mr. Kahn asked if there were any objections to applying those comments. No objections were stated at this time.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

Ms. Williams-Bader introduced the measure. For complete details from the Clinician Workgroup meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader summarized the points raised by the lead discussant during the consent calendar section of the meeting. Ms. Williams-Bader noted the lead discussant said it was important to do what was best for patients, but certain types of survey questions have led to unnecessary treatment, using opioids as an example. Ms. Williams-Bader further noted the lead discussant indicated there was not a good alternative right now, this measure was not a good gauge of quality, and it was important to hold organizations responsible for this type of quality action and not physicians. The lead discussant noted this was an important topic area, but there was still not a good alternative for the measure.

Dr. Schreiber noted there were no pain questions in the MIPS CAHPS survey. Dr. Schreiber further noted there were pain questions in the hospital HCAHPS survey, but those questions were removed. Dr. Schreiber stated that the questions asked of patients regarding experience with providers were extremely important and hearing the viewpoint from the patient point of view is important. Dr. Schreiber noted in MSSP the questions are mandatory, but in MIPS the questions are voluntary. Dr. Schreiber further noted CMS has a fundamental commitment to hearing the voice of the patient regarding experience.

A Committee member agreed with Dr. Schreiber's comment about the overall importance of the consumer patient experience. The lead discussant asked Committee members whether appointment wait times or front desk staff was the responsibility of the physician. A Committee member noted that families across the country have experienced medical practices headed by physicians that are not ideal and that was what CAHPS was intended to address. The Committee member further noted that family members are concerned with responsiveness and respect to patients. A co-chair agreed with the Committee member's comment. The co-chair stated that the physician does have responsibility for the individual who answers the practice phone. The co-chair further stated entry into the clinic via the telephone is just as important as walking across the threshold into the physician's office.

A Committee member noted this is an important measure to capture the voice of the consumer. This Committee member asked CMS if there is enough of a response rate to determine opportunities for improvement. Dr. Schreiber responded the measure is mandatory in MSSP, but on the MIPS side reporting may be lower. Dr. Schreiber noted that response rates for both CAHPS and HCAHPS declined during the pandemic, but there was enough reporting. Dr. Schreiber further noted there are few questions in the survey about office staff and questions are largely about the provider.

A Committee member echoed earlier comments that communication questions in the survey cut across the entire clinical practice. The Committee member further noted responsiveness and accessibility for the patient was the responsibility of the practice. Another Committee member noted from the patient and caregiver perspective there was a future opportunity with CAHPS to utilize what was endorsed as a palliative care measure around patients reporting on being heard and understood.

Mr. Kahn moved the Committee to vote on acceptance of the Workgroup decision, "support for retaining," for measure Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey. Voting results were as follows: Yes – 18, No – 1. Complete voting results are in Appendix B.

Public Comment

Mr. Kahn opened the meeting for public comment. There were no public comments provided.

Discussion of Gaps in Clinician, Hospital, and PAC/LTC MSR Programs

This section was removed due to amendments to the agenda for day two.

MAP Coordinating Committee Feedback on MSR Process

Ms. Williams-Bader thanked the Committee for their flexibility over the two days of the meeting. Ms. Williams-Bader moved to a poll and a discussion among Committee members regarding feedback on the MSR process. There were two poll questions, and the full results are detailed in Appendix D.

A co-chair commented that the Coordinating Committee did well over the two days of the meeting, but noted the Committee needed the complete context from all the Workgroups. The co-chair reiterated comments from earlier in the meeting regarding the need for quorum during meetings that require a vote. The co-chair noted positive feedback on the use of a consent calendar but suggested pulling measures should occur prior to the Coordinating Committee meeting. The co-chair noted that 80 percent is an incredible consensus and a high bar set by the Workgroups. The co-chair further noted in terms of the measure criteria that endorsement needs to be one of, if not, the highest criteria.

A Committee member agreed with the comments made by the co-chair. This Committee member noted the meeting materials, especially the summary documents, were extremely helpful. The Committee member suggested providing a one-page summary listing the measures with the Workgroup

recommendation, the Advisory Group feedback, and the decision category. The Committee member noted that often the Workgroup recommendation was different than the Rural Health Advisory Group recommendation. The Committee member also noted the Health Equity Advisory Group did not vote on all of the measures. Ms. Williams-Bader explained the Advisory Groups were asked a poll question about retaining the measure in the program. Ms. Williams-Bader further noted this question worked with the Rural Health Advisory Group, but the Health Equity Advisory Group found it a challenge. Due to the challenge, the poll was stopped during the meeting. Ms. Williams-Bader noted the need to continue to explore ways to gather feedback from the Advisory Groups.

A Committee member thanked the co-chairs and noted appreciation to CMS for their statements about each measure. The Committee member noted the context was helpful to understand how and why a measure was utilized in a program. The Committee member noted removing a measure was a different kind of recommendation than adding a measure, as in the MUC process. The Committee member further noted the need to review how the measure was being used and whether the measure was being used effectively and suggested adding that to the measure review criteria in some way. Ms. Williams-Bader asked the Committee member to expand on the comment as there are questions about use on the current criteria and the Committee member noted they would email NQF after further review.

Another Committee member provided further positive feedback on the materials. The Committee member noted the desire to have more performance data and testing information. Ms. Williams-Bader noted any data available was provided to the Committee. Ms. Williams-Bader further noted the lack of a single source of information, like a measure submission in the MUC process. The Committee member stated the ability to refer to past endorsement data submission was helpful for reviewing measures.

A Committee member commented on the need for quorum as the biggest challenge in day one of the meeting. Another Committee member commented on the need for quorum and the desire for stakeholder balance within the Workgroups. This Committee member also asked about public comment and were there a desired level of public comments. Ms. Williams-Bader noted the opportunities for public comment throughout the MSR process. Ms. Williams-Bader further noted that MSR was a brand-new process and as MSR moves forward with a stabilized timeline there may be an increased number of comments.

Ms. Williams-Bader stated challenges with these measures include determining endorsement status, as slight differences between an endorsed version of a measure and the measure in the program may mean the measure in the program is considered to be not endorsed. Ms. Williams-Bader asked the Committee whether it was helpful to have information about a measure, even if the slight difference between the version in the program and the endorsed measure means it is not endorsed. A Committee member responded if the measures are parallel in intent and description, it would be helpful to have the evidence for the measure. Another Committee member stated it was helpful to understand the context of voluntary measurement reporting, as that could impact how members interpret the range in performance and opportunity for improvement.

Next Steps

Ms. Williams-Bader shared that NQF staff will create a final recommendations spreadsheet that will be published in September, bringing the MSR cycle for 2022 to a close.

Ms. Williams-Bader asked the co-chairs to express their final comments. The co-chairs thanked the Committee members for their participation and expressed their appreciation for the Committee and NQF staff for navigating the two-day meeting well. The co-chairs also shared that the feedback received from the Committee is appreciated for improving the MSR process. Ms. Kimberly Rawlings from CMS

thanked the Committee for the feedback, commitment, and engagement in the process, and for the discussion that provides the information that CMS needs for their processes. Ms. Williams-Bader thanked everyone and adjourned the meeting.

Appendix A: MAP Coordinating Committee Attendance (Voting Only)

The following members of the MAP Coordinating Committee were in attendance:

Co-chairs

- Chip Kahn, MPH
- Misty Roberts, MSN

Organizational Members

- American Association on Health and Disability
- American College of Physicians
- American Health Care Association
- American Medical Association
- American Nurses Association
- America's Health Insurance Plans
- AmeriHealth Caritas
- Blue Cross Blue Shield Association
- Civitas Networks for Health
- Covered California
- The Joint Commission
- The Leapfrog Group
- National Committee for Quality Assurance
- National Patient Advocate Foundation
- Patient & Family Centered Care Partners
- Purchaser Business Group on Health

Individual Subject Matter Experts (SMEs)

- Dan Culica, MD, PhD
- Janice Tufte
- Ronald Walters, MD, MBA, MHA

Appendix B: Measure Voting Results

Some Coordinating Committee members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained during voting periods.

Measure	Program	Decision Category	Yes (N/%)	No (N/%)	Total (N/%)
00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain	Hospital OQR Program	Support for Removal Conditional Support for Retaining	6 (30) 18 (90)	14 (70) 2 (10)	20 (100) 20 (100)
00922-C-HOQR: Left Without Being Seen	Hospital OQR Program	Support for Removal	12 (63)	7 (37)	19 (100)
00930-C-HOQR: Median time for ED Arrival to ED Departure for Discharged ED Patients	Hospital OQR Program	Conditional Support for Removal	16 (84)	3 (16)	19 (100)
02599-C-HOQR: Abdomen Computed Tomography (CT) – Use of Contrast Material	Hospital OQR Program	Conditional Support for Retaining	19 (95)	1 (5)	20 (100)
02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery	Hospital OQR Program	Support for Retaining	20 (95)	1 (5)	21 (100)
01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	ASCQR Program	Conditional Support for Retaining	16 (84)	3 (16)	19 (100)
00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	MSSP	Support for Retaining	17 (89)	2 (11)	19 (100)
02936-C-ASCQR: Normothermia Outcome	ASCQR Program	Support for Retaining	17 (94)	1 (6)	18 (100)
05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report	MIPS	Support for Retaining	18 (86)	3 (14)	21 (100)
01246-C-MSSP: Controlling High Blood Pressure	MSSP	Conditional Support for Retaining	20 (95)	1 (1)	21 (100)
CMS eCQM ID: CMS165v10: Controlling High Blood Pressure	MSSP	Conditional Support for Retaining	18 (95)	1 (5)	19 (100)
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey	MSSP	Support for Retaining	18 (95)	1 (5)	19 (100)

Appendix C: Consent Calendar Results

The consent calendar was presented to the Coordinating Committee members. After committee discussion, there were no objections to the following recommendations.

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

- Conditional Support for Retaining
  - 05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice

MSSP

- Support for Retaining
  - CMS eCQM ID: CMS2v11, MIPS Quality ID: 134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
  - 06040-C-MSSP: Hospital-Wide, 30-day All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups
- Conditional Support for Retaining
  - 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Merit-Based Incentive Payment System (MIPS)

- Support for Retaining
  - 00641-C-MIPS: Functional Outcome Assessment
- Conditional Support for Retaining
  - 02381-C-MIPS: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
  - 00254-C-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
  - 05796-E-MIPS: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Conditional Support for Removal
  - 01101-C-MIPS: Barrett's Esophagus
  - 05837-E-MIPS: Children Who Have Dental Decay or Cavities

Home Health Quality Reporting Program (HH QRP)

- Support for Retaining
  - 02944-C-HHQR: Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
- Conditional Support for Retaining
  - 00185-C-HHQR: Improvement in Bathing
  - 00187-C-HHQR: Improvement in Dyspnea
  - 00189-C-HHQR: Improvement in Management of Oral Medications
  - 00196-C-HHQR: Timely Initiation of Care
  - 00212-C-HHQR: Influenza Immunization Received for Current Flu Season
  - 01000-C-HHQR: Improvement in Bed Transferring
- Conditional Support for Removal
  - 03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
- Support for Removal

- 02943-C-HHQR: Total Estimated Medicare Spending Per Beneficiary (MSPB) - Post Acute Care (PAC) HHQRP*
- 05853-C-HHQR: Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

*Measure 02943-C-HHQR was accidentally misclassified as "conditional support for removal" on the August 25, 2022 MAP Coordinating Committee 2022 MSR Meeting slide displaying measures on the consent calendar. The decision category "support for removal" was noted correctly in the PAC/LTC Workgroup June 30, 2022 meeting summary, the 2022 MSR preliminary recommendations spreadsheet posted for public comment from July 22, 2022 to August 5, 2022, and the PAC/LTC Workgroup measure summary sheet shared with the Coordinating Committee in the August 25, 2022 meeting materials. NQF conducted off-line voting via email with Coordinating Committee members. NQF asked the Coordinating Committee if they supported the PAC/LTC Workgroup's recommendation of "support for removal" and the voting results were as follows: Yes – 15, No – 2.

Appendix D: MSR Process Feedback Polling Results

Some Coordinating Committee members were unable to attend the entire meeting. The MSR feedback polling totals reflect members present during this section.

Poll Question	Yes	No
The Coordinating Committee review of the measures under review worked well.	13	7
The use of a consent calendar for the Coordinating Committee meeting worked well.	11	7