NATIONAL QUALITY FORUM
Driving measurable health improvements together

Summary

Measure Applications Partnership (MAP) Coordinating Committee Strategic Meeting

The National Quality Forum (NQF) convened a public virtual meeting on behalf of the Centers for Medicare & Medicaid Services (CMS) for the Measure Applications Partnership (MAP) Coordinating Committee Strategic Meeting on September 15, 2021.

Welcome, Introductions, Disclosures of Interest and Overview of Agenda

Tricia Elliott, Senior Managing Director, NQF, welcomed participants to the virtual meeting, reviewed housekeeping notes, and provided an agenda overview.

MAP Coordinating Committee co-chairs Chip Kahn and Misty Roberts welcomed the Coordinating Committee back and expressed gratitude for the Committee's ongoing efforts and participation in the MAP processes following the Measure Set Review (MSR) pilot meetings during the week prior. Co-chairs noted that the opportunity to meet with higher frequency was a benefit to keep members engaged and focused. Co-chairs introduced the following meeting objectives:

1. Reflect on accomplishments of the prior MAP cycle and identify opportunities for improvement
2. Review the scope of work and timeline for the 2021-2022 MAP cycle.

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director for Quality and Value, CMS greeted the Coordinating Committee and thanked everyone for the productive feedback during the MSR meetings. Dr. Schreiber additionally thanked co-chairs, NQF and CMS staff for their hard work in preparing for the events and stated that she looked forward to the recommendations of the 2021-2022 MAP Pre-Rulemaking Cycle.

MAP Implementation Results

Ms. Elliott introduced final rulemaking results for measures under consideration evaluated by the MAP during the 2017-2018, 2018-2019 and 2019-2020 MAP cycles. Ms. Elliott provided additional details on the 2019-2020 results, which were shared with Committee members for the first time. Ms. Elliott noted that in 2019-2020, the MAP supported five measures for rulemaking, one of which was finalized into rulemaking. Eleven measures received "Conditional Support" from the MAP, two of which were finalized into rulemaking. The decision categories of "Do Not Support with Potential for Mitigation" and "Do Not Support" received one measure each and neither were finalized into rulemaking. Ms. Elliott noted that NQF staff sent Committee members a detailed spreadsheet containing information on the rulemaking results for each measure in the 2019-2020 cycle as well as information about NQF endorsement status.

Committee members thanked NQF staff for providing a feedback loop of information about measures evaluated by the MAP and asked clarification questions on the tables provided. One Committee member noted that adoption of MAP recommendations seemed low in the categories of "Support for Rulemaking" and "Conditional Support for Rulemaking," and queried if there were ways in which the MAP could provide better assistance to CMS. Dr. Schreiber reminded Committee members that there

were many considerations and levels of clearance that influence the rulemaking process and narrow the number of measures being finalized into a small group. Dr. Schreiber noted that CMS is very intentional towards quantity of measures proposed for rulemaking to reduce burden on providers, in addition to other steps in the pre-rulemaking process that can eliminate measures from consideration in a given cycle. Dr. Schreiber expressed appreciation for the recommendations provided by the MAP and satisfaction with the current level of alignment between MAP recommendations and rulemaking results, noting that she did not anticipate that alignment would reach levels as high as 75% or above.

Committee members moved into discussion about the conditions stipulated by the MAP for decisions of "Conditional Support for Rulemaking." Dr. Schreiber noted that CMS generally works to accommodate requested changes, excepting the condition of NQF endorsement, which is a unique and self-governed process. Dr. Schreiber noted that many measures may be submitted for NQF endorsement and that improving the rate of success in endorsement is a separate question from that of finalization into rulemaking.

Dr. Schreiber expressed that the iterative process of evaluating measures under consideration, in partnership with the new MSR process, would provide a more balanced and holistic view of measure sets and programs over time.

MAP Voting Principles and Voting Process

Ms. Elliott reviewed the key voting principles and voting procedure of the MAP. Ms. Roberts asked for Committee input or proposed modifications to the existing approach.

A Committee member expressed concern for the credibility of the current quorum and consensus definitions, suggesting a higher percentage that could create a supermajority of 75 to 80% consensus after the establishment of quorum. The Committee member also put forth a suggestion for the MAP to adopt a similar voting process to the Core Quality Measures Collaborative (CQMC). Committee members held robust discussion around this proposal, noting the differences in objectives and structure of the MAP and CQMC. Some comments suggested comfort with the current level of consensus and clarified that the CQMC process involves a similar consensus level of 60%, but with different requirements based on stakeholder groups. Additional comments noted that the statutory charge of the MAP indicates that the comments and guidance provided by the MAP to CMS were more important than specific voting thresholds and suggested that conversation should be focused on how all comments are expressed in recommendations to CMS.

Several Committee members raised concerns that members and the public had not received prior notice to prepare for a vote on consensus level during the day's meeting. Committee members opted to explore support for changing the level of consensus through a post-meeting survey to be sent out by NQF staff, following the process conducted in the 2020-2021 Strategic Meeting after a similar discussion took place.

Dr. Schreiber posed a question to Committee members about their sentiments on occasions when Coordinating Committee members opt to overturn Workgroup decisions on measures under consideration and whether Committee members should have to vote on all measures under consideration each cycle. Co-chairs and Committee members noted that this occurs on occasion and was discussed during the 2020-2021 cycle after several instances of overturned decisions. Committee members felt this was a complex question that merited further data on these occurrences. One Committee member suggested that Workgroup decisions with smaller margins of support could be reviewed by Committee members.

Measure Selection Criteria (MSC)

Ivory Harding, Manager, NQF, provided an overview of the MSC to the Coordinating Committee. Mr. Kahn asked the Committee for any comments or proposed changes to the criteria.

Committee members discussed the inclusion of the word "parsimony" in MSC number seven, "Program measure set promotes parsimony and alignment." Committee members felt that this criterion should more explicitly denote parsimony across programs, not only within measure sets. Dr. Schreiber voiced support for this approach towards cross-cutting alignment. Other Committee members noted an aversion to the word "parsimony," citing that it could be too easily interpreted as an effort to cut corners on accountability in favor of cost savings. Committee members further discussed this viewpoint and noted that while cost-benefit analyses should not be ignored during measure review discussions, alternative language may be preferable to express the desired outcomes. Several Committee members stated a preference for "measure efficiency" through verbal comments and the chat.

Dr. Schreiber proposed two suggested changes to the MSC. Dr. Schreiber noted that MSC number two, "Program measure set adequately addresses national healthcare priorities," could be improved through more intentional language that moved beyond adequacy, noting measures should not be incorporated into rulemaking that do not have significant or meaningful impact for patients and beneficiaries. Committee members agreed with this statement, noting that the concept of "excellence" had become a key discussion point during the MSR meetings. Committee members clarified that "excellence" should result in improved outcomes for patients. Dr. Schreiber also commented on MSC number four, "Program measure set includes an appropriate mix of measure types with an emphasis on outcome, patient reported outcome, and digital measures," clarifying that a mix of measures may not always be necessary. Dr. Schreiber emphasized the transition towards digital measures and patient reported outcomes. However, both Dr. Schreiber and Committee members noted that process measures may still have value or promote safety and should not be automatically excluded from considerations.

Additional Committee comments included a preference for the term "health equity" over "cultural competency" in MSC number six, the inclusion of "Caregivers" in MSC number five, and a suggestion for an evaluation of the relative value of each criterion that could lead to improved presentation of information to support Committee decision making.

Mr. Kahn closed the discussion by noting that NQF staff would aggregate the suggestions from the conversation and would send revised language for review and approval to Committee members.

Preliminary Analysis Algorithm and MAP Decision Categories

Udara Perera, Senior Manager, NQF, reviewed the Preliminary Analysis (PA) Algorithm and Decision Categories for MAP. Ms. Perera opened the floor for any immediate questions or comments by the Committee.

One Committee member noted that the MAP's statutory charge is to provide advice and recommendations on whether measures are appropriate for rulemaking, yet the Preliminary Analysis Algorithm contains no language to explicitly determine whether a measure is appropriate for the proposed program's rulemaking. Other Committee members concurred with this comment and suggested that the language "fit for purpose" (or similar) be incorporated into Algorithm assessment number six.

Ms. Roberts opened the floor to discussion on the PA Algorithm and Decision Categories, and reviewed minor changes previously implemented to the PA Algorithm after the 2020-2021 Coordinating

Committee Strategic Meeting. These changes included removing references to "families of measures," and clarifying the difference between references to "performance gap"' and "variation" in Algorithm assessment number three. Following that meeting, suggested language edits were "The measure addresses a serious reportable event (i.e., a safety event that should never happen) or the measure addresses an unwarranted or significant performance gap (i.e., variation in care) that is evidence of a quality challenge". Ms. Roberts asked the Committee if these changes were acceptable for the 2021-2022 cycle.

Coordinating Committee members expressed concern verbally and through the chat that "gap" and "variation" were inappropriately being portrayed as the same concept, noting measures may have low performance but no variation, which is a separate quality problem than unwarranted variation. Ms. Elliott noted that this issue was previously raised due to the interchangeable use of the language in the MAP Member Guidebook and suggested edits to include "or" in the language, rather than using "variation" as an example, to define the assessment criteria more appropriately. Committee members agreed with this suggestion and further noted that the concept of "variation" may not be suitable for all programs. Comments suggested that "variation" may not be an appropriate category for rejecting a measure, depending on the specific program and purpose.

An additional Coordinating Committee comment noted digital measures often include language around "parent" and "child" measures, but felt that the removal of "families of measures" from the PA Algorithm dealt with a separate issue and was an appropriate modification.

MAP Measure Set Review (MSR) Pilot Debrief

Due to time restrictions, co-chairs and Committee members chose not to pursue additional comments on the MSR pilot, noting that robust discussion had been provided during the prior meetings. However, relevant comments were made at the start of the Strategic Meeting in appreciation of the patients who had provided vital public comment on MSR measures and Committee members noted it would be valuable to have similar input during future meetings.

Opportunity for Public Comment

Mr. Kahn opened discussion for public comment on any items from the day's meeting. No comments were received. Both co-chairs thanked all participants for the robust discussion.

Next Steps

Susanne Young, Manager, NQF, reviewed upcoming timelines and activities for the MAP. MSR activities will culminate with the publication of a final report and recommendations spreadsheet by October 1, 2021. MAP Pre-Rulemaking activities will continue next with an All-MAP Orientation on October 5, 2021, followed by individual orientations for MAP Advisory Groups in late October and setting-specific Workgroups in early November. The list of measures under consideration will be released on or before December 1, 2021, and will be followed by a public commenting period. MAP Advisory Groups and Workgroups will hold virtual review meetings in December, followed by the MAP Coordinating Committee Review Meeting in January 2022. A final report and recommendations will be submitted to the U.S. Department of Health and Human Services by February 1, 2022. Ms. Young also noted that Coordinating Committee members could access additional relevant information through the CMS 2021 Program-Specific Measure Needs and Priorities document (PDF) and Pre-Rulemaking Overview webpage. All MAP members will additionally receive a copy of the NQF MAP Member Guidebook via email in the coming weeks.