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Welcome to Today's Meeting!

- Housekeeping reminders:
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - Please raise your hand and unmute yourself when called on
  - Please lower your hand and mute yourself following your question/comment
  - Please state your first and last name if you are a Call-In-User
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPHospital@qualityforum.org

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Meeting Ground Rules

- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure review criteria and guidance
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

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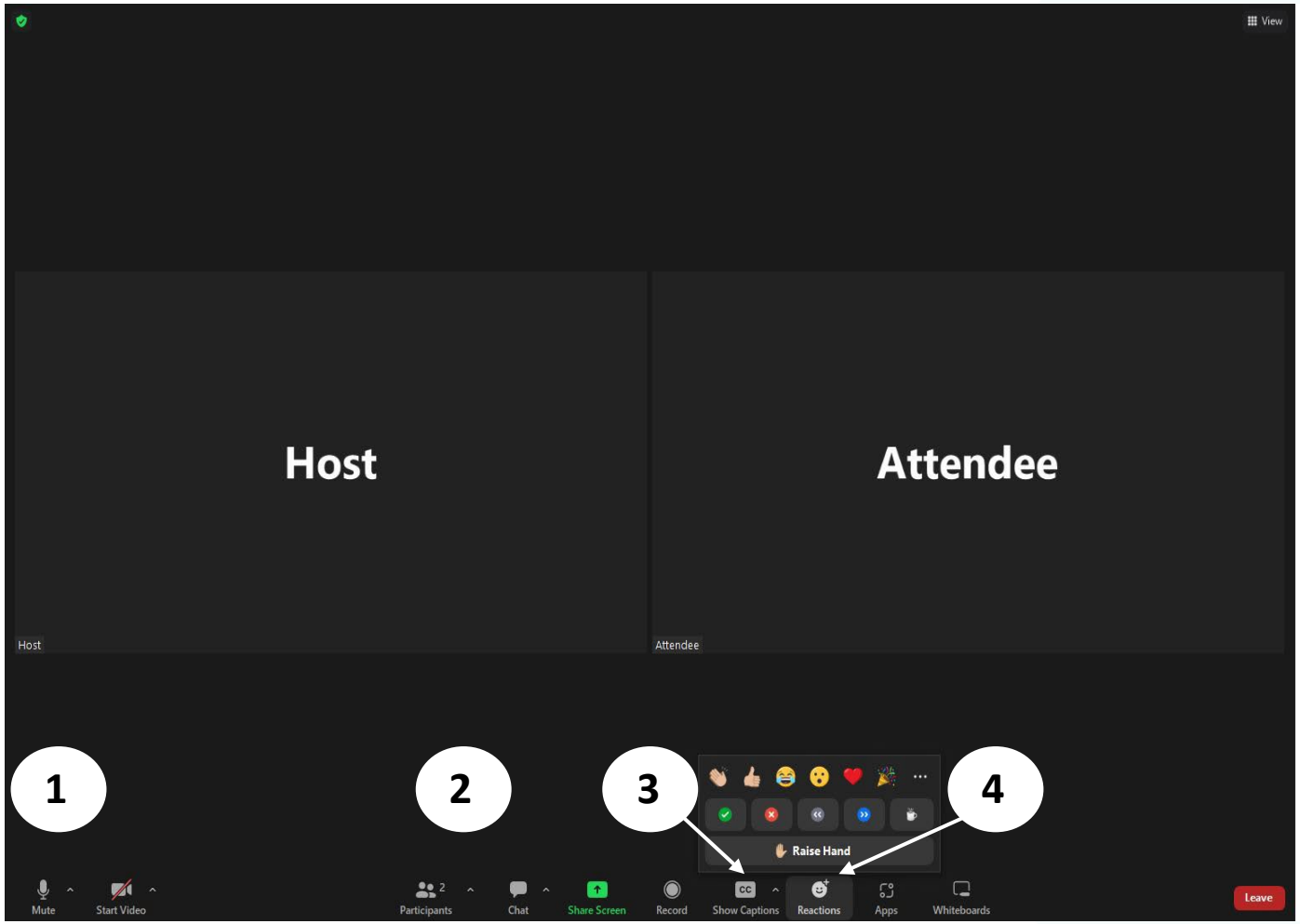
Using the Zoom Platform



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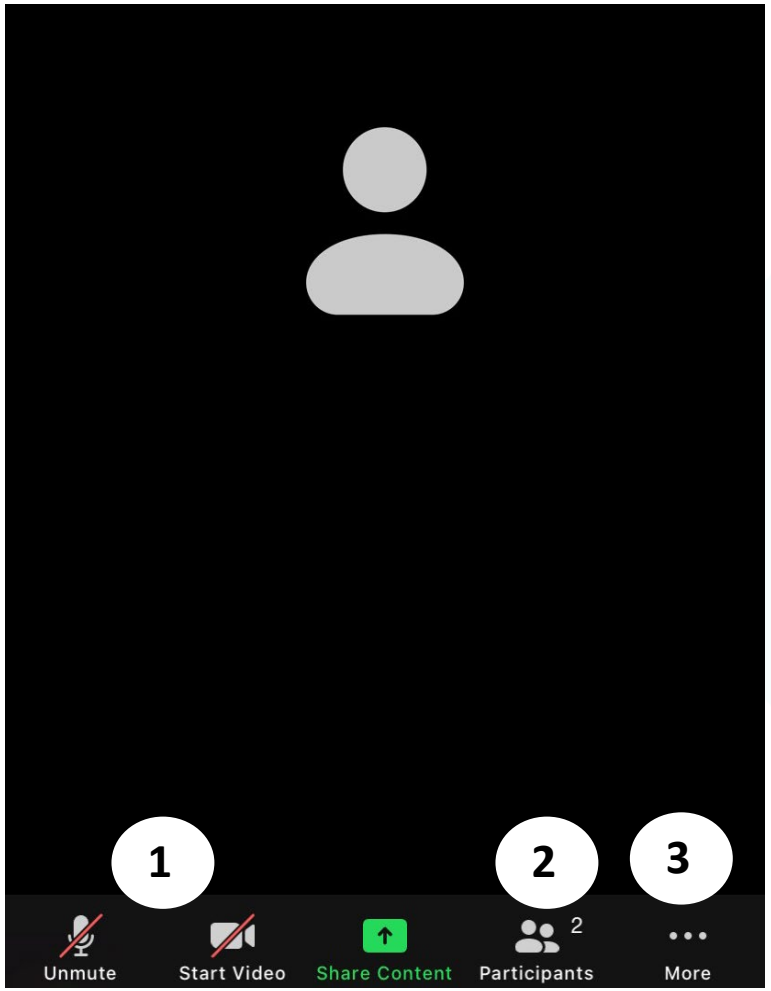
Using the Zoom Platform (Phone View)



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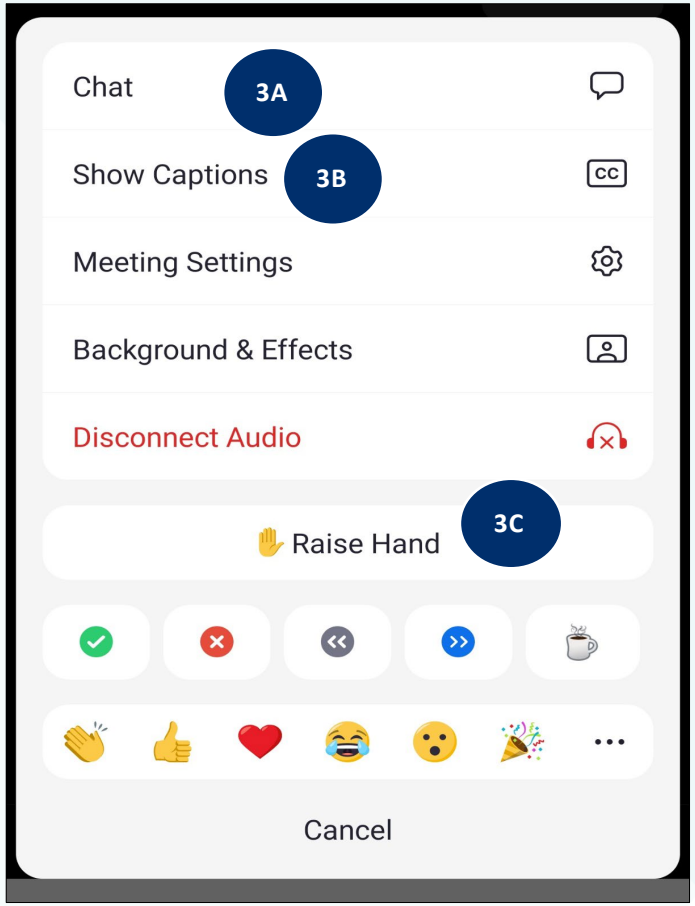

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https://www.qualityforum.org

Measure Applications Partnership (MAP)

Hospital Workgroup 2022-2023 Measures Under Consideration (MUC) Review Web Meeting – Day One

December 13, 2022

Funding provided by the Centers for Medicare & Medicaid Services, Task Order HHSM-500-T0003, Option Year 4

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Agenda – Day One

- Welcome, Introductions, Disclosures of Interest, and Review of Meeting Objectives
- Centers for Medicare & Medicaid Services (CMS) Opening Remarks
- Overview of MAP Hospital Workgroup and CMS Programs
- Overview of Decision Categories and Voting Process
- Review New Patient Experience/Goals Measures
- Break
- Review Sepsis and Septic Shock Measure
- Review New Cross-Cutting Measures

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Agenda – Day One (continued)

- Break
- Review New Cross-Cutting Measures (Continued)
- Review Volume Data Measures
- Break
- Review Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures
- Review Cross-Cutting COVID-19 Measure
- Preview of Day Two
- Adjourn

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

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Opening Remarks

Dana Gelb Safran, ScD

President and CEO, National Quality Forum (NQF)

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Welcoming Remarks from Workgroup Co-Chairs

Akin Demehin, MPH
American Hospital Association

R. Sean Morrison, MD
National Coalition for Hospice and Palliative Care – *not present*

Martin Hatlie, JD
Project Patient Care – *acting co-chair*

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Disclosures of Interest

- State your name, title, organization, brief bio, and acknowledge the disclosure(s) you listed in your DOI form if applicable
- Briefly note any of the following disclosures *relevant to the project*:
  - Engagement with project sponsors *(Centers for Medicare & Medicaid Services)*
  - Research funding, consulting/speaking fees, honoraria
  - Ownership interest
  - Relationships, activities, affiliations, or roles

Example: I'm Joan Smith, Chief Medical Officer of ABC Healthcare. I am also a Principal Investigator for a research project examining health disparities and health outcomes funded by XYZ Organization.

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Hospital Workgroup Membership

Workgroup Co-Chairs: Akin Demehin, MPH; Acting Co-Chair: Martin Hatlie, JD

Organizational Members (Voting)

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- Cigna Healthcare
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association (Inactive)
- Kidney Care Partners
- Medtronic
- Mothers Against Medical Error
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey Associates
- Project Patient Care
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

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Hospital Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Richard Gelb, MA
- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB
- Jennifer Wills, RD, MPPA

Federal Government Liaisons (Non-Voting)

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Veterans Health Administration (VHA)

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National Quality Forum MAP Team

- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Vice President
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
- **Ashlan Ruth, BS IE,** Project Manager
- **Susanne Young, MPH,** Senior Manager
- **Gus Zimmerman, MPP,** Analyst
- **Joelencia LeFlore,** Analyst
- **Magdelana Stinnett,** Analyst
- **Madeline Henry,** Associate
- **Bobby Burchard,** Associate

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CMS Staff

- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), CCSQ, CMS

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Meeting Objectives

1. Review the MAP Hospital Workgroup programs
2. Review the MAP decision categories and voting process
3. Review and provide input on the measures under consideration (MUCs) for the MAP hospital programs

CMS Opening Remarks

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Opening Remarks

Michelle Schreiber, MD

Deputy Director of the Center 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)

Welcome

A sincere **Thank You** for your participation.

Your goal today is to provide consensus recommendations to CMS regarding whether or not the measures presented should be used in various Value Based Quality Programs.

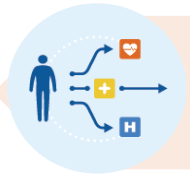
Measures in these programs help shape health system actions, support accountability and transparency, and are useful to patients/consumers.

Your recommendations are strongly considered in CMS deliberations about changes (measures removed/measures added) to these VBP programs.

While the final decision lies with CMS, your feedback is valuable and helps to represent those who will be impacted.

CMS National Quality Strategy Goals

Ensure best, safest, most effective care for all individuals



Improve quality & health outcomes across the care journey

Advance health equity & whole-person care

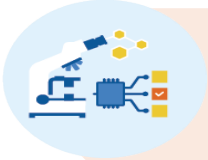
Target zero preventable harm

Engage individuals and communities as partners in their care

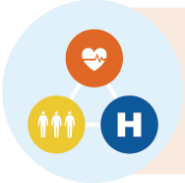
Enable a responsive, equitable, and resilient healthcare system

Enable a responsive and resilient healthcare system to improve quality

Accelerate and support the digital transition of health care



Promote innovation in science, analytics & technology



Align and coordinate quality across programs and care settings

National Quality Strategy Targets

Improve quality & health outcomes across the care journey	•Implement a universal set of impactful adult & pediatric measures across all CMS quality programs & across the care journey by 2026, benchmarked globally & stratified.
Advance health equity & whole-person care	•Implement a measurable equity component in every CMS quality program that encourages high quality care for underserved populations, beginning in 2022 with full implementation to follow in subsequent years.
Target zero preventable harm	•Improve safety metrics with a goal to return to pre-pandemic levels by 2025 & reducing harm by an additional 50% by 2030 through expanded safety metrics, targeted quality improvement & Conditions of Participation.
Engage individuals and communities as partners in their care	•Ensure individuals have a direct, significant & equitable contribution to how we evaluate quality & safety, and have the information needed to make the best health choices, with 25% of quality metrics being patient reported.
Accelerate and support the digital transition of health care	•Transition to all digital quality measures & achieve all-payer quality data collection by 2030 to reduce burden & make quality data rapidly available.
Enable a responsive and resilient healthcare system to improve quality	•Ensure support for healthcare workforce and systems and address workforce issues to reduce burnout and shortages to safeguard vital healthcare needs.
Promote innovation in science, analytics & technology	•Accelerate innovation in care delivery & incorporate technology enhancements to transform quality of care & advance value
Align and coordinate quality across programs and care settings	•Promote standardized approaches to quality metrics, quality improvement initiatives, and VBP (and other) programs through use of universal measures set and aligned quality policies

Strategic Priority Areas: Alignment for Measures and Program

CLINICAL	CROSS-CUTTING
Maternal Health	Equity
“Age Friendly” (Older Adult/Geriatrics)	Safety
Behavioral/Mental Health	Resilience
Diabetes	Interoperability/Digital Transformation
Cardiovascular, including Hypertension	Person Centered/CLAS
Kidney Care and Organ Transplantation	Alignment
Sickle Cell Disease	*
Wellness and Prevention	*
HIV and Hepatitis C	*
Cancer	*
Oral Health	*

* Indicates cell left intentionally blank

Considerations for Future Measure Priorities

As we continue filling priority gap areas in the CMS portfolio, measures should:

- Reflect areas of high impact where performance could lead to improvements of care for all individuals – especially in clinical priority or gap areas.
- Have no unintended consequences for rural communities/providers and no adverse impact on health equity
- Promote health equity by providing data which highlight areas of disparities or are suitable for stratification
- Be digitally specified (or “computable”), based on standardized data elements in USCDI
- Embody what is important to patients, including care aligned with goals and patient reported outcomes
- Promote safety

Alignment of Measures

Alignment is a key goal of the National Quality Strategy and Meaningful Measures Initiative. Wherever possible CMS aligns

- Within and across CMS programs
- Within and across other Federal programs
- Within and across other payers (Core Quality Measures Collaborative; Multi-payer Alignment workgroup of LAN)

Aligning measures will support a:

- Reduction of Burden
- Focus of provider attention on key clinical outcomes and metrics

Happy holidays!

MAP Hospital Workgroup Charge and CMS Programs

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MAP Hospital Workgroup Charge

- To provide recommendations on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals

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MAP Hospital Workgroup Programs

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (Hospital IQR)
- Hospital Outpatient Quality Reporting Program (Hospital OQR)
- Hospital Value-Based Purchasing Program (HVBP)
- Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) (Medicare Promoting Interoperability Program)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)
- Rural Emergency Hospital Quality Reporting Program (REHQRP)

  (New in 2023)

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Ambulatory Surgical Center Quality Reporting Program (ASCQR)

- **Program Type:** Quality Payment Program & Public Reporting
- **Incentive Structure:** Ambulatory Surgical Centers (ASCs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the ASC Fee Schedule (ASCFS) for not meeting program requirements
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about ASC quality so they can make informed choices about their care.

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End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions will be on a sliding scale, which could amount to a maximum of 2.0% per year.
- **Program Goals:** Improve the quality of dialysis care and produce better outcomes for beneficiaries

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Hospital-Acquired Condition Reduction Program (HACRP)

- **Program Type:** Pay for Performance and Public Reporting
- **Incentive Structure:** The worst performing 25% of hospitals in the program (as determined by the measures in the program) will have their Medicare payments reduced by 1.0%.
- **Program Goals:** Encourage hospitals to reduce HACs through penalties, and link Medicare payments to healthcare quality in the inpatient hospital setting.

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Hospital Inpatient Quality Reporting Program (Hospital IQR)

- **Program Type:** Pay-for-Reporting and Public Reporting
- **Incentive Structure:** Hospitals that do not participate, or participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about hospital quality so they can make informed choices about their care

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Hospital Outpatient Quality Reporting Program (Hospital OQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Hospitals outpatient departments (HOPDs) that do not participate, or participate but fail to meet program requirements, receive a two-percentage point (2%) reduction of their annual payment update (APU) under the OPPS for not meeting program requirements
- **Program Goals:** Progress towards paying providers based on the quality, rather than the quantity of care they give patients, and to provide consumers information about HOPD quality so they can make informed choices about their care.

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Hospital Value-Based Purchasing Program (HVBP)

- **Program Type:** Pay for Performance
- **Incentive Structure:** The amount equal to 2.0% of base operating DRG is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments
- **Program Goals:** Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

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Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0% reduction in annual payment update
- **Program Goals:** Provide consumers with quality-of-care information to make more informed decisions about healthcare options, and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices

Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) (Medicare Promoting Interoperability Program)

- **Program Type:** Pay for Reporting and Public Reporting
- **Incentive Structure:** Eligible hospitals that fail to meet program requirements, including meeting the Clinical Quality Measure requirements, receive a three-fourth reduction of the applicable percentage increase.
- **Program Goals:** Promote interoperability using Certified Electronic Health Record Technology (CEHRT), to improve patient and provider access to patient data.

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

- **Program Type:** Quality Reporting
- **Incentive Structure:** PCHQR is a voluntary reporting program. Data are reporting on Provider Data Catalog (PDC)
- **Program Goals:** Provide information about the quality of care in cancer hospitals, in particular the 11 cancer hospitals that are exempt from the Inpatient Prospective Payment System and the Inpatient Quality Reporting Program and encourage hospitals and clinicians to improve the quality of their care, to share information, and to learn from each other's experiences and best practices.

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Rural Emergency Hospital Quality Reporting Program (REHQRP)

- **Program Type:** Quality Reporting
- **Incentive Structure:** Provider reporting and public display of data required per statute
- **Program Goals:** Public reporting of quality data for consumer use and to inform quality improvement efforts

MAP Hospital Workgroup Questions?

MAP Decision Categories

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2022-2023 MUC Decision Categories

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

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2022-2023 MUC Decision Categories Descriptions

Decision Category	Definition	Evaluation Criteria
Support for Rulemaking	MAP supports implementation the measure as specified and has not identified any conditions that should be met prior to implementation.	The measure is fully developed and tested in the setting where it will be applied and meets assessments 1-6 of the MAP Preliminary Analysis Algorithm. If the measure is in current use, it also meets assessment 7.
Conditional Support for Rulemaking	MAP supports implementation of the measure as specified but has identified certain conditions or modifications that would ideally be addressed prior to implementation.	The measure meets assessments 1-3, but may need modifications. A designation of this decision category assumes at least one assessment 4-7 is not met. MAP will provide a rationale that outlines each suggested condition (e.g., measure requires NQF review or endorsement OR there are opportunities for improvement under evaluation). Ideally, the modifications suggested by MAP would be made before the measure is proposed for use. However, the Secretary retains policy discretion to propose the measure. CMS may address the MAP-specified refinements without resubmitting the measure to MAP prior to rulemaking.

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2022-2023 MUC Decision Categories Descriptions (continued)

Decision Category	Definition	Evaluation Criteria
Do Not Support for Rulemaking with Potential for Mitigation	MAP does not support implementation of the measure as specified. However, MAP agrees with the importance of the measure concept and has suggested modifications required for potential support in the future. Such a modification would be considered a material change to the measure. A material change is defined as any modification to the measure specifications that significantly affects the measure result.	The measure meets assessments 1-3 but cannot be supported as currently specified. A designation of this decision category assumes at least one assessment 4-7 is not met.
Do Not Support for Rulemaking	MAP does not support the measure.	The measure under consideration does not meet one or more of assessments 1-3.

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MAP MUC Decision Categories

- MAP Workgroups must reach a decision about every measure under consideration
- Decision categories are standardized for consistency
- Each decision should be accompanied by one or more statements of rationale that explains why each decision was reached

Review of Voting Process

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Key Voting Principles

- **Quorum** is defined as **66 percent** of the voting members of the Workgroup and Committee present virtually for live voting to take place.
  - Quorum must be established prior to voting. The process to establish quorum is constituted of (1) taking roll call and (2) determining if a quorum is present. At this time, only if a member of the Committee questions the presence of a quorum is it necessary to reassess the presence of the quorum.
- If quorum is not established during the meeting, MAP will vote via electronic ballot after the meeting.
- MAP has established a **consensus** threshold of greater than or equal to 60 percent of voting participants voting positively AND a minimum of 60 percent of the quorum figure voting positively.
  - Abstentions do not count in the denominator.
- Every measure under consideration will receive a decision.

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Key Voting Principles (continued)

- Staff will provide an overview of the process for establishing consensus through voting at the start of each in-person meeting.
- After additional introductory presentations from staff and the co-chairs to give context to each programmatic discussion, voting will begin.
- The Review Meeting agenda will organize content as follows:
  - Measures under consideration will be divided into a series of related groups for the purposes of discussion and voting.
- Each measure under consideration will have been subject to a preliminary staff analysis based on a decision algorithm approved by the Coordinating Committee.
  - MAP participants will receive a copy of the detailed preliminary analysis and staff decisions (i.e., support, do not support, or conditional support) and rationale to support how that conclusion was reached.

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Voting Procedure

- **Step 1.** NQF staff will review the preliminary analysis for each measure under consideration (MUC) using the MAP selection criteria.
  - NQF staff will summarize Advisory Group discussions, public comment, and programmatic objectives.
- **Step 2.** A CMS representative will present a brief overview and/or contextual background on the MUC.
- **Step 3.** Lead discussants will review and present their findings.
  - Lead discussants will state their own point of view, whether or not it is in agreement with the preliminary recommendation or the divergent opinion.

Voting Procedure (continued)

- **Step 4.** The co-chairs will then open for discussion among the Workgroup.
  - Workgroup members should participate in the discussion to make their opinions known. However, one should refrain from repeating points already presented by others in the interest of time.
  - Measure developers will respond to the clarifying questions on the specifications of the measure.
  - NQF staff will respond to clarifying questions on the preliminary analysis.
- **Step 5.** The Workgroup will vote on acceptance of the preliminary analysis decision.
  - After discussion ends, the co-chairs will open for a vote on accepting the preliminary analysis assessment. This vote will be framed as a "yes" or "no" vote to accept the result.
  - If greater than or equal to 60% of the Workgroup members vote to accept the preliminary analysis assessment, then the preliminary analysis assessment will become the Workgroup recommendation.
  - If less than 60% of the Workgroup votes to accept the preliminary analysis assessment, discussion will continue on the measure.

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Voting Procedure (continued 2)

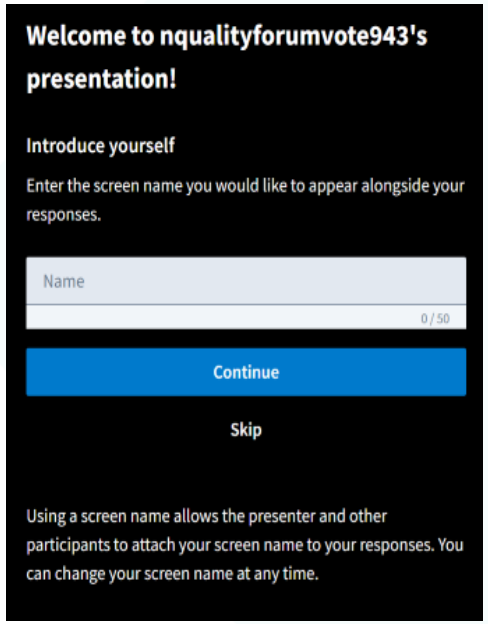
- **Step 6:** Discussion and voting on the MUC will take place if less than 60% accept the preliminary analysis assessment.
  - After discussion ends, the co-chairs will open the MUC for a vote.
  - The co-chairs will determine what decision category will be put to a vote first based on potential consensus emerging from the discussions.
  - If the co-chairs do not feel there is a consensus position to use to begin voting, the Workgroup will take a vote on each potential decision category one at a time. The first vote will be on support, then conditional support, then do not support with potential for mitigation, then do not support.
- **Step 7:** NQF staff will tally the votes.
  - If a decision category put forward by the co-chairs receives greater than or equal to 60% of the votes, the motion will pass, and the measure will receive that decision.
  - If no decision category achieves greater than 60% to overturn the preliminary analysis, the preliminary analysis decision will stand. This will be marked by staff and noted for the Coordinating Committee's consideration.

Decision Category or Voting Questions?

Voting Test

Voting Via Desktop or Laptop Computer (Poll Everywhere)

- Click on the voting link that was emailed to you. You will see a wait message until voting begins.
- When voting opens, you will see the screen below. Enter your first and last name, then click "Continue" to access voting from the options that will appear on the screen.



- Please alert an NQF staff member if you are having difficulty with our electronic voting system.

Measures Under Consideration (MUCs) for the MAP Hospital Programs

New Patient Experience/Goals Measures

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Public Comment for New Patient Experience/Goals Measures

- **MUC2022-078:** Psychiatric Inpatient Experience Measurement *(IPFQR)*
- **MUC2022-120:** Documentation of Goals of Care Discussions Among Cancer Patients *(PCHQRP)*

MUC2022-078: Psychiatric Inpatient Experience Measurement

- **Description:** The measure is a 23-item five-point Likert scale (i.e., "strongly agree, agree, neutral, disagree, strongly disagree" as well as a "does not apply" option) survey to assess the experience of patients who have received inpatient psychiatric services. The survey measures four key domains of patient experience for inpatient psychiatric care settings, including Relationship with the Treatment Team, Nursing Presence, Treatment Effectiveness, and the Healing Environment.
- **Level of Analysis:** Facility; Other: Hospital Units
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** IPFQR
- **NQF Recommendation:** Do Not Support for Rulemaking

MUC2022-120: Documentation of Goals of Care Discussions Among Cancer Patients

- **Description:** Measuring documentation of goals of care discussions is a critical step toward achieving the outcome of goal concordant care. Oncologists are responsible for ensuring documentation of these discussions. Documentation of goals in structured fields prompts discussions, enhances their quality and efficiency, and promotes accessibility. This measure assesses goals of care discussion documentation among patients with cancer who die while receiving care at the reporting hospital. In this process measure, reported annually, hospitals will report the percent of cancer patients who died during the reporting period and had the patient's goals of care documented prior to death.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** PCHQRP
- **NQF Recommendation:** Conditional Support for Rulemaking

Break: Meeting Day One

Sepsis and Septic Shock Measure

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Public Comment for Sepsis and Septic Shock Measure

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

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MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle

- **Description:** This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. As reflected in the data elements and their definitions, the first three interventions should occur within three hours of presentation of severe sepsis, while the remaining interventions are expected to occur within six hours of presentation of septic shock.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** HVBP
- **NQF Recommendation:** Support for Rulemaking

New Cross-Cutting Measures

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Public Comment for New Cross-Cutting Measures

- **MUC2022-018:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) *(Hospital IQR)*
- **MUC2022-020:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) *(Hospital OQR)*
- **MUC2022-064:** Hospital Harm - Pressure Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-024:** Hospital Harm - Acute Kidney Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*

MUC2022-018: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient)

- **Description:** This electronic clinical quality measure (eCQM) provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of eligible CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient hospital care settings are eligible.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Support for Rulemaking

MUC2022-020: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient)

- **Description:** This electronic clinical quality measure (eCQM) provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of eligible CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in hospital outpatient care settings (including emergency settings) are eligible.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** Yes
- **Program(s) submitted to:** Hospital OQR
- **NQF Recommendation:** Support for Rulemaking

Afternoon Break: Meeting Day One

New Cross-Cutting Measures (Continued)

MUC2022-064: Hospital Harm - Pressure Injury

- **Description:** The proportion of inpatient hospitalizations for patients 18 years of age or older at the start of the encounter, who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR; Medicare Promoting Interoperability Program
- **NQF Recommendation:** Conditional Support for Rulemaking

MUC2022-024: Hospital Harm- Acute Kidney Injury

- **Description**: The proportion of inpatient hospitalizations for patients 18 years of age or older who have an acute kidney injury (stage 2 or greater) that occurred during the encounter as evidenced by a substantial increase in serum creatinine value, or by the initiation of kidney dialysis (continuous renal replacement therapy [CRRT], hemodialysis or peritoneal dialysis).
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR; Medicare Promoting Interoperability Program
- **NQF Recommendation:** Conditional Support for Rulemaking

Volume Data Measures

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Public Comment for Volume Data Measures

- **MUC2022-028:** ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) *(ASCQR)*
- **MUC2022-030:** Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) *(Hospital OQR)*

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

- **Description:** Structural measure of facility capacity collects surgical procedure volume data on selected categories of procedures frequently performed in the ASC setting Categories include: Eye, Gastrointestinal, Genitourinary, Musculoskeletal, Nervous, Respiratory, Skin, and Other
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** ASCQR
- **NQF Recommendation:** Do Not Support for Rulemaking

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

- **Description:** Structural measure of facility capacity collects surgical procedure volume data on selected categories of outpatient procedures frequently performed within the outpatient department (e.g., outpatient surgery, cath lab, endoscopy). Gastrointestinal, Eye, Nervous System, Musculoskeletal, Skin, Genitourinary, Cardiovascular, Respiratory, and Other
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital OQR
- **NQF Recommendation:** Do Not Support for Rulemaking

Second Afternoon Break: Meeting Day One

Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures

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Public Comment for REHQRP Measures

- **MUC2022-039:** Median Time from emergency department (ED) Arrival to ED Departure for Discharged ED Patients *(REHQRP)*
- **MUC2022-066:** Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy *(REHQRP)*
- **MUC2022-067:** Risk-standardized hospital visits within 7 days after hospital outpatient surgery *(REHQRP)*
- **MUC2022-081:** Abdomen Computed Tomography (CT) Use of Contrast Material *(REHQRP)*

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

- **Description:** Median time from ED arrival to time of departure from the ED for patients discharged from the ED. The measure is calculated using chart abstracted data, on a rolling quarterly basis, and is publicly reported in aggregate for one calendar year. The measure has been publicly reported since 2013 as part of the ED Throughput measure set of the CMS Hospital Outpatient Quality Reporting (OQR) Program.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** REHQRP
- **NQF Recommendation:** Do Not Support for Rulemaking

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

- **Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a colonoscopy procedure performed at a Rural Emergency Hospital among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** REHQRP
- **NQF Recommendation:** Support for Rulemaking

MUC2022-067: Risk-standardized hospital visits within 7 days after hospital outpatient surgery

- **Description:** Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of an outpatient surgical procedure performed at a Rural Emergency Hospital among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** REHQRP
- **NQF Recommendation:** Support for Rulemaking

MUC2022-081: Abdomen Computed Tomography (CT) Use of Contrast Material

- **Description:** This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both).
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** REHQRP
- **NQF Recommendation:** Conditional Support for Rulemaking

Cross-Cutting COVID-19 Measure

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Public Comment for Cross-Cutting COVID-19 Measure

- **MUC2022-084:** COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) *(ASCQR, Hospital IQR, Hospital OQR, HVBP, HACRP, IPFQR, PCHQRP, ESRD QIP)*

MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision)

- **Description:** Percentage of healthcare personnel who are considered up to date with recommended COVID-19 vaccines.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ASCQR; Hospital IQR; Hospital OQR; HVBP; HACRP; IPFQR; PCHQRP; ESRD QIP
- **NQF Recommendation:** Conditional Support for Rulemaking

Preview of Day Two

THANK YOU.

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Welcome to Today's Meeting – Day Two

- Housekeeping reminders:
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - Please raise your hand and unmute yourself when called on
  - Please lower your hand and mute yourself following your question/comment
  - Please state your first and last name if you are a Call-In-User
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at MAPHospital@qualityforum.org

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Meeting Ground Rules – Day Two

- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure review criteria and guidance
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

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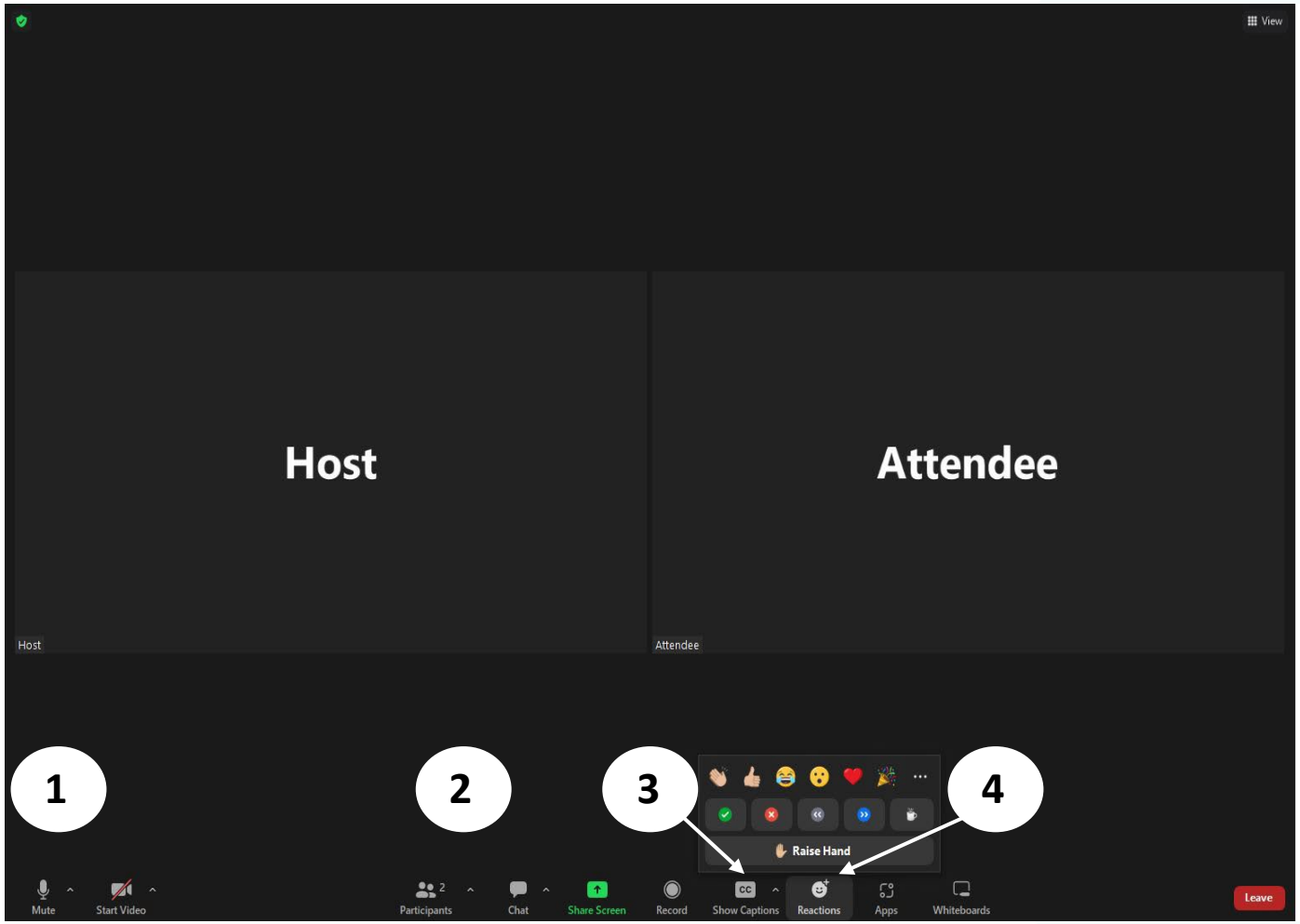
Using the Zoom Platform



1. Click the lower part of your screen to mute/unmute, start or pause video
2. Click on the participant or chat button to access the full participant list or the chat box
3. Click on show captions to enable closed captions
4. To raise your hand, select the raised hand function under the reactions tab

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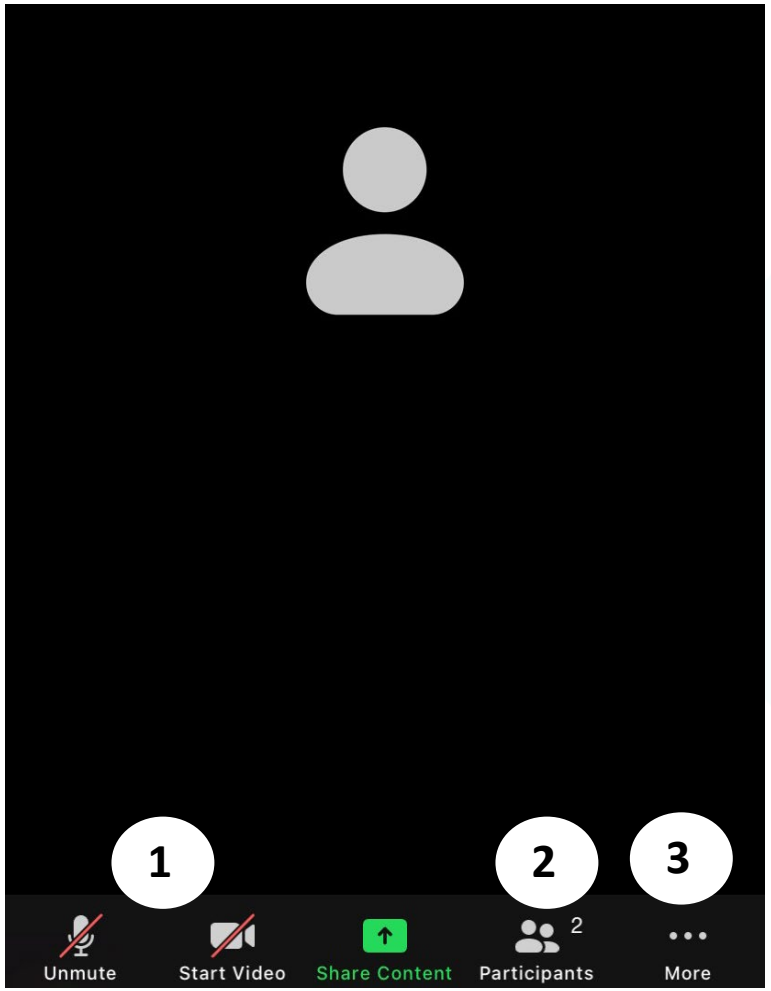
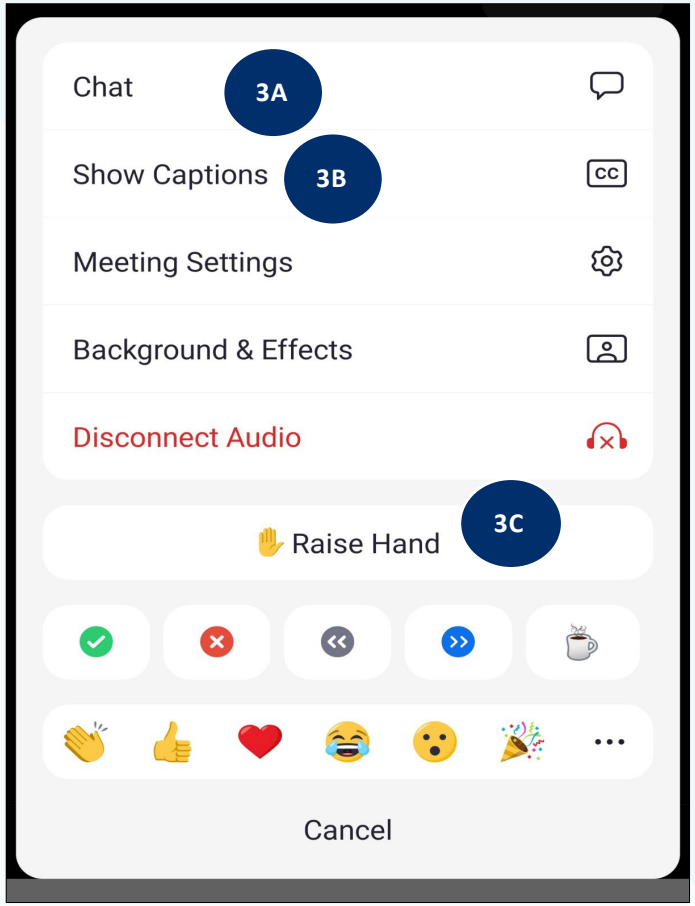
Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start or pause video

2. Click on the participant button to view the full participant list

3. Click on “more” button to (3A) view the chat box, (3B) show closed captions, or to (3C) raise your hand. To raise your hand, select the raised hand function under the reactions tab



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Measure Applications Partnership (MAP)

Hospital Workgroup 2022-2023 Measures Under Consideration (MUC) Review Web Meeting – Day Two

December 14, 2022

Funding provided by the Centers for Medicare & Medicaid Services under HHSM-500-T0003, Option Year 4

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Agenda – Day Two

- Welcome, Preview of Day Two, and Roll Call
- Review End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measures
- Review Cross-Cutting Arthroplasty Measure
- Break
- Review New Geriatrics Measures
- Break
- Review Equity Measures

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Agenda – Day Two (continued)

- Break
- Review Hybrid Readmission and Mortality Measures
- MAP Hospital Programs Measure Gaps Discussion
- Opportunity for Public Comment
- Next Steps
- Adjourn

MAP Hospital Workgroup Membership

Workgroup Co-Chairs: Akin Demehin, MPH; Acting Co-Chair: Martin Hatlie, JD

Organizational Members (Voting)

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- Cigna Healthcare
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association (Inactive)
- Kidney Care Partners
- Medtronic
- Mothers Against Medical Error
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey Associates
- Project Patient Care
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

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MAP Hospital Workgroup Membership (continued)

Individual Subject Matter Experts (Voting)

- Richard Gelb, MA
- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB
- Jennifer Wills, RD, MPPA

Federal Government Liaisons (Non-Voting)

- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Veterans Health Administration (VHA)

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National Quality Forum (NQF) MAP Team

- **Tricia Elliott, DHA, MBA, CPHQ, FNAHQ,** Vice President
- **Jenna Williams-Bader, MPH,** Senior Director
- **Katie Berryman, MPAP, PMP,** Director, Project Management
- **Ashlan Ruth, BS IE,** Project Manager
- **Susanne Young, MPH,** Senior Manager
- **Gus Zimmerman, MPP,** Analyst
- **Joelencia LeFlore,** Analyst
- **Magdelana Stinnett,** Analyst
- **Madeline Henry,** Associate
- **Bobby Burchard,** Associate

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CMS Staff

- **Kimberly Rawlings,** Task Order (TO) Contracting Officer's Representative (COR), CCSQ, CMS
- **Gequincia Polk,** Indefinite Delivery/Indefinite Quantity (IDIQ) Contracting Officer's Representative (COR), CCSQ, CMS

Voting Test (Poll Everywhere)

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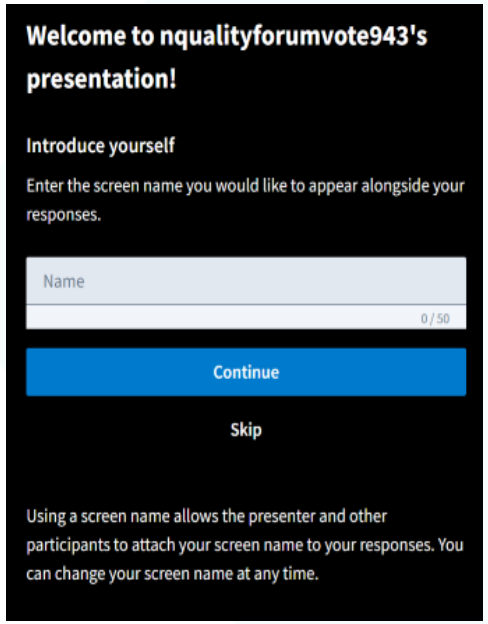
Voting Via Desktop or Laptop Computer (Poll Everywhere)

- Click on the voting link that was emailed to you. You will see a wait message until voting begins.
- When voting opens, you will see the screen below. Enter your first and last name, then click "Continue" to access voting from the options that will appear on the screen.



- Please alert an NQF staff member if you are having difficulty with our electronic voting system.

End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measures

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Public Comment for ESRD QIP Measures

- **MUC2022-075:** Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) *(ESRD QIP)*
- **MUC2022-076:** Standardized Fistula Rate for Incident Patients *(ESRD QIP)*
- **MUC2022-079:** Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities *(ESRD QIP)*
- **MUC2022-125:** Gains in Patient Activation Measure (PAM) Scores at 12 Months *(ESRD QIP)*

MUC2022-075: Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR)

- **Description:** The standardized modality switch ratio (SMoSR) is defined to be the ratio of numbers of observed modality switches (from in-center to home dialysis- peritoneal or home hemodialysis) that occur for adult incident ESRD dialysis patients treated at a particular facility, to the number of modality switches (from in-center to home dialysis- peritoneal or home hemodialysis) that would be expected given the characteristics of the dialysis facility's patients and the national norm of dialysis facilities. The measure includes only the first durable switch that is defined as lasting 30 continues days or longer.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP
- **NQF Recommendation:** Do Not Support for Rulemaking with Potential for Mitigation

MUC2022-076: Standardized Fistula Rate for Incident Patients

- **Description:** The Standardized Fistula Rate (SFR) for Incident Patients is based on the prior SFR (NQF #2977) that included both incident and prevalent patients. This measure was initially endorsed in 2016, but as part of measure maintenance review by the NQF Standing Committee in 2020, concerns were raised about the strength of evidence supporting the prior measure. Namely, recent updates to the KDOQI guidelines downgraded the evidence supporting fistula as the preferred access type and instead focus on catheter avoidance and developing an individualized ESKD Life plan.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP
- **NQF Recommendation:** Do Not Support for Rulemaking with Potential for Mitigation

MUC2022-079: Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities

- **Description:** The Standardized Emergency Department Encounter Ratio is defined to be the ratio of the observed number of emergency department (ED) encounters that occur for adult Medicare ESRD dialysis patients treated at a particular facility to the number of encounters that would be expected given the characteristics of the dialysis facility's patients and the national norm for dialysis facilities. Note that in this document an emergency department encounter always refers to an outpatient encounter that does not end in a hospital admission. This measure is calculated as a ratio but can also be expressed as a rate.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP
- **NQF Recommendation:** Support for Rulemaking

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

- **Description:** The Patient Activation Measure (PAM) (Registered Trademark) is a 10- or 13- item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM performance measure (PAM-PM) is the change in score on the PAM from baseline to follow-up measurement. A positive change would mean the patient is gaining in their ability to manage their health. The measure is not disease specific but has been successfully used with a wide variety of chronic conditions, as well as with people with no medical diagnosis.
- **Level of Analysis:** Clinician - Individual; Clinician - Group; Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP
- **NQF Recommendation:** Support for Rulemaking

Cross-Cutting Arthroplasty Measure

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Public Comment for Cross-Cutting Arthroplasty Measure

- **MUC2022-026:** Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting *(ASCQR, Hospital OQR)*

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MUC2022-026: Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting

- **Description:** The measure will estimate a facility-level risk-standardized improvement rate for patient-reported outcomes (PROs) following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit (SCB) improvement will be measured by the change in score on the joint-specific patient-reported outcome measure (PROM) instruments, measuring hip or knee pain and functioning, from the preoperative assessment (data collected 90 to 0 days before surgery) to the postoperative assessment (data collected 275 to 425 days following surgery).
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** ASCQR; Hospital OQR
- **NQF Recommendation:** Support for Rulemaking

New Geriatrics Measures

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Public Comment for New Geriatrics Measures

- **MUC2022-032:** Geriatrics Surgical Measure *(Hospital IQR)*
- **MUC2022-112:** Geriatrics Hospital Measure *(Hospital IQR)*

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MUC2022-032: Geriatrics Surgical Measure

- **Description:** This programmatic measure assesses hospital commitment to improving surgical outcomes for patients greater than or equal to 65 years of age through patient-centered competencies aimed at achieving quality of care and safety for all older adult surgical patients. The measure will include 11 attestation-based questions across 7 domains representing a comprehensive framework required for optimal care of the older surgical patient. A hospital will receive a point for each domain where they attest to all items from at least one question (for a total of 7 points). Note that "patients" in all elements refers to surgical patients greater than or equal to 65 years of age at time of operation.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Do Not Support for Rulemaking

MUC2022-112: Geriatrics Hospital Measure

- **Description:** This structural measure assesses hospital commitment to improving outcomes for patients greater than or equal to 65 years of age through patient-centered competencies aimed at achieving quality of care and safety for all older patients. The measure will include 14 attestation-based questions across 8 domains representing a comprehensive framework required for optimal care of older patients admitted to the hospital or being evaluated in the emergency department. A hospital will receive a point for each domain where they attest to at least one corresponding statement (for a total of 8 points). For each item, attestation of all elements is required to qualify for the measure numerator.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Do Not Support for Rulemaking

Equity Measures

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Public Comment for Equity Measures

- **MUC2022-050:** Screen Positive Rate for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-053:** Screening for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-027:** Facility Commitment to Health Equity *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-058:** Hospital Disparity Index (HDI) *(Hospital IQR)*

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

- **Description:** The Screen Positive Rate for Social Drivers of Health is a structural measure that provides information on the percent of patients admitted for an inpatient facility stay or that have received established care in the case of dialysis facilities, and who are 18 years or older on the date of admission or date of established care in the case of dialysis facilities, were screened for all five HSRNs, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** Yes
- **Program(s) submitted to:** ESRD QIP; IPFQR; PCHQRP
- **NQF Recommendation:** Conditional Support for Rulemaking

MUC2022-053: Screening for Social Drivers of Health

- **Description:** The Screening for Social Drivers of Health measure assesses the total number of patients, aged 18 years and older, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during an inpatient facility stay, or during established care in the case of dialysis facilities. The measure cohort includes patients who are admitted to an inpatient facility or who have established care in the case of dialysis facilities and are 18 years or older on the date of admission or on the date of established care in the case of dialysis facilities.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP; IPFQR; PCHQRP
- **NQF Recommendation:** Conditional Support for Rulemaking

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MUC2022-027: Facility Commitment to Health Equity

- **Description:** This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Facilities will receive one point each for attesting to five different domains of commitment to advancing health equity for a total of five points.
- **Level of Analysis:** Facility
- **Risk Adjustment:** No
- **Stratification:** No
- **Program(s) submitted to:** ESRD QIP; IPFQR; PCHQRP
- **NQF Recommendation:** Conditional Support for Rulemaking

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MUC2022-058: Hospital Disparity Index (HDI)

- **Description:** The HDI is a prototype method for a single score that summarizes several measurements of disparity in care at a hospital. This score will summarize existing results of the Centers for Medicare and Medicaid Services (CMS) Disparity Methods (stratified measure results) across a range of measures and social and demographic risk factors, to provide more accessible information about variations in healthcare disparity across hospitals.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Conditional Support for Rulemaking

Hybrid Readmission and Mortality Measures

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Public Comment for Hybrid Readmission and Mortality Measures

- **MUC2022-055:** Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure *(Hospital IQR)*
- **MUC2022-057:** Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure *(Hospital IQR)*

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

- **Description:** Hospital-level, risk-standardized readmission rate (RSRR) of all-cause 30-day unplanned readmission after admission for any eligible condition within 30 days of hospital discharge. The measure, based on NQF #2879, uses enrollment data, inpatient claims, and electronic health record data. Hospitals receive a single summary RSRR, derived from the volume-weighted results of five specialty cohorts. Conditionally supported by the MAP pending NQF endorsement and currently in the IQR Program (voluntary reporting 7/1/2021, mandatory reporting beginning 7/1/2023). This MUC submission expands the cohort from Medicare fee-for-service (FFS) patients to include Medicare Advantage patients age 65 & older.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Support for Rulemaking

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

- **Description:** Hospital-level, risk-standardized 30-day all-cause mortality rate (RSMR) for Medicare fee-for-service (FFS) and Medicare Advantage (MA) patients (65 to 94). The measure, based on NQF #3502, uses enrollment data, inpatient claims, and electronic health data to identify 30-day all-cause mortality outcome, and adjust for comorbidities based on the ICD-10 diagnosis/procedure codes and clinical risk factors from electronic health data for the measure score calculation. This measure, previously conditionally supported for use in IQR and planned for use by CMS for voluntary reporting in IQR, is being expanded to include Medicare Advantage patients in addition to FFS patients in the cohort.
- **Level of Analysis:** Facility
- **Risk Adjustment:** Yes
- **Stratification:** No
- **Program(s) submitted to:** Hospital IQR
- **NQF Recommendation:** Support for Rulemaking

Discuss MAP Hospital Programs Measure Gaps

Opportunity for Public Comment

Next Steps

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Timeline of Upcoming Activities

- **Clinician Workgroup Review Meeting**
  - December 15 and December 16
- **Public Comment Period 2**
  - January 6-12, 2023
- **Coordinating Committee Review Meeting**
  - January 24 and January 25, 2023
- **Recommendations Spreadsheet Published**
  - By February 1, 2023

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MAP Resources

- CMS' 2022 MUC List Needs and Priorities Document
  - 2022 Needs and Priorities (PDF)
- CMS' Pre-Rulemaking Overview
  - CMS Pre-Rulemaking Webpage
- MAP Member Guidebook
  - Member Guidebook (PDF)
- Measure Applications Partnership Overview
  - National Quality Forum webpage

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MAP Contact Information

- Hospital Workgroup project page: Hospital Workgroup webpage
  - Email: MAPHospital@qualityforum.org

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Appendix

MAP Implementation Results

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2019-2020 MUC Recommendations

Support for Rulemaking (5 Measures)
Finalized Into Rulemaking
• 06064-C-MIPS: Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS)*
Not Finalized Into Rulemaking
• 06077-C-PARTD: Use of Opioids at High Dosage in Persons without Cancer (OHD)
• 06076-C-PARTD: Use of Opioids from Multiple Providers in Persons without Cancer (OMP)
• 01364-C-PCHQR: National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure*
• 01475-C-PCHQR: National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection Outcome Measure*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2019-2020 MUC Recommendations (continued)

Conditional Support for Rulemaking (11 Measures)

Finalized Into Rulemaking

- 06154-C-HIQR: Maternal Morbidity
- 06141-E-HIQR: Hospital Harm – Severe Hyperglycemia*
- 06166-C-MIPS: Hemodialysis Vascular Access: Practitioner Level Long-term Catheter Rate
- 06062-C-MIPS: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups
- 06159-C-PARTC: Transitions of Care between the Inpatient and Outpatient Settings including Notifications of Admissions and Discharges, Patient Engagement and Medication Reconciliation Post-Discharge
- 06156-C-PARTC: Follow-up after Emergency Department (ED) Visit for People with Multiple High-Risk Chronic Conditions
- 06111-C-HQR: Hospice Visits in the Last Days of Life (HVLDL)*
- MUC19-64: Standardized Transfusion Ratio for Dialysis Facilities*
- 06161-C-HHQR: Home Health Within-Stay Potentially Preventable Hospitalization Measure

Not Finalized Into Rulemaking

- 02816-C-MSSP: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions*
- MUC19-22: Follow-Up After Psychiatric Hospitalization

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2019-2020 MUC Recommendations (continued 2)

Do Not Support for Rulemaking with Potential for Mitigation (1 Measure)
Not Finalized Into Rulemaking
• MUC19-37: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions; in the Medicare Shared Savings Program, the score would be at the MIPS provider (or provider group) level.
Do Not Support for Rulemaking (1 Measure)
Not Finalized Into Rulemaking
• 06078-C-PARTD: Use of Opioids from Multiple Providers and at a High Dosage in Persons without Cancer (OHDMP)
Removed from Consideration (2 Measures)
Not Finalized Into Rulemaking
• 05858-C-MIPS: Emergency Department Utilization (EDU)
• 05859-C-MIPS: Acute Hospital Utilization (AHU)

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2020-2021 MUC Recommendations

Support for Rulemaking (2 Measures)
Finalized Into Rulemaking
• 07047-C-HIQR: Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty: Hospital-Level Performance Measure* • 01013-C-ESRDQIP: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2020-2021 MUC Recommendations (continued)

Conditional Support for Rulemaking (16 Measures)

Finalized Into Rulemaking

- 06114-C-SNFQRP: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization
- 12735-C-HOQR: Breast Cancer Screening Recall Rates
- 06090-E-HIQR: Global Malnutrition Composite Score*
- 06090-C-PI: Global Malnutrition Composite Score*
- 08060-C-HQR: Hospice Care Index
- 08061-C-MIPS: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)
- 08062-C-IRFQR: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08062-C-LTCHQR: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08062-C-SNFQRP: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08062-C-ASCQR: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08062-C-HOQR: COVID–19 Vaccination Coverage among Healthcare Personnel*
- 08062-C-IPFQR: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08062-C-PCHQR: COVID-19 Vaccination Coverage among Healthcare Personnel
- 08062-C-HIQR: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel*
- 08062-C-IRFQR: COVID–19 Vaccination Coverage among Healthcare Personnel
- 08051-E-HOQR: ST-Segment Elevation Myocardial Infarction (STEMI) Electronic Clinical Quality Measure (eCQM)*

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2020-2021 MUC Recommendations (continued 2)

Conditional Support for Rulemaking (5 Measures)
Not Finalized Into Rulemaking
• 08058-C-MIPS: Melanoma Resection Episode-Based Cost Measure • MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions • MUC20-0045: SARS-CoV-2 Vaccination by Clinicians • 08064-C-ESRDQIP: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities • 08056-C-MIPS: Colon and Rectal Resection Episode-Based Cost Measure

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2020-2021 MUC Recommendations (continued 3)

Do Not Support for Rulemaking with Potential for Mitigation (6 Measures)
Not Finalized into Rulemaking
• 08055-C-MIPS: Asthma/Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure • 08057-C-MIPS: Diabetes Episode-Based Cost Measure • 08059-C-MIPS: Sepsis Episode-Based Cost Measure • 06162-C-MIPS: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System • 06167-C-MIPS: Intervention for Prediabetes • 05726-C-MIPS: Preventive Care and Wellness (composite)

*Measure is CBE Endorsed

Note: Information about rulemaking and CBE endorsement status pulled from Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), 10/06/2022

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2022 Measure Set Review Recommendations

Clinician Workgroup (14 Measures)
Support for Retaining (6 Measures)
• 00515-C-MSSP: Preventive Care and Screening: Screening for Depression and Follow-Up Plan • 05826-E-MIPS: Closing the Referral Loop: Receipt of Specialist Report • Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey • 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 • 00641-C-MIPS: Functional Outcome Assessment
Conditional Support for Retaining (6 Measures)
• 01246-C-MSSP: Controlling High Blood Pressure • CMS eCQM ID: CMS165v10: Controlling High Blood Pressure • 02816-C-MSSP: Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions • 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 (2 Measures)
• 01101-C-MIPS: Barrett's Esophagus • 05837-E-MIPS: Children Who Have Dental Decay or Cavities
Support for Removal (0 Measures)

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2022 Measure Set Review Recommendations (continued)

Hospital Workgroup (8 Measures)
Support for Retaining (2 Measures)
• 02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery • 02936-C-ASCQR: Normothermia Outcome
Conditional Support for Retaining (4 Measures)
• 00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain • 02599-C-HOQR: Abdomen Computed Tomography (CT) – Use of Contrast Material • 01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery • 05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice
Conditional Support for Removal (1 Measure)
• 00930-C-HOQR: Median time for ED Arrival to ED Departure for Discharged ED Patients
Support for Removal (1 Measure)
• 00922-C-HOQR: Left Without Being Seen

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2022 Measure Set Review Recommendations (continued 2)

PAC/LTC Workgroup (10 Measures)
Support for Retaining (1 Measure)
• 02944-C-HHQR: Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
Conditional Support for Retaining (6 Measures)
• 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 (1 Measure)
• 03493-C-HHQR: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
Support for Removal (2 Measures)
• 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

Measures in CMS Hospital Programs

ASCQR

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ASCQR: Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0263	ASC-1: Patient Burn	Endorsement Removed
Outcome	0266	ASC-2: Patient Fall	Endorsement Removed
Outcome	0267	ASC-3:Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Endorsement Removed
Structural	0265	ASC-4: All-Cause Hospital Transfer/ Admission	Endorsement Removed
Process	0658	ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed
Outcome	1536	ASC-11: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Endorsement Removed
Outcome	2539	ASC-12: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed
Outcome	3357	ASC-19: Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers*	Endorsed

*ASC-19 Will be added and used in 2024

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ASCQR: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	N/A	ASC-13: Normothermia Outcome	Not Endorsed
Outcome	N/A	ASC-14: Unplanned Anterior Vitrectomy	Not Endorsed
Outcome	N/A	ASC-15: Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey-based Measures (ASC-15a-e)	Not Endorsed
Intermediate Outcome	3470	ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures	Endorsed
Intermediate Outcome	3366	ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures	Endorsed

ESRD QIP

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ESRD QIP: Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0258	CAHPS In-Center Hemodialysis Survey	Endorsed
Outcome	1454	Proportion of Patients with Hypercalcemia	Endorsed
Outcome	1463	Standardized Hospitalization Ratio (SHR) Clinical Measure	Endorsed
Outcome	2496	Standardized Readmission Ratio (SRR) for dialysis facilities	Not Endorsed
Outcome	2977	Hemodialysis Vascular Access: Standardized Fistula Rate Clinical Measure	Endorsed
Outcome	2978	Hemodialysis Vascular Access: LongTerm Catheter Rate Clinical Measure	Endorsed
Outcome	2979	Anemia of chronic kidney disease: Dialysis facility standardized transfusion ratio (STrR)	Endorsed
Process	2988	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities (MedRec)	Endorsed

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ESRD QIP: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	Based on NQF #1460	National Healthcare Safety Network (NHSN) Bloodstream Infection in Hemodialysis Patients	Not Endorsed
Outcome	N/A	Kt/V Dialysis Adequacy Comprehensive Clinical Measure	Not Endorsed
Process	Based on NQF #0418	Clinical Depression Screening and Follow-Up Reporting Measure	Not Endorsed
Process	N/A	Ultrafiltration Reporting Measure*	Not Endorsed
Structural	N/A	National Healthcare Safety Network (NHSN) Dialysis Event Reporting Measure	Not Endorsed
Process	N/A	Percentage of Prevalent Patients Waitlisted	Not Endorsed

*Based off NQF #2701 - Avoidance of Utilization of High Ultrafiltration Rate (>/= 13 ml/kg/hour)

HACRP

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HACRP: Current Measures

Type	NQF #	Measure Title	NQF Status
Composite	0531	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Outcome	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Outcome	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed

Hospital IQR

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Hospital IQR: Current Measures

Type	NQF #	Measure Title	NQF Status
Hybrid-Outcome	3502	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (Hybrid HWM)*	Endorsed
Claims-based Outcome	N/A	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke	Not Endorsed
Claims-based Outcome	1789	Hospital-Wide All-Cause, Unplanned Readmission Measure (HWR)	Endorsed
Claims-based Outcome	2881	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	Endorsed
Claims-based Outcome	2880	Excess Days in Acute Care after Hospitalization for Heart Failure	Endorsed
Claims-based Outcome	2882	Excess Days in Acute Care after Hospitalization for Pneumonia	Endorsed

*The hybrid measure adds 10 clinical risk variables, derived from a set of core clinical data elements (CCDE) extracted from the EHR.

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Hospital IQR: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Claims-based Outcome	0351	Death among Surgical Inpatients with Serious, Treatable Complications	Endorsed
Cost/ Resource Use	2431	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI)	Endorsed
Cost/ Resource Use	2436	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF)	Endorsed
Cost/ Resource Use	2579	Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	Endorsed
Cost/ Resource Use	N/A	Hospital-Level, Risk-Standardized Payment Associated with a 90-Day Episode of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Endorsed
Process	N/A	Maternal Morbidity Structural Measure	Not Endorsed
Process	N/A	COVID-19 Vaccination Coverage Among Healthcare Personnel	Not Endorsed

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Hospital IQR: Current Measures (Continued 2)

Type	NQF #	Measure Title	NQF Status
eCQM Process	3503e	Hospital Harm—Severe Hypoglycemia*	Endorsed
eCQM Process	3533e	Hospital Harm—Severe Hyperglycemia*	Endorsed
eCQM Process	0435/3042	Discharged on Antithrombotic Therapy**	Endorsed-Reserve
eCQM Process	0436/3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter**	Endorsed-Reserve
eCQM Process	0438/3045	Antithrombotic Therapy by the End of Hospital Day Two**	Endorsed-Reserve
eCQM Process	0371	Venous Thromboembolism Prophylaxis**	Endorsed
eCQM Process	0372/ 2933	Intensive Care Unit Venous Thromboembolism Prophylaxis**	Endorsed

*Data collection beginning with the CY 2023 reporting period/FY 2025 payment determination
**In CY 2023/FY 2025 hospitals are required to report a full year of data for three self-selected eCQMs and the Safe Use of Opioids eCQM; in CY 2024/FY 2026 hospitals are required to report a full year of data for three self-selected eCQMs, as well as the Safe Use of Opioids eCQM, the Severe Obstetric Complications eCQM, and the Cesarean Birth eCQM

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Hospital IQR: Current Measures (Continued 3)

Type	NQF #	Measure Title	NQF Status
eCQM Process	3316e	Safe Use of Opioids – Concurrent Prescribing*	Endorsed
eCQM Process	0439	Discharged on Statin Medication**	Endorsed
eCQM Process	0497	Admit Decision Time to ED Departure Time for Admitted Patients**	Endorsed
eCQM Process	0480	Exclusive Breast Milk Feeding**	Endorsed
eCQM Process	N/A	Cesarean Birth*	Pending Endorsement
eCQM Outcome	N/A	Severe Obstetric Complications*	Pending Endorsement
eCQM Process	3592e	Global Malnutrition Score*	Endorsed
eCQM Process	3501e	Hospital Harm – Opioid-Related Adverse Events*	Endorsed

*In CY 2023/FY 2025 hospitals are required to report a full year of data for three self-selected eCQMs and the Safe Use of Opioids ecQM; in CY 2024/FY 2026, hospitals are required to report a full year of data for three self-selected eCQMs, as well as the Safe Use of Opioids eCQM, the Severe Obstetric Complications eCQM, and the Cesarean Birth eCQM

**Finalized for removal beginning with the CY 2024 reporting period/FY 2026 payment determination

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Hospital IQR: Current Measures (Continued 4)

Type	NQF #	Measure Title	NQF Status
Chart-abstracted Composite	0500	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	Endorsed
Chart-abstracted Process	0469	Elective Delivery	Endorsed
Patient Survey	0166 (0228)	HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transitions Measure)	Endorsed
Process	0431	Influenza Vaccination Coverage Among Healthcare Personnel	Endorsed
Structural/Process	N/A	Hospital Commitment to Health Equity	Not Endorsed
Structural/Process	N/A	Screening for Social Drivers of Health*	Not Endorsed
Structural/Process	N/A	Screen Positive for Social Drivers of Health*	Not Endorsed

*Measure is voluntary for the CY 2023/FY 2025 payment determination, and mandatory beginning with the CY 2024/FY 2026 payment determination

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Hospital IQR: Current Measures (Continued 5)

Type	NQF #	Measure Title	NQF Status
Claims	2158	Medicare Spending Per Beneficiary	Endorsed
Claims-based Outcome	1550	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Endorsed
Patient-Reported Outcomes	3559	Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)*	Pending Endorsement

*Voluntary reporting of the measure occurs across two periods – July 1, 2023 through June 30, 2024, and July 1, 2024 through June 30, 2025 – and is followed by mandatory reporting for the reporting period which runs from July 1, 2025 through June 30, 2026, impacting the FY 2028 payment determination

Hospital OQR

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Hospital OQR: Current Measures

Type	NQF #	Measure Title	NQF Status
Process	0496	OP-18: Median time from ED Arrival to ED Departure for Discharged ED Patients	Endorsement Removed
Structural	0499	OP-22: Left Without Being Seen	Endorsement Removed
Process	0288	OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Endorsement Removed
Process	0290	OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention	Endorsed
Process	0661	OP-23: ED- Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of Arrival	Endorsed
Efficiency	N/A	OP-10: Abdomen CT - Use of Contrast Material	Not Endorsed
Efficiency	0669	OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Endorsement Removed

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Hospital OQR: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	0514	OP-8: MRI Lumbar Spine for Low Back Pain	Endorsement Removed
Process	0658	OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Endorsed
Outcome	2539	OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Endorsed
Outcome	1536	OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary Measure)	Endorsed
Outcome	3490	OP-35: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Endorsed
Outcome	2687	OP-36 Hospital Visits after Hospital Outpatient Surgery	Endorsed
Outcome	N/A	OP-37 Outpatient CAHPS Facilities and Staff**	Not Endorsed

**OP-37 Finalized for the CY 2020 PD (81 FR79784). Implementation delayed beginning with the CY 2020 payment determination (CY 2018 data collection) until further action in future rulemaking (82 FR59433)

HVBP

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HVBP: Current Measures

Type	NQF #	Measure Title	NQF Status
Efficiency and Cost Reduction	2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	Endorsed
Person and Community Engagement	0166 (0228)	HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition measure 0228)	Endorsed
Clinical Care	0230	Hospital 30-day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization	Endorsed
Clinical Care	0229	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) hospitalization	Endorsed
Clinical Care	0468	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Pneumonia Hospitalization	Endorsed
Clinical Care	1893	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Endorsed
Clinical Care	1550	Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Endorsed

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HVBP: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Clinical Care	2558	Hospital 30-Day All-Cause Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (CABG)	Endorsed
Safety	0138	NHSN Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Safety	1717	NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Safety	0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Safety	0753	ACS-CDC Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed
Safety	1716	NHSN Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
Safety	0531*	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	Endorsed

*Measure finalized for removal beginning with the FY 2023 program year

IPFQR

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IPFQR: Current Measures

Type	NQF #	Measure Title	NQF Status
Process	N/A	Screening for Metabolic Disorders	Not Endorsed
Process	0640	Hours of Physical Restraint	Endorsed
Process	0641	Hours of Seclusion Use	Endorsed
Process	1654	TOB-2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Endorsed
Process	1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Endorsed
Process	1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Endorsed
Process	1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Endorsed

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IPFQR: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Process	1659	Influenza Immunization	Endorsed
Process	0560	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Endorsed
Process	0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Endorsed
Process	0648	Timely Transmission of Transition Record	Endorsed
Process	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Endorsed
Outcome	2860	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF	Endorsed
Process	3205	Medication Continuation Following Discharge from an Inpatient Psychiatric Facility	Endorsed
Process	N/A	COVID-19 Vaccination Coverage among Healthcare Personnel	Not Endorsed

Medicare Promoting Interoperability Program

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Medicare Promoting Interoperability Program: Current Measures

Type	NQF #	Measure Title	NQF Status
eCQM Process	3503e	Hospital Harm — Severe Hypoglycemia**	Endorsed
eCQM Process	3533e	Hospital Harm — Severe Hyperglycemia**	Endorsed
eCQM Process	0435/3042	Discharged on Antithrombotic Therapy*	Endorsed-Reserve
eCQM Process	0436/3043	Anticoagulation Therapy for Atrial Fibrillation/Flutter*	Endorsed-Reserve
eCQM Process	0438/3045	Antithrombotic Therapy by the End of Hospital Day Two*	Endorsed-Reserve
eCQM Process	0371	Venous Thromboembolism Prophylaxis*	Endorsed
eCQM Process	0372/ 2933	Intensive Care Unit Venous Thromboembolism Prophylaxis*	Endorsed

*In the CY 2022 EHR reporting period, hospitals are required to report three self-selected calendar quarters of data for four self-selected eCQMs of the eight available eCQMs, and the Safe Use of Opioids eCQM
**Data collection beginning with the CY 2023 EHR reporting period

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Medicare Promoting Interoperability Program: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
eCQM Process	3316e	Safe Use of Opioids – Concurrent Prescribing*	Endorsed
eCQM Process	0439	Discharged on Statin Medication***	Endorsed
eCQM Process	0497	Admit Decision Time to ED Departure Time for Admitted Patients***	Endorsed
eCQM Process	0480	Exclusive Breast Milk Feeding***	Endorsed
eCQM Process	N/A	Cesarean Birth*	Pending
eCQM Outcome	N/A	Severe Obstetric Complications*	Pending
eCQM Process	3592e	Global Malnutrition Composite Score*	Endorsed
eCQM Process	3501e	Hospital Harm – Opioid-Related Adverse Events*	Endorsed

*In CY 2022/FY 2024 hospitals are required to report three self-selected calendar quarters of data for four self-selected eCQMs of the eight available eCQMs, and the Safe Use of Opioids eCQM
***Finalized for removal beginning with the CY 2024 EHR reporting period

PCHQRP

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PCHQRP: Current Measures

Type	NQF #	Measure Title	NQF Status
Outcome	0166	HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems Survey	Endorsed
Intermediate Outcome	0210	Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	Endorsed
Intermediate Outcome	0213	Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Endorsed
Intermediate Outcome	0215	Proportion of Patients Who Died from Cancer Not Admitted to Hospice	Endorsed
Intermediate Outcome	0216	Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days	Endorsed
Outcome	0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Endorsed
Outcome	0139	National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure	Endorsed
Outcome	0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Endorsed

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PCHQRP: Current Measures (Continued)

Type	NQF #	Measure Title	NQF Status
Outcome	1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Endorsed
Outcome	1716	National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	Endorsed
Outcome	3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Endorsed
Process	0383	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology	Endorsed
Process	0431	Influenza Vaccination Coverage among Healthcare Personnel	Endorsed
Outcome	3478	Surgical Treatment Complications for Localized Prostate Cancer	Not Endorsed
Process	1822	External Beam Radiotherapy for Bone Metastases	Endorsement Removed
Process	N/A	COVID-19 Vaccination Coverage Among HCP	Not Endorsed

MAP Pre-Rulemaking Approach – Measure Selection Criteria

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MAP Measure Selection Criteria (MSC)

- Identify characteristics that are associated with ideal measure sets for public reporting and payment programs
- Not absolute rules; provide general guidance and complement program-specific statutory and regulatory requirements
- Focus should be on the selection of high-quality measures that address the National Quality Strategy's (NQS) three aims, fill measurement gaps, and increase alignment
- Reference for:
  - evaluating the relative strengths and weaknesses of a program measure set
  - how the addition of an individual measure would contribute to the set
- MAP uses the MSC to guide its recommendations; MSC are the basis of the preliminary analysis algorithm

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MAP Measure Selection Criterion 1:

NQF-endorsed measures are preferred for program measure sets. Measures are based on scientific evidence and meet requirements for validity, feasibility, reliability and use.

Demonstrated by a program measure set that contains measures that meet the NQF endorsement criteria, including importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization of competing and related measures.

- **Subcriterion 1.1** Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need.
- **Subcriterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs.
- **Subcriterion 1.3** Measures that are in reserve status (i.e., topped out) should be considered for removal from programs.

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MAP Measure Selection Criterion 2:

Program measure set uses impactful measures which significantly advance healthcare outcomes for high priority areas in which there is a demonstrated performance gap or variation.

Demonstrated by a program measure set that promotes improvement in key national healthcare priorities such as CMS's Meaningful Measures Framework, emerging public health concerns and ensuring that the set addresses key improvement priorities for all providers.

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MAP Measure Selection Criterion 3:

Program measure set is responsive to specific program goals and requirements, including all statutory requirements.

Demonstrated by a program measure set that is "fit for purpose" for the particular program.

- **Subcriterion 3.1** Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s).
- **Subcriterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers.
- **Subcriterion 3.3*** Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness.
- **Subcriterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program.
- **Subcriterion 3.5** Emphasize inclusion of endorsed measures that have electronic clinical quality measure (eCQM) specifications available.

**For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period*

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MAP Measure Selection Criterion 4:

Program measure set may include a mix of measure types; however, highest priority is given to measures which are digital, or patient centered/patient reported outcomes, and/or support equity. Process measures must have a direct and proven relationship to improved outcomes in a high impact area where there are no outcome/intermediate outcome measures.

Demonstrated by a program measure set that includes an appropriate mix of process, outcome, experience of care, cost/resource use/appropriateness, composite, and structural measures necessary for the specific program.

- **Subcriterion 4.1** In general, preference should be given to measure types that address specific program needs.
- **Subcriterion 4.2** Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes.
- **Subcriterion 4.3** Payment program measure sets should include outcome measures and cost measures to capture value.

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MAP Measure Selection Criterion 5:

Program measure set enables measurement of person- and family-centered care and services AND are meaningful to patients and useful in making best care choices.

Demonstrated by a program measure set that addresses access, choice, self-determination, and community integration.

- **Subcriterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination.
- **Subcriterion 5.2** Measure set addresses shared decision making, such as for care and service planning and establishing advance directives.
- **Subcriterion 5.3** Measure set enables assessment of the person's care and services across providers, settings, and time.

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MAP Measure Selection Criterion 6:

Program measure set supports healthcare equity, helps identify gaps and disparities in care, and promotes access, culturally sensitive, and unbiased care for all.

Demonstrated by a program measure set that promotes equitable access and treatment by considering healthcare disparities. Factors include addressing race, ethnicity, socioeconomic status, language, gender, sexual orientation, age, or geographical considerations (e.g., urban vs. rural). Program measure set also can address populations at risk for healthcare disparities (e.g., people with behavioral/mental illness).

- **Subcriterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services).
- **Subcriterion 6.2** Program measure set includes measures that are sensitive to disparities measurement (e.g., beta blocker treatment after a heart attack) and that facilitate stratification of results to better understand differences among vulnerable populations.

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MAP Measure Selection Criterion 7:

Program measure set is aligned across programs and settings as appropriate and possible.

Demonstrated by a program measure set that supports efficient use of resources for data collection and reporting and supports alignment across programs. The program measure set should balance the degree of effort associated with measurement and its opportunity to improve quality.

- **Subcriterion 7.1** Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals).
- **Subcriterion 7.2** Program measure set places strong emphasis on measures that promote alignment and can be used across multiple programs or applications.

Preliminary Analysis Algorithm

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Preliminary Analysis of Measures Under Consideration

- The preliminary analysis is intended to provide MAP members with a succinct profile of each measure and to serve as a starting point for MAP discussions.
- Staff use an algorithm developed from the MAP Measure Selection Criteria to evaluate each measure considering MAP's previous guidance.
- To facilitate MAP's discussions, NQF staff will conduct a preliminary analysis of each measure under consideration.
- The preliminary analysis is an algorithm that asks a series of questions about each measure under consideration.
- This algorithm was approved by the MAP Coordinating Committee to evaluate each measure.

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MAP Preliminary Analysis Algorithm

1. The measure addresses a critical quality objective not adequately addressed by the measures in the program set.
2. The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.
3. The measure addresses a quality challenge.
4. The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.
5. The measure can be feasibly reported.
6. The measure is applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).
7. If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.

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MAP Preliminary Analysis Algorithm-1

Assessment 1: The measure addresses a critical quality objective not adequately addressed by the measures in the program set.

- **Definition:**
  - The measure addresses key healthcare improvement priorities; or
  - the measure is responsive to specific program goals and statutory or regulatory requirements; or
  - the measure can distinguish differences in quality, is meaningful to patients/consumers and providers, and/or addresses a high-impact area or health condition.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a “do not support for rulemaking.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-2

Assessment 2: The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.

- **Definition:**
  - For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s).
  - For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a "do not support for rulemaking."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-3

Assessment 3: The measure addresses a quality challenge.

- **Definition:**
  - The measure addresses a serious reportable event (i.e., a safety event that should never happen); or
  - the measure addresses unwarranted or significant variation or a gap in care that is evidence of a quality challenge.
- **Result:**
  - Yes: The review can continue.
  - No: The measure will receive a “do not support for rulemaking.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-4

Assessment 4: The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.

- **Definition:**
  - The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or
  - the measure captures a broad population; or
  - the measure contributes to alignment between measures in a particular program set (e.g., the measure could be used across programs) or
  - the value to patients/consumers outweighs any burden of implementation.
- **Result:**
  - Yes: The review can continue.
  - No: The highest rating can be “do not support for rulemaking with potential for mitigation.”
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-5

Assessment 5: The measure can be feasibly reported.

- **Definition:**
  - The measure can be operationalized (e.g., the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care).
- **Result:**
  - Yes: The review can continue.
  - No: The highest rating can be "do not support for rulemaking with potential for mitigation."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-6

Assessment 6: The measures is applicable to and appropriately specified for the program's intended care setting(s), level(s) of analysis, and population(s).

- **Definition:**
  - The measure is NQF-endorsed; or
  - the measure is fully developed and full specifications are provided; and
  - measure specifications are provided for the level of analysis, program, and/or setting(s) for which it is being considered.
- **Result:**
  - Yes: The measure could be supported or conditionally supported.
  - No: The highest rating can be "conditional support for rulemaking."
  - MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

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MAP Preliminary Analysis Algorithm-7

Assessment 7: If a measure is in current use, no unreasonable implementation issues that outweigh the benefits of the measure have been identified.

- **Definition:**
  - Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or
  - feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and
  - feedback is supported by empirical evidence.
- **Outcome:**
  - If no implementation issues have been identified: Measure can be supported or conditionally supported.
  - If implementation issues are identified: The highest rating can be "conditional support for rulemaking." MAP can also choose to not support the measure, with or without the potential for mitigation. MAP will provide a rationale for the decision to not support or make suggestions on how to improve the measure for a future support categorization.

Review of Measures Under Consideration (MUCs) by MAP Advisory Groups

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MAP Health Equity Advisory Group Charge and Feedback on Measures Under Consideration (MUCs)

- Provide input on MUCs with a lens to measurement issues impacting health disparities and the over 1,000 United States critical access hospitals
- Provide input on MUCs with the goal to reduce health differences closely linked with social, economic, or environmental disadvantages
- Health Equity Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December
- Preliminary analyses (PAs) will contain a qualitative summary of Health Equity Advisory Group's discussion of the MUCs for MAP Coordinating Committee

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MAP Rural Health Advisory Group Charge and Feedback on Measures Under Consideration (MUCs)

- Provide input on MUCs with emphasis on rural-specific measurement issues impacting rural populations, rural providers, and rural facilities
- Provide input on MUCs to address priority rural health issues, including the challenge of low case-volume and access
- Rural Health Advisory Group discussion will be summarized at the setting-specific Workgroup pre-rulemaking meetings in December
- Preliminary analyses (PAs) will contain a qualitative summary of Rural Health Advisory Group's discussion of the MUCs for MAP Coordinating Committee