NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Measure Applications Partnership (MAP) Measure Set Review (MSR) Meetings – Day 1

The National Quality Forum (NQF) convened a public virtual meeting for the Measure Applications Partnership (MAP) Measure Set Review (MSR) on September 8-9, 2021.

Welcome, Introductions, Disclosures of Interest and Overview of Agenda

Tricia Elliott, Senior Managing Director, welcomed participants to the virtual meeting, reviewed housekeeping notes and provided an agenda overview. Dr. Dana Gelb Safran, NQF President and CEO, welcomed participants to the MSR meeting for the 2021-2022 Measure MAP cycle, the first meeting of its kind. Dr. Safran expressed gratitude for the Centers' for Medicare & Medicaid (CMS) partnership for this new process, noting that the goal for the MSR meetings should be to create a holistic review process for considering which measures might be appropriate to remove from use in federal programs. Dr. Safran thanked the MAP Coordinating Committee for their time, energy and commitment to the process and offered special thanks and appreciation to the Co-chairs.

Coordinating Committee Co-chairs Chip Kahn and Misty Roberts provided additional opening remarks. Mr. Kahn thanked CMS for providing this opportunity to step back for a more strategic measure review and noted the additional opportunity to strategically consider program gaps. Mr. Kahn emphasized that this year's meetings are a pilot process that will set the foundation for a set of assessments and processes that will occur each year. Ms. Roberts echoed thanks to CMS for the opportunity to expand the MAP Coordinating Committee scope and reiterated the ability of the Committee to assume a holistic approach to measure sets. Mr. Kahn also thanked the Coordinating Committee members for their increased level of participation for the pilot process. Ms. Elliott conducted roll call and disclosures of interest for each member.

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director for Quality and Value, CMS thanked NQF and Dr. Safran. Dr. Schreiber noted that the MSR process provides the opportunity to identify measures that could be removed in addition to the inclusion of measures through the traditional MAP processes. Rationales for removal may include changing priorities, measure impacts, filling gaps, and loss of clinical relevance or attainment of topped-out status. Dr. Schreiber emphasized that CMS reviews programs annually and iteratively to reduce burden and provide the most impact to beneficiaries, with the ultimate goal of improving outcomes and ensuring that patients have the necessary information to make clinical decisions. CMS endeavors to make all processes for measure inclusion and removal as transparent as possible by incorporating several public commenting channels and changes are generally implemented through rule-writing. Dr. Schreiber highlighted the importance of receiving consensus through the MAP on measures for removal, in addition to those being considered for inclusion, and encouraged Coordinating Committee members to focus on the impact to programs beyond the measures alone. Dr. Schreiber stated that CMS looked forward to the discussions and expressed thanks for the partnership in this endeavor.

Review of MSR Process and Measure Review Criteria (MRC)

Ms. Elliott reviewed the MSR process and Measure Review Criteria (MRC). Following the MAP Coordinating Committee education meeting on August 9, 2021, Coordinating Committee members selected measures for the MSR meeting. The top 22 selected measures were included in the MSR process. Additional measure information was made available to Committee members in the measure summary document distributed prior to the MSR meeting via email and meeting invite. Ms. Elliott reviewed the MSR discussion process:

- NQF staff provides an overview of each program for context to the discussion
- Co-chairs call on Lead Discussants to share their rationale for selecting the measures
- Co-chairs open discussion to all Coordinating Committee members

Ms. Elliott instructed Committee members to share their opinions and thoughts on support for removing measures, referencing any relevant measure removal criteria. Following discussion, Committee members complete a poll indicating support for removal from the program, 'yes' to remove, or 'no' not to remove. Ms. Elliott reviewed the MRC for the pilot year:

1. Measure does not contribute to the overall goal and objectives of the program
2. Performance or improvement on the measure does not result in better patient outcomes
3. Measure is not NQF endorsed
4. Evidence base for measure has changed and measure no longer reflects current evidence
5. Measure performance is uniformly high and lacks variation in performance overall and by subpopulation
6. Measure is not feasible to implement
7. Measure is duplicative of other measures in the program
8. Measure has negative unintended consequences

Ms. Roberts reiterated two objectives for the MSR pilot: 1) to seek feedback on the selected measures, and 2) to seek feedback on the criteria used to select the measures. Ms. Elliott reminded the Committee that the MSR process is a pilot being tested and that quorum and consensus percentages were not being utilized this year. Several Coordinating Committee members expressed a desire to reach the MAP's standard consensus minimum of 60% and Ms. Elliott noted that NQF staff would capture all totals and percentages.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Measures – Miscellaneous

Ms. Elliott provided a brief overview of the three selected measures, a synopsis of the IPFQR Program, and an overview of the individual measures. Ms. Roberts called upon the Lead Discussants for feedback on each of the selected measures. Committee members felt it was confusing to jump around all three measures within the group at once and all participants agreed to adjust the review process to focus on one measure at a time.

CMIT 2725: Screening for Metabolic Disorders

Lead Discussants noted the lack of NQF endorsement of the measure and that the measure was a process measure. Lead Discussants expressed concern that the measure was not aligned with clinical guidelines and additionally called for measure review criteria to include criterion that distinguish between adequacy and excellence.

CMIT 1645: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification

A Lead Discussant was concerned about the lack of NQF endorsement, the measure not being evidence based, and the lack of capacity to differentiate measure excellence and adequacy.

CMIT 2584: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Lead Discussants noted the lack of NQF endorsement, concern about capacity to differentiate measure excellence from adequacy and the burden of collection on relevance to outcome. NQF endorsement status was a primary criterion for selection by Lead Discussants, but additional concerns were expressed around the reporting level of the measure and the measure's inability to ensure action based on results. Lead Discussants felt more could be done on a measure that matters to patients and families and that while process measures can still provide value, they cannot substitute for quality of care.

Committee members asked if there were alternative endorsed measures around transitions and records, and additionally posed questions about similar measures that may have been removed from the IPFQR due to privacy concerns. Dr. Schreiber did not think there were any similar measures regarding transitions and noted the measure was meant to determine whether information was transmitted to the patient and next level of care. Dr. Schreiber also indicated there have been no issues regarding privacy and acknowledged that CMS endeavors to ensure individuals have the information so that care does not fall through the gaps.

Dr. Schreiber asked Committee members if they felt that CMIT 2584 and 1645 were patient safety issues to ensure patients and others are receiving records. Committee members expressed differing opinions, with some individuals noting that the measure still had room for improvement and does have safety value, while others noted that the measure did not allow for assessment of level of quality and was burdensome. A Committee member requested clarification on other discharge medication documentation that may or may not include antipsychotic measures not included in the portfolio and noted the combination of medication is a significant element in the health and wellness of individuals with serious mental illness being discharged from inpatient facilities. CMS representatives noted that the medication continuation measure is the most closely aligned measure following discharge. The measure looks at whether patients filled a prescription for their medications, including antipsychotics, and is broader than the antipsychotic medication measure that does not report the specific type of medications filled. This measure looks at patients who were discharged with major depressive disorder, schizophrenia, or bipolar disorder, who have filled at least one evidence-based medication throughout a 30-day discharge window; and the public reporting aggregates those diagnoses and medications. Dr. Schreiber emphasized that CMIT 1645 is focused on being a safety issue concerning individuals taking multiple antipsychotic medications.

Polling Results

Mr. Kahn and Ms. Elliott clarified that the polling process would occur for each measure individually, but after discussion of all measures. Committee members asked about the opportunity to abstain from voting and it was agreed that abstentions would be allowed, but that there was no option to select to declare this choice.

CMIT 2584: Yes 14, No 3, 82% in favor of removal.

CMIT 1645: Yes 15, No 2, 88% in favor of removal.

CMIT 2725: Yes 13, No 3, 81% in favor of removal.

Opportunity for Public Comment on the IPFQR Measures – Miscellaneous

No public comments were provided for these measures.

Committee members debated the value of allowing public comment before opening polls for voting and several individuals felt that public comments were valuable contributions that would be beneficial to hear in advance of decision making. Ms. Elliott clarified that voting would not be re-opened after public comment and as a result, Committee members agreed to adapt the meeting process to place public comment after Committee discussions, but before polling.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Measures – Tobacco and Alcohol

Ms. Elliott re-established meeting procedures and clarified that she would provide a brief overview of measures and programs, Lead Discussants would comment first, then discussion would open to all Committee members focusing on one measure at a time. After completing Committee discussion on the group of measures, public comment would be opened and polling would come last. Ms. Elliott proceeded to provide an overview of the tobacco and alcohol measures.

CMIT 1677: Tobacco Use Treatment Provided or Offered

Lead Discussants supported removal of the measure due to the removal of its NQF endorsement, evidence base, challenges of implementing the measure, and specifications of the measure. Lead Discussants felt that specifications of the measure did not sufficiently allow for alternatives such as contra-indications from medication without classification of 'refusal' and that exclusion criteria and both numerator and denominator data elements would require further clarification. Furthermore, Lead Discussants thought that tobacco cessation may be better addressed in outpatient settings or in coordination with outpatient settings. This sentiment was echoed by several Committee members.

Dr. Schreiber reminded the Coordinating Committee that several of these measures had been proposed for removal based on similar concerns that Committee members brought forth, but removal was not finalized because of significant public comment and feedback from across the U.S. Department of Health and Human Services (HHS). There is evidence that these topics are salient problems in the psychiatric patient population and it was felt by many that these were important interventions for patients while in these facilities. Dr. Schreiber noted that if CMS were to re-propose these measures for removal, there would need to be broader conversations to gain consensus. Mr. Kahn asked for clarification regarding the comments that were set forth by the Coordinating Committee during this meeting.

Committee members indicated that the age cut-off for the measure was problematic, noting that youth also struggle with tobacco use, but felt that the overall topic of the measure was important. Committee members debated the challenge of how to address measures that were inadequate, but on topics of great importance to the public.

CMIT 2588: Tobacco Use Treatment

Lead Discussants noted many items from the last measure were relevant for the current discussion and reiterated their feedback.

CMIT 2589: Tobacco Use Treatment at Discharge

Two Lead Discussants reiterated similar feedback to the last two measures. Another Lead Discussant provided similar comments to the last two measures, but wondered if the Lead Discussants should include members of the Committee who did not vote to remove the measure. Mr. Kahn asked for comments, particularly anyone who did not vote to remove. There were no additional or comments.

CMIT 2590: Tobacco Use Treatment Provided or Offered at Discharge

Comments provided by Lead Discussants reiterated points for the prior three measures and there were no additional comments.

CMIT 2591: Alcohol Use Brief Intervention

Ms. Elliott provided a brief overview of the three alcohol measures. A Lead Discussant stated although it represents an important clinical concept, the developers did not present evidence supporting benefits of this intervention in an outpatient setting, particularly improvements in consumption rates. Lead Discussants also felt that the measure could unfairly penalize clinicians in rural or urban areas where patients have limited access to counseling and reiterated concerns that the measure had lost its NQF endorsement and was not a quality measure of excellence.

CMIT 2592: Alcohol Use Brief Intervention Provided or Offered

Two Lead Discussants reiterated similar comments for this measure to CMIT 2591. Another Lead Discussant noted there should be evidence for any measure that leads to outcomes.

CMIT 5555: Sub-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

Lead Discussants maintained the same rationales for this measure, but additionally noted that implementation of this measure may encourage overuse of medically assisted therapies. Lead Discussants highlighted issues with the measure numerator, including its exclusion of Alcoholics Anonymous or primary care for treatment and of off-label medications.

Additional Comments on the IPFQR Measures – Tobacco and Alcohol

A Committee member reiterated comments that the third measure may unfairly penalize rural health providers and urban providers in resource-limited areas and emphasized that the measure does not allow for nuances between refusals and inability to meet the measure standards.

Measure Stewards noted that while the measures were imperfect, there were national trends in uptake of tobacco and alcohol use during the pandemic and that the removal of these measures at this time would not be ideal.

Committee members discussed at length the challenge of deciding between continuing measures they did not feel were adequate or removing measures on important topics without any improved replacements. Three items of concern for measures should be improvement, accountability and transparency, and Committee members expressed concern that measures not meeting these standards may be continued based on their topic area. However, Committee members also noted that these topics are important public health areas and cautioned against eliminating entire categories of measures.

Dr. Schreiber noted that mental health is a public health emergency that has increased during the pandemic and that tobacco and alcohol are even more problematic in the psychiatric population than in

the general population. Dr. Schreiber emphasized that CMS does believe the needle is still moving forward with these measures.

Co-chairs expressed desire for additional information as part of the decision-making process in future MSR meetings, and Co-chairs and Committee members agreed that future MSR processes should include some degree of prioritization for removal.

Polling Results

CMIT 1677: Yes 18, No 1, 94% in favor of removal.

CMIT 2588: Yes 14, No 5, 74% in favor of removal.

CMIT 2589: Yes 7, No 11, 41% in favor of removal.

CMIT 2590: Yes 8, No 9, 47% in favor of removal.

CMIT 2591: Yes 14, No 5, 74% in favor of removal.

CMIT 2592: Yes 15, No 4, 79% in favor of removal.

CMIT 5555: Yes 10, No 10, 50% in favor of removal.

Opportunity for Public Comment on the IPFQR Measures – Tobacco and Alcohol

No public or NQF member comments were provided for these measures.

Ambulatory Surgical Center Quality Reporting (ASCQR) Measures

Ms. Elliott provided a brief overview of the measures in the Ambulatory Surgical Center Quality Reporting (ASCQR) Program and provided a further overview of each measure.

CMIT 1049: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

The MAP noted NQF endorsement had been removed from this measure. MAP discussion included the lack of data due to this measure's voluntary reporting status and committee members questioned if this low uptake was due to reporting burden. CMS representatives emphasized the change in pending rulemaking to a mandatory reporting status. CMS representatives agreed with the low reporting, but noted the facilities who do respond strongly believe in this measure. Committee members discussed the need for measures in Ambulatory Surgical Centers (ASC) and that few look at outcomes other than mortality. Committee members noted cataract surgery is by far the number one surgery performed at these facilities.

CMIT 1061: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

MAP discussion included the need for appropriate follow-up intervals, but there was concern with the frequency of provider outreach. Dr. Schreiber reiterated this measure was designed to decrease the frequency and wanted providers to screen/report every 10 years.

CMIT 2936: Normothermia Outcome

MAP noted the lack of measures in this area. CMS indicated this measure is an ASC quality collaborative measurement; it has yet to go through the endorsement process due to the effort involved. There was

discussion among Committee members regarding chart abstraction burden, but CMS indicated there have been no comments or complaints. Committee members and CMS discussed the migration towards electronic measures. CMS noted the decrease on Medicare inpatient-only procedure reimbursements will lead to more measures in the ASC. CMS agreed this is a popular area for future development and emphasized public comment was sought for measure development.

Opportunity for Public Comment on the ASCQR Measures and Polling

There was a public comment that advocated for measures in this area because there are not many outcome measures. The public comment noted it is easy for nurses to capture this information on the PACU notes because patients are in the room for one to two hours in the ASC.

Polling Results

CMIT 1049: Yes 6, No 14, 28% in favor of removal.

CMIT 1061: Yes 3, No 17, 15% in favor of removal.

CMIT 2936: Yes 1, No 20, 5% in favor of removal.

Coordinating Committee Discussion – Day 1

Discussion among co-chairs and Committee members included the need for more information on the gaps that will result if measures are removed. CMS indicated that NQF and CMS could be more helpful in providing background information on measures in the future. CMS noted both points of view, both pros and cons, were missing. CMS stated measure stewards may need to be brought to the table to enhance this discussion or Committee members could be assigned each viewpoint. Discussion among co-chairs and committee members indicated the need for a different voting process, more choices, or a gradation in the process, such as “no with provision”.

Coordinating Committee Feedback: Frequency of Changes to Measures in the Rules

The final discussion of Day 1 was a question from CMS for Committee input. Dr. Schreiber indicated the timeline for measure changes is getting shorter and shorter and it is hard for everyone to process annual changes. Dr. Schreiber noted the CMS IT group asked if there was an opportunity to extend the timeframe of changing measures instead of annually to every other year. CMS would like to gather the Coordinating Committee’s opinion on what the pros and cons might be of extending that cycle of change. There was extensive dialogue from the Coordinating Committee regarding this posed question. Committee members agreed and recognized the struggle, especially for the challenges of implementation. Committee members and co-chairs concluded that the measure cycle may not fit a binary result, but more so a priority setting process to lengthen time. This process may need priority setting for a two-to-four-year period to help stretch things out and keep others the same.

Dr. Schreiber gave thanks to the Coordinating Committee for the comments. Dr. Schreiber reiterated a key point about electronic quality measures that take time for systems to build and at some point, CMS will get to where electronic and digital measures are standard. The issue of prioritization is right. To be clear, mental health is dynamic and changing and a high priority area from the current administration. Dr. Schreiber noted there are conversations about aligning Medicare and Medicaid, but also looking more at all-payor data and making sure we are capturing all patients, certainly all CMS patients across the continuum because care really should be the same.

MAP MSR Meetings – Day 2

Welcome, Summary of Day 1, and Roll Call

Ms. Elliott welcomed Committee members back to Day 2 of the MSR meeting and turned to Ms. Roberts for a summary of the first day's events. Ms. Roberts commented on the robust discussions of Day 1 and expressed appreciation for the adjustments made to processes in response to feedback from Committee members, in real time. Ms. Roberts highlighted the key feedback from day one, including the need for more information about each program containing measures being discussed and information on similar existing measures that could provide clues as to whether measure removal would leave programmatic gaps. Ms. Elliott then conducted roll call.

Hospital Readmissions Reduction Program (HRRP) Measures

Ms. Elliott provided a brief overview of the measures selected by the Committee and of the HRRP. Ms. Elliott highlighted that within the HRRP, measures for condition-specific readmissions are a statutory requirement. CMS clarified that this requirement does not dictate which measures specifically must be included in the program. Ms. Elliott also provided a further overview of the specifications for each measure.

CMIT 78: Heart failure (HF) 30-day Readmission Rate

While strongly supportive of reducing hospital readmissions, Lead Discussants shared reservations about condition-specific measures due to the possibility of a high number of measures that could be brought forward. Additional concerns were raised about the risk adjustment model and 30-day timeframe. One suggestion was a non-specific 30-day readmission measure that could be utilized for specific areas and evaluated by condition through data queries. Lead Discussants noted that hospitals receive a report of readmissions data in advance of this information becoming publicly available that include patient cohorts and readmissions dates and diagnosis codes which can be queried for similar information.

Dr. Schreiber noted prior literature on heart failure readmission rate included concerns about unintended consequences and issues around risk adjustment. At that time, CMS conducted an internal audit but was unable to substantiate that claim. Dr. Schreiber also asked Committee members to consider what value patients might find in condition-specific measures, rather than in seeing results for an all-cause readmissions measure.

Committee members raised the following concerns:

- Program structure creates a high level of penalization of hospitals from the readmissions measures and it is difficult to show improvement.
- The minimum reliability score of the measure may indicate that it has topped out.
- It is difficult to evaluate only three of six readmission measures in the program without the context of the other measures.
- Offshoots to create other condition specific 30-day readmissions measures will increase burden.
- The 30-day timeframe of the measure could disproportionately impact rural hospitals.

Committee members agreed with Lead Discussants, with some support for the measure, agreement on issues presented by the program structure and support for the idea of an all-cause readmission rate that could be queried for specific conditions in HRRP or the Hospital IQR Program. CMS and measure stewards for the existing all-cause readmissions measure in the Hospital IQR Program noted the measure was composed of five cohorts and patient-level data is provided to hospitals privately.

In response to concerns about the measure's reliability, Dr. Schreiber clarified there has been a trend for improvement and the question remains whether the trend is flattening. Dr. Schreiber also noted the HRRP has begun to stratify by dual eligibility, which has impacted performance for some hospitals.

Dr. Schreiber reminded Committee members that each measure within the HRRP carries its own penalty and removing a measure removes the penalty. Changes to measures will result in significant changes to hospitals' performance, in addition to changes in the program itself. The MAP recognized the need to include holistic considerations of each program during MSR processes and expressed a desire to have more information about the federal programs under discussion.

CMIT 80: Acute Myocardial Infarction (AMI) 30-day Readmission Rate

Lead Discussants generally felt that their comments during the prior conversation were relevant to this measure. However, both Lead Discussants and Committee members emphasized that any decisions should be based on data and questioned whether enough data had been provided to make decisions at this time. Dr. Schreiber noted that additional information could be provided and measure stewards supplied some initial performance data through the chat. Committee members closed discussion by considering the need for risk adjustment with particular attention to comorbidities and the COVID-19 pandemic.

CMIT 899: Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) 30-day Readmission Rate

Lead Discussants carried over their previous comments, but noted this procedure was shifting into outpatient settings. Committee members confirmed this shift but pointed out that any complications result in patients being admitted to inpatient facilities, which may complicate the picture provided by data. One Committee member noted that it is not possible to compare inpatient and outpatient quality reporting on the initial procedure when a procedure necessitates follow up in an inpatient setting. Committee members also questioned the possibility for other confounding factors, including comorbidities.

Strategic Discussion of Condition-Specific Readmission Measures Versus Hospital-Wide Readmission Measurement

Ms. Elliott asked the Committee, on behalf of CMS, if there was any additional feedback on condition-specific readmission measures. Committee members debated comparison to the hospital Star Ratings programs, which were the focus of prior NQF reports indicating that greater emphasis should be placed on units treating specific conditions in hospitals, rather than generic ratings. Committee members noted the Star Ratings programs do differ significantly from the HRRP due to the sensitive nature of readmissions. Committee members noted that hospitals with higher readmission rates may be those that high acuity patients prefer.

MAP expressed strong support for trends in the discussions towards focusing and refining readmission measures to be person-centered, valuable sources of information for consumer decision making. Additional measures may be needed to provide a person-centered approach to quality expectations that exist today from the patient perspective, and patient input should be sought to identify those measures. Committee members advised that additional focus should be given to health equity in these measures and suggested stratification to improve understanding of any differences in readmission rates across populations. Dr. Schreiber affirmed the importance of this idea and noted that the HRRP is beginning to undergo stratification, beginning with dual eligibility status.

Ms. Roberts noted that several concerns raised during the HRRP discussions had focused on the program structure. Dr. Schreiber reiterated to the Committee that while all measures receive annual review and are available for public comment throughout several processes, the program requires legislation for structural change. Readmissions remain prominent as a critical area to both consumers and CMS.

Opportunity for Public Comment on the HRRP Measures and Polling

Ms. Roberts opened the dialogue up for public comment. There was one public comment offered, which encouraged the MAP to think more about how topping out on measures is defined. The comment noted that while developers had been sharing performance data demonstrating variability of these measures in the chat, further conversation should be had about what is the right amount of variability. Even if the ideal state were achieved, the comment pointed out that variability may still exist and therefore more robust data is needed to understand outliers.

Before moving into polling, Ms. Roberts raised concerns about having insufficient information for the decisions and opened the floor for additional Committee member thoughts. There was some agreement and additional concerns raised that if condition or disease-specific readmission measures were removed in favor of all-cause readmissions measures, both consumers and hospitals would be at a disadvantage. Follow up comments from Committee members reiterated the challenges of the program's structure and penalties, and questioned the consequences for removing or maintaining measures that may or may not be topped out.

Polling Results

CMIT 78: Yes 4, No 15, 21% in favor of removal.

CMIT 80: Yes 4, No 15, 21% in favor of removal.

CMIT 899: Yes 5, No 11, 31% in favor of removal.

Mortality Measures – Hospital Value-Based Purchasing Program (VBP) and Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

Ms. Elliott provided a brief overview of the mortality measures in this section and the Hospital VBP Program. Dr. Schreiber added that the Hospital VBP Program is a net-neutral program with four categories, each equally weighted: clinical, person and community engagement, safety, and cost efficiency. In contrast, Dr. Schreiber noted that the Hospital IQR Program includes many more measures across topics, frequently serves as the host for new measures and these measures are reported publicly. Dr. Schreiber acknowledged that each program is different in build and design and stems from unique statutory requirements. Dr. Schreiber clarified that the program penalties and incentives are calculated based on Medicare payments, but some measures within the programs include Medicaid patients.

CMIT 89: Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization

Lead Discussants shared concerns that the measure and penalties may create perverse incentives against admittance of patients towards end-of-life and reiterated a suggestion issued during discussions of the HRRP measures that perhaps an all-cause measure would be preferable to condition-specific measures for mortality. Dr. Schreiber informed Committee members that a hybrid hospital-wide mortality measure was recently finalized and would be publicly reported in the coming years.

CMIT 86: Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization

Two Lead Discussants shared similar comments on the measure, expressing a slight preference for a more general mortality measure and concerns patients for complex comorbidities and the burden that condition-specific claims-based measures may impose. One Lead Discussant felt that the measure was valid and supported its continuation within the program.

MAP noted that burden was not an initial criterion for measure set review and considered its relevance for inclusion in future years. Dr. Schreiber reiterated that condition-specific measures are important to patients seeking information, as well as for quality improvement on low performance areas, and suggested that other adjustments to future criteria should include the impact and importance to patients. Committee members additionally discussed the benefits and intents of measures CMIT 89 and CMIT 86 as reflecting gaps in end-of-life care and acute management of care, respectively.

CMIT 1357: CMS Death Rate among Surgical Inpatients with Serious Treatable Complications

Ms. Elliott provided a brief overview of the Hospital IQR Program, which includes CMIT 1357 and CMIT 902. Lead Discussants supporting removal felt this measure had lost endorsement and was possibly a duplicate with existing electronic clinical quality measures (eCQMs) and additionally reiterated concerns for burden that could result from a high number of condition-specific mortality measures.

Committee members asked for clarification on whether this measure had been considered for removal in rulemaking and why its endorsement status had been removed. CMS representatives stated the measure had been proposed for removal, but was continued after review of public comments. Developers of the measure noted that endorsement was removed when the measure steward was unable to continue supporting the measure through the endorsement process and withdrew as steward.

Committee members noted that the Hospital IQR Program includes a high number of measures and continues to receive additions, in contrast to programs previously discussed such as ASCQR, and cautioned again about the level of burden created as a result.

CMIT 902: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke

Lead Discussants reiterated prior comments regarding endorsement status and a preference for a properly risk-adjusted overall mortality measure that would not be disease-specific.

Committee members and CMS representatives discussed competing measures that would allow for more granular data evaluation and improved risk adjustment if implemented as replacements. Currently, alternatives do not have NQF endorsement and are not implemented. However, some Committee members questioned if a forthcoming composite measure was sufficient reason to remove a current measure if no actual performance concerns were raised. CMS clarified that the measure still results in variation, and as part of the Hospital IQR Program, no penalties are associated with performance.

Strategic Discussion of Condition-Specific Mortality Measures Versus Hospital-Wide Mortality Measurement

Committee members felt that their feedback on this discussion point had been adequately covered during discussions of each measure, and did not have any comments to add.

Opportunity for Public Comment on the Mortality Measures and Polling

No public comments were made on the measure. One additional comment from a Committee member reemphasized the importance of measure CMIT 1357 to consumers.

Polling Results

CMIT 89: Yes 9, No 8, 53% in favor of removal.

CMIT 86: Yes 6, No 11, 35% in favor of removal.

CMIT 1357: Yes 3, No 16, 16% in favor of removal.

CMIT 902: Yes 8, No 11, 42% in favor of removal.

Hospital IQR Program Measures

Ms. Elliott provided an overview of the Hospital IQR Program and the measures in this group. Ms. Elliott noted that measure CMIT 5756 was recently finalized for removal from the program in fiscal year 2022.

CMIT 1017: Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

A Lead Discussant referenced an editorial written about the removal by the Infectious Diseases Society of America (IDSA) and other professional associations with rational that this measure would be the driver for the overuse of antibiotics. The discussant also noted there was an accompanying editorial criticizing the IDSA and are other articles about the claims-based denominator. The discussant noted the prediction of who has serious sepsis or sepsis shock is bad and the reliability of the denominator is bad. This discussant indicated there is data on good guidelines on how to manage sepsis and sepsis shock, but no one has really looked at the outcomes on clearly a high mortality event. The discussant noted whether this measure is accomplishing that goal is unclear, but acknowledged the purpose of this program is public reporting. Another Lead Discussant noted so much about sepsis is that it should be treated early. Other comments from the Committee questioned the outcomes of this measure and whether there is a collection issue at the hospital level. CMS measure maintenance responded to the comment regarding the denominator reliability. The denominator is not defined solely by coding; coding casts the initial net, but patients who meet the criteria are defined.

CMS representative thanked the Committee members for their comments. There have been concerns with burden since this is a chart-based measure and noted CMS considers all input to evaluate measures within programs. CMS representatives indicated there is overwhelming evidence behind the measure and there was robust public dialogue during this year's NQF reindorsement. CMS representatives referenced a recently published journal article, which indicated compliance with the measure produced an outcome of a 5.7% mortality reduction for Medicare beneficiaries. Per the 1.7 million sepsis cases a year, this is 15,000 lives saved. CMS is aware of the concerns of overuse and there has been talk about creating a balancing metric to evaluate. Committee members agreed with the statements about the evidence and public robust discussion.

CMIT 5756: Exclusive Breast Milk Feeding (eCQM)

Ms. Elliott provided a brief overview of the measure and noted this measure has been finalized for removal. A Lead Discussant emphasized amazement that the measure was slated for removal. The discussant indicated the data on breastfeeding is overwhelming and noted this measure has kept endorsement with NQF. CMS representatives indicated there was low reporting by hospitals and that was a big part of the decision. CMS also noted some instances where mothers were feeling undue pressure.

Opportunity for Public Comment on the Hospital IQR Measures and Polling

Comments were offered on CMIT 1017 by representatives for a sepsis advocacy organization to shine light on the important role of the measure in decreasing time to diagnosis of sepsis, due to its focus on screening and reporting. The comments stated that one in three inpatient deaths will result from sepsis, and that mortality can increase as much as eight percent for every hour that treatment is delayed. Commenters shared personal stories of how sepsis had personally impacted their lives and families, and emphasized that measures and protocols requiring close monitoring for sepsis, such as CMIT 1017, can be lifesaving for patients. Commenters acknowledged that the measure was imperfect and could be improved, but encouraged Committee members to support its continuation as a critical opportunity to prevent mortality. Measure stewards confirmed that risk stratification has allowed for almost a 20% mortality reduction through early screening for sepsis.

No further public comments were offered. Representatives from CMS added final comments on CMIT 5756 to emphasize that although the measure had been finalized for removal, CMS has ongoing work in maternal health and continues to consider this a priority area. Committee members shared final comments on CMIT 1017, noting the need for earlier identification and diagnosis of sepsis and the impact of the measure on this identification.

Polling Results

CMIT 1017: Yes 1, No 15, 6% in favor of removal.

CMIT 5756: Yes 8, No 7, 53% in favor of removal.

Coordinating Committee Discussion – Feedback on the MSR Process and Measure Review Criteria

Ms. Roberts introduced the Coordinating Committee discussion, seeking feedback from all Committee members on the pilot process. Committee members broadly thanked CMS and NQF for the opportunity to partake in these discussions and for the level of effort put into supporting the information requests from the Committee. Committee members responded positively to the use of Lead Discussants and the grouping of measures by both programs and topic areas, and thanked NQF for flexibility in making live adjustments to processes.

Committee members identified several opportunities for improvement of the MSR process:

- Background information
    - More data is needed in advance of measure selection and review, including trends, performance data, gaps and variation across subpopulations, endorsement status and rationales, and any recent literature discussing the measures.
    - More information should be provided on the context of the programs housing the measures, including other measures in the program to identify gaps or possibilities for gaps pending measure removal.
    - Information on similar measures in the development or implementation pipeline could help Committee members understand the impact of removing or continuing measures.
- Measure Review Criteria
    - Criteria should be added to evaluate measures as part of the overall set of measures in a program and to explicitly address gaps.
    - Criteria should be added to determine if the measure differentiates between excellence and adequacy of performance.

    - Criterion #8 should be split to create criteria explicitly assessing how the measure diminishes inequities or promotes equity.
    - Criterion #8 could also be used to ask about positive unintended consequences.
    - NQF should look at how much criteria were used during discussions as part of considerations for future iterations.
- Voting
    - MSR voting should include gradations of support, possibly in a similar matrix to MAP Pre-Rulemaking voting.
    - Possible gradations may include support for removal contingent upon the availability of replacement measures, timing of removal (i.e., 'okay to wait'), and continuation of the measure with recommended changes, among others.
    - Voting abstention should be allowed, but Committee members debated its inclusion as a voting category vs. a notification process.
- Representation
    - Committee members encouraged increased representation of consumer (patient, family, and caregiver or advocate) voices.
    - Committee members encouraged continued or increased representation of nurses and social workers.
    - Committee members strongly appreciated the voices of impacted patients and families during public comment and would appreciate the continuation or expansion of these voices.

Committee members repeatedly emphasized the need to approach MSR processes holistically and to examine the role and fit of measures within a program. Committee members identified MSR as an opportunity to step back from individual measure scrutiny to broadly look at the role of quality measurement and programs in achieving desired health outcomes.

During discussions of increased representation of consumer voices, Committee members called for increased simplification of the technical information provided in advance of meetings and measure selection in order to allow for greater participation by consumers. Committee members suggested possible solutions such as consumer-focused orientations to increase understanding of quality measurement, and provision of plain-language materials.

Structurally, Committee members suggested that in future iterations, NQF should provide MAP members more time to select and review measures and that it may be useful to build out specific agenda time to discuss federal programs rather than solely individual measures, as this seemed to be an important topic for Committee members.

Final Opportunity for Public Comment

Ms. Roberts opened the discussion for public comment on the pilot MSR process and the MRC. No public comments were made.

Dr. Schreiber offered final comments in response to Committee members' discussion. She emphasized that the feedback provided during the MSR pilot was productive and meaningful to CMS and that clear messages were sent regarding the need to further review the IPFQR measure set and the structure of the HRRP, but reiterated that the latter would require legislative action. Dr. Schreiber noted that one additional criterion for consideration in future years could be whether quality measures are being advanced broadly, including moving to outcome measures, digital measures, or patient-reported measures. Dr. Schreiber thanked all parties for their participation and noted that the process had

required large efforts from many stakeholders. Future iterations of the MSR process may need to be thoughtful about the number of measures reviewed each cycle to allow for bandwidth limitations by participants.

Closing Remarks

Mr. Kahn thanked all parties for their participation and support of the pilot MSR process and echoed Dr. Schreiber's comments on the workload and bandwidth evaluations needed to conduct this work. Mr. Kahn supported the idea of spacing out the review of current programs to ensure the review is manageable for all stakeholders. Ms. Roberts echoed thanks to NQF, CMS and Committee members, and appreciated the patience shown by Committee members during the pilot process and the robust feedback provided. Ms. Roberts felt the pilot was a strong success and expressed optimism for future conversations.

Next Steps

Ms. Elliott highlighted the remaining timeline for the MSR process, noting that Coordinating Committee members would have a final opportunity to provide input on the MSR pilot during the Coordinating Committee Strategic Meeting on September 15, 2021. This meeting will also serve as the kickoff for MAP Pre-Rulemaking activities. Final recommendations from the MSR pilot will be published by October 1, 2021. Ms. Elliott encouraged Committee members and the public to share any additional thoughts on the MSR pilot by contacting MAPCoordinatingCommittee@qualityforum.org.