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Measure Applications Partnership (MAP) Hospital Workgroup: 2022 Measure Set Review Meeting

Meeting Summary
July 19, 2022

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-T0003, Option Year 3.

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Meeting Summary

Measure Applications Partnership (MAP) Hospital Workgroup 2022 Measure Set Review (MSR) Meeting

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Hospital Workgroup on June 22, 2022. The purpose of the meeting was to discuss the measures for review within hospital programs for the 2022 Measure Set Review (MSR). There were seventy-three attendees at this meeting including MAP Hospital Workgroup members, NQF staff, government representatives, and members of the public.

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

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP Hospital Workgroup 2022 MSR meeting and reviewed housekeeping reminders, meeting ground rules and the meeting agenda. Ms. Williams-Bader then invited Dr. Elizabeth Drye, chief scientific officer, NQF, to provide opening remarks.

Dr. Drye welcomed all to the MAP Hospital Workgroup 2022 MSR meeting. Dr. Drye stated NQF is honored to partner with CMS to bring together stakeholders. Dr. Drye noted NQF and CMS piloted the measure set review process to offer a holistic view of measures within programs. After summarizing the pilot year of the MSR program, Dr. Drye explained NQF and CMS are now expanding the process to a broader set of measures and the full set of MAP workgroups and advisory groups. Dr. Drye remarked as the MSR process expands to the different workgroups and advisory groups, NQF welcomes feedback, and is looking forward to the outcomes of this complex process.

Dr. Drye outlined the focus of the meeting is measures for review in the hospital setting, including the PPS-Exempt Cancer Hospital program, Ambulatory Surgical Center Quality Reporting program, and the Hospital Quality Reporting program. Dr. Drye continued to explain during the meeting the workgroup reviews each measure and their challenges, which may include data and reporting, methodological issues, and any potential unintended consequences of retaining or removing a measure. Dr. Drye stated each of these challenges contributes to retaining or removing a measure from the set. Dr. Drye thanked all participants again and additionally thanked CMS and the program leads for providing guidance and specific context on measures used in federal programs. Lastly, Dr. Drye thanked the co-chairs for their leadership and their time.

Ms. Williams-Bader then introduced co-chair Akin Demehin and acting co-chair Cristie Upshaw Travis to provide opening remarks. Ms. Williams-Bader noted that co-chair Dr. Sean Morrison was not avaialble to attend the meeting. Both co-chairs extended their welcome and thanks to the workgroup members for their time and patience during MAP's first MSR meeting. They expressed they were looking forward to the conversation and from hearing any feedback to help improve the process going forward.

Ms. Williams-Bader then introduced Dr. Tricia Elliott, senior managing director, NQF, to facilitate the disclosure of interests (DOI) and roll call for the meeting. Dr. Elliot started by explaining how the DOI process is split into two parts, as the workgroup has organizational members and subject matter experts (SMEs).

Of the twenty organizational members, sixteen attended the meeting. In addition, there were two co-chairs, and two subject matter experts, totaling twenty voting members. Dr. Elliott noted, however, three organizational representatives expressed they needed to drop off the call early. This adjusted the count to seventeen voting members, which is the minimum quorum for voting. One workgroup member disclosed membership on the Alliance for Dedicated Cancer Centers (ADCC) Quality Committee. ADCC is in discussion for potential measure steward of measure 05735-C-PCHQR and this member recused themselves from voting on the measure. The full attendance details are available in Appendix A. Dr. Elliot concluded by introducing the nonvoting federal government liaisons.

Ms. Williams-Bader then introduced the NQF team and CMS staff supporting the MSR meeting activities. She continued by reviewing the meeting objectives:

1. Review the 2022 MSR process and measure review criteria (MRC)
2. Provide MAP members with an opportunity to discuss and recommend measures for potential removal
3. Seek feedback from the workgroup on the MSR process.

CMS Opening Remarks

Alan Levitt, medical officer in the Division of Chronic and Post-Acute Care, CMS, started his introductions by mentioning that he was filling in for Dr. Michelle Schreiber, CMS Deputy Director for Quality and Value, CMS. Dr. Levitt thanked workgroup members, workgroup co-chairs and NQF staff for convening.

Dr. Levitt expressed how one of the lessons learned during the public health emergency is the importance of public-private partnership. He continued by stating NQF is an excellent example of how this partnership successfully works. He noted the measure set review is another step in this partnership, which also includes the measures under consideration (MUC) review. Dr. Levitt reviewed how CMS leadership participated and listened to the Rural Health and Health Equity Advisory Group meetings and heard thought-provoking feedback. He reiterated as a new process it is okay there may be challenges but NQF and CMS will learn from them and keep building for a better future together. Dr. Levitt expressed his thanks again.

Review of MSR Process and Measure Review Criteria (MRC)

Ms. Williams-Bader began the review of the MSR process by stating CMS and NQF together prioritized programs to include for the 2022 measure set review. Ms. Williams-Bader explained there are several programs falling under MAP's purview. Since there were too many to discuss at once, the NQF team divided the programs into groups; several will be discussed during the meeting. She stated NQF refined the list of measures by program and created a survey for advisory group and workgroup members to complete. From this survey, members nominated measures for removal by reviewing the criteria and providing a rationale. Ms. Williams-Bader explained NQF staff selected measures to discuss based on the number of MAP members who nominated the measure for discussion. That narrowed list was posted for public comment.

Ms. Williams-Bader detailed NQF staff were able to take the narrowed list to prepare measure summary sheets (MSS). The measure summary sheets provide members more detailed information including reporting information, performance data, further endorsement history and whether the measure was previously reviewed by MAP. Throughout the meeting, NQF staff will provide a summary of Rural Health and Health Equity Advisory Groups' discussions for each measure. She explained the Coordinating Committee meets in August to review the workgroup recommendations.

Ms. Williams-Bader then presented the ten measure review criteria (MRC) the workgroup uses to evaluate the measures. Ms. Williams-Bader detailed the 2022 MSR decision criteria categories. The four categories are support for retaining, conditional support for retaining, conditional support for removal, and support for removal

Ms. Williams-Bader explained the quorum and key voting principles. Quorum is 66 percent of the voting members present virtually for live voting to take place. A consensus threshold is set at 60 percent of voting, and every measure under review during the meeting receives a recommendation. An important note is MAP workgroup votes via electronic ballot after the meeting if quorum is not established during the meeting.

Continuing her review of the meeting process, Ms. Williams-Bader explained the process for the workgroup's discussion. Each measure set begins with a review of the program by NQF staff and then the co-chairs offer a public comment period on the program. Following the public comment, the workgroup reviews each measure, led by the lead discussants and the co-chairs. After workgroup discussions, the co-chairs put forward a decision category based on the review criteria, and NQF staff facilitate a vote on the measure. If a measure does not reach a consensus of 60% the category of "Support for Retaining" will be applied.

Ms. Williams-Bader opened the call to questions on the MSR process and meeting overview. A workgroup member asked if there are not any members from the Rural Health or Health Equity Advisory Groups, would NQF staff provide an overview of their discussions. Ms. Williams-Bader confirmed NQF is prepared to present the information if representatives from either advisory group are not available. There were no further questions from participants.

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

Ms. Williams-Bader provided an overview of the PCHQR program, including the program type, incentive structure, and program goals. For complete details of the program, please refer to the MAP Hospital Workgroup MSR meeting slides (PDF). Ms. Williams-Bader turned the meeting to Ms. Upshaw Travis to open public comment on the measure for review within the PCHQR program.

Opportunity for Public Comment on PCHQR Program Measure

Ms. Upshaw Travis opened the meeting for public comment on the PCHQR program measure. No public comments were presented during the commenting period.

PCHQR Program Measure

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader read a statement indicating the measure for review is a new claims-based measure developed by the ADCC based on the concept of a CBE endorsed, registry version measure under the same name. The American Society of Clinical Oncology (ASC0) notified they would no longer maintain the registry version of the measure because it has not been used in the Merit-Based Incentive Payment System (MIPS) since 2019. There was no data to retain CBE endorsement. CMS approved this new claims-based measure, and this is the first year the measure is implemented in the program. ADCC and ASCO are in discussion about the stewardship of this claims-based measure moving forward. Ms. Williams-Bader turned to the

CMS program and measure leads to provide any further clarification. No further comments were provided by CMS. A co-chair asked for clarification regarding whether the workgroup was reviewing the registry measure or the claims-based measure. Ms. Williams-Bader explained the measure summary sheet information and endorsement is based on the old measure. The CMS program lead explained this is the first year this new claims-based measure is in use and thus there is no data. The co-chair asked for further clarification if the intention of the new measure was the same and the CMS program lead stated it was the same.

A lead discussant reviewed the rationale indicated on the advisory group and workgroup survey during the nomination process. During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is duplicative of other measures within the same program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure has negative unintended consequences, including potential negative impacts to the rural population or possible contribution to health disparities

This lead discussant also noted comments from the public strongly wanting to retain the measure. Another lead discussant posed a question wanting to know if there is a measure gap in the program. This lead discussant was also curious about feedback from the advisory groups and stated there might be unfairness. A third lead discussant commented that who better to do hospice referrals than cancer hospitals. This discussant also asked about gaps and noted they would not want to see the measure removed if it created a gap.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting and zero members supported retaining the measure in the program and 100 percent, or seven members, did not support retaining the measure. Ms. Williams-Bader stated the Rural Health Advisory Group noted there was no way to discern why patients declined hospice. She also noted the group indicated a concern about the availability of hospice services in rural settings. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader also provided a summary of the Health Equity Advisory Group review of the measure. Ms. Williams-Bader explained the Health Equity Advisory Group was not polled as it was determined the poll was not working for the context of equity. Ms. Williams-Bader summarized there was a robust discussion during the Health Equity Advisory Group meeting acknowledging equity issues. She noted one member raised concern hospice may not be for everyone, especially Black, Indigenous, and people of color (BIPOC) patients or those who are non-English speaking. Ms. Williams-Bader commented the group also noted hospice may not be available for everyone. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Upshaw Travis opened the meeting for Hospital Workgroup discussion. The co-chair clarified the new claims-based version of the measure has not been through the CBE endorsement process. The co-chair asked if there were duplicative measures in the program and NQF staff noted there are two similar measures indicated on the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT). A MAP member stated those measures do not appear to be duplicative and if so, there would be a gap in the program without this measure and thus was inclined to vote to keep the measure. A member of the Health Equity Advisory Group noted the measure is not interpreted fairly from an equity standpoint. A co-chair noted based on the new claims-based form of the measure, it may be premature to remove this measure, but it may need further review. Further discussion among workgroup members included

suggestions for the measure developer to harmonize this measure with other measures within the program, along with considering input from both of the advisory groups.

Ms. Upshaw Travis summarized the workgroup's discussion as indicating a general level of support for retaining the measure in the program with conditions. Those conditions included: (1) take the measure through the CBE endorsement process, (2) encourage the measure be paired or harmonized with other measures in the program related to hospice and intensive care units, and (3) consider the health equity and rural health implications. Ms. Upshaw Travis moved the Hospital Workgroup to vote "conditional support for retaining" measure 05735-C-PCHQR in the program with the three indicated conditions. Voting results were as follows: Yes – 18, No – 0. Complete voting results are in Appendix B.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures

Ms. Williams-Bader reviewed the ASCQR program, including the program type, incentive structure, and program goals. For complete details of the program, please refer to the MAP Hospital Workgroup MSR meeting slides (PDF). Ms. Williams-Bader turned the meeting to Ms. Upshaw Travis to open public comment on the measures for review within the ASCQR program.

Opportunity for Public Comment on ASCQR Program Measures

Ms. Upshaw Travis opened the meeting for public comment on the ASCQR program measures. No public comments were presented during the commenting period.

ASCQR Program Measures

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. A CMS program lead stated this is a voluntary measure and there are ambulatory surgical centers (ASCs) that do report this measure. The program lead further stated it does take time to collect, but it is an important patient outcome measure. Dr. Schreiber noted this measure is one of the few patient reported outcome measures and a frequently performed procedure within ASCs. Ms. Upshaw Travis asked if this measure is becoming mandatory and its timeframe. Dr. Schreiber responded it was decided last year to make the measure mandatory, but there is still conversation about when this will occur.

During the survey nominations process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure leads to a high level of reporting burden for reporting entities

A lead discussant noted the measure steward is working on a new measure and thus explains why they took a step back from this measure. The lead discussant further stated this measure is burdensome because the patient completes the survey and if vision is difficult, staff would need to assist the patient. The lead discussant noted this patient assistance may be biased towards a better score for the ASC.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. Zero members supported retaining

the measure in the program and 100 percent, or six members, did not support retaining the measure. Ms. Williams-Bader commented the group noted concerns about the definition of improvement. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). The Health Equity Advisory Group was not polled during their meeting. A Health Equity Advisory Group volunteer noted the advisory group's concerns of how follow up would occur with marginalized patients and this measure would be imbalanced as those patients responding to the survey would be White individuals, and not those of color. The health equity volunteer also stated the advisory group's concern of those with social needs may not have access to respond to a patient reported survey. The health equality volunteer further noted the advisory group's desire to ensure patients can respond to the survey questions, specifically for those non-English patients. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Upshaw Travis opened the meeting for Hospital Workgroup discussion. A MAP member posed a question to Dr. Schreiber regarding whether CMS is still conducting cost-benefit analysis on measures. Dr. Schreiber noted CMS has heard the measure is burdensome, but it is one of the few patient reported measures. A CMS program lead responded there has not been a cost benefit analysis on this measure, but burden estimates are routinely completed. The program lead further clarified CMS is aware the measure developer is working on a new measure and noted it was their understanding the measure developer will address survey question concerns, specifically that questions are outdated. There was robust discussion among the workgroup members regarding survey burden. A MAP member commented this measure is a perfect example of a patient reported outcome performance measure (PRO-PM) and is important for the feedback loop. This member further commented PROMs in general are burdensome. Another MAP member stated surveys can be subjective. The CMS program lead reminded the workgroup this measure does not look at visual acuity, but how the patient is functioning. A co-chair asked if there is a performance gap. Dr. Schreiber responded this measure is voluntary, but there is still a performance gap in those reporting.

There was further discussion among the Hospital Workgroup regarding clinician burden, especially with the current healthcare workforce under strain. A workgroup member prompted discussion about the use of this measure in the Hospital Outpatient Quality Reporting (OQR) program and asked why the workgroup was considering the measure for removal only from the ASCQR program. Dr. Schreiber reminded the group this measure rose to the top during the survey process for the ASCQR program. A co-chair noted one of the statements during public comment indicated what is being measured here may be the surgeon versus the ASC. This co-chair further noted the facility can have an impact on the improvement in functioning. Dr. Schreiber noted with any procedure both the surgeon and the facility are important. Dr. Schreiber further noted the benefit of having this measure in both the ASCQR program and the Hospital OQR program is the potential for a patient to compare where to have a procedure. There was discussion among workgroup members regarding whether they wanted conditions on retaining the measure, such as endorsement. Workgroup members discussed the survey used in the measure. The CMS program lead explained in both the ASCQR program and Hospital OQR program, facilities have the option to choose either the short or long version of the survey. Ms. Upshaw Travis reminded the workgroup their job during this meeting is to look at the measure in the ASCQR program.

Ms. Upshaw Travis moved the Hospital Workgroup to start the vote with "support for retaining" measure 01049-C-ASCQR in the program. There were not enough voting members at the meeting for quorum immediately after the discussion, so the vote was placed on hold. After completing discussion of the following measure, the workgroup reached quorum and Ms. Upshaw Travis circled back to start the vote with "support for retaining" measure 01049-C-ASCQR in the program. Voting results were as

follows: Yes – 10, No – 7. Consensus was not reached, and workgroup discussion continued to the next decision category. Co-chairs were experiencing technical difficulties, so Dr. Elliott continued the discussion and asked the workgroup if they had conditions to pose for conditional support for retaining the measure. One MAP member mentioned temporarily extending measure use in anticipation of the new survey instrument from the measure developer. Another MAP member noted the desire to harmonize this measure across settings, specifically the measure survey utilized in the MIPS program. There was further discussion about the survey used in the measure and the difference in scoring the long and short versions of the survey. Another MAP member clarified the short version of the survey was utilized in the MIPS program. Ms. Upshaw Travis returned to the meeting and Ms. Williams-Bader summarized the workgroup's conditions as: (1) the measure developer integrate the new survey instrument into the measure and (2) the measure align to use the same survey version across programs. Ms. Upshaw Travis moved the Hospital Workgroup to start the vote with "conditional support for retaining" measure 01049-C-ASCQR in the program with the two indicated conditions. Voting results were as follows: Yes – 15, No – 2. Complete voting results can be found in Appendix B.

02936-C-ASCQR: Normothermia Outcome

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "not endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The CMS program lead noted the measure came from the ASC Quality Collaboration and the measure has not gone through the CBE endorsement process. The program lead further noted although there is high overall performance on the measure and there are some outliers. The program lead explained this is a stringent measure and CMS finds merit in it but has heard from stakeholders it is burdensome.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure leads to a high level of reporting burden for reporting entities

A lead discussant noted there was no public comment. This discussant also noted the high performance, but there was not much information about the range. The discussant stated that a condition could be endorsement, particularly as endorsement includes a performance gap analysis.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. Zero members supported retaining the measure in the program and 100 percent, or six members, did not support retaining the measure. Ms. Williams-Bader noted there was minimal discussion regarding this measure, but the Rural Health Advisory Group indicated this measure could be a standard of care. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). The Health Equity Advisory Group was not polled during their meeting. A Health Equity Advisory Group volunteer noted there was minimal discussion, especially related to implications to equity. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Ms. Upshaw Travis opened the meeting for workgroup discussion. The program lead was asked about the performance gap in specific studies. The program lead noted they had not looked at those studies, but the standard within this measure is more stringent than other normothermia standards. The program lead also noted although most performers are high, there are outliers and room for improvement. A co-chair questioned whether performance would decline if the measure was removed

from the program. A workgroup member stated they did not understand why the data cannot be captured by something other than manual review. Another workgroup member noted the measure has not gone through the process of mapping for an electronic clinical quality measure (eCQM). The member stated it could be a suggestion to do this but did not think the suggestion rose to the level of a condition and questioned if recommending these types of changes was the role of the workgroup. Ms. Upshaw Travis noted if the group wanted a condition, endorsement could be the condition.

Ms. Upshaw Travis moved the Hospital Workgroup to start the vote with "support for retaining" measure 02936-C-ASCQR in the program. Voting results were as follows: Yes – 15, No – 2. Complete voting results can be found in Appendix B.

Hospital Outpatient Quality Reporting (Hospital OQR) Program

Ms. Williams-Bader reviewed the Hospital OQR program, including the program type, incentive structure, and program goals. For complete details of the program, please refer to the MAP Hospital Workgroup MSR meeting slides (PDF). Ms. Williams-Bader turned over the meeting to Mr. Demehin to open public comment on the measures for review within the Hospital OQR program.

Opportunity for Public Comment on Hospital OQR Program Measures

Mr. Demehin opened the meeting for public comment on the Hospital OQR program measures. No public comments were presented during the commenting period.

Hospital OQR Program Measures

00922-C-HOQR: Left Without Being Seen

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The CMS program lead noted the measure responds to quality of care, and it is a low burden. Another program lead further noted facilities find the measure useful because they can compare value, review their policies, and adjust.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

A lead discussant noted there were no public comments, but MAP survey respondents asked if there was information about the endorsement removal. This lead discussant commented there are only two variables reported for the measure. This lead discussant questioned if this is a value for providers or patients deciding on where to get care. Another lead discussant noted this was an interesting measure especially with the COVID-19 public health emergency. This lead discussant noted there was an increased wait time with COVID-19 and patients did not want to wait with other sick patients. This lead discussant further noted small rural facilities produced creative ways to address wait times including

having patients wait in cars or examining patients in the parking lot. A CMS lead reacted to the third criteria from the survey, stating there have been better patient outcomes in critical access hospitals.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. One member supported retaining the measure in the program, four members did not support retaining the measure, and one was unsure. Ms. Williams-Bader commented the Rural Health Advisory Group saw this measure as an internal metric, although they noted low volume could be a factor. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader also provided a summary of the Health Equity Advisory Group review of the measure. Ms. Williams-Bader stated the Health Equity Advisory Group thought this measure could highlight inequities and the group noted the desire to stratify by population. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Mr. Demehin opened the meeting for workgroup discussion. A workgroup member asked if there had been consideration to stratify the measure to ensure granular data. A CMS program lead responded they are looking to stratify in the future. A co-chair asked about the CBE endorsement removal as the measure summary sheet mentioned the measure was retired. Dr. Schreiber responded they did not have the information but can track that down. There was workgroup discussion regarding whether the data from the measure by itself is beneficial. Workgroup members agreed the measure itself may not be telling patients what they need to know. A member noted the measure may not have enough granularity to give value. Another member stated hospitals during the COVID-19 public health emergency are providing non-acute care in communities.

Mr. Demehim stated based on the conversation, the vote would start with “support for removal” for measure 00922-C-HOQR in the program. There were not enough voting members at this point in the meeting for quorum. After the meeting, workgroup members were sent a meeting recording and voting opportunity via an electronic survey. There were not enough responses via the electronic survey for the quorum threshold. The discussion from the workgroup will be conveyed to the MAP Coordinating Committee and they will review this measure at the MSR review meeting in August. Complete voting results can be found in Appendix B.

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as “endorsement removed,” and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The CMS program lead stated like the prior measure, this measure has low burden and is an important measure for consumers to compare facilities. The program lead noted the measure is also important for facilities to compare their practices against peers. The program lead also noted this measure is stratified based on overall rate and psychiatric patients.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes

A lead discussant stated there are differences across emergency departments (EDs) and variation across EDs warranting risk adjustment. This lead discussant noted this measure is a patient experience measure and the measure itself may not be capturing quality of care in a meaningful way. This lead discussant further noted there could be a higher value measure, but from a hospital perspective the data capture could be more burdensome. This lead discussant recommended removal of the measure. Another lead discussant also questioned if there was a better way to improve hospital quality and recommended removal of the measure.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. One member supported retaining the measure in the program, and 100 percent or seven members did not support retaining the measure. Ms. Williams-Bader stated there was minimal discussion regarding this measure. She mentioned the Rural Health Advisory Group noted this measure is an internal quality improvement metric and noted low volume providers could perform well. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader also provided a summary of the Health Equity Advisory Group review of the measure. Ms. Williams-Bader noted the Health Equity Advisory Group stated this measure could be retained for determining community need. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Mr. Demehim opened the meeting for workgroup discussion. The CMS program lead noted the measure is publicly reported and is a useful measure. The program lead also stated stratification was discussed during rule making. A MAP member suggested stratification for case complexity. There was discussion among workgroup members regarding measure burden. The program lead responded it is chart abstracted, but not burdensome. A member noted the measure may not be burdensome, but there may be inaccuracies. Mr. Demehim stated the lead discussants are recommending removal and asked for perspective from other members of the workgroup. A member noted the desire for a stratified measure for ED distinction and one in which the ambiguity of the ED arrival is removed. A member commented about the impact of COVID 19 pandemic on this measure. Another member responded that the lag time of the measure reporting may not be relevant in decision making. There was discussion among workgroup members to look at measures and the bigger picture within the program. A co-chair asked if there were any other ED quality measures if this measure and the prior measure (00922-C-HOQR) were removed. The program lead clarified there would be one measure remaining having to do with ED arrival for head CT and stroke. Mr. Demehim suggested conditional support for removal based on the potential measurement gap with the removal of the measure from the program. There was member agreement of the co-chair's statement.

Mr. Demehim stated the vote would start with "conditional support for removal" for measure 00930-C-HOQR in the program, with mention of the measurement gap. There were not enough voting members at this point in the meeting for quorum. After the meeting, workgroup members were sent a meeting recording and voting opportunity via an electronic survey. There were not enough responses via the electronic survey for the quorum threshold. The discussion from the workgroup will be conveyed to the MAP Coordinating Committee and they will review this measure at the MSR review meeting in August. Complete voting results can be found in Appendix B.

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsement removed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The program lead

stated this measure was originally endorsed in 2008 within the outpatient efficiency project and brought back in 2014 within the musculoskeletal project. The CBE standing committee did not recommend endorsement based on results for scientific acceptability, but the Consensus Standards Approval Committee (CSAC) overturned the standing committee votes for inconsistency related to exclusions. The program lead further noted during the 2016 cycle the measure did not pass the scientific acceptability criteria and its endorsement has not been pursued since endorsement was removed.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Performance or improvement on the measure does not result in better patient outcomes
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure leads to a high level of reporting burden for reporting entities

A lead discussant noted in 2018 MAP did not support the measure for rulemaking with the rationale from the committee relating to the CBE's standing committee decision in 2016. Another lead discussant noted this is an older measure with updates for telehealth which would impact the measure in a post COVID-19 health care system. This lead discussant supported removal of the measure. This lead discussant asked if the measure was topped out. Dr. Schreiber responded CMS considers above 95 percent for measures to be topped out but noted CMS does not have a topped out threshold for reverse measures. The measure developer noted this measure is not considered topped out according to the methodology.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. Zero members supported retaining the measure and 100 percent, or seven members, did not support retaining the measure. Ms. Williams-Bader stated the advisory group did not see this measure as helpful. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader also provided a summary of the Health Equity Advisory Group review of the measure. Ms. Williams-Bader noted the Health Equity Advisory Group was indifferent from an equity perspective. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Mr. Demehim opened the meeting for workgroup discussion. The program lead noted there are factors to remove or replace a measure in the Hospital OQR program and one of them is being topped out. A MAP member mentioned the feasibility of the measure is related to the data elements based on codes. This member further stated the accuracy of those codes should be taken into account, but it is not easy when using a third-party vendor for coding. A co-chair noted this measure may have served its purpose and it is time to be retired. A member agreed and noted overuse was an issue when the measure was first developed so commercial health plans took action. This member also noted the measure no longer reflects the time of today. A co-chair commented the patient experience of going through the antecedent steps prior to an MRI may not be relevant today.

Mr. Demehim stated the vote starts with "support for removal" for measure 00140-C-HOQR in the program. There was member agreement to the vote category. There were not enough voting members at this point in the meeting for quorum. After the meeting, workgroup members were sent a meeting recording and voting opportunity via an electronic survey. There were not enough responses via the

electronic survey for the quorum threshold. The discussion from the workgroup will be conveyed to the MAP Coordinating Committee and they will review this measure at the MSR review meeting in August. Complete voting results can be found in Appendix B.

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "not endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The program lead stated this is an efficiency measure to promote high efficiency care and decrease exposure to contrast material. The program lead further stated the data is publicly reported to ensure facilities are appropriate in their imaging.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure does not contribute to the overall goals and objectives of the program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. Zero members supported retaining the measure in the program and 100 percent, or seven members, did not support retaining the measure. Ms. Williams-Bader commented the group noted this measure does not provide information about clinical quality and does not provide a response to poor quality imagining. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). A Health Equity Advisory Group member noted there was no real consensus on equity concerns from the group. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Mr. Demehim stated this measure is different from the previous imaging measure as it more directly reflects quality by assessing inappropriate use of contrast material. Mr. Demehin, however, noted the measure failed endorsement on specificity. The co-chair further stated the use of contrast material could have quality implications and opened the discussion to the workgroup. The measure developer noted the initial endorsement attempt was in 2008 and there have been changes to the measure since that date. The measure developer also stated there have been no other attempts to submit the measure for endorsement due to resources. A MAP member noted concern with removal of the measure without knowing if there would be a program gap.

Mr. Demehim suggested a condition for CBE endorsement to answer the underlying questions related to scientific acceptability. There was discussion among workgroup members in agreement that removing the measure may impose a gap in the program.

Mr. Demehim stated the vote would start with "conditional support for retaining" for measure 02599-C-HOQR in the program. The condition was based on CBE endorsement. There were not enough voting members at this point in the meeting for quorum. After the meeting, workgroup members were sent a meeting recording and voting opportunity via an electronic survey. There were not enough responses via the electronic survey for the quorum threshold. The discussion from the workgroup will be conveyed to the MAP Coordinating Committee and they will review this measure at the MSR review meeting in August. Complete voting results can be found in Appendix B.

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

Ms. Williams-Bader introduced the measure for review with an overview of the measure description, noting the measure endorsement status as "endorsed," and the number of survey votes received during the nomination process by MAP advisory and workgroup members. Ms. Williams-Bader turned to the CMS program and measure leads to provide any further clarification. The program lead noted that more than 72 percent of surgeries occur in an outpatient setting and it is important to retain this measure based on those increasing outpatient numbers. The program lead also noted visits following same day surgery can reflect quality of care.

During the survey nomination process, MAP members selected the measure for discussion based on the following criteria:

- Measure is duplicative of other measures within the same program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation
- Measure is duplicative of other measures within the same program
- Measure is not endorsed by a Consensus-Based Entity (CBE), or lost endorsement
- Measure performance does not substantially differentiate between high and low performers, such that performance is mostly aggregated around the average and lacks variation in performance overall and by subpopulation

A lead discussant reviewed the above criteria. This lead discussant noted this measure highlights their organization's concern of ratio measures, preference for risk adjusted measures, and year over year normalized rates. This lead discussant noted the desire for actual performance instead of competency intervals where actual performance is misrepresented.

Ms. Williams-Bader provided a summary of the Rural Health Advisory Group review of the measure. The Rural Health Advisory Group was polled during their review meeting. One member supported retaining the measure in the program, four members did not support retaining the measure, and one member was unsure. Ms. Williams-Bader stated the group did not note any specific rural health concerns but did note having a general measure, rather than measures of specific adverse events, could deter patients from returning if they had a concern after surgery. For complete details from the Rural Health Advisory Group meeting, please refer to the meeting summary (PDF). Ms. Williams-Bader also provided a summary of the Health Equity Advisory Group review of the measure. Ms. Williams-Bader summarized the Health Equity Advisory Group had minimal comments, but the group did note the data from the CMS Impact Assessment included variations based on age, income, dual eligibility, and performance. For complete details from the Health Equity Advisory Group, please refer to the meeting summary (PDF).

Mr. Demehim opened the meeting for workgroup discussion. A co-chair asked if there is a similar measure in the ASCQR program. The measure developer responded there are no overlapping measures for this setting, including none in the Hospital OQR program that address same day surgery. The measure developer further stated the measure captures a million same day surgeries done for those fee-for-service patients and surgeries that are shifting towards the outpatient setting. The developer noted the results reported are better than the national rate, or worse at 95 percent confidence levels. The developer also stated approximately eight percent of facilities were identified as outliers. The developer noted the worst performer is 130 percent worse than the average and the best performer is 50 percent better than the average, which is a decent spread in performance variation. The co-chair commented cross-setting information can be used by consumers and for quality improvement. The

measure developer responded this measure captures a wide range of surgeries and breaks them down into categories. A co-chair asked if the hospital receives reports in granular detail and the developer confirmed reports are facility level, but not divided by surgery category. Dr. Schreiber noted the readmission all-cause measure is broken down into categories and this measure for discussion is comprised of many procedures. Dr. Schreiber further noted if the organization is an outlier, they should look to their own data to determine why.

Mr. Demehim prompted the group for a decision category. There was workgroup member agreement with "support for retaining." Several members agreed with retention given the explanation from the measure developer. Mr. Demehim noted concern about the variation in services offered by hospital outpatient departments and whether risk adjustment would account for those differences. He also noted as ambulatory settings perform more complex surgeries the outcome comparability could become more difficult. Mr. Demehim reflected this was not enough to sway to conditional support, but noted it was good to reflect this back to CMS.

Mr. Demehim stated the vote would start with "support for retaining" for measure 02930-C-HOQR in the program. There were not enough voting members at this point in the meeting for quorum. After the meeting, workgroup members were sent a meeting recording and voting opportunity via an electronic survey. There were not enough responses via the electronic survey for the quorum threshold. The discussion from the workgroup will be conveyed to the MAP Coordinating Committee and they will review this measure at the MSR review meeting in August. Complete voting results can be found in Appendix B.

Public Comment

Ms. Upshaw Travis opened the meeting up for public comment by inviting members of the public to contribute remarks based on the discussions of the day. There were no public comments provided.

Discussion of Gaps in Hospital MSR Programs

Mr. Demehin started discussion regarding gap areas MAP members saw throughout the discussions of the measure sets that they wanted to share with CMS.

A workgroup member commented on the conversations around imaging and emergency departments and noted the conversations around these topics were shaped by the limited number of measures in these areas. The member commented this gap could lead to innovative approaches, as to what matters and what is a priority in emergency rooms and in imaging and reflecting those priorities in the measure. The member concluded by saying they would consider there to be gaps in emergency care and imaging categories, which are critical to outpatient care.

Another workgroup member offered thoughts regarding the difficulty of outpatient quality reporting programs to develop measures because of the wide breadth and variability in ambulatory services provided by hospitals. The member noted outpatient surgical procedures are a critical area to maintain focus. In addition, the member explained it is important for CMS to remain focused on the sets of services offered and the volume of patients in the ambulatory setting, and to use that information to identify potential gap areas. The member concluded by saying doing the best for the most patients would serve the program well.

Another workgroup member noted the shift in the understanding of patient safety since the pandemic. Across the three programs reviewed, the member felt it would be beneficial to identify which existing measures contribute to assuring patient safety and use that information to then identify if there are still

gaps that exist. The member then observed how the discussion during the meeting was specific within the setting measure sets, while other times the conversation was more broad and not inclusive of specific conditions. The member noted it is important to ensure there are no gaps in the balance between these two patterns.

MAP Hospital Workgroup Feedback on MSR Process

Ms. Williams-Bader moved to hold a poll and a discussion among workgroup members regarding feedback on the MSR process. There were three poll questions, and the full results are detailed in Appendix C.

Workgroup members contributed that participating in the meeting clarified the larger picture of the MSR process. The workgroup found the measure summary sheets helpful in the preparation for measure discussions. Members commented having a brief version of the measure summary sheet at the time of the survey would be helpful. This brief information included performance and reporting data, if the measure was topped out, how long the measure had been in the program, measure endorsement history, how the measure is used in the field, and further details around the crosscutting nature would provide better understanding. For additions to the measure summary sheet, one member did suggest including any concerns around construct validity or content validity. One member contributed by saying the survey was a successful method to filter through the larger group of measures. The wide breath of experience from the workgroup resulted in the set of measures they were able to spend time discussing in the meeting.

A workgroup member stated it would be helpful to have some context of the other measures in the set so the workgroup is not looking at a single measure, but the program as a whole. This was echoed by many other members. An additional member added the importance of looking at the full set of measures and feared the structure of the workgroup can make it feel siloed. This member explained holding a meeting to discuss adding a measure at a different time than the meeting to discuss removing a measure, prevented a harmonized process. The member encouraged a more holistic approach in thinking as a workgroup.

A few workgroup members mentioned NQF's Quality Positioning System (QPS) could be a resource for members to locate additional measure information. Ms. Williams-Bader cautioned there can be specific instances where a similar measure is listed as endorsed or previously endorsed in QPS but does not align to the specific measure considered for the programs. Ms. Williams-Bader explained NQF worked closely with the CMS program leads to make sure the correct measure was identified.

A workgroup member raised a concern if a measure is identified by the workgroup to have a gap but there is not currently a measure to fill the gap if removed, the workgroup may be compelled to leave the measure in the program because of the risk of removing. They worried this would work against encouraging new measure creation. An additional member agreed on this point and encouraged the group to be specific when referring to a gap. For example, when identifying gaps, the member commented it should be clear whether (1) the topic is right, but the design of the measure is off; or (2) that the topic of the measure is off. They noted MAP can struggle with conditional, versus outright, support. The member noted the workgroup is sensitive to the use of the measures, as they are used by a variety of people and a variety of perspectives. However, the member also commented it is important to note when the time has come to create something different.

A workgroup member mentioned the financial impact of accumulating measures. The member noted each measure has a human interest and quality story, and the workgroup members do a good job adding measures, but not as good at harmonizing or reducing the number of measures. The member

commented when a decision is made in this context it can cost tens of millions of dollars in time and personnel across the country, and the weight is hard to feel when making these decisions. The member suggested incorporating a sense of what the measure is going to cost in time or money, to help the larger context around burden.

Lastly, a workgroup member summarized they felt there were a few ideas it was important to remember when voting on a measure: is it making a difference? Is care better? Is health better? Is care more equitable? The member also posed the idea it may be better to have fewer measures, rather than more, if those measures truly make a difference in care and equity.

Next Steps

Joelencia LeFlore, associate, NQF, summarized the next steps in the MSR process. Ms. LeFlore noted that the MAP Coordinating Committee MSR meeting will take place in late August, following a second public commenting period between July 22 and August 5, 2022. All MAP events can be accessed through the relevant project pages. The final Recommendations Report will be published on September 22, 2022.

Ms. Williams-Bader reminded the members the MAP team would be forwarding a meeting recording and a survey to vote on measures where quorum was not reached, following the discussion held during the meeting.

Ms. Williams-Bader invited both co-chairs to give closing remarks on the day. The co-chairs again expressed their gratitude for the members' contributions during discussions of measures, as well as during the feedback portions of the meeting. They stressed how the workgroup's feedback will be useful in improving the process going forward. Ms. Williams-Bader then adjourned the meeting.

Appendix A: MAP Hospital Workgroup Attendance (Voting Only)

The following members of the MAP Hospital Workgroup were in attendance for the web meeting:

Co-chairs

- Akin Demehin, MPH
- Cristie Upshaw Travis, MSHA (acting co-chair)

Organization Members

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- City of Hope
- Dialysis Patient Citizens
- Greater New York Hospital Association
- Henry Ford Health System
- Kidney Care Partners
- Medtronic
- National Association for Behavioral Healthcare
- Press Ganey
- Project Patient Care
- Service Employees International Union
- Stratis Health
- UPMC Health Plan

Individual Subject Matter Experts

- Lindsey Wisham, MPA
- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB

Appendix B: Full Voting Results

Some MAP hospital members were unable to attend the entire web meeting. The vote totals reflect members present and eligible to vote. The measures with an asterisk (*) reflect post-meeting voting opportunity via electronic survey. There were not enough responses via the electronic survey for the quorum threshold. The MAP Coordinating Committee will review these measures at the MSR review meeting in August.

Measure	Program	Decision Category	Yes (N/%)	No (N/%)	Total (N/%)
05735-C-PCHQR: Proportion of Patients Who Died from Cancer Not Admitted to Hospice	PCHQR Program	Conditional Support for Retaining	18 (100)	0 (0)	18 (100)
01049-C-ASCQR: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	ASCQR Program	Support for Retaining Conditional Support for Retaining	10 (59) 15 (88)	7 (41) 2 (12)	17 (100) 17 (100)
02936-C-ASCQR: Normothermia Outcome	ASCQR Program	Support for Retaining	15 (88)	2 (12)	17 (100)
*00922-C-HOQR: Left Without Being Seen	Hospital OQR Program	Support for Removal	**	**	**
*00930-C-HOQR: Median time from ED Arrival to ED Departure for Discharged ED patients	Hospital OQR Program	Conditional Support for Removal	**	**	**
*00140-C-HOQR: Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain	Hospital OQR Program	Support for Removal	**	**	**
*02599-C-HOQR: Abdomen Computed Tomography (CT)—Use of Contrast Material	Hospital OQR Program	Conditional Support for Retaining	**	**	**
*02930-C-HOQR: Hospital Visits after Hospital Outpatient Surgery	Hospital OQR Program	Support for Retaining	**	**	**

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Appendix C: MSR Process Feedback Polling Results

Some MAP members were unable to attend the entire meeting. The polling totals reflect members present and eligible to vote.

Poll Question	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	Total
The MSR survey to nominate measures for discussion worked well	0	3	1	7	1	12
I had what I needed to respond to the MSR survey	0	7	3	2	0	12
The advisory group review of the measures under review worked well	0	1	1	9	1	12