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Meeting Summary

Measure Applications Partnership Hospital Workgroup Web Review Meeting

The National Quality Forum (NQF) convened a public web meeting for the Measure Applications Partnership (MAP) Hospital Workgroup on December 15, 2021.

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

Dr. Matthew Pickering, NQF Senior Director, began by welcoming participants to the web meeting and reviewing the day's agenda. Dr. Dana Gelb Safran, NQF President and CEO, provided opening remarks to welcome participants and highlight the importance of the unique, multistakeholder input provided by the MAP to the Centers for Medicare & Medicaid Services (CMS). MAP Hospital Workgroup Co-chairs, Akin Demehin and Dr. Sean Morrison, also greeted participants and expressed their anticipation for the day's discussion. Both Co-chairs thanked participants and NQF and CMS staff for their hard work to support the meeting.

Dr. Pickering facilitated introductions and disclosures of interest from members of the MAP Hospital Workgroup (for detailed attendance, see Appendix A). Disclosures included receiving stocks or company equity, and one member noted that they are a patient representative member of a measure development plan and serve on a quality measure index technical panel. These disclosures were not deemed to be in conflict with the measures under consideration, and therefore, no recusals from measure voting were necessary.

CMS Opening Remarks

Dr. Michelle Schreiber, CMS Deputy Director for Quality and Value, offered welcoming remarks and provided an overview of the MAP Hospital Workgroup and the future of Hospital Inpatient Prospective Payment Systems (IPPS) rules. Dr. Schreiber highlighted the importance of input from the diverse multistakeholders composing MAP membership and expressed excitement for new opportunities for MAP members to provide input to CMS through the Health Equity Advisory Group and Measure Set Review pilot. Dr. Schreiber reviewed the strategic priorities of the new administration and key focus areas for quality review and emphasized that the vision for CMS continues to be that of serving the public as a trusted partner and steward dedicated to advancing health equity, expanding coverage, and improving health outcomes.

Acknowledging the tragedy of the COVID-19 pandemic, Dr. Schreiber extended sincere gratitude to all of the frontline healthcare workers for their heroic work during the public health emergency. Dr. Schreiber reviewed modifications to several federal programs, including suppression of measures and data exclusions, that have been made to avoid punishing hospitals for challenges faced during the pandemic. Finally, Dr. Schreiber introduced updates to the Medicare Promoting Interoperability Program for Hospitals, including public health reporting, bidirectional health information exchanges, expansion of reporting quarters and public reporting of electronic clinical quality measures (eCQMs), and the addition of attestation to electronic medical record (EMR) safety guidelines.

Overview of Pre-Rulemaking Approach

Ivory Harding, NQF Manager, provided an overview of the pre-rulemaking approach for the Measures Under Consideration (MUC). Ms. Harding reviewed the seven assessment criteria included in the MAP preliminary analysis (PA) algorithm, the four decision categories, and the MAP voting process. Ms. Harding facilitated questions regarding the voting process and procedure and summarized the charge and the review process of the two advisory groups, the Rural Health Advisory Group, and the Health Equity Advisory Group. Advisory groups were polled on a scale of one to five. The Rural health Advisory Group responded to a poll on agreement that the measure is suitable for use with rural providers within the specific program of interest, where a score of five indicates agreement that the measure is highly suitable for the program from a rural perspective. The Health Equity Advisory Group responded to a poll on the potential impact on health disparities if the measure is included within a specific program, where a score of five indicates the greatest potential for positive impact on health equity. For complete details on Advisory Group polling scales and discussion, please refer to the Health Equity and Rural Health Advisory Group Summaries.

Following the overview of the MAP voting process, Dr. Pickering clarified that several measures on the 2021 MUC List were cross-cutting measures, appearing in more than one program. For these measures, MAP Hospital Workgroup members (MAP) would review the measure in one program, and for each subsequent program, the MAP would be asked to speak up if they had any opposition to carrying over the voting decision to that respective program. Only one opposition voice would be needed to re-open discussion on the measure for that program. The goal of this modified approach was to create efficiencies in the measure review process.

Measures Under Consideration

Cross-Cutting Measure: MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal. Voting totals for each measure can be found in Appendix B.

Public Comment

Dr. Morrison opened the discussion for public comment on the measure. No comments were offered.

MUC2021-118 was considered for multiple programs. Each program is outlined below.

Hospital Inpatient Quality Reporting (IQR) Program

The MAP sought clarification on the additional codes being added to this updated measure, and representatives of the developers shared the complete list within the meeting chat, which covered topics such as fractures following orthopedic implants and periprosthetic fractures. The MAP and CMS also clarified that by statutory requirement, any measure intended for the value-based purchasing (VBP) Program must be implemented for at least one year in the Hospital IQR Program first. MUC2021-118 was also submitted for consideration to the Hospital VBP Program. The MAP noted that since an older version of the measure is currently implemented in federal programs, it may be helpful for hospitals to receive communications to clarify why there may be performance changes in the future. The Rural Health Advisory Group did not raise any issues with the measure and the measure received an average score of 4.1, indicating suitability for use with rural providers in the program. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the Health Equity Advisory

Group meeting. The average polling score for the measure was 3.1, indicating neutral impact on health equity and health disparities.

The MAP conditionally supported this measure for rulemaking, pending NQF endorsement and review of the 26 codes added to the mechanical complication's definition. This fully developed and tested measure addresses risk-standardized payment for elective THA and TKA. This recently updated measure was designed to be used with harmonized complications and readmissions measures and aspires to drive quality improvement in care coordination and post-acute costs and resource use.

Hospital Value-Based Purchasing (VBP) Program

Following the discussion of the measure for the Hospital IQR Program, Dr. Morrison asked the MAP if there were any oppositions to carrying over the vote to the measure for the VBP Program. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group did not have any changes to recommendations for the measure in the VBP Program. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the meeting. The average polling score for the measure was 2.9, indicating neutral impact on health disparities.

Cross-Cutting Measure: MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal.

Public Comment

Mr. Demehin opened the discussion for public comment on the measure. No comments were offered.

MUC2021-131 was considered for multiple programs. Each program is outlined below.

Hospital Inpatient Quality Reporting (IQR) Program

The MAP raised two primary concerns about the measure, 1) that facilities may be double counted for re-hospitalization, and 2) that the measure does not include social risk stratification. The developer and CMS staff clarified that the focus of the measure is costs, rather than readmissions, and the measure has expected readmission costs built in, so double counting should not occur. CMS also clarified that adding social risk stratification would be creating a new measure. CMS is currently considering ways to provide measure stratification information back to hospitals more broadly. The Rural health Advisory Group expressed concerns that the measure might exclude critical access hospitals (CAHs) and rural hospitals, and sought clarification on the measure's prior removal from the program. The developer clarified that some CAHs were included in the measure and testing did not show significant differences between urban and rural facilities. The measure was removed from the program to make space for the updated version. The measure received an average score of 3.7, indicating that the Advisory Group agreed that the measure was suitable for use with rural providers within Hospital IQR Program. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the meeting. The average polling score for the measure was 2.9, indicating neutral impact on health disparities.

After not accepting the staff recommendation of "Conditional Support for Rulemaking," (11 yes, 12 no, 48%) the MAP voted to support this measure for rulemaking. Endorsement of this measure was retained during the last review cycle in June of 2021, and performance data from prior years of implementation of this measure indicates a substantial opportunity for improvement. This measure will continue to incentivize hospitals to identify methods of cost savings such as care coordination initiatives and patient safety initiatives to reduce the number of costly adverse events.

Hospital Value-Based Purchasing (VBP) Program

Following the discussion of the measure for the Hospital IQR Program, Mr. Demehin asked the MAP if there were any oppositions to carrying over the vote to the measure for the VBP Program. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group did not have any changes to recommendations or polling results for the measure in the VBP Program. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the meeting. The average polling score for the measure was 3.2, indicating neutral impact on health disparities.

Hospital IQR Program Measures

Dr. Pickering introduced the Hospital IQR Program by providing information on the program type, the incentive structure, and the program goal. For each measure under consideration, Dr. Pickering provided an overview of the measure and the input provided by MAP Advisory Groups and public comment.

Public Comment

Dr. Morrison opened the discussion for public comment. Comments were shared in support of MUC2021-134 and MUC2021-136. The developer stated that the measures are intended to be interrelated and were tested in over one million patients in 600 clinical sites via the Center for Medicare & Medicaid Innovation (CMMI) Accountable Health Communities model. The developer clarified that these measures do not currently require that providers act on the findings from the screen, though they may still do so.

Commenters further highlighted the need for measures that enable clinicians to build strong relationships with patients and agreed that these measures could address provider burnout and reduce healthcare costs. Commenters noted that the public health emergency has escalated food insecurity and housing instability among patients and expressed hope that these measures would allow providers and facilities to examine the specific needs of their patient populations in order to eventually develop services to meet those needs. Commenters shared personal and professional anecdotes to express the importance of having measures focused on social determinants of health (SDOH) in federal quality reporting and payment programs for the first time.

MUC2021-136: Screening for Social Drivers of Health

The MAP requested clarity on requirements for the screening tool, how many domains would be screened, and the reporting mechanism. The developer shared that there was no requirement of a standard screening tool, all five domains would be required to be screened, and that reporting options would include chart abstraction or electronic health records (EHR). The developer strongly suggested that the results of the measure be stratified by race and ethnicity data. The measure would be a quarterly statistic asked to all individuals admitted to inpatient care upon admission. NQF staff provided clarifications on how the NQF endorsement process would examine validity and reliability testing for the measure. The Rural Health Advisory Group expressed concern about how data would be collected and the burden this may create for admission or discharge settings as well as for the scientific acceptability of the measure. The Rural Health Advisory Group expressed that there were potential unintended consequences if data were collected without follow-up to appropriate community resources. However, it was also noted that the topic is critical and measurement must start somewhere. The average score was 3.5, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers within Hospital IQR Program. The Health Equity Advisory Group noted concerns about standardization of screening tools, stratification of results, and the need for clear and specific definitions and consistent methodology. The Health Equity Advisory Group reiterated concerns about

identification of needs without follow-up action but acknowledged the importance of beginning to collect these data. It was noted that the burden of collecting data for this measure may be lesser at the hospital level than at the clinician level. The average polling score for the Health Equity Advisory Group was 4.1, indicating that the Advisory Group shared that there was some potential for the measure to have positive impact by decreasing health disparities.

The MAP offered conditional support for rulemaking pending NQF endorsement. This measure assesses the rate at which providers screen their adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. As the first screening measure addressing social determinants of health and health care equity, this measure is consistent with CMS' Meaningful Measures 2.0 priority areas.

MUC2021-134: Screen Positive Rate for Social Drivers of Health

The MAP listed several concerns with MUC2021-134. The reporting statistic of the measure is what percent of patients screen positive for one or more health-related social need (HRSN), and the MAP was apprehensive about how this measure would be publicly reported and used for benchmarking, and how the measure would be interpreted by consumers on Care Compare since the lack of threshold may prompt confusion. MAP noted that a low score could represent a lack of accurate reporting from patients that could lead to missed identification of HRSNs. Furthermore, the MAP noted that the measure was not linked to action steps to help navigate the patient to the appropriate services. One MAP member questioned if the metric was truly a quality measure but acknowledged that the topic was exciting and important. Other MAP members expressed that it would not be logical to screen for social drivers of health without reporting the results and expressed that the measure would be crucial data for facilities and providers to begin planning interventions or connections to community services.

The developer clarified that the measure is not formally paired with MUC2021-136, although both are intended to be used in the Hospital IQR Program.

The Rural Health Advisory Group expressed similar concerns to those outlined for MUC2021-136 and also noted concern for the impact of the measure on payment. The average polling score for the measure was 3.5, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use in rural settings for the Hospital IQR program. The Health Equity Advisory Group raised concerns about the intent and performance interpretation of the measure and reiterated comments similar to MUC2021-136 regarding standardization of tools and unintended consequences. The Health Equity Advisory Group average score was 3.7, indicating that this measure had some potential to have a positive impact on health equity by decreasing health disparities.

After not accepting the staff recommendation of "Do Not Support for Rulemaking" (13 yes, 11 no, 54%) and then not accepting "Support for Rulemaking" (3 yes, 20 no, 13%) and "Conditional Support for Rulemaking" (9 yes, 14 no, 39%), the MAP ultimately provided a vote of do not support for rulemaking with the potential for mitigation. Mitigation is contingent upon NQF endorsement to resolve reliability and validity concerns, and that there should be updates to the measure which link the positive screens to actionable interventions conducted by the accountable entity.

MUC2021-106: Hospital Commitment to Health Equity

The Rural Health Advisory Group did not see clear evidence in the literature linking elements of the measure to clinical outcomes, but it did not see burden for reporting as the measure was electronic and agreed that the measure had importance. The Rural Health Advisory Group average score was 3.9, indicating that the measure was suitable for use by rural providers. The Health Equity Advisory Group

expressed similar concerns about the evidence linking the measure to outcomes and also noted the risk that hospitals may signal that they are committed to proving health equity without providing clarity on tangible efforts. The Health Equity Advisory Group suggested that future iterations of the measure include items around data transparency, accessibility, and disability. The average score was 3.7, indicating that the Health Equity Advisory Group determined that this measure had some potential for positive impact on health equity by decreasing health disparities.

The MAP did not have any clarification questions on the measure, and it did not support this measure for rulemaking. The measure assesses whether hospitals have developed plans to address health equity issues, collected, and analyzed the data needed to act on that plan and evaluated progress towards attaining their objectives. While reducing healthcare disparities would represent a substantial benefit to overall quality of care, the measure is not closely linked to clinical outcomes; likewise, a performance gap at the individual hospital level on these specific structural elements has not been established.

Following the vote on the measure, CMS requested context for the results of the vote and further input from the MAP since there was little discussion of the measure. The MAP expressed that the measure was a structural checkbox that may not lead to tangible action, and the measure includes many components that may be subject to interpretation. The MAP did note the importance of the measure concept, and one MAP member noted that the structural measure was a step in the right direction and that structural measures can be beneficial in federal programs.

MUC2021-122: Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)

The Rural Health Advisory Group expressed that the measure was not relevant to rural settings as patients with this condition would be transferred to other facilities. The average polling score was 3.7, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers. The Health Equity Advisory Group suggested that the measure should be stratified and should be updated to include social risk factors. The Health Equity Advisory Group average score was 3.3, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

The MAP did not have any clarification questions on the measure and supported this measure for rulemaking. The measure is currently included in the Hospital IQR Program; the measure under consideration updates the minimum admissions threshold, strengthening the reliability of the measure result. This measure distinguishes itself both for its condition specificity, and the inclusion of other health care visits beyond hospital readmissions.

MUC2021-120: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA)

The MAP and the measure developer clarified that the measure included the same updated codes as MUC2021-118. The Rural Health Advisory Group noted that there could be potential unintended consequences of patient-selection by some facilities where the patients could not be cared for and that low-case volume may impact calculation. The Rural Health Advisory Group gave an average score of 3.9, indicating that the measure was suitable for the program. The Health Equity Advisory Group questioned if variation in payment may be influenced by disparities of care and expressed concern that the measure could lead to underutilization if not tied to additional quality measures to understand context. The average score was 2.5, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

The MAP conditionally supported this measure for rulemaking, pending NQF endorsement and review of the 26 codes added to the mechanical complication's definition. The measure addresses risk-standardized payment for elective THA and TKA. This recently updated measure was designed to be used with harmonized complications and readmissions measures and aspires to drive quality improvement in care coordination and post-acute costs and resource use.

Cross-Cutting Measure: MUC2021-084 Hospital Harm – Opioid-Related Adverse Events

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal.

Public Comment

Mr. Demehin opened the discussion for public comment on the measure. No comments were offered.

MUC2021-084 was considered for multiple programs. Each program is outlined below.

Hospital IQR Program

The MAP asked the developer for clarity on the 12-hour window and the exclusion of operating rooms (ORs). The developer stated that the time window was shortened based on suggestions from the NQF Standing Committee reviewing the measure for endorsement, and that ORs were excluded to account for administrations of naloxone that may be part of intentional anesthesia plans. The Rural Health Advisory Group agreed that the measure was very relevant for rural settings and raised no concerns. The average polling score for the Rural Health Advisory Group was 4.2, indicating suitability for rural health providers. The Health Equity Advisory Group was unclear on equity implications of the measure but noted the measure was important for safety. The average score was 3.2, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

The MAP supported this measure for rulemaking. The measure addresses a critical and preventable safety event in the Hospital IQR Program. The program does not currently include a measure that addresses opioid-related adverse events and subsequent administration of naloxone in the inpatient setting. The measure was submitted for endorsement review to the Patient Safety Standing Committee, Spring Cycle 2021 and received NQF endorsement.

Medicare Promoting Interoperability Program for Hospitals

CMS clarified that all measures in the Hospital IQR Program are publicly reported, and all eCQMs in that program must also be included in the Medicare Promoting Interoperability Program for Hospitals to ensure alignment of eCQMs across programs. Mr. Demehin asked the MAP if there were any oppositions to carrying over the vote to the measure for the Medicare Promoting Interoperability Program for Hospitals. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group had no changes to recommendations for the measure in this program. The Health Equity Advisory Group average polling score was 3.3, indicating that the Advisory Group was neutral on this measure's impact on health equity and on health disparities.

Cross-Cutting Measure: MUC2021-104 Hospital Harm – Severe Obstetric Complications

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal.

Public Comment

Dr. Morrison opened the discussion for public comment on the measure. One comment was offered, stating concerns about the inclusions of blood transfusions and intensive care unit (ICU) admissions, and the lack of risk stratifying. The commenter noted that it is difficult to know without risk stratification if morbidities are the result of care received or of underlying health conditions of the population.

MUC2021-104 was considered for multiple programs. Each program is outlined below.

Hospital IQR Program

The developer addressed several questions and comments from the MAP, noting that ICU admissions are not included as numerator events and that blood transfusions are addressed with two separate outcomes to account for times when transfusion is the only reason a patient would reach the numerator. The developer added clarifications about the risk adjustment of the measure, specifying that housing insecurity was selected as a risk factor because it is one of the most consistently captured SDOH factors in electronic health record (EHR) systems. The MAP questioned if the measure would be able to reach a significant sample size given the rarity of the events, and CMS and the measure developer confirmed that the events were occurring with sufficient frequency to measure. The Rural Health Advisory Group noted that rural communities tend to have a higher obstetric-related mortality rate and measure does not consider population prevalence and expressed concern that the measure cited blood transfusions as a severe complication, rather than an early intervention. The Rural Health Advisory Group average score for the measure was 4.1, indicating that it was suitable for use with rural providers within the Hospital IQR program. The Health Equity Advisory Group agreed that the measure addressed a critical clinical area with large racial disparities and suggested stratification of the measure by federal poverty level, race/ethnicity, and insurance status. The average score was 4.4, indicating that the Health Equity Advisory Group determined that this measure had some potential for positive impact by decreasing health disparities.

The MAP conditionally supported this measure for rulemaking pending successful completion of testing and NQF endorsement. This newly developed measure is an outcome eCQM, a high priority area for the Hospital IQR Program, and it addresses the Meaningful Measures area of patient safety.

Medicare Promoting Interoperability Program for Hospitals

Following the discussion of the measure for the Hospital IQR Program, Dr. Morrison asked the MAP if there were any oppositions to carrying over the vote to the measure for the Medicare Promoting Interoperability Program for Hospitals. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group and Health Equity Advisory Group had no changes in their respective recommendations for this program.

Cross-Cutting Measure: MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal.

Public Comment

Mr. Demehin opened the discussion for public comment on the measure. The measure developer provided a statement to clarify that the measure is a refinement that can serve as a proxy for provider judgement of clinical infections. The developer noted that the measure will be submitted to NQF for endorsement in 2022.

MUC2021-098 was considered for multiple programs. Each program is outlined below.

Hospital IQR Program

The MAP and the developer clarified the start date of measure and the developer noted that these dates help to clarify inherent imprecision with Clostridioides difficile (C-diff) diagnosis. The MAP also advised the developer to consider collecting patient and consumer input as part of the measure development process, and the developer noted that the measures arose from provider feedback requesting more algorithm-based measurements. The MAP and the developer also clarified that the current measure is not Fast Healthcare Interoperability Resources (FHIR)-based, but FHIR specifications may be introduced in the future as more facilities obtain that reporting capacity. The Rural Health Advisory Group noted that low case volume is a potential challenge for measure calculation and reporting. The Advisory Group polled on the suitability of this measure for inclusion in the Hospital IQR Program. The average score was 3.9, indicating that the Advisory Group agreed that the measure was suitable for use with rural providers within the Hospital IQR Program. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the meeting. The average polling score for the measure was 3.4, indicating neutral impact on health disparities.

MAP conditionally supported this measure for rulemaking pending NQF endorsement and resolution of duplication concerns by CMS. This updated measure is intended to capture healthcare associated C-diff infections (HA-CDI) more precisely than the existing similar measure in other hospital programs by only counting those infections among inpatients that have both a positive laboratory test and evidence of treatment. The measure corresponds to the Patient Safety focus within CMS' Meaningful Measures 2.0.

Medicare Promoting Interoperability Program for Hospitals

Dr. Pickering stated that the MAP would need to vote independently of the decision for the measure in the Hospital IQR Program, given the different recommendation. The measure is not an eCQM, although it is a digital measure. During deliberations the MAP Hospital Workgroup discussed how the Medicare Promoting Interoperability Program for Hospitals was interpreted to exclusively contain eCQMs. Because of this, the MAP did not support this measure for rulemaking.[1] The Rural Health Advisory Group did not have program-specific comments for the measure. The average score was 4.0, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers within the program. The Health Equity Advisory Group average online polling score for the measure was 3.5, indicating some potential for positive impact or reducing health disparities.

Hospital-Acquired Condition Reduction Program (HACRP)

Mr. Demehin asked the MAP if there were any oppositions to carrying over the vote from the Hospital IQR Program to the measure for the HACRP. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Committee expressed similar comments for the measure in this program, and the average polling score was 3.6, indicating that the Advisory Group agreed that the measure was suitable for use with rural providers within the HACRP. The Health Equity Advisory Group average online polling score for the measure was 3.4, indicating neutral impact on health disparities.

[1] In discussions after the meeting it was determined that the Coordinating Committee should focus their review of the measure solely on its specifications and appropriateness for the program. CMS will continue to review and ensure compliance with statutory requirements for the Medicare Promoting Interoperability Program for Hospitals. The MAP Coordinating Committee for final recommendation.

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

Mr. Demehin asked the MAP if there were any oppositions to carrying over the vote from the Hospital IQR Program to the measure for the PCHQR Program. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group did not have program-specific comments for the measure. The average score was 4.0, indicating that the Rural Health Advisory Group agreed that the measure was suitable for use with rural providers within the PCHQR Program. The Health Equity Advisory Group average online polling score for the measure was 3.6, indicating some potential for positive impact, or reducing health disparities.

Cross-Cutting Measure: MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

Dr. Pickering introduced the measure and feedback from the MAP Advisory Groups and public comment on the measure. For each program, Dr. Pickering provided information on the program type, the incentive structure, and the program goal.

Public Comment

Dr. Morrison opened the discussion for public comment on the measure. The measure developer provided a statement that the measure was intended to be patient-centered, as it addresses a serious risk to patient safety. The developer noted that the measure will hopefully spur innovations to prevent bloodstream infections and will be an algorithmically determined digital quality measure. The measure will be submitted to NQF for endorsement in 2022.

MUC2021-100 was considered for multiple programs. Each program is outlined below.

Hospital IQR Program

The MAP sought clarification on overlap of the measure with the central-line associated bloodstream infections (CLABSI) and Methicillin-resistant Staphylococcus aureus (MRSA) measures in the program, asking if the two measures would eventually be retired. The developer acknowledged that if a patient had a MRSA bloodstream infection, it would count towards all three, and that collaborative decisions would be made over time about other metrics as understanding of MUC2021-100 evolves. The Rural Health Advisory Group had no program-specific comments. The average polling score was 3.8, indicating that the Advisory Group agreed that the measure was suitable for use. Due to time constraints, the Health Equity Advisory Group conducted polling via an online poll after the meeting. The average polling score for the measure was 3.5, indicating some potential for positive impact, or reducing health disparities.

The MAP conditionally supported this measure pending NQF endorsement. This measure tracks the number of hospital-onset bacteremia or fungemia infections (HOB), indicated by positive test results, among inpatients – but excluding those present on admission or for which not treatment was administered. The measure corresponds to the Patient Safety focus within CMS' Meaningful Measures 2.0.

Medicare Promoting Interoperability Program for Hospitals

Dr. Pickering stated that the MAP would need to vote independently of the decision for the measure in the Hospital IQR Program, given the different recommendation. The measure is not an eCQM, although it is a digital measure, and during deliberations the Medicare Promoting Interoperability Program for Hospitals was interpreted to exclusively contain eCQMs. Due to this interpretation, the MAP did not

support this measure for rulemaking.[2] The Rural Health Advisory Group had no program-specific comments and had no changes to recommendations. The Health Equity Advisory Group average online polling score was 3.2, indicating neutral impact on health equity and on health disparities.

HACRP

Dr. Morrison asked the MAP if there were any oppositions to carrying over the vote from the Hospital IQR Program to the measure for the HACRP. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group noted similar concerns to MUC2021-098 regarding low-case volume and the potential for reporting burden but had no changes to recommendations. The Health Equity Advisory Group average online polling score was 3.4, indicating neutral impact on health equity and on health disparities.

PCHQR

Dr. Morrison asked the MAP if there were any oppositions to carrying over the vote from the Hospital IQR Program to the measure for the PCHQR Program. No opposition was raised, and the vote was successfully carried over. The Rural Health Advisory Group had no program-specific comments and had no changes to recommendations. The Health Equity Advisory Group average online polling score was 3.5, indicating some potential for positive impact on health equity and reducing health disparities.

PCHQR Program

Dr. Pickering introduced the PCHQR Program by providing information on the program type, the incentive structure, and the program goal. For the measure under consideration, Dr. Pickering provided an overview of the measure and the input provided by the MAP Advisory Groups and public comment.

Public Comment

Mr. Demehin opened the discussion for public comment on the measure. No comments were offered.

MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer

The developer responded to several clarifying questions, noting that the measure was not tested exclusively in PPS-exempt cancer centers and that the timeframe for the measure looks at the advent treatment course. The developer also clarified that the measure in an updated version of an existing measure in the Merit-based Incentives Payment System (MIPS) program by the same title. One MAP member expressed concern that exclusion criteria for the denominator were too broad. The Rural Health Advisory Group noted that rural providers do not typically treat breast cancer and the measure may not be applicable for them, but there will still be importance for rural providers to know if treatment has been initiated for their patients. The Rural Health Advisory Group average score was 3.4, indicating that the Advisory Group was neutral on the suitability of the measure from a rural perspective. The Health Equity Advisory Group noted that a significant equity issue for the measure was the restriction of the measure by sex or gender, which could exclude transgender or nonbinary patients. The Health Equity Advisory Group also noted that there are known racial disparities in screening and diagnosing breast cancer and expressed that stratification by race would be helpful. The average polling

[2] In discussions after the meeting it was determined that the Coordinating Committee should focus their review of the measure solely on its specifications and appropriateness for the program. CMS will continue to review and ensure compliance with statutory requirements for the Medicare Promoting Interoperability Program for Hospitals. The MAP Coordinating Committee for final recommendation.

score was 2.5, indicating that the Advisory Group was neutral on this measure's impact on health equity and on health disparities.

The MAP conditionally supported the measure for rulemaking pending NQF endorsement. Although this measure has undergone measure score reliability and validity testing, validity testing of the critical data elements (e.g., numerator, denominator) should be considered. The measure does not currently have NQF endorsement. The measure aligns with the CMS Meaningful Measures Framework as an eCQM.

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

Dr. Pickering introduced the ESRD QIP by providing information on the program type, the incentive structure, and the program goal. For the measure under consideration, Dr. Pickering provided an overview of the measure and the input provided by the MAP Advisory Groups and public comment.

Public Comment

Mr. Demehin opened the discussion for public comment on the measure. One comment was offered, expressing concern with the measure primarily due to the loss of NQF endorsement from failure to pass on validity criteria. The commenter also emphasized that the reliability of the measure was also not strong and may negatively impact smaller facilities.

MUC2021-101 Standardized Readmission Ratio (SRR) for dialysis facilities

The MAP sought clarification on the rationale for consideration in the program, and CMS noted that the measure creates accountability and could assist with the evaluation of readmissions across programs. Furthermore, CMS and the developer clarified that this updated version of the measure corrects biases inherent in the data collection of the older version (NQF #2496). The Rural Health Advisory Group expressed concerns over the failure to pass NQF endorsement and noted that measures requiring travel may put rural patients at a disadvantage. The average polling score for the Rural Health Advisory Group was 3.3, indicating that the Advisory Group was neutral on the suitability of the measure from a rural perspective. The Health Equity Advisory Group noted the gap in equitable kidney care and outcomes, and reiterated concerns over the failure to pass NQF endorsement. The average polling score was 3.4, indicating that the Health Equity Advisory Group was neutral on this measure's impact on health disparities.

The MAP did not support this measure for rulemaking. The measure addresses the high-priority area of care coordination for the ESRD QIP; however, this measure was submitted for NQF endorsement in Spring 2020 but did not pass scientific acceptability on validity and was not endorsed.

Public Comment

Mr. Demehin opened the web meeting to allow for a final public commenting period. No public comments were offered.

Next Steps

Rebecca Payne, Senior Analyst, NQF, summarized the next steps. A second public comment period will be held from December 30, 2021, through January 13, 2022, following the release of the preliminary recommendations' spreadsheet. The MAP Coordinating Committee will convene to finalize the MAP recommendations for all measures on January 19, 2022, and the final recommendations will be submitted to the U.S. Department of Health & Human Services no later than February 1, 2022. Dr. Pickering, Dr. Schreiber, and the MAP Hospital Co-chairs all thanked participants, NQF and CMS staff, the measure developers, and the public for their tremendous work throughout the day's meeting and for their high level of engagement.

Appendix A: MAP Hospital Workgroup Attendance (Voting Only)

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

Co-chairs

- Akin Demehin, MPH
- Sean Morrison, MD

Organization Members

- America's Essential Hospitals
- American Case Management Association
- 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
- Memphis Business Group on Health
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey
- Project Patient Care
- Service Employees International Union
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

Individual Subject Matter Experts

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

Appendix B: Full Voting Results

Some MAP members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained for the entirety of the meeting.

	Measure Name	Program	Yes	No	Total	Percent
1	MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Hospital Inpatient Quality Reporting (IQR) Program	24	0	24	100%
2	MUC2021-118 Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Hospital Value-Based Purchasing (VBP) Program	24	0	24	100%
3	MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital	Hospital IQR Program	16	5	21	76%
4	MUC2021-131 Medicare Spending Per Beneficiary (MSPB) Hospital	VBP	16	5	21	76%
5	MUC2021-122: Excess days in acute care (EDAC) after hospitalization for acute myocardial infarction (AMI)	Hospital IQR Program	19	4	23	83%
6	MUC2021-120: Hospital-level, risk-standardized payment associated with an episode of care for primary elective total hip and/or total knee arthroplasty (THA/TKA)	Hospital IQR Program	23	1	24	96%
7	MUC2021-106: Hospital Commitment to Health Equity	Hospital IQR Program	19	4	23	83%
8	MUC2021-134: Screen Positive Rate for Social Drivers of Health	Hospital IQR Program	18	6	24	75%
9	MUC2021-136: Screening for Social Drivers of Health	Hospital IQR Program	23	2	25	92%
10	MUC2021-084 Hospital Harm – Opioid-Related Adverse Events	Hospital IQR Program	20	3	23	87%
11	MUC2021-084 Hospital Harm – Opioid-Related Adverse Events	Medicare Promoting Interoperability Program for Hospitals	20	3	23	87%

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	Measure Name	Program	Yes	No	Total	Percent
12	MUC2021-104 Severe Obstetric Complications	Hospital IQR Program	23	1	24	96%
13	MUC2021-104 Severe Obstetric Complications	Medicare Promoting Interoperability Program for Hospitals	23	1	24	96%
14	MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure	Hospital IQR Program	21	2	23	91%
15	MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure	Medicare Promoting Interoperability Program for Hospitals	TBD*			
16	MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure	Hospital-Acquired Condition Reduction Program (HACRP)	21	2	23	91%
17	MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-associated Clostridioides difficile Infection Outcome Measure	Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)	21	2	23	91%
18	MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	Hospital IQR Program	22	2	24	92%
19	MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	Medicare Promoting Interoperability Program for Hospitals	TBD*			
20	MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	HACRP	22	2	24	92%

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	Measure Name	Program	Yes	No	Total	Percent
21	MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	PCHQR	22	2	24	92%
22	MUC2021-091 Appropriate Treatment for Patients with Stage I (T1c) through III HER2 Positive Breast Cancer	PCHQR	19	3	22	86%
23	MUC2021-101: Standardized Readmission Ratio (SRR) for dialysis facilities	End-Stage Renal Disease Quality Improvement Program (ESRD QIP)	19	1	20	95%

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*Please note: The MAP did not support this measure for rulemaking; however, the measure will be discussed at the MAP Coordinating Committee for final recommendation.