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# Measure Applications Partnership (MAP) Hospital Workgroup: 2022-2023 Measures Under Consideration (MUC) Review Meeting

*Meeting Summary*
*December 28, 2022*

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# Contents

# Meeting Summary

## Measure Applications Partnership (MAP) Hospital Workgroup 2022-2023 Measures Under Consideration (MUC) Review Meeting (Day 1)

The National Quality Forum (NQF) convened a two-day, public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Hospital Workgroup on December 13, 2022, and December 14, 2022. The purpose of the meeting was for the MAP Hospital Workgroup to review and provide recommendations for the 2022-2023 Measures Under Consideration (MUCs) proposed for CMS hospital programs. There were 202 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 2022-2023 Measures Under Consideration (MUC) Review Meeting, and reviewed housekeeping reminders, meeting ground rules and the meeting agenda. Ms. Williams-Bader then invited NQF leadership to provide opening remarks. Dr. Dana Gelb Safran, president & CEO, NQF, provided opening remarks to the Hospital Workgroup. She expressed the privilege of working in partnership with CMS to provide guidance on measures and recognizes the important role of the hospital sector on making care safer, more affordable and equitable.rs. Following Dr. Safran, opening remarks were provided by the Hospital Workgroup co-chairs, Akin Demehin and Marty Hatlie (serving as acting co-chair for this meeting).

Dr. Tricia Elliott, vice president, NQF, performed roll call and disclosures of interest (DOIs). Of the 19 organizational members, 17 attended day one of the meeting. In addition, there was one co-chair, and two subject matter experts, totaling 20 voting members. One organizational member served as acting co-chair for the meeting. Sixteen members was the minimum quorum for voting. One MAP member disclosed that they were part of a measure expert panel for MUC2022-120, Documentation of Goals of Care Discussions Among Cancer Patients, and indicated they would recuse themselves from voting and discussion for the measure. The full attendance details are available in Appendix A. Dr. Elliott also introduced the nonvoting federal government liaisons.

Ms. Williams-Bader recognized the NQF team and CMS staff supporting the MAP meeting activities. Ms. Williams-Bader then reviewed the meeting objectives:

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

### Centers for Medicare & Medicaid Services Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for CMS and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG), welcomed participants to the meeting and thanked NQF staff, MAP members, CMS staff, federal liaisons, and members of the public for their participation. Dr. Schreiber provided an overview of CMS'

strategic priorities by reviewing the CMS National Quality Strategy Goals and National Quality Strategy Targets. Dr. Schreiber also previewed future priorities for measure development through the review of strategic priority areas for programs as well as considerations for future measure priorities. Dr. Schreiber closed by thanking the Workgroup for their time and feedback on the current measures for the 2022-2023 pre-rulemaking cycle.

## Overview of MAP Hospital Workgroup and CMS Programs

Ms. Williams-Bader provided an overview of the MAP Hospital Workgroup's charge to provide recommendations on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals. Ms. Williams-Bader also reviewed the program type, incentive structure, and program goals for the 10 hospital programs with MUCs for the 2022-2023 pre-rulemaking cycle. Before concluding the discussion, Ms. Williams-Bader opened the floor for MAP members to ask questions. A MAP member asked which hospitals were eligible hospitals under the Hospital Outpatient Quality Reporting (OQR) Program. Dr. Schreiber noted that the definition was established by legislation but included most U.S. hospitals. A CMS representative included the definition in the meeting chat, which indicated that the Hospital Outpatient Prospective Payment System is applicable to any hospital participating in the Medicare program, except for Maryland hospitals that are reimbursed under a cost containment waiver; critical access hospitals; hospitals located outside the 50 states, the District of Columbia, and Puerto Rico; and any Indian Hospital Service hospitals. A CMS representative also clarified that critical access hospitals may voluntarily participate in the Hospital OQR Program.

## Overview of Decision Categories and Voting Process

Ms. Williams-Bader provided an overview of the four decision categories that the Workgroup can assign to each MUC: support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, and do not support for rulemaking. Ms. Williams-Bader noted the decision categories were standardized for consistency and the Workgroups must reach a decision on every MUC accompanied with a rationale for the decision. Ms. Williams-Bader reviewed that for the Workgroup to reach quorum, 66 percent of the voting members of the Workgroup must be present virtually for live voting and noted that the Workgroup had reached quorum for the day one of the meeting. Ms. Williams-Bader shared that MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting for a decision category and a minimum of 60 percent of the quorum figure voting positively for a decision category.

Ms. Williams-Bader also reviewed the process for discussion and voting:

1. NQF staff will review the preliminary analysis for each MUC using the MAP selection criteria.
2. A CMS representative will present a brief overview and/or contextual background on the MUC.
3. Lead discussants will review and present their findings.
4. The co-chairs will then open for discussion among the Workgroup.
5. The Workgroup will vote on acceptance of the preliminary analysis decision.
6. Discussion and voting on the MUC will take place if less than 60 percent accept the preliminary analysis assessment.
7. NQF staff will tally the votes.

Before concluding the discussion of the pre-rulemaking process, Ms. Williams-Bader opened the floor for MAP members to ask questions. Two comments were made:

- A co-chair stated the importance of clearly outlining conditions when voting "Conditional

Support for Rulemaking" or mitigation strategies when voting "Do Not Support for Rulemaking with Potential for Mitigation" and noted that they would press MAP members to do so before voting on those categories.
- Another co-chair reinforced a previous request by NQF staff to avoid repetition in comments due to the large amount of material on the agenda.

NQF staff then conducted a voting test with the Workgroup.

## Measures Under Consideration

### New Patient Experience/Goals Measures

Dr. Elliott provided an overview of new patient experience/goals measures and the two measures included in the section.

- **MUC2022-078:** Psychiatric Inpatient Experience Measurement *(IPFQR [Inpatient Psychiatric Facility Quality Reporting Program])*
- **MUC2022-120:** Documentation of Goals of Care Discussions Among Cancer Patients *(PCHQRP [Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program])*

#### *Public Comment*

Mr. Demehin opened the web meeting to allow for public comment. A member of the public spoke in favor of MUC2022-078, noting that inpatient psychiatric hospitals are the only hospitals that are currently not required to complete a patient experience of care measure as part of the Medicare program, which prevents comparison between facilities. The member of the public noted that they have heard from members of their organization that quality of care in inpatient psychiatric facilities is subpar and the measure will give a voice to people with mental illnesses and improve quality of care in those facilities.

Another member of the public spoke in strong support of MUC2022-078, noting the differences in requirements for quality between hospitals that treat physical health and those that treat mental health contributing to discrimination against individuals with mental health conditions. The member of the public stated that the measure is particularly timely given the rise in rates of distress and suicidal thoughts. The member of the public noted that the nature of inpatient psychiatric care is quite different from other kinds of health care, particularly around the involuntary nature of some of it. The member of the public stressed the importance of considering privacy and their belief in the measure's ability to make a difference from the patient side.

#### *MUC2022-078: Psychiatric Inpatient Experience Measurement*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the six public comments received during the public comment period, of which five were in support of the measure. Dr. Elliott noted a comment with a concern about privacy and making sure patients feel secure in providing information. Dr. Elliott also stated that one commenter expressed concern that the tool had been tested only in one regional system and thought that additional testing was required before implementing this measure on a national level. Dr. Elliott noted the Health Equity Advisory Group shared that this measure is a step in the right direction for behavioral health; that the denominator may not represent the population; that the treatment effectiveness should be more specific; and that patients may get "survey fatigue." Dr. Elliott noted that the Rural Health Advisory Group expressed support for collection of psychiatric inpatient experience data collection. Dr. Elliott also noted that the Rural Health Advisory

Group expressed reservations regarding costs to implement and maintain the measure and noted concerns about selection bias or submission bias if the survey is conducted before discharge. Dr. Elliott also noted that the Rural Health Advisory Group discussed the applicability of the measure to rural settings as there are few inpatient psychiatric hospitals in rural areas. She stated that the Rural Health Advisory Group noted the strong patient support for the measure and that the Veterans Administration (VA) supported the measure.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber noted that CMS is very excited about the measure since it would fill a gap in both mental health and patient reporting. Dr. Schreiber also noted the strong support in public comment and input during the rule writing process that sought measures such as MUC2022-078. A CMS representative noted that reliability testing demonstrated strong reliability and internal consistency and content validity analysis supported the measure's theoretical construct. A CMS representative noted that measuring patient experience is a high priority for the program and that this is the first non-proprietary measure that has been tested in the inpatient psychiatric facility setting.

A lead discussant stated that measuring in this type of facility is a critical part of capturing patient experience and determining a patient's willingness to engage in future treatment and active treatment. The discussant recognized the limitations of the measure including the fact that the measure covers an acute care period where individuals are highly symptomatic, patients may have difficulties determining reality during psychosis, and that those covered by the measure may be in the facilities involuntarily, which will have an impact on experience of care that may or may not be related to the quality of care delivered in the facility. Another lead discussant welcomed the measure as providing insight into the patient viewpoint. The discussant also noted difficulties in fully capturing the experience of patients who were admitted to facilities involuntarily and noted that discharged patients may still be in recovery and have difficulties reflecting reality which makes capturing their real perceptions difficult. A third lead discussant expressed appreciation for comments supportive of the measure and had a question about plans for testing the measure more broadly. The measure developer noted that the measure is well tested within the developer's own health system and that they were talking to other sites in other cities to implement wider testing. A CMS representative also noted that CMS is considering making the measure voluntary to report initially to generate additional implementation data prior to full roll out.

Mr. Demehin opened the meeting for clarifying questions and discussion. A federal liaison noted that the concept was important to measure but had some reservations around the measure specifications, specifically issues around construct validity. The federal liaison also noted that these issues could be particularly acute in the post-discharge period. The measure developer responded that they were trying to mitigate those issues by administering the survey prior to discharge, which was an approach that was supported by the federal liaison. A MAP member agreed with the importance of the measure concept and agreed that a condition could be more testing. The MAP member also asked if the measure submission included the survey questions and if the survey included a question about physical violence. The measure developer noted that the survey asks about physical safety when in the facility, but it does not ask if a patient experienced any violent episodes when in treatment. A CMS representative noted that the specific language in the survey asks if the patient "felt physically safe" while in the facility. Another MAP member agreed with the need for more robust testing. The member also raised concerns about the use of convenience sampling versus random sampling and noted that the survey is administered 24 hours prior to the discharge process, which the member noted was unusual compared to other surveys. The measure developer noted that response rates were quite low post-discharge and moving the timing of the survey to pre-discharge increased sample size. The measure developer also noted that the data did consist of an initial convenience sample from which a random sample was

extracted from the data set.

A co-chair noted that the preliminary analysis recommendation was correct with important considerations including endorsement by a consensus-based entity (CBE). Based on the conversation, the co-chair suggested testing as broadly as possible prior to implementation and considering the implications of data collection and how measure performance is impacted by individuals still in recovery when taking the survey, which could qualify as conditions. A MAP member agreed with the decision category of "Conditional Support for Rulemaking" and suggested that testing should include different types of providers (such as safety net and rural providers) and examine the implementation period of the survey (pre- versus post-discharge) as well as the mode of administration (electronic versus paper). Another MAP member stated that they were uncomfortable with the conditions as stated by Mr. Demehin but agreed with the recommendation for more diverse testing. A lead discussant noted that they would support more analysis specifically around construct validity pre-discharge versus post-discharge, which may require funding for following up with patients' post-discharge. The discussant also stated that some institutions are public institutions with large numbers of involuntarily committed patients and others have significantly less numbers of patients who are involuntarily committed so the measure specifications should take that difference into account.

Mr. Demehin moved the workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking" for measure MUC2022-078. Mr. Demehin stated that the conditions are as follows: endorsement by a CBE, broader testing in a variety of settings, an analysis of the timing of survey administration (pre- versus post-discharge), an analysis of other factors that may drive differences in performance (e.g., involuntary commitments, patient factors), and a consideration of how the proportion of involuntary versus voluntary admissions affects the measure outcome. MAP members had several procedural questions including: if conditions could be added to those in the preliminary analysis recommendation, who verifies if conditions are met, and if the measure will be resubmitted to the MAP process if conditions are not met. NQF staff confirmed that additional conditions can be added by the Workgroup and that MAP is an advisory body so CMS will determine when to bring a measure back through the MAP process. Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the additional conditions for MUC2022-078. Voting results were as follows: Yes – 16, No – 3, and percentage voting Yes – 84 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the two public comments received during the public comment period, both of which supported the measure. Dr. Elliott noted that one comment seemed inconsistent with the measure but was supportive and another comment supported expanding the measure to all patients with serious illness and not just those with cancer. Dr. Elliott shared that the Health Equity Advisory Group noted that this measure does not have broad generalized applicability as there are only eight PPS-exempt cancer hospitals. Dr. Elliott also noted that the Health Equity Advisory Group did not share any concerns specifically related to health equity. Dr. Elliott stated that the Rural Health Advisory Group shared strong patient support for this measure. Dr. Elliott also stated that the Rural Health Advisory Group noted that access to this information is important since care may be provided in the primary care setting in rural areas. Dr. Elliott also stated that the Rural Health Advisory Group commented that electronic health records (EHRs) can create templates within the EHR to make information accessible and structured.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber shared that the measure developer represents an alliance of eleven dedicated cancer centers. A CMS representative noted that the measure would fill a gap in patient-centered care, integrates patient and family goals in care, is a process measure based on templates in a patient's electronic health record (EHR) and will be reported in via a web form.

A lead discussant acknowledged the need for goals of care discussions and noted that the measure would be a positive step. The lead discussant asked if there is flexibility in which staff had discussions with patients as they had concerns about adequate training. The lead discussant also noted that they had concerns about the measure being a "check-box" measure. The lead discussant also asked if CMS could consider the measure for the Merit-based Incentive Payment System (MIPS) program. The measure developer noted that they would prefer for oncologists to have the conversation but stated that the measure allows for any trained clinician to document the conversation. The measure developer also agreed with the lead discussant that the measure could be used in other CMS programs.

Mr. Demehin opened the floor for clarifying questions and Workgroup discussion. A MAP member asked if there were standard questions required for patient discussions. The measure developer noted that they did not have standardized questions for patients as they wanted to provide flexibility in patient discussions as well as how clinicians capture those discussions, and that the measure gives credit for any discussions on goals in care. Several MAP members expressed support for the measure. A MAP member expressed the need for stratification of the measure by race and gender and eventually expanding the measure to look at long-term outcomes in the measure's target population. Another MAP member noted that, while they support having conversations with patients, they had concerns that this measure is a "check-box" measure that is not very meaningful to patients. The MAP member also noted that the measure does not outline specific issues that should be covered in discussions. The measure developer was supportive of these comments and responded that they ultimately plan to develop a patient outcome measure to pair with the current measure. The measure developer also noted that the literature indicates there are three components of goal concordant care: provider training, documentation of goals of care discussions, and, finally, impacting outcomes. The measure developer stated that the measure is being promoted for end-of-life cancer care and that they may eventually see some positive outcomes in reducing unnecessary care utilization in that population. A MAP member noted that they did not consider the measure to be a "check box" measure and noted their personal experience with goals of care being changed by a clinician without input from family or the patient. The MAP member expressed the importance of the measure as it would provide guidance for clinicians and recommended limiting which clinicians can change goals of care in the EHR.

Another MAP member expressed support for this measure and noted it is a positive step with great potential but noted that the highest category they could usually support was "Conditional Support for Rulemaking" due to the measure not having CBE endorsement. The MAP member also noted that they wanted to take the developer's plans for additional development of an outcome measure into account when voting on a decision category and asked for guidance on how best to do so. A co-chair agreed with the MAP member's comments on the decision category normally assigned to measures that do not have CBE endorsement and added some additional clarifications about when the Workgroup would choose to add conditions to a measure or decide to add a more fundamental reworking of the measure, which would require a shift to the decision category "Do Not Support with Potential for Mitigation." Ms. Williams-Bader added that measures that are not CBE endorsed can receive a decision category of "Support for Mitigation" only when the measure is fully developed, fully specified, and has demonstrated validity and reliability testing for the level of analysis, program, or setting for which it is being considered, which was supported by Dr. Elliott.

A MAP member asked if this measure affects all acute hospitals or only cancer hospitals. Dr. Schreiber responded that only cancer hospitals were targeted in this measure. A CMS representative shared the four components for evaluation for goals of care in the chat: 1) a formal communications skills training program for hematologists or oncologists, 2) structured goals-of-care documentation in EHRs, 3) expectations regarding the patients who are prioritized to receive goals-of-care discussions, and timing for communication, and 4) an evaluation and measure framework. A MAP member asked if hospitals would have to satisfy all four components to satisfy the measure requirements. The measure developer stated that this measure currently only addresses the second component of structured goals-of-care documentation. Mr. Demehin moved the workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the conditions being testing indicating the measure is reliable and valid, and endorsement by a CBE, for measure MUC2022-120. Voting results were as follows: Yes – 16, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

## Sepsis and Septic Shock Measure

Dr. Elliott provided an overview of the sepsis and septic shock measure included in the section.

- **MUC2022-082**: Severe Sepsis and Septic Shock: Management Bundle *(HVBP [Hospital Value-Based Purchasing Program])*

### *Public Comment*

Mr. Demehin opened the meeting for public comment. A member of the public that is an emergency physician spoke in favor of the measure and stated that doctors need to be incentivized with payment for measure compliance. The commenter noted that compliance with the sepsis measure resulted in reductions in mortality.

Two comments from the public were submitted to the meeting chat after the close of public comment. Both comments supported the measure. One commenter noted they have helped hospitals to improve their sepsis outcomes by applying measures. The commenter also noted that compliance with the measure is associated with reduced mortality, which is why they supported including the measure in programs with value-based payments. The second comment, from an infectious disease physician, said that although they came from a community hospital, they were about to teach about the importance of measure bundle adherence, and that this helped with survival of severe sepsis and septic shock patients, despite the community hospital having fewer resources than an academic hospital.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and NQF staff preliminary analysis recommendation. Dr. Elliott summarized 13 public comments received during the public comment period, of which 11 did not support due to a burden on providers in using changing guideline recommendations and updates to sepsis and shock care, poor alignment of the measure with recommendations, lack of provider training, unintended consequences on the increasing use of antibiotics and difficulties with data collection. Dr. Elliott added that the Health Equity Advisory Group did not offer specific comments related to health equity but noted this measure filled a gap in care. Dr. Elliott also stated that the Rural Health Advisory Group noted that rural facilities struggle to perform chart abstractions due to staffing challenges and while abstraction for the measure is particularly time intensive, this measure is important for rural health.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber introduced that this measure has been in the Hospital Inpatient Quality Reporting program (IQR) for

several years, is NQF endorsed and passed appeal, and is now being proposed for HVBP to incentivize clinicians to use this measure as its use may be linked to a reduction in mortality. Dr. Schreiber noted that outcome measures are needed so this process measure would represent a first step. A CMS representative emphasized that specifications would not change in the process measure in the interim. The CMS representative noted that this measure is being reported for some critical access hospitals but recognized there may be an associated reporting burden.

A lead discussant noted the disconnect between the public comments in favor of the measure and those that were opposed, which may represent the fact that practice and policy groups cannot reach consensus. The lead discussant supported moving the measure forward. Another lead discussant spoke in favor of the measure and noted the important gaps demonstrated by the measure, the evidence in support of the measure and the categories of stratification included in the measure. A third lead discussant stated they supported the measure due to the potential impact of reducing harm from sepsis infection and the measure's connection to outcomes. The lead discussant also noted flexibility in how providers can report the measure, with providers having the ability to report this measure either electronically or by paper. The lead discussant also expressed agreement with another lead discussant's comments on the measure's stratification and demonstration of a performance gap. The lead discussant also suggested eventually pairing this process measure with the mortality outcome measure under development to further increase the link to outcomes. The lead discussant recommended moving forward an antibiotic overuse measure as a countermeasure to address any concerns raised about the possible overuse of antibiotics in the sepsis population. The lead discussant also stated that they would like to see development of a version of the measure for children.

Mr. Demehin opened the floor for clarifying questions and Workgroup discussion. A MAP member agreed with the measure concept and recognized that it is used for public reporting. However, the MAP member was reluctant to support the member due to the possible reporting burden of the measure. The MAP member also noted the need to send correct signals to hospitals with limited resources post-COVID about what they should prioritize. Another MAP member asked how often guidelines change and if current guidelines are included in this measure. A MAP member commented that there have been measure specification changes over time and that it has been a challenge for hospitals to keep data collection up to date. The measure developer shared that the most recent Surviving Sepsis Campaign guidelines were published in October 2021 and that the previous update to those guidelines was in 2016. The measure developer noted that measure is updated twice a year, both to incorporate any changes to those guidelines but also to reflect any feedback from abstractors on how to better provide guidance around data collection for the measure.

A MAP member noted they would not currently support the measure as hospitals they work with have provided feedback that changes to the measure and updates to definitions are confusing for clinicians. Another MAP member noted that they would not support the measure and expressed concerns about introducing the measure into a pay for performance program. A federal liaison noted that their agency's health system had successfully implemented the measure and had seen buy-in from their providers with real impact on sepsis care. Another MAP member indicated they would not support the measure as they felt it needed to have additional development to align with best practices and better incorporate stakeholder input and stated that the measure may have unintended consequences, especially regarding antibiotic overuse.

A MAP member noted that previous comments reflect the divide on the measure's worth between the practice and policy communities. The MAP member noted that the question for the Workgroup is if that divide is resolved enough to move the measure into a program that is pay for performance. The MAP

member stated that they agreed with previously raised concerns about antibiotics overuse but that they could not argue against sepsis being a high priority issue for hospital systems. The MAP member noted there are clearly opportunities for the field as whole to making progress in implementing evidence-based practices to make further progress in reducing sepsis mortality. The MAP member noted that the as the measure is currently in the Hospital IQR program, there is an opportunity for providers to give feedback as the measure is considered for other programs. The MAP member also noted that a sepsis outcome measure is currently under development and that measure would provide an opportunity to focus providers on improving sepsis outcomes. The MAP member noted that they would not support moving the measure into the Hospital VBP program but also that the conversation was important to have.

The measure developer noted that the measure specifications around fluid administration had changed and that there is now an allowance for less than 30 milliliters per kilogram. A MAP member asked if those changes were reflected in the Hospital Workgroup meeting materials. The measure developer noted that the specifications were changed shortly after the MUC submission deadline and provided an update that if a hospital documents a reason for lower fluid administration, they will receive credit for that portion of that measure. Another MAP member commented they had mixed feelings as smaller facilities might struggle with this measure, but also noted putting the measure into the HVBP would ensure that facilities place more emphasis on sepsis care. The MAP member indicated they would not support placing the measure into HVBP. Another MAP member stated that this measure could create an opportunity to provide more resources to rural hospitals to address any burdens the measure may create and noted that measures are often modified prior to rulemaking and that the MAP will not consider those changes unless the general concept has changed. A co-chair asked when other MAP members would feel comfortable moving forward as the guidelines are not frequently modified and asked MAP members to identify if the most recent updates to the measure had missed something important to them. A MAP member indicated they understood that the measure had been updated to reflect the most recent Surviving Sepsis Campaign guidelines but that the member wanted to be sure the measure that went into the program reflected those changes. A co-chair asked if that concern could be remedied by including a condition that the measure specifications reflected current guidelines. The MAP member raised the question if the Workgroup was reviewing the most recent specifications. The measure developer stated that most likely the specifications submitted to the Workgroup were unable to reflect the latest updates due to the MUC application timeline. The measure developer noted there will always be a lag to reflect updates to specifications due to the process required to reflect those changes. A MAP member asked if the measure had any exclusions or modifications for pregnant patients, as they do not necessarily fit the model of the measure. The measure developer said they worked with a maternal care coalition and made changes to criteria thresholds for patients who are 20 weeks gestation through three weeks post-delivery. The measure developer noted they added had an element to identify those patients and apply the pregnancy criteria to those patients.

Mr. Demehin moved the workgroup to vote on the NQF staff recommendation of “Support for Rulemaking,” for measure MUC2022-082. Voting results were as follows: Yes – 6, No – 13, and percentage voting Yes – 32 percent. Complete voting results are in Appendix B.

A co-chair asked the Workgroup to clarify what conditions they would like to add to the measure and suggested that one possible condition could be ensuring the version of the measure that enters the program contains the most recent measure specifications. A MAP member noted that the measure evaluates the ability to abstract data rather than the outcome of the patient. The MAP member asked if the Workgroup could add a condition to evaluate performance based on type of facility and support facilities with lower performance with their abstraction efforts. Another MAP member noted that

hospitals have a choice whether to report electronically or on paper and asked if electronic reporting could reduce the burden of the measure. A co-chair noted that, while some hospitals choose to use paper reporting, abstracting is a burden regardless of the method. A MAP member provided context by noting that some hospitals have one or two full time employees dedicated to the measure to ensure that the chart abstractions for the measure are performed properly. A co-chair proposed adding a condition that CMS should resolve any differences in specifications as soon as possible, noting that sepsis care was an area where hospitals lost ground during COVID-19 and stressed a sense of urgency in improving care for patients with septic shock. Another co-chair noted the concern of some MAP members that measure specifications for the measure were not up to date and would not be updated. A CMS representative noted that the specifications included in the meeting materials were aligned with the NQF-endorsed measure and that CMS could provide any updated measure specifications. The measure developer agreed that version of the measure submitted to the MUC process was the same as the NQF-endorsed measure and noted that the most recent specifications are publicly posted on QualityNet. A MAP member noted that while they understood the measure developer may have updated the measure's specifications, they were concerned with the higher stakes of placing the measure in a value-based program as compared to a pay for reporting program. Another MAP member noted that they see connecting the measure to payments as a plus for patients and that they saw a contradiction in that hospitals requested that a measure's specifications reflect the most current guidelines but hospitals also provided feedback that they did not like that the measure is constantly changing. A co-chair noted that the updates to the measure to reflect current guidelines may have alleviated some of the hospitals' previous concerns with the measure. Dr. Schreiber noted that the measure specification manual is updated every six months and that measures are continually updated in response to any issues that arises. A MAP member noted concerns with those changes as the HVBP is backwards looking and raised concerns about data consistency when comparing data from two different time periods. Dr. Schreiber noted that CMS routinely updates its measures in almost all of its programs so the process is not unusual.

Mr. Demehin moved the Workgroup to vote on "Conditional Support for Rulemaking," with the condition being clarity around the version of the measure being reviewed by MAP to ensure that the most recent measure specifications are implemented in the program, for measure MUC2022-082. Voting results were as follows: Yes – 12, No – 7, and percentage voting Yes – 63 percent. Complete voting results are in Appendix B.

## New Cross-Cutting Measures

Dr. Elliott provided an overview of new cross-cutting measures in the section.

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

### *Public Comment*

Mr. Hatlie opened the web meeting to allow for public comment. A member of the public who also developed measures MUC2022-018 and MUC2022-020 spoke in favor of the measures. The member of the public provided a basic overview of the process of the measures, noting that the measures capture diagnostic and procedure codes to assign the CT scan to a category, extract electronic data from the CT scan to quantify the radiation dose and image quality, and then compare the dose and image quality to evidence-based thresholds for the assigned category. The member of the public noted that over 40 letters were written from a variety of stakeholders in support of the measures and highlighted support from five organizations that served as test sites for the measures.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott summarized the 40 comments received during the public comment period, with 39 supporting the measure and one not supporting the measure. Dr. Elliott also noted that one commenter stated that as the measure assesses several things, it may not be clear where quality improvement is needed. Dr. Elliot reported that the Health Equity Advisory Group had no concerns specifically related to health equity and felt it filled a care gap. Dr. Elliott noted that the Rural Health Advisory Group reported concerns about data capture.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber expressed that this is an important gap area, and that because it is an electronically reported measure it will also be considered for the Medicare Promoting Interoperability program. A CMS representative stated that this measure provides standardization in quality imaging, that the measure is NQF-endorsed, and that the measure would fill a gap in the CMS measure set to account for patient safety in radiation.

A lead discussant agreed that the measure fills a measurement gap and noted that public comment was extremely supportive of the measure. Another lead discussant spoke in support of the measure and noted that the measure covers a lot of domains of care and has benefits to patients. The lead discussant also noted that the measure has an opportunity to decrease occupational hazards for radiation technicians by reducing their exposure to radiation. A third lead discussant expressed support for the measure and noted that patients are often unaware of the dangers of radiation scans. The lead discussant also noted that the measure is an outcome measure, is NQF-endorsed, and is electronically reported, which reduces reporting burden. The lead discussant also noted the variation in radiation dosing between facilities.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. A co-chair noted that their organization did support the measure and that the measure has an opportunity to improve shared decision making between patients and providers about radiation risk. A MAP member noted that they were struck by the overwhelming public comment in support of the measure. The MAP member noted that they did not have any conditions they would like to attach to the measure but noted they might want to include some implementation considerations around allowing hospitals to gain experience with the electronic clinical quality measure (eCQM) before mandating its use so they can identify any issues, as well as taking into consideration that some hospitals will not have access to the required information for the measure. Dr. Schreiber noted that the reporting of the measure would not be mandatory. Another MAP member noted that they supported the measure because of the radiation and safety components. The MAP member asked if CT machines can be set to limit radiation dose and still get a quality image. The measure developer stated that they had previously created a dose registry and

discovered the high rate of dose variability even with the same machines. The measure developer noted that when they explored what was causing that variation, it was not the machine or even technician decisions, but rather hospital policy. The measure developer noted that their measure can set standards for radiation dose and provide hospitals feedback on how to set their machines for radiation dosing. Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-018. Voting results were as follows: Yes – 19, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then reviewed the 40 public comments received during the public comment period, of which 39 were in support of the measure with one not in support of the measure. Dr. Elliot reported that the Health Equity Advisory Group did not raise any issues related to health equity and felt it filled a care gap. Dr. Elliott noted that the Rural Health Advisory Group reported concerns about data capture.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber had no additional comments.

A lead discussant noted differing reporting requirements for eCQMs in the Hospital OQR program and stated that patients may have difficulties in comparing data across settings due to those differing requirements. Dr. Schreiber noted that CMS would take that concern under advisement when implementing the measure. Another lead discussant noted they did not have additional comments and expressed support for the measure in the Hospital OQR program. A third lead discussant noted that they would support the measure being included for the outpatient setting, especially due to the low number of measures currently included in that setting.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. A co-chair asked if EHR data would be available for this measure in the outpatient setting. The measure developer confirmed there were no concerns about EHR availability and data was available during testing in both inpatient and outpatient settings. A co-chair asked if a hospital could choose to report the same set of data for both the inpatient and outpatient side. Dr. Schreiber noted that they would take this concern under advisement when implementing the measure. Mr. Hatlie asked the workgroup if there were any oppositions to carrying over the vote MUC2022-018 to the measure for the Hospital OQR Program. A MAP member requested a separate vote for this version of the measure. Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-020. Voting results were as follows: Yes – 18, No – 1, percentage voting Yes – 95 percent. Complete voting results are in Appendix B.

### *MUC2022-064: Hospital Harm - Pressure Injury (Hospital IQR)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then reviewed the six public comments received during the public comment period, all of which were supportive of including the measure in the Hospital IQR and Medicare Promoting Interoperability programs. Dr. Elliot reported that the Health Equity Advisory Group had no issues with the measure and felt it filled a care gap. The Rural Health Advisory Group reported concerns about data capture for the measure and were concerned with higher rates in rural settings due to staffing shortages.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber explained that this measure represents CMS' drive towards eCQMs, particularly ones related to safety. Dr. Schreiber referenced other safety eCQMs introduced by CMS in recent years. Dr. Schreiber noted that the harm eCQMs are advantageous because they: (1) capture all-payer data, and (2) allow organizations to learn from and use real-time data to build real-time electronic trigger tools that address patient safety. Dr. Schreiber acknowledged that pressure injuries are reported widely in different ways, and noted that pressure ulcers are important to address as they are one of the most common patient safety issues. A CMS representative echoed Dr. Schreiber's comments, noting the measure is an all-payer outcome eCQM.

One lead discussant noted appreciation for the measure being an eCQM. The lead discussant then asked if this measure was duplicative of PSI-3 (which is part of PSI-90) and if that measure would be removed if MUC2022-064 was accepted. The lead discussant noted that MUC2022-064 appears to be more inclusive than PSI-3 as it includes stage 2 ulcers. Dr. Schreiber indicated that the plan was to move in that direction. The lead discussant continued that pressure ulcers create workforce issues and staffing needs because the workforce needs to be aware of the pressure ulcers and the progression of those ulcers, patients need to be turned in their beds to prevent pressure ulcers, and there needs to be staff with expertise in staging the ulcers. The lead discussant noted they would conditionally support the measure; however, they recommended adding conditions, in addition to endorsement by a CBE. The lead discussant recommended thinking about risk adjustment for facilities with complex patients (e.g., academic medical centers, safety net hospitals). The lead discussant noted, as an example, that food insecurity can impact skin quality and frailty, and may exacerbate the risk for skin ulcers. The second lead discussant supported the measure and noted appreciation for the inclusion of stage 2 ulcers, that the measure is an eCQM, and that it collects data on patients younger than age 65. The lead discussant, however, noted that they were not supportive of excluding higher risk populations because those populations are the ones that need assessment the most. The third lead discussant noted they supported the comments provided already, and commended CMS on the development of important eCQMs, particularly this one as it addresses an important area of patient safety.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. A MAP member asked if this measure aligns with NDNQI [National Database of Nursing Quality Indicators] or would additional data be necessary. Dr. Schreiber noted she had not reviewed NDNQI in some time but explained that the measure would draw from a different data set than NDNQI, as it would come from EHR documentation. Dr. Schreiber noted NDNQI would be complementary to the eCQM. A MAP member commented that pressure injuries are the most common adverse health event reported in their adverse health events reporting system for both PPS and critical access hospitals, which supports the importance of the measure. The MAP member noted that the Medicare Promoting Interoperability Program [one of the programs under consideration for the MUC] is one of the few that includes critical access hospitals but noted critical access hospitals may struggle with eCQMs; ultimately, they supported the measure. Another MAP member supported the measure, particularly the use of the EHR to capture patient safety-related information but asked how the encounter was defined. Dr. Schreiber replied that the encounter is defined as a hospitalization. The same member then asked if pressure ulcers would be identified during an admission screening. Dr. Schreiber replied that the measure assesses for pressure ulcers a certain period after admission to take into account pressure ulcers that may be present on admission. The same member then recommended stratification by unit type and supported the NQF staff recommendation. The measure developer responded that risk adjustment was extensively discussed with the measure's technical expert panel (TEP) and other stakeholder groups and noted that a discussion of risk adjustment would likely be part of the measure's endorsement review. The measure developer continued that there are views on both sides of risk adjustment (those in support of risk

adjusting the measure and those against). The developer noted that while the evidence indicates that some patients may be at higher risk for pressure ulcers, the literature is not clear that the level of preventability is tied to higher patient risk; therefore, they noted that the majority of the TEP and stakeholders said that risk adjustment for the measure is not necessary. The developer further said that if hospitals implement best practices for the prevention of skin ulcers, they will be able to prevent most ulcers in both high risk and low risk patients. The developer also noted that there are harmonization issues, as there are measures in other programs for other settings that address pressure ulcers, and that these measures are not risk-adjusted.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking." A lead discussant requested that the endorsement process include a discussion of risk adjustment and stratification. Therefore, the conditions for the measure were endorsement by a consensus-based entity (including an assessment of risk adjustment and stratification) for measure MUC2022-064. Voting results were as follows: Yes – 18, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix B.

### *MUC2022-064: Hospital Harm - Pressure Injury (Medicare Promoting Interoperability Program)*

Dr. Elliott asked if the Workgroup had any additional comments on the measure for the Medicare Promoting Interoperability Program. There were no additional comments from the Workgroup.

Mr. Hatlie asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the Medicare Promoting Interoperability Program. No opposition was raised, and the vote was carried over. The previous vote was on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with conditions being endorsement by a consensus-based entity (including an assessment of risk adjustment and stratification) for measure MUC2022-064. Voting results were as follows: Yes – 18, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix B.

### *MUC2022-024: Hospital Harm - Acute Kidney Injury (Hospital IQR)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott summarized the public comments received during the public comment period, two of which supported the measure, one which supported with conditions, and one which did not support the measure. The comment with conditions encouraged CMS to work with technical experts to identify what is considered a substantial increase in serum to ensure it accurately captures instances of acute kidney injury. The comment that was not in support stated that the cause of acute kidney injury (AKI) is often nebulous, and that it is often related to the underlying disease that caused the patient's hospital admission, as opposed to substandard or harmful care. The comment also noted that some increases in serum creatinine may be appropriate and requested more information about risk adjustment. Dr. Elliott also reviewed feedback from the Health Equity Advisory Group, which found no issues with the measure and noted that it fills a gap. The Rural Health Advisory Group had concerns regarding data capture for the measure and higher rates in rural communities due to staffing challenges.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber noted that this measure is also a patient safety eCQM. Dr. Schreiber acknowledged that acute kidney injury can occur from disease but that it can also be the result of multiple factors at the hospital which are controllable. Dr. Schreiber noted the measure is an important harm measure and that it addresses a common harm. A CMS representative echoed Dr. Schreiber's comments, noting that the measure is an all-payer outcome eCQM.

A lead discussant commended CMS on the eCQM, noting that concerns raised by the public comments appear to have been addressed by the measure specifications, particularly around considerations to ensure that the kidney damage occurs during the visit. The lead discussant conditionally supported the measure. The second lead discussant conditionally supported the measure following endorsement as the measure addresses an important safety issue and is an outcome measure. The discussant recognized that acute kidney injury is a growing problem and noted the need to ensure patients do not become worse.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. The measure developer noted that this measure has a sophisticated risk adjustment model that has a c-statistic of 0.86, which they noted is considered excellent for this kind of model. The developer reviewed that the risk adjustment model adjusts for age, sex, vital signs at presentation, baseline eGFR, comorbidities, and extended hospitals stays, and that it was designed with expert input. The developer also explained that the numerator assesses for a doubling in the serum creatinine level, which accounts for modest increases in serum creatinine that may occur in the hospital. Lastly, the developer noted the measure requires a stable baseline creatinine, so patients with creatinine levels that are rising when entering the hospital (e.g., patients with sepsis) will not be captured in the denominator. A MAP member asked if pregnancy was included in the risk adjustment model and asked specifically about rare situations in which patients develop severe pre-eclampsia or who have a non-preventable postpartum hemorrhage and acute renal failure. The developer responded there were not a sufficient number of cases from their test sites with those scenarios to explore, but that this could be assessed as they collect data from more sites. Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the condition being endorsement by a consensus-based entity (CBE), for measure MUC2022-024. Voting results were as follows: Yes – 16, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

### *MUC2022-024: Hospital Harm - Acute Kidney Injury (Medicare Promoting Interoperability Program)*

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Hatlie asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the Medicare Promoting Interoperability Program. No opposition was raised, and the vote was carried over. The previous vote was on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the condition being endorsement by a consensus-based entity (CBE), for measure MUC2022-024. Voting results were as follows: Yes – 18, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix B.

## Volume Data Measures

Dr. Elliott provided an overview of the two volume data measures included in the section.

- **MUC2022-028**: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) *(ASCQR [Ambulatory Surgical Center Quality Reporting Program])*
- **MUC2022-030**: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) *(Hospital OQR)*

### *Public Comment*

Mr. Demehin opened the discussion to allow for public comment. There were no comments.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during the public comment period; there were four public comments, three of which were in support. One comment did not support the support, commenting that studies indicate there is significant variation in outcomes regardless of volume and it would be more meaningful to use outcomes. Another comment suggested expanding the measure to use all-payer data, to include more clinical areas, and to provide more granular data. Dr. Elliott reviewed feedback from the Health Equity Advisory Group which had noted concerns about using volume as a proxy for quality and that publicly reporting the measure may negatively impact equity. Dr. Elliott also noted that the Health Equity Advisory Group recommended collecting demographic data to understand if there are different populations accessing or receiving services from an ambulatory care setting versus hospital. Dr. Elliott reviewed that the Rural Health Advisory Group discussed voluntary reporting measures, volume of reporting is low, that more complicated procedures would not be performed in these facilities, and that all data elements are in defined fields so no manual abstraction would be needed.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber acknowledged that CMS had previously used volume measures and explained that CMS is reintroducing the measures in recognition of how some procedures are migrating from hospitals to ambulatory facilities in large numbers. Dr. Schreiber noted that the measures will identify the top procedures performed in ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs) and make them publicly available. Dr. Schreiber acknowledged the concerns that the measures are not quality measures but said that CMS believes there is enough evidence that links numbers of procedures that are done to quality and noted the importance of this information to consumers when making care choices. A CMS representative noted that MUC2022-028 and -030 were previously removed from ASCQR and Hospital QOR programs in calendar year (CY) 2018 based on measure burden outweighing the benefit of reporting. The CMS representative said the measures are aligned to allow comparisons across ASCs and HOPDs. The representative noted the measures have not changed although they do include procedures not previously included in the measures. The representative noted that MUC2022-028 includes six categories of procedures that are commonly performed by ASCs and MUC2022-030 includes nine categories of procedures. The CMS representative reiterated Dr. Schreiber's comments about the correlation between volume and outcomes, and the importance of volume data to consumers. The CMS representative noted that the measure has not been tested for reliability or validity, as it is a structural measure and does not lend itself to this type of testing. The representative also noted that as the measure uses claims data, CMS is confident the data is correct.

A lead discussant asked if the measure identifies a minimum volume for ASCs. The measure developer answered that the measure does not identify minimum volumes or thresholds and clarified that it reports aggregate totals. Another discussant commented that raw volume data may not be helpful for consumers without additional context. The discussant also noted that quality reporting should be focused on precise measures of outcomes and patient-reported outcomes, rather than volume as a proxy for outcomes. A third discussant also questioned using volume as a proxy for quality and recommended using outcomes that can be measured across settings.

Mr. Demehin opened the meeting for clarifying questions and Workgroup discussion and asked to confirm that MUC2022-028 and -030 use all-payer data, not just Medicare data. The measure developer confirmed that data is aggregated across all payers. The developer also noted that consumers value volume data, and that this data is often used by other groups which combine the data with other quality

data. One of the MAP members asked for the strength of the correlation between volume and outcomes. The measure developer responded that the strength varies but noted hip and knee replacements is of particular interest as these have moved largely from the inpatient setting to the outpatient setting, and there are relationships between volume and outcomes at both the surgeon and facility level. The developer also noted that there will be a PRO-PM [patient-reported outcome performance measure] available to assess these procedures, although they acknowledged this is not the case for all conditions. Lastly, the developer also stated the goal is to move patients away from facilities with zero or very low volume. One of the MAP members asked if states regulate which care settings can provide certain surgical procedures, if that drove the selection of categories, if there would there be any value in including other categories (e.g., cardiovascular), and if it would be more valuable to include more granular categories. Dr. Schreiber responded that the surgical procedures included in the measure are in the topmost used 100 CPT codes and noted state regulations did not factor into these decisions. Dr. Schreiber stated, however, that state regulations would need to be monitored, as well as the procedures that qualify for the inpatient-only list versus those not on the inpatient-only list. The measure developer commented that categories change over time and may be added or removed. A MAP member asked if categories were informed by correlation studies. The measure developer responded that the categories were broader than procedure-specific studies. The MAP member then questioned whether it was appropriate to assume a correlation between the volume of all procedures at an ASC and outcomes, when studies indicate a correlation between the volume of certain procedures and outcomes. The measure developer responded that the median number of procedures for all categories was zero (except for gastrointestinal) and noted there was wide variation in volumes. A MAP member expressed concern about using volume as an indicator for quality and stated this measure may provide a false sense of security. The MAP member noted there are other measures that more directly assess the quality of care provided. Another MAP member asked if the move to EHR reporting has reduced burden for this measure. Dr. Schreiber commented that the burden should be minimal because the measure is claims-based.

The co-chair questioned the measure conditions. A MAP member questioned whether the Workgroup wanted to add a condition to limit the measure to procedures where the literature indicates a strong correlation between volume and outcomes. The co-chair and another MAP member expressed interest in the condition, although the MAP member questioned whether that change would be substantive enough to warrant the "Do Not Support with the Potential for Mitigation" decision category. Dr. Elliott clarified that this would be considered a substantive change, and not just a condition. A MAP member expressed disagreement with the change, noting that the measure will help to drive better data on outcomes, and that patients use volume data, along with other data points, to make decisions. Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," the conditions being testing indicating the measure is reliable and valid, and endorsement by a CBE, for measure MUC2022-028. Voting results were as follows: Yes – 11, No – 7, and percentage voting Yes – 61 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during the public comment period. There were three comments in support and one which did not support the measure due to the variation in outcomes regardless of volume. Dr. Elliott also noted a comment recommending the measure include more categories, provide more granular data, and expand into using all-payer data. Dr. Elliott reviewed feedback from the Health Equity Advisory Group which had

noted concerns about using volume as a proxy for quality and that publicly reporting the measure may negatively impact equity. Dr. Elliott also noted that the Health Equity Advisory Group recommended collecting demographic data to understand if there are different populations accessing or receiving services from an ambulatory care setting versus hospital. Dr. Elliott reviewed that the Rural Health Advisory Group discussed voluntary reporting measures, volume of reporting is low, that more complicated procedures would not be performed in these facilities, and that all data elements are in defined fields so no manual abstraction would be needed.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber said CMS had no additional comments as the measure is similar to the prior measure.

A lead discussant noted that the measure is very similar to the prior measure, that there is a large migration of procedures to outpatient settings, and that this measure will be one of many data points that patients can use. The lead discussant noted the measure should be reviewed for endorsement, that a public comment suggested the categories are too broad but acknowledged that CMS had provided rationale for the categories used in the measure. Another lead discussant had no additional comments.

Lead discussants stressed the movement to ambulatory care, the use of the volume data point by patients and the use of overly broad categories.

Mr. Demehin opened the meeting for clarifying questions and Workgroup discussion. A MAP member noted that a key difference between the prior measure and this measure is that critical access hospitals report in the Hospital OQR program, and that these small, rural facilities will have low volume. The MAP member said that, as a result, precise outcome measures will be more useful as these reflect the care delivered. Another MAP member asked if the procedure categories are the same for MUC2022-030 and MUC2022-028. The measure developer responded that the categories are not the same, as the proportion of procedures completed at ASCs and HOPDs differs. The MAP member then asked a follow-up question about whether the measures are meant to compare performance within settings (e.g., within ASCs) or whether they are meant to compare performance across settings (e.g., comparing ASCs to HOPDs). The measure developer replied that comparisons can only be performed at the category level and not the individual CPT code level. Another MAP member asked for clarification about whether the conditions are the same but the procedures within the categories are different. The developer responded that the categories are different between the two measures and reiterated that the conditions may change based on the volumes at the different types of facilities. A MAP member asked if the Rural Health Advisory Group had provided feedback on the impact of this measure on rural hospitals. Dr. Elliott shared that the Advisory Group had noted that the volume of reporting is low and that more complicated procedures would not be occurring in these facilities. The MAP member then asked whether these considerations for rural hospitals, if recommended for inclusion in the endorsement review, would be considerations or conditions. A co-chair replied that it would depend on how substantive the change being recommended was. Dr. Elliott concurred that it would depend on how substantial the recommended change was. Dr. Elliott also stated that all comments would be passed to CMS for consideration. A MAP member stated that there is a need for outcome measures to create the context for using volume to measure quality. A co-chair shared a consideration for CMS that the measure is not ready for a Stars Rating system. Dr. Schreiber responded that the programs under review currently do not include Star Ratings programs. The measure developer added that CPT codes are not the same between measures.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the conditions being testing indicating the measure is reliable and valid, and endorsement by a CBE, for measure MUC2022-030. Voting results were as

follows: Yes – 11, No – 7, and percentage voting Yes – 61 percent. Complete voting results are in Appendix B.

## Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures

Dr. Elliott provided an overview of the four Rural Emergency Hospital Quality Reporting Program (REHQRP) measures included in the section.

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

### *Public Comment*

Mr. Hatlie opened the discussion to allow for public comment. There were no comments.

### *MUC2022-039: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during the public comment period. Three of the four comments supported the measure, and one did not support due to the burden of reporting outweighing the benefit. Dr. Elliott reviewed the Health Equity Advisory Group comments about the importance of this measure, and that it provided an opportunity to advance health equity. The Rural Health Advisory Group expressed concerns as to how weather and local facility transport modalities may be a consideration in transfer times (e.g., some remote locations may hold a patient locally for longer times due to weather and transport safety issues). Dr. Elliott noted that the Advisory Group also discussed how time with trauma patients is very important, and stakeholders have raised concerns that distance/time issues can be outside the control of the hospital.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. Dr. Schreiber noted that the REHQRP is a new program and that the designation is new, and that REHs are a way that CMS is attempting to preserve critical access in rural facilities that are struggling financially and to maintain volume. Dr. Schreiber noted that the measures proposed for REHQRP are used in other programs and are therefore familiar to facilities. Dr. Schreiber continued by explaining that this measure is particularly important in this new program as facilities may experience longer wait times than anticipated, and that longer ED wait times may be a particular issue in these facilities. A CMS representative noted this measure is in the Hospital OQR program, it has been publicly reported since 2013, and it has stakeholder support. The representative noted the measure uses chart abstracted data to calculate a continuous variable (time in minutes). The representative noted that the measure reports patients with psychiatric primary diagnoses separately.

A lead discussant supported the NQF staff recommendation and asked if the measure was tested in rural populations, if the measure is still in use (as it has lost NQF endorsement) and whether there is performance data for rural hospitals. A CMS representative replied that the measure is reported in the Hospital OQR program. The measure developer provided additional information, stating that the measure did lose endorsement because the length of time in the ED may not be a true indicator or quality, and that the literature does not demonstrate a strong association between outcomes (e.g.,

mortality) and length of time in the ED, although the developer noted there is a strong association between patient satisfaction and length of time in the ED. The measure developer also noted that the measure is used across a wide scope of hospital EDs in the Hospital OQR program, and that CMS provides measure results stratified by ED volume but stated the measure has not been tested specifically in the rural setting. The developer concluded by noting that the measure is stratified based upon patients who are sent home without a mental health diagnosis, patients with a mental health diagnosis, and patients who are transferred to another facility (the first two rates of which are reported publicly). Another lead discussant agreed with the NQF staff recommendation and noted the questions about whether wait time is an indicator of quality, raising a concern that patients may avoid EDs with longer wait times even though they need care. The discussant noted wait times are an indicator of patient satisfaction. The discussant also noted that it is important to know that the measure is stratified by ED volume, and that some EDs may have longer wait times due to the morbidity of patients seen in the ED. Lastly, the discussant recommended some consideration for testing the measure in rural areas.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. One of the MAP members noted that the measure is part of the MBQIP (Medicare Beneficiary Quality Improvement Project) program, which critical access hospitals participate in, and that CMS could access this data to assess the measure's performance for rural hospitals. Dr. Schreiber noted that CMS does not yet know how many REHs there will be, and it is not feasible to test the measure with rural hospitals, but that hospitals are familiar with the measure. A co-chair said that as the program and designation is so new, it is difficult to make recommendations for measures to include in the program, although the co-chair also expressed appreciation that CMS is bringing measures for the program to MAP. The co-chair then noted that the measure lost endorsement and that MAP recommended removing the measure from another program. Dr. Schreiber responded that because this is a different kind of program, these facilities will likely focus on ED and ambulatory care, and that staffing will be relatively limited, therefore this measure is particularly important for this setting. Another MAP member asked if there was a way to use data that is already reported for this measure. Dr. Schreiber responded that these facilities would become a new type of facility. The MAP member then followed up by asking about the timeframe for conversion. Dr. Schreiber noted that according to the law they can start converting in 2023, because the REHQRP can start collecting data in 2023 to report in 2024. A co-chair noted that rural hospitals are interested in the model and are assessing if their capabilities align with the model. A CMS representative clarified that CMS is ready to accept applications, and that there is a technical assistance center which has been contacted by four facilities to date. Dr. Schreiber noted it will be difficult for communities to relinquish inpatient care. A co-chair asked CMS whether the four measures under review by MAP for the REHQRP will serve as the initial core measures for the program. Dr. Schreiber responded affirmatively but noted the measures will change over time as CMS assesses which services are provided by REHs. Dr. Schreiber noted that CMS chose measures for the program that are already in use and that will be meaningful for REHs. The measure developer noted that hospitals in the REHQRP will be more alike than the hospitals currently reporting the measure.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Do Not Support for Rulemaking" for measure MUC2022-039. Voting results were as follows: Yes – 10, No – 6 and percentage voting Yes – 63 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during

the public comment period, two of which supported the measure and one which supported with conditions, the condition being for CMS to explore combining the measure with MUC2022-067 (which could help with small numbers in rural facilities). Dr. Elliott reviewed the Health Equity Advisory Group feedback which noted the importance of this measure, and that it provided an opportunity to advance health equity. Dr. Elliott noted that the Health Equity Advisory Group had a concern that there may be surgeon bias towards who they choose to operate on. The Rural Health Advisory Group did not have specific concerns.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. A CMS representative shared that the measure uses claims and enrollment data, that it has been publicly reported in the Hospital OQR program since 2017 and that it was endorsed by NQF in 2020. The representative also noted that the measure will promote care coordination for patients receiving colonoscopies.

A lead discussant noted appreciation for the previous discussion reflecting on the uncertainty of which facilities will convert to REHs. The discussant noted a concern about low volume, and requested more information on exclusions (i.e., if hospitals do not opt to provide colonoscopies that they will not be included in the measure). Another lead discussant did not have additional questions or comments but noted support for adding the measure to the program. A CMS representative noted that the minimum case threshold is 25. The measure developer noted that the measure is reliable, already reported by hospitals that could qualify to be REHs, and that approximately 50 percent of critical access hospitals report the measure.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. A MAP member asked if MUC2022-066 and -067 could be combined, as this would help to address concerns about volume. Dr. Schreiber noted the measure would need to be reconstructed into a new measure. The measure developer shared that according to their data, only about 20 percent of critical access hospitals report "Risk-standardized hospital visits within 7 days after hospital outpatient surgery," and noted that colonoscopies may be more likely to be provided by REHs. The developer also noted that having both measures as options may be optimal is it is not yet known what services REHs will provide and that consumers appreciate having more granular information. Another MAP member shared that the colonoscopy measure is useful, as colonoscopies are a common procedure that patients are more likely to have close to home in a rural setting, and that it is an important outcome measure. A co-chair recommended that once CMS has applications from potential REHs, to assess if those hospitals are meeting the minimum case threshold (if they are reporting as MBQIP and the data is available). The co-chair asked if this would be considered an implementation consideration or a condition. Ms. Williams-Bader responded that conditional support could be considered if MAP wants CMS to look at the applications and MBQIP data before the measure's implementation in the program. In response, the co-chair noted that they thought this would be conditional support. A MAP member asked for clarification about the minimum case threshold. A CMS representative clarified that it is 25 colonoscopies over a three-year period. The CMS representative noted how this measure was discussed with the Rural Health and Health Equity Advisory Groups, and how patients often stay within their own community for care related to colonoscopies. A MAP member noted their support for the measure in the program as it is already used and is NQF-endorsed.

Mr. Hatlie moved the workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking" for measure MUC2022-066. Voting results were as follows: Yes – 11, No – 4, and percentage voting Yes – 73 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during the public comment period, two of which supported the measure and two of which supported under conditions, the conditions being for CMS to explore combining the measure with MUC2022-067 (which could help with small numbers in rural facilities), and CMS continuing to work with stakeholders on this measure in the Hospital OQR program as there have been some challenges with the existing methodology. Dr. Elliott clarified that Health Equity and Rural Health Advisory Groups reviewed groups of measures, leading to Advisory Group feedback being similar sometimes across measures. Dr. Elliott reviewed the Health Equity Advisory Group feedback which noted the importance of this measure, and that it provided an opportunity to advance health equity. Dr. Elliott noted that the Health Equity Advisory Group had a concern that there may be surgeon bias towards who they choose to operate on. The Rural Health Advisory Group did not have specific concerns.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. A CMS representative shared that the measure is in the Hospital OQR program and that it was endorsed by NQF in 2020. The representative noted that the measure is assessed for fee-for-service patients 65 years of age and older, and that it is risk-adjusted using patient-level demographics, patient health status, and clinical conditions. The representative noted that the measure allows for the reduction of adverse events after hospital outpatient surgery at REHs.

A lead discussant commented that this measure is endorsed and used in the Hospital OQR program, but volume may be an issue more so for this measure than the previous measure. The lead discussant shared that they would prefer to vote “Conditional Support for Rulemaking” with the condition being assessing measure reliability once volume levels are established for hospitals seeking the REH designation. Another lead discussant also commented on volume but noted that the program is a quality reporting program which alleviated their concern about low volume. The discussant noted that they supported getting these measures into rural communities as well. Dr. Schreiber confirmed that the REHQRP is a reporting program. The third lead discussant supported comments from the previous lead discussants and noted that the type of procedures and the volume of facilities will be important. The lead discussant supported the measure for the program given it has been in use for some time and noted a comment from the measure developer that the number of hospital visits ranges widely, which demonstrates a performance gap. The discussant also noted that getting the data to the physicians is important, as physicians do not always know where the patient goes after a procedure.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. A MAP member expressed their support for this measure and noted that the measure allows for an assessment of outcomes and what happens to a patient after the surgeon and anesthesiologist complete the procedure. The MAP member then commented that the measure will allow for the identification of patients who are appropriate candidates for outpatient surgery. A CMS representative commented that this measure would use the same minimum case threshold as MUC2022-066 of 25 cases, and noted that volume is a reporting issue, and not a measurement issue. A MAP member asked for clarification on the condition proposed previously by another MAP member. The co-chair responded that the condition was to combine MUC2022-066 and -067. The MAP member then responded that they would not support that condition. Ms. Williams-Bader clarified that the first vote on the preliminary analysis recommendation would be for “Support for Rulemaking,” but noted that if there was a vote on “Conditional Support for Rulemaking,” NQF believed the condition would be to assess measure reliability once volume levels are established. Dr. Schreiber responded that CMS would not have access

to that data for several years, and therefore it would not be possible to apply the condition in order to recommend the measure in a proposed rule. A MAP member suggested that the condition could be to remove this measure from the program after two years of reporting if not enough hospitals have the volume to report. Dr. Schreiber agreed CMS would do this regardless of conditions. Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking" for measure MUC2022-067. Voting results were as follows: Yes – 14, No – 3, and percentage voting Yes – 82 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott then summarized the public comments received during the public comment period, one of which supported the measure one of which supported with conditions, and one of which did not support. The comments submitted stated that the measure does not measure performance nor foster care improvement, and that it does not include risk adjustment. Another comment recommended that the measure should not be used unless the case volume minimum is lowered, as REHs have lower patient volumes. Dr. Elliott reviewed the Health Equity Advisory Group feedback which noted the importance of this measure, and that it provided an opportunity to advance health equity. The Rural Health Advisory Group did not have specific concerns.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. A CMS representative commented that this is an important measure, and that it has been in the Hospital OQR program since 2010. The representative stated that CMS thinks it is important to include a safety measure in the REHQRP, and this measure fits into the program well.

A lead discussant commented that there has been significant performance improvement in the Hospital OQR program for this measure, particularly for rural settings. The discussant noted there were clarifications sought about minimum case volume but that this would be addressed over time as more experience is gained with the program. Another discussant seconded previous comments, noting that this measure has been in use for some time and should be added to the program to address a quality gap. The third lead discussant expressed support for the measure as a patient safety measure.

Mr. Hatlie opened the meeting for clarifying questions and Workgroup discussion. The measure developer commented that performance gaps remain in rural settings. A MAP member sought clarification on the inclusion of imaging studies with and without contrast in the measure. The measure developer clarified that there are codes for imaging studies that are performed with contrast, without contrast, and with and without contrast, and that measure numerator only includes imaging studies performed with and without contrast (after the removal of exclusions).

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking" for measure MUC2022-081. The conditions for the measure were testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 15, No – 2 and percentage voting Yes – 88 percent. Complete voting results are in Appendix B.

## Cross-Cutting COVID-19 Measure

Dr. Elliott provided an overview of the cross-cutting COVID-19 measure included in the section.

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

### *Public Comment*

Mr. Demehin opened the discussion for public comments. Dr. Schreiber agreed with the last statement and stated that the measure has been in use in various programs since 2020, has been updated to align with CDC guidelines, to extend to additional programs. There were no comments.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Ms. Williams-Bader clarified that the measure is no longer being considered by CMS for the HACRP and HVBP programs, and that the Workgroup will not vote for the measure's use in those programs. Dr. Schreiber agreed with this clarification. Dr. Elliott then reviewed the 16 public comments received for this measure, of which three were in support, 13 were in support with conditions, and 10 were not in support of the measure. Dr. Elliott noted the comments in support of conditions to the measure included concerns about variations to the up-to-date definition negatively impacting the reliability and validity of the measure and recommended a standardized way to collect this information. The comment also suggested harmonization with other COVID-19 measures. Dr. Elliott further noted the comments not in support for ASCQR, HVBP and HACRP included concerns with the burden of measure reporting, the changing of guideline requirements, and difficulties with the National Healthcare Safety Network (NHSN). Dr. Elliott provided a summary of the Advisory Groups' discussion and noted the comments applied to all programs. Dr. Elliott noted the Health Equity Advisory Group acknowledged the importance of COVID-19 measures. Dr. Elliott noted the Rural Health Advisory Group stated it is difficult to collect and document the information, and it is a very manual to collect.

Dr. Elliott then turned the meeting over to CMS for any comments on the measure. A CMS representative noted this measure is an update, reflecting current CDC recommendations for boosters, to an older measure currently in program use from 2020, and it is not being considered for HVBP and HACRP. The CMS representative stated the prior version of the measure recently received NQF endorsement, however reliability and validity testing for the updated measure have only recently been completed with an intent to submit for endorsement to NQF in January 2023.

A lead discussant commented on the importance of COVID-19 vaccination among healthcare personnel but was concerned with the reporting burden, the changing of the up-to-date definition over time, and questioned how potential annual reporting of the measure (versus the current quarterly sampling) would impact the ability to discern who is included in the measure. This lead discussant also asked to see the updated validity testing. Another lead discussant acknowledged the frustration within the public comments about vaccine access and the changing of criteria over time. This lead discussant questioned the facility benchmark and which guidelines they were benchmarked against but expressed full support of the measure.

Mr. Demehin asked for discussion on clarifying questions from the lead discussants. The measure developer commented that COVID-19 vaccination of healthcare personnel remains a critically important patient safety issue. The measure developer confirmed completion of validity and reliability testing from the third quarter of 2022 which will be incorporated into NQF measure submission, with medium correlation when comparing updated vaccination to the original measure, and an excellent signal-to-noise ratio (SNR) among facilities. The developer also shared the measure reflects the current up-to-date recommendation and the definition of up-to-date on the first day of the reporting quarter is utilized to maintain stable data over the quarter. A MAP member stated support for the measure but noted the need for more real time data on vaccination compliance. Another MAP member commented

that healthcare personnel should comply to the latest recommendations but there have been variations between those receiving only the primary vaccination versus those with bivalent or other boosters, so it is a complicated process for reporting. Another MAP member commented that while this measure is complicated, the measure is relevant and useful, so they strongly supported the measure. The co-chair asked how exemptions were noted. The measure developer explained that they provide definitions on up-to-date and exemptions to facilities at the beginning of the reporting quarter and complete outreach to reinforce the definitions for accurate and stable data. The developer noted the only exclusion for vaccine compliance was medical contraindications, including anaphylaxis or allergic reactions to the components of the vaccine, not any broader exemptions. A federal liaison explained that the data is collected in aggregate. The co-chair asked if it is known how much the vaccine is reducing transmission. The measure developer responded that efficacy has changed from the initial approval of the vaccine and represents an active area of research with more data coming from SNFs, but they are currently seeing protection from severe disease and a reduction in absenteeism. The federal liaison noted that while they cannot predict the future trends in vaccine efficacy, this measure allows for monitoring of data while allowing a gradual updating of measures in alignment with clinical recommendations. Another MAP member asked how the COVID-19 vaccine was different from the influenza or any other required vaccination. Dr. Schreiber responded that traditionally the influenza vaccine was seasonal, but that for the COVID-19 measure, the recommendations are changing and acknowledged there would be confusion on the part of hospitals about the definition of up-to-date. Dr. Schreiber also noted that the timeframe is different for COVID-19 as there is not a defined season but explained that the measure is purposefully flexible to account for changing guidelines.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," with the conditions being testing indicating the measure is reliable and valid, and endorsement by a CBE, for measure MUC2022-084. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94 percent. Complete voting results are in Appendix B.

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

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the Hospital IQR Program. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94 percent. Complete voting results are in Appendix B.

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

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the Hospital OQR Program. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94. Complete voting results are in Appendix B.

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

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the IPFQR Program. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94 percent. Complete voting results are in Appendix B.

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

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the PCHQRP Program. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94 percent. Complete voting results are in Appendix B.

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

Dr. Elliott asked if the Workgroup had any additional comments on this version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the ESRD QIP. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 16, No – 1, and percentage voting Yes – 94 percent. Complete voting results are in Appendix B.

## Preview of Day 2

Ms. Williams-Bader provided a preview of day two of the Hospital Workgroup 2022-2023 MUC Review Meeting.

## Adjourn

Ms. Williams-Bader closed the meeting.

# Measure Applications Partnership (MAP) Hospital Workgroup 2022-2023 MUC Review Meeting (Day 2)

## Welcome, Preview of Day Two, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the Hospital Workgroup 2022-2023 MUC Review Meeting on December 14, 2022, thanked participants for their attendance, and reviewed the ground rules and the day two agenda (listed below). There were 192 attendees at this meeting, including MAP members, NQF staff, government representatives, measure developers and stewards, and members of the public.

- Review of Measures Under Consideration
    - End-Stage Renal Disease Quality Incentive Program (ESRD QIP) Measures
    - Cross-Cutting Arthroplasty Measure
    - New Geriatrics Measures
    - Equity Measures
    - Hybrid Readmission and Mortality Measures
- Discussion of Broad Themes
- Opportunity for Public Comment
- Next Steps
- Adjourn

Ms. Williams-Bader turned the meeting to Dr. Elliott for a roll call of Hospital Workgroup members. Twenty of 22 MAP members were present (see Appendix A for detailed attendance).

## Measures Under Consideration

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

Dr. Elliott provided an overview of the End-Stage Renal Disease Quality Incentive Program (ESRD QIP) measures included in the section.

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

#### *Public Comment*

Mr. Hatlie opened the meeting to allow for public comment. A member of the public spoke in support of MUC2022-125. The member of the public stated that they were a kidney transplant patient with past difficulties in managing their care until they became employed as a health care technician. The member of the public closed their comment with a story about the importance of care coordination, noting an experience they had where a coworker who is a care coordinator used the measure to help work with a patient to make an appointment, which helped catch a complication that would have been fatal for the patient.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the five public comments

received during the public comment period, three of which were supportive of the measure and two of which were not supportive of the measure. Dr. Elliott noted that commenters had several concerns with the measure, including that the measure does not discern whether the switch to home modality is appropriate, the approach used to address facilities that do not offer home dialysis is lacking, and that the measure focuses on incident patients. Dr. Elliott noted the Health Equity Advisory Group stated that the measure is important to health equity. Dr. Elliott also noted that the Health Equity Advisory Group stated that racial differences are not just socioeconomic, recommended reporting the measure with risk adjustment and stratification, noted that stratification of the measure would be helpful and noted the need to consider the measure's upstream impacts on health. Dr. Elliott noted the Rural Health Advisory Group shared that this is an important measure for rural communities and that there is low utilization of home dialysis and low access to home dialysis services in rural areas.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that CMS has several measures under consideration for the ESRD QIP program and that the measure supports conversion to home dialysis where appropriate, gets dialysis patients to transplantation as soon as possible, and is a patient-centered measure. Dr. Schreiber closed by noting that dialysis is one of the leading costs for Medicare and is an important clinical issue. A CMS representative noted that the measure is critical to encouraging ongoing education and discussion for modality switches while considering care goals and end-stage life plans for dialysis patients. The CMS representative also noted that the measure seeks to encourage safe and effective modality switches and fills a gap due to the low use of home dialysis.

A lead discussant noted that the measure covers a very important patient population with a high burden of care for the patient, their caregiver, and the health care system. The lead discussant noted that the measure is patient-centered and fills an important gap. The lead discussant noted large public support for the measure concept, but noted some additional work remains to be done on the measure's evidence, validity, and specifications. The lead discussant also noted that they would support the preliminary analysis recommendation of "Do Not Support for Rulemaking with Potential for Mitigation." Another lead discussant expressed agreement with the preliminary analysis recommendation and noted that there are alternative measures in the pipeline. The lead discussant stated they did not detect significant enthusiasm for this measurement approach in the community. A third lead discussant also expressed agreement with the preliminary analysis recommendation. The lead discussant noted that while it is important to encourage and support home dialysis, the issue is complex, with some clinician and dialysis center discomfort with home dialysis. The lead discussant stressed the importance of health equity factors in determining the possible success of home dialysis. The lead discussant noted that they did not want the measure to penalize patients that stay in a dialysis center or switch modalities. The lead discussant noted significant opportunities to improve the measure and stressed the importance of the measure concept.

Mr. Hatlie opened the meeting for Workgroup discussion. A MAP member asked if there is any additional financial burden or additional costs to patients for home dialysis. A CMS representative noted that there should not be any additional financial burden, but that patients will need a space in the home to perform dialysis and store supplies. The measure developer added that they agreed with CMS on the burdens of peritoneal dialysis and noted that there may be some additional costs to upgrade home plumbing for hemodialysis, but this is a small number of dialysis patients. A MAP member asked what kinds of support patients get for home dialysis as gaps can occur when patients move from an institution or facility-based care to home care. A CMS representative noted that the whole kidney care team should consult with the patient in ways to support the patient even before they consider home dialysis and that patients will have extensive support from their dialysis facility when they are doing dialysis at home. The

CMS representative also noted that patients will come into the facility once a month for a visit. The MAP member asked a follow-up question about how the measure is risk-adjusted. The measure developer stated that the model that determines expected modality switch is adjusted for incident co-morbidities recorded by facilities during registration at the initiation of dialysis. The measure developer noted that additional factors including race and ethnicity, age, and other demographic factors were tested during measure development, but were strongly rejected by the measure's Technical Expert Panel (TEP). The measure developers also noted that they could not use Medicare claims data for risk adjustment as a significant portion of patients were not active Medicare beneficiaries. The MAP member asked the developer to confirm that the risk adjustment only adjusts for co-morbidities and not for demographic factors, which the measure developers confirmed.

A federal liaison asked how the measure incorporates caregiver burden. A CMS representative noted that the measure does not directly consider caregiver burden but that the end-stage kidney disease life plan discussion does need to incorporate the needs of the patient's caregiver and that patients may reject a home modality due to caregiver burden, so the conversations allow for opportunities to identify ways to relieve that burden and make a switch to home dialysis possible. The measure developer stated that end-stage renal disease is a disease of families and that families choose to take on home dialysis along with the patient. The measure developer also noted that the measure is calculated to identify outlier dialysis facilities and can adjust for a number of patient factors. The measure developer stated that caregiver burden may not have significant variation across dialysis facilities and may be covered by flagging outlier facilities. The federal liaison asked if social determinants of health are included in the measure. A CMS representative noted that including social determinants of health is a challenge since clinicians may consider someone with multiple social needs and not consider them a candidate for home dialysis. The measure developer noted that having a productive conversation with the patient can help the provider determine what might make the patient a good candidate for home dialysis or what might make the patient most successful in their dialysis care. The measure developer agreed with the CMS representative.

A MAP member noted that having to go into a dialysis center every day is a burden on patients and families. The MAP member agreed with the goal of enabling home dialysis whenever possible. A lead discussant noted that it is even more burdensome for the patient to go into a facility every day if they are in a rural area or have a social need. The lead discussant noted there is a disproportionate burden on patients like that and expressed a goal to find measures that support home dialysis to help alleviate that burden.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Do Not Support for Rulemaking with Potential for Mitigation," for measure MUC2022-075. The potential mitigation for this measure would be to address the concerns raised by the Renal Standing Committee regarding the evidence base and specifications, and validity, and resubmit the measure for endorsement by a consensus-based entity (CBE). Voting results were as follows: Yes – 18, No – 2, and percentage voting Yes – 90 percent. Complete voting results are in Appendix B.

### *MUC2022-076: Standardized Fistula Rate for Incident Patients*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the four public comments received during the public comment period, of which one was supportive of the measure and three were not supportive of the measure. Dr. Elliott noted that commenters had several concerns including, that that the time period of the measure is not clear, the choice of attributable clinician, that the

measure is not patient-centered as it focuses on arteriovenous fistula (AVF) as the sole means of vascular access, and the lack of alignment of the measure with guidelines. Dr. Elliott noted the Health Equity Advisory Group stated that the measure is important to health equity. Dr. Elliott also noted that the Health Equity Advisory Group stated that racial differences are not just socioeconomic, recommended reporting the measure with risk adjustment and stratification, noted that stratification of the measure would be helpful and also noted the need to consider the measure's upstream impacts on health. Dr. Elliott noted the Rural Health Advisory Group shared that this is an important measure for rural communities and that there is low utilization of home dialysis and low access to home dialysis services in rural areas.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted that a patient's decision about vascular access is a personal choice and must fit into their individualized end-stage kidney disease life plan. The CMS representative also noted that the measure is adjusted for co-morbidities and patient characteristics associated with low success rates for fistula to account for patients where other methods of vascular access may be more appropriate. The CMS representative noted that the measure seeks to encourage the creation of a fistula within the first year of dialysis for patients where it is their best option for vascular access.

All three lead discussants expressed agreement with the preliminary analysis recommendation of "Do Not Support for Rulemaking with Potential for Mitigation." A lead discussant also noted that they agreed with the comments by the NQF Renal Standing Committee on the previous version of the measure. The discussant also noted that they found public comment indicating that some patients may choose not to go through the process of evaluation or maturation of an arteriovenous fistula particularly noteworthy.

Mr. Hatlie opened the meeting for Workgroup discussion. A MAP member noted they were confused about what the measure is assessing and asked if the measure is only capturing the preferences of patients who wanted to move from catheter to fistula. A CMS representative noted that they agreed with the concern and noted that there is no way for the measure to account for patient preference or exclude patients who did not want a fistula. The measure developer noted that the measure cannot assess a patient's knowledge base and acknowledged that patient choice is extremely important. The measure developer also noted that the science behind a low-burden patient choice variable is lacking and that they did not attempt to incorporate one into the measure. A federal liaison asked about why the measure focuses on incident patients and noted that focusing on incidence can lead to a host of attribution issues. A CMS representative noted concerns about prevalent patients in the previous measure because there are patients who have reached the end of their vascular access and their only option is a catheter. The CMS representative noted that including prevalent patients may not accurately reflect a facility's ability to get patients other vascular access methods. The CMS representative also noted that the lack of a facility's ability to move prevalent patients off a catheter was one reason the measure TEP decided to focus on incident patients, as most start dialysis with a tunneled catheter and have the option to move to a fistula for vascular access. The CMS representative closed by noted that CMS' preference is for providers to talk with patients about vascular access and modality well before they start dialysis. The measure developer agreed with the CMS representative's comments and noted that need and performance gap is greatest in incident patients as 80-85 percent of those patients start with a catheter while 60 percent of prevalent patients have a fistula with only 10-15 percent having a catheter. The measure developer noted that the gap is much less and the motivation to rapidly change to a permanent vascular access is much less urgent in the prevalent population.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Do Not Support for Rulemaking with Potential for Mitigation," for measure MUC2022-076. The potential

mitigation for this measure would be to address the concerns raised by the Renal Standing Committee regarding the evidence base and resubmit the measure for endorsement by a consensus-based entity (CBE). Voting results were as follows: Yes – 20, No – 0, and percentage voting Yes – 100 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the two public comments received during the public comment period, of which one was supportive of the measure and one was not supportive of the measure. Dr. Elliott noted that commenters expressed concerns about the exclusion of Medicare Advantage patients and the inclusion of all emergency department (ED) visits by ESRD patients, and that commenters suggested some revisions to the measure, including additional exclusions. Dr. Elliott noted the Health Equity Advisory Group stated the measure is important to health equity. Dr. Elliott also noted that the Health Equity Advisory Group stated that much of use in EDs is for complications, so it is important to keep patients healthy and reduce ED use. Dr. Elliott also noted that the Health Equity Advisory Group stated that if the measure is risk-adjusted it could give people "an out" for analyzing the measures as it would be hard to determine the disparities, and that the Health Equity Advisory Group felt positively that the measure can be reported as stratified as that ability is part of the design of the measure. Dr. Elliott noted the Rural Health Advisory Group shared that the dialysis measures are important and that there is concern about ED visits and travel for services related to dialysis, which can create barriers to access in rural areas.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted that the measure tracks ED use among ESRD patients as use is high among those patients. The CMS representative also noted that the measure is complementary, fills a gap and seeks to reduce use of ED and unscheduled care by promoting use of prevention care by ESRD patients.

A lead discussant noted that the measure fills a gap and measures care coordination for the ESRD patient population. The lead discussant also noted that they were interested in why the measure does not include Medicare Advantage beneficiaries. The lead discussant noted they supported the preliminary analysis recommendation of “Support for Rulemaking.” Another lead discussant also expressed support for the preliminary analysis recommendation and expressed interest in the exclusion of Medicare Advantage beneficiaries from the measure as it could create regional variation based on the proportion of patients enrolled in Medicare Advantage. The lead discussant also noted that they supported stratification of the measure by social risk factors. Another lead discussant expressed support for the measure as ED visits are stressful for patients and expensive for the system, and the measure seeks to avoid them. The lead discussant also indicated support for the preliminary analysis recommendation. The lead discussant also asked if the measure developer thought of limiting diagnostic codes included in the measure to conditions that dialysis centers can impact. The lead discussant noted that if dialysis centers know they are evaluated based on ED visits, they may direct a patient to primary care or urgent care. The lead discussant also noted that care may not be available, and this may result in unintended consequences.

Mr. Hatlie opened the meeting for Workgroup discussion. A CMS representative responded to the comment about unintended consequences by noting that the measure is looking at whole patient care for dialysis patients to keep them healthy on a regular basis and that they would hope that clinicians would refer a patient to the ED if emergency care was needed. The CMS representative also noted that

the exclusion of Medicare Advantage beneficiaries is more due to data issues, but CMS wants to make sure that all ESRD patients are captured eventually. The measure developer noted that the exclusion of Medicare Advantage beneficiaries is purely a data issue as the measure uses Medicare claims and Medicare Advantage claims are delayed and incomplete. The measure developer also noted that due to those data issues, they believe they cannot include Medicare Advantage events in the numerator, so it is less biased to exclude those beneficiaries entirely. A co-chair asked the developer to comment on the possibility of using diagnostic codes directly related to dialysis care. The measure developer noted that early in development ESRD specific CPT codes were looked at but it was difficult to strike balance between specificity and inclusivity or to define what is an ED visit related to dialysis complications. The measure developer noted that ultimately there are a number of potential issues that can be directly related to care provided by the dialysis team and that the measure's TEP voted for an all-cause numerator rather than a "dialysis-related" code numerator. A lead discussant asked about potential exclusions for things clearly not related to dialysis care such as trauma or COVID-19. The lead discussant noted that they wanted the measure to capture anything that is ERSD related but also wanted to be fair for events that are not related to ERSD such as a car accident. The measure developer agreed with that comment. A CMS representative also expressed agreement with that comment and note that they had had patients who fainted in the parking lot after dialysis and had to go to ED with head trauma.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-079. Voting results were as follows: Yes – 18, No – 2, and percentage voting Yes – 90 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the nine public comments received during the public comment period, of which six were supportive of the measure and three were not supportive of the measure. Dr. Elliott noted that commenters wanted to see more specific testing of the measure in the kidney disease population and CBE endorsement for the dialysis facility setting and suggested waiting until after the current Kidney Care Choices Model before adding the measure to the program. Dr. Elliott noted the Health Equity Advisory Group discussed that this measure could help improve health equity and patient engagement in their health. Dr. Elliott also noted that the Health Equity Advisory Group shared that safety net providers may have challenges making gains in the measure. Dr. Elliott noted the Rural Health Advisory Group shared that this measure could have unintended consequences for the rural health community due to limited access to health care resources with regard to attitudes, motivators, behaviors and outcomes in seeking healthcare.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted that the measure is currently in use in the Kidney Care Choices model. The CMS representative also noted that in first 6 months of the program, 65% of patients received an initial PAM with approximately 78% of participating groups administered an initial PAM to over 50% of their patients. The CMS representative noted that a range of groups were successful in hitting the first milestone for the model and that in the second half of the year participating groups are working on re-administration of PAM to their patients. The CMS representative noted that aggregate of differences from baseline and follow up PAM scores are planned to be publicly reported. The CMS representative noted that the measure is critical that all ESRD patients are empowered to take an active role in their care and especially critical for adolescent patients who are transitioning from pediatric to adult care. The CMS representative concluded by noted that free version of the tool will be posted available online.

A lead discussant noted that it was great to see the utilization of PAM in ESRD and that seeing positive changes in helping people to manage their own health in order to improve outcomes is great. The lead discussant noted that the preliminary analysis for the measure did a great job of highlighting background of the measure and specifically called out the information that 85% of articles indicated some type of statistically significant relationship between PAM and positive outcomes. The lead discussant also noted that earlier public comment from the meeting indicated the measure had potential to be used in positive ways. The lead discussant noted that while the measure background did indicate a gap in care, does the range of performance reflect at the reflect dialysis facility level?

Another lead discussant noted that the measure may observe the patient's perception rather than a true reflection of self-efficacy, as literature on self-efficacy finds that those measures should be task specific. The lead discussant also noted that PAM is not disease specific which is a concern. The lead discussant also asked if the change in PAM scores is going to be tied to pay for performance, does the measure examine a patient's perception or does the score have a direct correlation with observable outcomes. A CMS representative noted that they would need a little more time to think through performance scoring before submitting the measure to pay for performance. The measure developer noted that the PAM is not disease specific, and that self-efficacy is part of the PAM measure. The measure developer noted that the measure is more of a global measure as patients are thinking about general ability rather than specific disease when surveyed. The measure developer also noted strong evidence of link between PAM score and behavior as well as change of PAM score and behavior with over 750 publications that quantify the PAM including quite a few on kidney disease patients. A co-chair asked the measure developers to comment on the use of PAM without care coordination and clarified that they were asking about the correlation between a patient's PAM score and self-management of their condition in situation where there is coordination with providers. A lead discussant added that that there is a lot of literature indicating that self-efficacy is not generalizable and asked if a PAM score changes would an objective observer such as a care provider agree with that change. The measure developer noted that some studies have provided evidence of changed patient behavior after changes in PAM score. The measure developer also noted that the PAM is not just a measure of self-efficacy. The measure developer stated that Rasch analysis was used to create the measure, which can allow for the measurement of one inherent concept, in this case, a patient's inherent sense of self-confidence. A lead discussant noted that the measure deals with a complex set of issues and there has not been a significant amount of research done correlating changes in PAM scores to observed changes in behavior by providers. The measure developer noted that a Stanford study tracked changes in PAM score in high-cost populations and found that when PAM scores go up, costs go for those patients go down. The measure developer also noted that the study found decreased rates of hospitalization and ED use and increased use of preventative services by that population.

Mr. Hatlie opened the meeting for Workgroup discussion. A MAP member noted that while the measure and underlying concept are valuable, it may be premature to add the measure to the ERSD QIP. The MAP member noted the measure is still being piloted and would prefer to wait until testing and demonstration data become available. The MAP member also noted that it is important for CMS to be agnostic on measures as measures are tested and evaluated. The MAP member asked if the developer observed any regional variation in PAM scores. The measure developer noted that they did not observe significant variation by region. The measure developer also noted some studies of the PAM had observed the chronic kidney disease population. The measure developer noted that one study assessed over 3,000 chronic kidney disease patients and found higher PAM scores in kidney disease populations had lower symptom burden, better health, and quality of life, and more adherence to treatment regiments. The measure developer also noted that the measure had been studied in home dialysis and dialysis patients with similar findings in a similar sample size. Another MAP member asked if studies

were provided in meeting materials. The measure developer provided links to those studies in the chat. A MAP member asked in chat how many languages in the PAM is available in. The measure developer noted that the PAM is available in 38 languages with about half having been extensively tested.

Mr. Hatlie moved the workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-125. Voting results were as follows: Yes – 13, No – 7, and percentage voting Yes – 65 percent. Complete voting results are in Appendix B.

## Cross-Cutting Arthroplasty Measure

Dr. Elliott provided an overview of the Cross-Cutting Arthroplasty Measure included in the section.

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

### *Public Comment*

Mr. Demehin opened the meeting to allow for public comment. There were no comments.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the six public comments received during the public comment period, two of which were supportive of the measure, three of which were supportive of the measure under certain conditions, and one of which was not supportive of the measure. Dr. Elliott noted that commenters shared several concerns, including burden on facilities, the ability of ASCs to collect the data given the timeframes, the lack of testing in ASCs, and a suggestion that CMS should not implement this measure in other programs before learning more from implementation in the Hospital IQR program. Dr. Elliott noted the Health Equity Advisory Group expressed concern regarding unintended consequences of patient selection (less risky patients) and the impact to health equity. Dr. Elliott noted the Rural Health Advisory Group discussed challenges with implementing the patient-reported outcome measure (PROM) instrument, with data collected prior to and post-operatively, and noted that post-operative care may present a challenge (i.e., PT [physical therapy] availability in the rural health setting and face to face contact versus virtual, and that there may be no bandwidth). Dr. Elliott also noted the Rural Health Advisory Group discussed if virtual care could be part of the care process.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that the measure is a PRO-PM and acknowledged that there are too few of these measures in the measure set. Dr. Schreiber also noted that the measure is intended to determine from the patient's point of view how they are doing after a very common procedure. Dr. Schreiber also discussed the history and implementation of the measure as the measure was first developed in CMMI's [Center for Medicare & Medicaid Innovation] Comprehensive Care for Joint Replacement model and that the measure is currently in the Hospital IQR program. Dr. Schreiber also noted the importance of the measure given that procedures are moving to outpatient settings, particularly ASCs and HOPDs, and it is important to capture a similar measure in those settings to compare patient outcomes across all settings. A CMS representative noted that CMS anticipates that there will be sufficient variation in measure scores given that total knee arthroplasties (TKAs) are being performed in both settings. The CMS representative also noted that following the COVID-19 outbreak, outpatient procedures for the measured procedures have outnumbered inpatient procedures with inpatient TKA volumes down 30

percent. The CMS representative also noted that the measure has the same specification as the hospital and clinician group versions of the measure. The CMS representative noted that the goal of bringing forth these measures for consideration is to align measures across CMS programs where these procedures are being performed.

A lead discussant expressed support for the measure as a well fleshed-out patient-reported outcome measure. The lead discussant also noted that the measure has been adopted in the Hospital IQR program for voluntary reporting. The lead discussant stated alignment between settings for the different versions of the measures is well thought out. The lead discussant highlighted comments from the Health Equity Advisory Group noting that survey fatigue and response bias could be an issue. The lead discussant also noted a possible issue with the length of the post-op timeframe and asked the measure developer if they observed differences in measure scores when they collected at the start or at the end of the reporting window. The measure developer noted that the measure had a statistical approach to adjust for any non-response bias.

Another lead discussant noted agreement with the comments of the first lead discussant and highlighted comments in the preliminary analysis that documented concerns during the MAP's 2021 review about attribution for changes in joint function to the hospital versus rehabilitation providers, exclusion of staged procedures which eliminated over 40 percent of procedures, and the measure's 25 case volume exclusion threshold. The lead discussant acknowledged the importance of the measure as TKAs move to ASCs after CMS removed knee and joint procedures from the inpatient-only list and also noted that projections indicated that, by 2030, over 2 million procedures will be performed in the ASC or outpatient setting. The lead discussant acknowledged that the intent of the measures is to see equivalent quality in those settings and allow consumers to compare across settings. A co-chair noted that the post-procedure windows were slightly different between the inpatient and outpatient versions of the measure. The measure developer noted that exclusion criteria and staged procedures were discussed during development but that it would be difficult to differentiate recovery after the singular procedure. The measure developer also acknowledged that they will be looking at staged procedures quite closely. The measure developer also noted that CMS will look closely at case volume upon measure implementation and that the case volume threshold allows the measure to take care in attributing a measure score that because of a low case volume might have reliability concerns. The measure developer also noted that the measure is voluntary, and that the measure has a rigorous, statistical approach to address non-response bias. The measure developer also noted that these procedures are being performed in outpatient settings more frequently and heard from experts, during development of hospital and clinician versions of the measure, that as those procedures are moving into those settings there was a concern that that is not a measure for the outpatient settings. The measure developer also acknowledged the differing follow-up windows and attributed that to a communication hiccup. The measure developer noted that during development of the hospital and clinician group versions of the measure, experts provided feedback that ending the post-op window at 12 months was problematic for data collection, as a number of patients may have a follow-up appointment that is one week or one month after the 12 months. The measure developer stated that they decided to shift the post-op response window to the 10–14-month period in order to capture all 1-year follow-up visits. The measure developer concluded by noting that CMS may be considering alignment across the different versions of the measure.

Mr. Demehin opened the meeting for Workgroup discussion. A MAP member expressed support for the measure, especially with the procedures moving to outpatient settings. The MAP member noted that the measure approach would be effective when paired with team-based approaches where techniques have changed, such as multimodal anesthesia. The MAP member emphasized the importance of care

teams working together to advance patient safety. The MAP member also stated that non-response by patients is a difficult issue. Another MAP member noted that when a patient comes in for a procedure, they have a certain level of expectation, and that the provider needs to set expectations based on those conversations with their patient. The MAP member asked if the measure developers had considered having a way to measure expectations from the start of the process and then at the end of the process. The measure developer noted that the measure is asking patients to report their pain and functioning both pre- and post-operatively. The measure developer also noted that they had strongly suggested that this measure, and the PROM instruments used for the measure, are important not only for quality measurement but also clinical decision making. The measure developer noted this would benefit patients but would also increase investment in PRO-PM involvement. The measure developer stated that while the measure does not capture patient expectation, they would advocate for its use in clinical decision making. Another MAP member indicated strong support for the measure. The MAP member stated that the measure is an important measure for collecting information from patients to determine their physical reactions to surgery and may be important for determining future treatment for these conditions. The MAP member also noted they were eager to see the results of the measure.

Another MAP member noted that the measure had a lot to like about it but also noted that patient time and survey burden as a concern, reflecting comments from a lead discussant. The MAP member also noted that a patient experience measure will be rolling out into the program at the same time and that CMS should be mindful of the number of times patients are asked for the same information. The MAP member also asked if patients needed clarification for what providers are asking about. The MAP member also noted significant data collection requirements for hospitals and that the measure could pose a burden on hospitals. The MAP member noted that they would support voluntary reporting periods before mandating reporting of the measure and suggested that CMS assess the experience of the measure as it is implemented in the Hospital IQR program. Dr. Schreiber noted that CMS considers patient experience surveys to be different from PRO-PMs, such as this, as PROM instruments assess if a patient improved after a procedure and is an extension of clinical care. A co-chair also noted that the timing for the two surveys is different, with the PRO-PM being administered a few months after a procedure to see how it impacted a patient's life. A federal liaison noted that they were excited that the measure is being introduced across the care continuum.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-026 for the ASCQR program. Voting results were as follows: Yes – 19, No – 1, and percentage voting Yes – 95 percent. Complete voting results are in Appendix B.

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

Dr. Elliott opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the Hospital OQR version of the measure. A MAP member asked if the measure is just for the Medicare fee-for-service (FFS) patient population or if Medicare Advantage is included in the measure. The measure developer noted that the measure was developed solely for the FFS population. The MAP member asked a follow-up question about why the measure did not include Medicare Advantage patients as the lack of inclusion of Medicare Advantage is normally due to data collection issues. Dr. Schreiber noted that there are ongoing conversations inside CMS to try and include Medicare Advantage patients in more measures and it is top of mind for CMS. A co-chair asked if the measure needs to have data to link the Medicare encounter to the data being collected by the hospital. Dr. Schreiber agreed that that is one of the challenges with including Medicare Advantage patients. The

measure developer noted that the measure is primarily based on patient-reported outcomes but does require a linkage to claims data to confirm the eligible procedure as well as for risk adjustment purposes.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-026 for the Hospital OQR program. Voting results were as follows: Yes – 19, No – 1, and percentage voting Yes – 95 percent. Complete voting results are in Appendix B.

## New Geriatrics Measures

Dr. Elliott provided an overview of the new geriatrics measures included in the section.

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

### *Public Comment*

Mr. Hatlie then opened the meeting to allow for public comment. There were no comments.

### *MUC2022-032: Geriatrics Surgical Measure*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the 10 public comments received during the public comment period, seven of which supported the measure, one which supported the measure under certain conditions, and two which did not support the measure. Dr. Elliott noted that commenters had concerns about the measure's subjectivity and the value of attestation-based measures and that a commenter recommended CMS conduct an analysis on the effectiveness of attestation to closing care gaps. Dr. Elliott noted the Health Equity Advisory Group expressed that geriatric patients are more fragile, and it is important to assess their needs. Dr. Elliott also noted the Health Equity Advisory Group was not opposed to concept of the measure but did express concerns regarding implementation and limited evidence that attestations lead to improved patient outcomes or improved equity. Dr. Elliott noted the Rural Health Advisory Group expressed that this is a critically important measure, however, rural hospitals do not have the provider pool to hire providers, which means there is an ever-rotating staff of locums. Dr. Elliott also noted the Rural Health Advisory Group stated that rural hospitals may be at a reporting disadvantage for compliance with measures and consistent documentation, as rural hospitals also have limited social services resources which impact one of the attestation questions of the measure. Dr. Elliott also noted the Rural Health Advisory Group also commented that community trust could be an issue if the outcomes are reported publicly that measures are applicable across settings, and that these are the right processes to take care of an older adult.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber stated that she recognized that CMS has introduced structural measures which are controversial, but that recently introduced structural measures have caused changes in behavior. Dr. Schreiber pointed to the maternal structural measure and the equity structural measures as positive examples. Dr. Schreiber stated quality improvement initiatives are not just about collecting the data but also ensuring that the structural elements of quality improvement are in place. Dr. Schreiber also noted that CMS wants to target structural measures in specific areas and that the geriatric population is important for Medicare as it is a vulnerable population, particularly given the impact of COVID-19 on that population. A CMS representative noted that CMS had enthusiasm for the measure, especially to draw attention to the care of the geriatric population. The CMS representative noted that the measure

is new and has not been previously submitted to MAP or the NQF endorsement process. The CMS representative also noted that the measure did not give any partial credit for attestations.

A lead discussant noted that they understood CMS' plans for the measure and understood that MAP members need to take multi-pronged approach to the measure. The lead discussant noted that the data is there to support the measure but that the presentation of the data is lacking. The lead discussant emphasized the need to be specific about which individual studies prove that each criterion in the measure has a performance gap and prove the measure criteria have an impact on the quality of patient care. The lead discussant also noted that while social risks are planned to be part of the measure, there was no further description of how that data would be captured. The lead discussant concluded by noting that they would support mitigation to improve the measure. Another lead discussant acknowledged the important work done in developing the measure and identifying an important patient care area. The lead discussant also expressed appreciation for the inclusion of domain 2 regarding medication management. The lead discussion also agreed with Dr. Schreiber's outlined approach in using structural measures to build out areas of care. The lead discussant noted that they had mixed feelings about the measure and agreed with many of the points raised by the previous lead discussant. The lead discussant also noted that they would not support the preliminary analysis recommendation but would support a decision category of "Do Not Support with Potential for Mitigation" and would support additional review and development of the measure. The lead discussant also asked if the measure domains aligned with accreditation and Medicare Standard Operating Procedures. A third lead discussant expressed agreement with the measure's intent and lauded its holistic approach. The lead discussant also noted that they were excited to read about the measure as they support composite measures. The lead discussant noted that they had difficulties with the attestation portion of the measure. The lead discussant also stated that they would not support the preliminary analysis recommendation. The lead discussant noted that they agree with comments by the other two lead discussants and that they see the measure as a building block step that needs additional refinement before coming back to MAP.

Mr. Hatlie opened the meeting for Workgroup discussion. The measure developer expressed appreciation for the comments of the MAP members. The measure developer noted that they envision the measure as a way to help geriatric patients who may have a vulnerability or frailty to find a facility that can fit their needs and goals. The measure developer noted that attestation is a starting point based on what was done with past structural measures such as the maternity measure. The measure developer noted that the measure is specifically designed to help the geriatric patient and help the facility know where they stand related to the care of geriatric patients, and that it and seeks to improve accountability for a vulnerable population. A MAP member noted that they would support "Conditional Support for Rulemaking" or "Do Not Support for Rulemaking with Potential for Mitigation" for this measure. The MAP member also noted that they normally dislike attestation measures but that the measure captures an important topic where there are not a lot of outcome measures. The MAP member noted that the measure could be a way to build systems for the implementation of future outcome measures. Another MAP member noted that they appreciated the CMS introduction of the measure and that structural measures may impact provider behavior. The MAP member also noted that the measure seems like a "check box" measure without much meaning. The MAP member stated that they were not sure that doing more research or getting additional evidence would change their opinion. The MAP member noted that they would like to see more development of outcome measures, as they were unsure if, as a patient, they could trust attestation. Another MAP member noted the challenge for the Workgroup and questioned when does the Workgroup decide that the need for the measure is important enough to vary from the MAP standards or criteria. Another MAP member echoed those comments and noted that their organization had been involved in the measure topic. The MAP member also acknowledged the thoughtful work that went into developing the composite. The MAP member

stated that the most impact could be in bringing forward direct measures of care being delivered. The MAP member also noted that they did not disagree with Dr. Schreiber's comments on the role of structural measures as starter measures. The MAP member noted that the preliminary analysis documented that the performance gap on the measures was pretty small and recommended that the developers might want to look at a more streamlined set of attestations that have a larger performance gap. The MAP member noted that they would support the preliminary analysis recommendation while acknowledging the importance of the measure concept.

Another MAP member stated that they understood the need for structural measures but also understood not wanting to rely on structural measures. The MAP member also suggested meeting in the middle with process measures to avoid measures that feel like they check a box. The measure developer responded by noting that they have spent millions of dollars to shepherd outcome measures through the NQF review process but noted that those measures have not moved care forward enough. The measure developer noted that, in coordination with CMS and others, they moved towards evaluations of providers using assessments like the measure or accreditation programs with a low bar of attestation. The measure developer noted that there are gaps in the current CMS programs and the measure raises important issues for the geriatric population. The measure developer also noted that the measure puts care for geriatric population onto the docket of things that hospitals need to do and that it moves it up their list of priorities. The measure developer noted that attestation is the first step before outcome measures can be fully rolled out. The measure developer also noted that the measure is a way to capture similar information without requiring all hospitals to join the accreditation program. Another MAP member expressed strong support for the measure as a signal to hospital leadership to change norms and culture. The MAP member, as a patient safety advocate, noted that they were tired of the conversation around the need for cultural change and did not want to postpone needed changes for an increasingly vulnerable population. The MAP member also noted their previous experience with their organization helping CMS develop structural measures for patient and family engagement that accelerated other work that hospitals were already doing to improve outcomes. The MAP member also emphasized Dr. Schreiber's comments about the importance of structural measures as a building block to further quality improvement work.

A federal liaison asked a question about If attestation-based questions in the measure were already in Medicare's SOP requirements. Dr. Schreiber noted in chat that they were not all tied to Medicare's SOP requirements as those tended to be broader requirements for quality or safety. The federal liaison asked CMS to comment about what other policy levers CMS could use to capture the measure's concepts outside of quality metrics. The federal liaison also commented that driving quality change happens through the type of work identified by other commenters, but that they also wanted to know what other measures are available. A MAP member noted that they worked on the patient safety committee for the National Board of Medical Examiners writing test questions and that the work that committee did propelled what is taught in medical schools and compared that work to the measure concept. The MAP member noted that the measure is a first step and gets hospitals headed in the direction of where care needs to go. Dr. Schreiber noted agreement with the MAP members' comments and noted that the measure sets the table for important elements for hospitals to think of in the care of geriatric patients. Dr. Schreiber acknowledged that the measure may set a low bar, be a "check box" measure, or just be a place to start, but the measure is a single standard containing elements that all hospitals need to think of when trying to improve the care of geriatric patients. Dr. Schreiber noted that alternate CMS policy levers are mostly around payment. Dr. Schreiber also stated that Medicare SOP is a strong lever but is very broad. Dr. Schreiber pointed to the Quality Improvement Network for training opportunities, and noted the Partnership for Patients and other quality improvement organization activities can lend support to the goals of the measure, though they are broader than the geriatric population. Dr.

Schreiber also noted that quality metrics, which make up the building block of value-based programs, have brought about change through public reporting, through transparency, through informing consumers, and through getting on the agendas of leadership and provider boards, even with the challenges in their use. Dr. Schreiber noted that CMS believes the measure concept fits where it belongs in the realm of quality metrics. Dr. Schreiber stated that CMS might use other levers in the future if it finds it appropriate to do so. A federal liaison noted that tying the measure concept to quality improvement is critical and that the measure concept fits with the work of the CMS Center for Clinical Standards and Quality. Dr. Schreiber noted that the conversation will continue Quality Improvement Organization's 13th Scope of Work.

A co-chair noted that they appreciate the perspective and framing of the measure. The co-chair noted that their concern is that the Workgroup has measure selection criteria and noted they would not support the Workgroup ignoring those criteria. The co-chair noted that a broader philosophical question is there are a lot of important topics for quality measures and wondered if the Workgroup is focused on the most critical issues for inclusion. The co-chair noted that the Workgroup has sometimes lost sight of philosophical conversations over the years. The co-chair also noted that they want the Workgroup to approve meaningful measures. The co-chair noted that they are not concerned about reporting burden, but rather how the measure will get balanced across reporting priorities as reporting resources are finite. The co-chair noted that the developer had done great work on the measure and that is an important topic, but that they worried about drifting from the measure selection criteria. A MAP member raised the consideration that if the measure is a building block, they would ask the Workgroup to consider whether to combine the discussion and vote on MUC2022-032: Geriatrics Surgical Measure with the discussion and vote on MUC2022-112. The measure developer noted that they submitted this measure because of work done in geriatric surgery demonstrating that care for older adults shows the greatest opportunity for improvement. The measure developer noted that MUC2022-112 focuses on ED care because they identified that as another area for improvement.

Ms. Williams-Bader noted that she had a clarification for a MAP member's question about when the MAP can stray from the measure selection criteria. Ms. Williams-Bader stated that MAP has a different function than endorsement committees as MAP makes recommendations on policy. Ms. Williams-Bader stated that NQF staff provide a preliminary analysis that assesses the measure against the measure selection criteria, but that MAP may consider other information, such as public comment, CMS feedback, or other information received during the process. Ms. Williams-Bader noted that the measure selection criteria serve as guidance to MAP members and standardize recommendations during preliminary analysis review and that they serve as guidance, but there may be times when MAP members may want to move in another direction. A co-chair noted that the discussion itself during the MAP meetings has been very useful to CMS. A MAP member asked a question about the equity measures getting preliminary analysis recommendations of "Conditional Support for Rulemaking" despite not meeting the measure selection criteria. Ms. Williams-Bader noted that the equity measures were similar to measures that had previously been reviewed by MAP in last year's pre-rulemaking cycle and, in recognition that MAP is making recommendations based on policy, NQF used the ending recommendations from that review as the starting point for those measures. Ms. Williams-Bader explained that this was because MAP members had already reviewed the information and supplied that decision category for those measures. Ms. Williams-Bader noted that would not apply for MUC2022-032 or MUC2022-112 as they are new measures to the MAP process. A MAP member noted in the chat that if the measure is to inform care choices, it seems surgical or condition specific would be best for the measure. The MAP member also asked how the measure would be reported (i.e., on what scale), and how CMS would approach education so that the measure is meaningful to consumers. The MAP member noted that they were concerned that a patient would still not know of a hospital's quality of

care in this population.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Do Not Support for Rulemaking," for measure MUC2022-032. Voting results were as follows: Yes – 9, No – 10, and percentage voting Yes – 47 percent. Complete voting results are in Appendix B.

A co-chair asked MAP members to outline mitigation strategies or conditions they would like to see before suggesting another vote on the measure. A lead discussant noted that, as a mitigation strategy, they would like to see the developers demonstrate performance gaps and include evidence that each attestation included in the measure is valid. A co-chair suggested moving to the decision category "Do Not Support with Potential for Mitigation" and that a mitigation would be to streamline the list of attestations to those with strong evidence on outcomes. Another co-chair suggested that the Workgroup consider the decision category "Support for Rulemaking" to gauge support for the measure and outline additional conditions or mitigations that the Workgroup might want to see attached to the measure.

Mr. Hatlie moved the workgroup to vote on "Support for Rulemaking," for measure MUC2022-032. Voting results were as follows: Yes – 7, No – 11 and percentage voting Yes – 39 percent. Complete voting results are in Appendix B.

A co-chair asked if MAP members had any additional conditions or mitigations to add apart from CBE endorsement or the provision of more data in support of the measure. A MAP member noted that they would support more opportunities to incorporate process measures into each domain to get more granular. The measure developer noted that data on performance gaps was included in the submission and that they could pull the data they have for that and stated that each attestation is a process measure supported by the entire structure of the measure. The MAP member also noted that there may be an opportunity to pull data from the EHR to confirm that a process was performed. The measure developer noted they would consider that request to be a higher order than the current measure and noted that documentation and retrieval of the data could be a huge burden on hospitals. The measure developer also noted that they would consider their measure as a first step and that in-depth data collection like the MAP member's recommendation would need to be scoped out as a second step. A co-chair noted that better presentation of the data on performance gaps could be a condition for support. A MAP member asked a question that in order to attest, does the hospital need to do all processes, even if there is not a way to verify that those processes were completed. The measure developer confirmed that the hospital does need to complete all processes to attest. Several MAP members had a brief discussion about whether the outlined conditions would be considered conditions or mitigations and determined that since the measure would ultimately not be significantly changed, they would be conditions. A MAP member noted that while they did not have a statistical background, they had concerns about paring back attestations as it would leave less strong of a foundation to build off in the future.

Mr. Hatlie moved the Workgroup to vote on "Conditional Support for Rulemaking," for measure MUC2022-032. The conditions were endorsement by a CBE, and further work on paring down the elements included in the attestation, and presenting information about gaps for components covered by the measure. Voting results were as follows: Yes – 12, No – 6 and percentage voting Yes – 67 percent. Complete voting results are in Appendix B.

### *MUC2022-112: Geriatrics Hospital Measure*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff

preliminary analysis recommendation. Dr. Elliott presented a summary of the 11 public comments received during the public comment period, eight of which supported the measure, one which supported the measure under certain conditions, and two which did not support the measure. Dr. Elliott noted that commenters had concerns about the measure's subjectivity and value of attestation-based measures and that a commenter recommended CMS conduct an analysis on the effectiveness of attestation to actually closing care gaps. Dr. Elliott noted the Health Equity Advisory Group expressed that geriatric patients are more fragile, and it is important to assess their needs. Dr. Elliott also noted the Health Equity Advisory Group was not opposed to the concept of the measure but did express concerns regarding implementation and limited evidence that attestations lead to improved patient outcomes or improved equity. Dr. Elliott noted the Rural Health Advisory Group expressed that this is a critically important measure, however, rural hospitals do not have the provider pool to hire providers, which means there is an ever-rotating staff of locums. Dr. Elliott also noted the Rural Health Advisory Group stated that rural hospitals may be at a reporting disadvantage for compliance with measures and consistent documentation, as rural hospitals also have limited social services resources which impact one of the attestation questions of the measure. Dr. Elliott also noted the Rural Health Advisory Group also commented that community trust could be an issue if the outcomes are reported publicly that measures are applicable across settings, and that these are the right processes to take care of an older adult.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that CMS had no additional comments except to note that the measure is similar to MUC2022-032 but broader.

Lead discussants added no additional comments for this measure, except to note the concerns of the Rural Health Advisory Group about the use of two measures where one may be sufficient. The measure developer noted that the measure is not for geriatric accreditation. The measure developer noted that the clinical need and impact of the measure is great and that the measure is feasible based on the number of hospital ED departments that are accredited. The measure developer stated that the measure's value is in cultural change and that hospital EDs that follow the measure program have seen decreases in rates of admission and repeat ED visits, along with a number of other indicators that support the impact of the measure on outcomes. The measure developer also noted that different entities can have different definitions of rural hospitals. The measure developer noted that hospitals are doing these measures with their current workforce. The measure developer noted that their equity programs have been very impactful but noted that there may be lack of impact in rural areas that have no pressure to join accreditation due to being the sole provider for their region. The measure developer also stated that they would prefer that the Workgroup not pick one version of the measure as they wanted to have both surgical and ED procedures represented. A lead discussant noted that they understood the concerns about multiple measures but wanted to better understand the differences between the two measures. The measure developer noted that they would prefer to have both measures and a crosswalk between them. Dr. Schreiber noted that the conversation was very important and thanked the Workgroup for their attention and discussion.

Mr. Hatlie opened the meeting for Workgroup discussion. There were no additional comments.

Mr. Hatlie moved the Workgroup to vote on "Conditional Support for Rulemaking," for measure MUC2022-112. The condition was endorsement by a consensus-based entity (CBE). Voting results were as follows: Yes – 9, No – 9 and percentage voting Yes – 50 percent. Complete voting results are in Appendix B.

A lead discussant noted that they would encourage some level of harmonization or combination of

MUC2022-032 and MUC2022-112. Another lead discussant recommended cross-walking the two measures to identify similarities and differences and then fold any unique elements into MUC-032 to eliminate redundancy. The measure developer noted that the measures are basically identical except for the inclusion of delirium in the ED measure and that one measure has a larger patient universe.

Mr. Hatlie moved the Workgroup to vote, "Do Not Support for Rulemaking with Potential for Mitigation," for measure MUC2022-112. The potential mitigation for this measure would be consideration for combining the two measures (MUC2022-112 and MUC2022-032) into a measure that is less burdensome and cross-walking the measures to be clear about where they align and where there are differences. Voting results were as follows: Yes – 16, No – 3 and percentage voting Yes – 84 percent. Complete voting results are in Appendix B.

## Equity Measures

Dr. Elliott provided an overview of the equity measures included in the section.

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

### *Public Comment*

Mr. Demehin opened the meeting to allow for public comment. A member of the public supported the preliminary analysis recommendations for MUC2022-050 and MUC2022-053. The member of the public noted that they encourage adoption of these measures in the programs they are recommended for because they are adopted in the Hospital IQR program, and this avoids measure fragmentation across programs. The member of the public noted the need to look at health equity and the need to move beyond pilots and to make an impact at scale and build the will for change. The member of the public also stated the need to use quality improvement science, to demonstrate gaps, to use data to help frontline and leadership move towards triple aims.

Another member of the public urged support for both MUC2022-050 and MUC2022-053. The member of the public retold a story of a patient who needed a hysterectomy for over 10 years but could not get discharged after surgery because they did not have a place to go. The member of the public also emphasized the need to enact both measures and decrease the risk of measure fragmentation across CMS programs.

Another member of the public noted their support for both MUC2022-050 and MUC2022-053. The member of the public noted the connection between social determinants of health, health outcomes, and quality of life, especially in behavioral health. The member of the public noted that providers should ask about determinants if they want the best outcomes for their patients. The member of the public noted that the fields of psychiatry and oncology have called for increased standardization but that providers need incentives for them to enact standardized measures as well as time and resources to implement.

Another member of the public spoke in support of MUC2022-050 and MUC2022-053. The member of the public noted that their state made screening for social drivers mandatory in Medicaid and got alignment in that Medicaid program and beyond. The member of the public noted that measurement was not perfect out of the gate but urged not to let a lack of perfection keep the Workgroup from moving forward on the measures. The member of the public stressed the need to think globally and measure what matters.

Another member of the public spoke in favor of MUC2022-050 and MUC2022-053. The member of the public noted that the path to health equity must pass through the reality of factors in patient's everyday lives. The member of the public also noted that social risks drive burnout and create financial risk factors for providers. The member of the public noted that the Accountable Communities for Health [ACH] model tested and implemented measures and has demonstrated the feasibility of the measures, with thousands of providers screening their patients for social needs without any formal measures, guidance or tools from CMS. The member of the public also stated that both measures are needed to contextualize the impact of social needs. The member of the public noted that the same versions of the measures should be enacted to minimize the burden of different versions in different CMS programs.

Another member of the public spoke in support of MUC2022-050 and MUC2022-053. The member of the public noted that social risk factors are major risk factors for behavioral health conditions. The member of the public also noted that the measures support CMS priorities. The member of the public also stated that the measures help to identify social needs and essential resources patients may need. The member of the public noted that the American Psychological Association is aligned with the measures. The member of the public also stated that both measures are important in order to provide a full picture of health disparities.

Another member of the public spoke in favor of MUC 2022-050 and MUC 2022-053. The member of the public noted HHS's [Department of Health and Human Services] support of health equity and highlighted the CMS priority of measures to assesses SDOH. The member of the public noted that the measures have been well tested in the ACH model. The member of the public noted that the measures can identify screen positive rates in racial and ethnic minorities and that more patients are screened in primary care settings. The member of the public noted that the measures are involved in 20 models connecting patients to services, but only five models required them to do so. The member of the public stated that they would encourage MAP to move both measures forward in this cycle to give a full picture of health disparities and to support CMS priorities.

Another member of the public spoke in support of MUC 2022-050 and MUC 2022-053. The member of the public noted that they work in an emergency care setting where patient outcomes are often determined by social drivers of health and that similar situations occur in a wide variety of care settings and disciplines. The member of the public asked that MAP support the measures to look at the critical context of patient outcomes. The member of the public also noted that the measures were a key part of creating an investment map for equity and encouraging communities to provide social supports and resources prior to a patient entering a critical care situation. The member of the public also encouraged the adoption of both measures to support alignment across programs and avoid fragmentation across CMS programs.

### *MUC2022-053: Screening for Social Drivers of Health (ESRD QIP)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the six public comments received during the public comment period, four of which supported the measure and two which did not support the measure. Dr. Elliott noted that commenters expressed several concerns, including that dialysis facility staff will have to be trained, that there will need to be processes in place to protect patient privacy, that staffing and resources will be needed to enable data collection which will strain already understaffed facilities, and that the measure lacked reliability and validity testing and risk adjustment or stratification. Dr. Elliott noted the Health Equity Advisory Group expressed support for the collection of data related to social drivers, but also raised concerns of unintended consequences

related to public reporting of the measure. Dr. Elliott also noted that the Health Equity Advisory Group raised concerns about repeatedly asking patients the same questions in different health care settings. Dr. Elliott stated that the Rural Health Advisory Group noted reporting challenges but that the measure had potential to identify health disparities that are underrepresented in some areas. Dr. Elliott also noted that the Rural Health Advisory Group asked CMS to provide statistical significance when providing data on these measures as statistical tools are not readily available, which would help with evaluating outcomes. Dr. Elliott also noted that the Rural Health Advisory Group stated that sample size, populations served, and having community resources available could be an issue in rural areas. Dr. Elliott also noted that the Rural Health Advisory Group discussed that the measure is looking to advance the drivers of health and that the measures are a starting point to determine where screening is happening.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that there is no quality, safety, or resiliency or even appropriate care without equity. Dr. Schreiber noted that the measures were initially stewarded by the Physician Foundation but have been moved to Yale CORE. Dr Schreiber noted that CMS plans to continually improve the measures to eventually move from screening to documenting that need gaps are being closed. Dr. Schreiber noted that the measures had been used in CMMI programs. Dr. Schreiber noted that the measures are being introduced to new programs in order to align measures across all programs and stated CMS is working toward the goal of all CMS programs eventually having appropriate equity measures in their measure sets. A CMS representative noted that the measure examines the total number of patients screened for all five elements and that the only demographic element needed for collection is patient age. The CMS representative also noted that data can be electronically collected using the tool in the measure and that some elements of the measure are already existing within fields of electronic sources, which may minimize the burden of the measure. The CMS representative also noted that SDOH screening is already occurring at scale in the health care sector and cited a JAMA study that 24 percent of hospitals are already screening for the social needs documented by the measure.

A lead discussant spoke in support of the measure and aligning measure approaches across programs. The lead discussant noted the critical nature of the measure in measuring what matters. The lead discussant also pointed out the significant public comment in support of the measure. Another lead discussant expressed agreement with those points and thanked CMS for putting the measure forward. The lead discussant also noted that they were happy to hear that CMS is working to close gaps in social needs. A third lead discussant had no additional comments.

Mr. Demehin opened the meeting for Workgroup discussion. A MAP member asked if the measure was required in acute care hospitals. Dr. Schreiber noted that the measure was finalized for those hospitals last year. A federal liaison asked why these five particular social risk factors were included in the measure and noted that the VHA is screening for a wider variety of social risks. The federal liaison also asked if there was a specific tool required for screening. Dr. Schreiber noted that a lot of social needs can be screened for and that the most important needs were selected for the measure. Dr. Schreiber also noted that the social needs included in the measure may be refined as the measure is refined. Dr. Schreiber also noted that a specific tool is not required for the measure and in the future CMS would like to hone down and suggest better screening tools. A federal liaison noted that the VHA is making their screening tool interoperable. Dr. Schreiber noted that CMS plans to do the same.

A MAP member noted that they strongly supported the measure as quality and health equity are important goals for their organization. Another MAP member asked if the Hospital IQR measure was endorsed by NQF and asked NQF staff to explain the conditions requesting additional testing. Dr.

Schreiber noted that the Hospital IQR version of the measure is not NQF-endorsed. Ms. Williams-Bader confirmed the endorsement status of the measure and noted that the condition for additional testing was included in the preliminary analysis as it was unclear if submitted reliability and validity testing is sufficient for settings in programs that the measure is being considered for. A MAP member raised a concern in the chat about how often a single patient is asked personal and sensitive questions to screen for social risks. Another MAP member indicated support for the preliminary analysis recommendation for the measure. The measure developer noted that testing of the screening tool was done using the Accountable Health Communities model and that the measure would not require a specific screening tool. A MAP member stated that they understood the goal of having a standardized screening tool but noted a concern from the previous MAP cycle in what screening tools would be required. The MAP member also stated that they were heartened to see the flexibility that MAP had called for in the previous year's process. The MAP member expressed support for the preliminary analysis recommendation as the measure concept is critical and organizing and uniting the hospital field around this approach to screening for social needs is important. The MAP member also raised concerns about asking patients the same question over and over and noted that they want to find ways to minimize the need to repeatedly collect data for the measure in the same patient population.

A lead discussant noted a possible concern about variability in the data due to the use of different tools and in reporting to CMS. Dr. Schreiber noted that this would not be a concern because all tools are screening for the same types of social needs. The measure developer noted that the concern was important, but the goal of the measure was to get screening started and the developer will consider how to ensure standardization in future measure updates. A lead discussant noted that they would be interested in seeing outcomes for patients. A MAP member circled back to the concern about patients being asked the same questions over and over and tied it to patients not having access to their own records or having a centralized information location where patients can point a provider to collect social needs data.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," for measure MUC2022-053 for the ESRD QIP. The conditions for supporting this measure are: (1) testing of the measure's reliability and validity; (2) endorsement by a consensus-based entity (CBE); (3) additional details on how potential tools map to the individual drivers, as well as best practices; (4) what resources may be available to assist patients; and (5) alignment with data standards, particularly the GRAVITY project. Voting results were as follows: Yes – 17, No – 3, and percentage voting Yes – 85 percent. Complete voting results are in Appendix B.

### *MUC2022-053: Screening for Social Drivers of Health (IPFQR)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the IPFQR version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the IPFQR Program. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 17, No – 3, and percentage voting Yes – 85 percent. Complete voting results are in Appendix B.

### *MUC2022-053: Screening for Social Drivers of Health (PCHQRP)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the PCHQRP version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for PCHQRP. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 17, No – 3, and percentage voting Yes – 85 percent. Complete voting results are in Appendix B.

### *MUC2022-050: Screen Positive Rate for Social Drivers of Health (ESRD QIP)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the six public comments received during the public comment period, three of which were supportive of the measure and three which were not supportive of the measure. Dr. Elliott noted that commenters expressed several concerns, including that the measure will be burdensome for settings (like dialysis facilities) with workforce challenges, that the measure lacked standardization and documentation or a standardized screening tool, and that the measure will reflect the facility's patient population, not quality of care provided by the facility. Dr. Elliott also noted a commenter's request for more detailed risk adjustment strategies. Dr. Elliott noted the Health Equity Advisory Group expressed support for the collection of data related to social drivers, but also raised concerns of unintended consequences related to public reporting of the measure. Dr. Elliott also noted that the Health Equity Advisory Group raised concerns about repeatedly asking patients the same questions in different health care settings. Dr. Elliott stated that the Rural Health Advisory Group noted reporting challenges but that the measure had the potential to identify health disparities that are underrepresented in some areas. Dr. Elliott also noted that the Rural Health Advisory Group asked CMS to provide statistical significance when providing data on these measures as statistical tools are not readily available, which would help with evaluating outcomes. Dr. Elliott also noted that the Rural Health Advisory Group also stated that sample size, populations served, and having community resources available could be an issue in rural areas. Dr. Elliott also noted that the Rural Health Advisory Group discussed that the measure is looking to advance the drivers of health and that the measures are a starting point to determine where screening is happening.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted that a higher or lower score is not better for the measure and that the measure is more an indicator of need and identifies the opportunities of social needs in the population.

A lead discussant noted that they had similar comments to the Hospital IQR version of the measure. The lead discussant noted that they understood the concept of interconnectedness of screening and screening positive to referral to services and then eventually developing the feedback from services to provider. The lead discussant noted that patients may not have the full context when they see the measure score. The lead discussant also noted that they had concerns about ambiguity in the measure score (i.e., does the measure reflect if facilities are screening well or the facility's patient population). The lead discussant noted that they would support use of the measure as an internal metric but was not sure it is ready to be publicly reported. The lead discussant asked if the measure would be reported as five different rates of who screens positive for each need or if it would be a unified rate. The lead discussant noted that the measure can help in terms of redirecting resources to help address social needs, but that they are not sure the measure is well suited to addressing these needs by itself. The lead discussant noted they were not sure about the preliminary analysis recommendation. Another lead discussant expressed agreement with the previous lead discussant's comments in terms of using the measure for internal quality improvement and reducing the gap in social needs. The lead discussant noted that the measure may not have a lot of utility in terms of public reporting and that CMS may get more information about social needs from this measure without public reporting. A third lead discussant also expressed hesitation about publicly reporting the measure and noted the measure might be a good

internal way for hospitals to focus resources.

Mr. Demehin opened the meeting for Workgroup discussion and noted that the use of public reporting was a common theme. Dr. Schreiber noted that it may be important to the community for the measure rates to be publicly reported and that public reporting is required when a measure enters the program. A MAP member noted that the core rationale of publicly reported scores is to drive patients to higher quality providers and noted that they did not believe that a measure where a higher score does not reflect better performance belongs in a quality program. A MAP member noted that this measure is a denominator measure. The MAP member noted that the goal of the measure is to connect patients to support. The MAP member stated that they would recommend confidential reporting periods and allow feedback, as the public might be confused without an opportunity for provider feedback. Another MAP member noted that the measure is important to patients as well as policymakers at the state and local level in the communities that hospitals service. The MAP member noted that the measure can highlight challenges in communities that have a high level of social need.

A co-chair noted that the conditions included in the preliminary analysis may be sufficient to address the concerns of the Workgroup surrounding public reporting and asked the Workgroup to consider if those conditions address their concerns. A MAP member asked for clarification on how the condition that the measure not be used to criticize health providers would be implemented. A co-chair noted that they believed that the measure score would be reported as a straight rate and not included in systems such as the Medicare Star Rating system as the measure score is extremely contextual. The co-chair noted that it would be helpful for CMS to try and explain the measure's data points on the Care Compare website. The co-chair also noted that health-related needs are social needs that hospitals are working on, but that solving those needs will take the entire community. A MAP member indicated that they were in favor of public reporting. Another MAP member gave an example of their local hospital that had a significant shift in the hospital's patient population from a Medicare population to one with a significantly higher proportion of social needs. The MAP member noted that the measure could reflect a shift in a hospital's patient population as the changes in the patient population can lead to changes in a facility's quality. A co-chair noted that they shared all the same reservations around the potential misuse or mischaracterization of the data, but also noted the real value of getting the data out there in order to build community support for closing social need gaps. The co-chair noted that they supported the preliminary analysis recommendation. A MAP member noted that the measure addresses an important concept but also that the measure is imprecise without operationalization, no hierarchical ranking, and no regional adjustment. The MAP member noted that the measure may cause more confusion than consensus and that any pathway to inclusion should tighten up the measure's imprecision. The MAP member also acknowledged that a review of reliability and validity testing would resolve some of those concerns. A co-chair recommended adding some language reflecting those concerns as a condition.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," for measure MUC2022-050 for the ESRD QIP. The conditions for support of the measure are endorsement by a consensus-based entity (CBE) to address reliability and validity concerns, attentiveness to how results are shared and contextualized for public reporting, and encouraging CMS to examine any differences in reported rates by reporting process (to see if they are the same or different across hospitals). Voting results were as follows: Yes – 14, No – 5, and percentage voting Yes – 74 percent. Complete voting results are in Appendix B.

### *MUC2022-050: Screen Positive Rate for Social Drivers of Health (IPFQR)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the IPFQR version of the measure. There were no additional comments from

the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the IPFQR. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 14, No – 5, and percentage voting Yes – 74 percent. Complete voting results are in Appendix B.

### *MUC2022-050: Screen Positive Rate for Social Drivers of Health (PCHQRP)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the PCHQRP version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the PCHQRP. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 14, No – 5, and percentage voting Yes – 74 percent. Complete voting results are in Appendix B.

### *MUC2022-027: Facility Commitment to Health Equity (ESRD QIP)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the seven public comments received during the public comment period, two of which were supportive of the measure, two which were supportive of the measure under certain conditions, and three which were not supportive of the measure. Dr. Elliott noted that commenters had concerns about the value and subjectivity of an attestation-based measure, that time dedicated to attestation would be better used on interventions, and that dialysis facilities may lack the necessary expertise, training, and resources to build equity-focused organizational competencies. Dr. Elliott also noted a request by a commenter that CMS conduct an analysis on the effectiveness of attestation to closing quality gaps before adding the measure to the program. Dr. Elliott noted the Health Equity Advisory Group expressed concern that the measure was a "check box" measure and not able to get to the root of health inequities. Dr. Elliott noted the Rural Health Advisory Group expressed support for better access and quality of care but also observed challenges with obtaining the resources needed in rural communities.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that the measure goes back to earlier discussions about the role of structural measures. Dr. Schreiber noted that after the measure was introduced in the Hospital IQR program, CMS has seen much greater interest in developing health equity programs among hospitals. Dr. Schreiber also noted that CMS is introducing this measure into additional programs to promote alignment across programs. A CMS representative noted that the measure has five domains to attest to with some having multiple elements. The CMS representative noted that facilities must complete a self-attestation during the measure's time period. The CMS representative also noted that the measure reflects CMS priorities of health equity and data collection on health equity factors.

A lead discussant noted that the earlier discussion on attestation applies to this measure. The lead discussant stated that health equity is important and that they support issues raised by the measure. The lead discussant noted that the current form of the measure lacks a prescriptive nature and that they could foresee that some institutions will attest without making material changes. The lead discussant noted that if institutions are allowed to address domains in any manner, there could be a lot of effort or activities implemented without impact on patients. The lead discussant noted that they would recommend, rather than an open-ended measure, that there be a tighter, more prescriptive and

outcome-focused process. Another lead discussant noted they did not have much to add outside of the previous discussion on structural measures and noted that they agree with the conditions included in the preliminary analysis recommendation.

Mr. Demehin opened the meeting for Workgroup discussion. A federal liaison asked why the measure allowed for the collection of demographic information, including self-reported race and ethnicity or SDOH information. The federal liaison noted that while there is some overlap depending on how sociodemographic information and SDOH are defined, they are not interchangeable and have different implications. Dr. Schreiber noted that the measure seeks to include as much data as possible and provides flexibility to providers. Dr. Schreiber also noted some civil rights concerns about mandating the collection of data on race and ethnicity and the need to provide flexibility to hospitals. A co-chair noted that they strongly supported how the measure domains complement and connect to one another. The co-chair noted that the measure is a signal to shape a facility's culture and priorities, especially engaging leadership in the process. The co-chair noted that the measure signals the importance of the measure concept to CMS and that the concept may be refined later with process or outcome measures. A MAP member noted that while they had previously spoken out against attestation measures earlier in the meeting, they believed that the measure showed that there are useful ways to drive systematic change and that they would support similar structural measures being used in that manner. Another MAP member noted that the conditions in the preliminary analysis are the ones their organization articulated to CMS when the measure was adopted in the Hospital IQR program. The MAP member noted that this kind of structural measure has a bit more specificity than the previous measures, as the attestations are written in a specific manner to provide guidance in order to ensure that hospitals are providing consistent information.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," for measure MUC2022-027 (ESRD QIP). Conditions for support of this measure are: (1) endorsement by a consensus-based entity (CBE); (2) committing to look at outcomes in the future; (3) providing more clarity on the measure and supplementing interpretations with results; and (4) verifying attestation provided by the accountable entities. Voting results were as follows: Yes – 17, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

### *MUC2022-027: Facility Commitment to Health Equity (IPFQR)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the IPFQR version of the measure. A lead discussant noted that the measure should be made as specific as possible. There were no other comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the IPFQR. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 17, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

### *MUC2022-027: Facility Commitment to Health Equity (PCHQRP)*

Mr. Demehin opened the meeting for additional discussion and asked if the Workgroup had any additional comments on the PCHQRP version of the measure. There were no additional comments from the Workgroup.

Mr. Demehin asked the Workgroup if there were any oppositions to carrying over the vote to the measure for the PCHQRP. No opposition was raised, and the vote was carried over. Voting results were as follows: Yes – 17, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in

Appendix B.

### *MUC2022-058: Hospital Disparity Index (HDI)*

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the five public comments received during the public comment period, two of which were supportive of the measure, two which were supportive of the measure under certain conditions, and one which was not supportive of the measure. Dr. Elliott noted that commenters had concerns that this measure is duplicative of other measures, that the measure is not actually reflective of the full care provided by a hospital as it only focuses on readmissions, and whether readmissions alone can serve as an indicator of a disparity in care. Dr. Elliott also noted that commenters noted a lack of reliability and validity testing using the approach in the measure and they had concerns with the measure's use of Medicare Bayesian Improved Surname and Geocoding (MBISG). Dr. Elliott also noted that commenters requested that CMS provide detailed specifications that include more information on minimum volume thresholds, benchmarking, any existing metrics for this measure, as well as CMS's intended use for this measure and that CMS delay adoption of this measure for at least two years to give hospitals additional time to familiarize themselves with the disparity methods and equity initiatives. Dr. Elliott noted the Health Equity Advisory Group expressed concerns about the use of a composite measure which may mask any health equity findings as the disparities may be high and difficult to determine the subgroups with only a composite score. Dr. Elliott also noted the Health Equity Advisory Group raised concerns about the use of dual eligible rates. Dr. Elliott noted the Rural Health Advisory Group discussed reporting challenges as patients may distrust being asked these questions about social determinants of health (SDOH) and that patients may want to refuse services.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted that the measure is a prototype measure that CMS is strongly considering. Dr. Schreiber noted that the Medicare Part C and D Star Rating program did something similar to the measure concept and looked at performance of the total patient population versus a vulnerable population. Dr. Schreiber noted that future measure development may look at if measure performance is comparable to the performance of the measure nationally and that CMS plans to use indexes to influence performance on specific measures. A CMS representative noted that the measure includes seven readmissions measures. The CMS representative noted that the measure uses risk factors, imputes ethnicity, and provides a single measure score to summarize results. The CMS representative also noted that the measure seeks to examine within-hospital gaps in readmissions, accounting for clinical risk factors also referred to as ("within-disparities"), and the overall quality of care provided to a group with an identified social risk termed "across-disparities."

A lead discussant noted that the measure is a much-needed measure to address health equity. The lead discussant noted that the measure is based on claims and does not rely on attestations. The lead discussant noted that they were impressed by the amount of work CMS invested in imputing the race/ethnicity of patients. The lead discussant also noted that the index summarizes several measures of disparities. The lead discussant expressed the hope that CMS would expand the measure concept to other areas such as mental health. The lead discussant noted they would support the preliminary analysis recommendation. Another lead discussant noted they found the measure fascinating and commended CMS for its work on the prototype measure. The lead discussant noted the measure seems to be focused on readmissions and asked if the plan was to publicly report the measure as its own entity or pair it with current readmission measures. The lead discussant also noted that the measure might need to have a different name as it currently only includes readmission measures. The lead discussant

also asked if the same index methodology could be applied to other areas such as mortality or mental health. Dr. Schreiber noted that some lead discussants were reading the minds of CMS and reading between the lines. Dr. Schreiber noted CMS has had internal discussions about renaming the measure to reflect the focus on readmissions. Dr. Schreiber also noted CMS will likely look to expand the measure concept. Dr. Schreiber noted she could not guarantee how the measure would be deployed and the measure would likely be paired with other readmission measures. The measure developer noted there are known, important gaps in readmissions. The measure developer noted CMS is already providing confidential reports to hospitals on individual measures. The measure developer noted those reports could be an obvious place to start when providing summary information.

Mr. Demehin opened the meeting for Workgroup discussion. A MAP member noted their organization participated in the ACO REACH model using area deprivation index alone but that this measure uses an approach that combines it with dual eligibility status and imputed race and ethnicity. The MAP member noted that using multiple data sources may serve as a better way to calculate disparities. The MAP member noted a challenge is identifying how to close the gap in social needs. The MAP member also noted that providing more access could be another open question and questioned if gaps in social need are being closed in the right communities to provide access to care. Dr. Schreiber noted the closing of gaps is a subject of intense investigation at CMS and that different parts of CMS are looking at different methods for measuring disparities. Another MAP member noted they agree with some other comments by MAP members that this is an innovative approach to important issues. The MAP member raised an additional concern that many lower volume smaller hospitals do not have the case load to calculate all seven readmission measures. The MAP member asked CMS to clarify what happens if hospital is not able to report all seven measure rates. Dr. Schreiber noted the issue is challenging but it was one reason the index included all-cause readmissions as most hospitals can at least report that measure. Dr. Schreiber noted that, in general, if a hospital cannot report a measure, CMS does not count it. The measure developer noted that the measure index will still be calculated as the index does not require all seven measures. The measure developer also noted some hospitals will have indexes based on fewer measures. The measure developer noted each measure requires at least 12 patients in their respective groups as the calculations are not reliable otherwise. The measure developer acknowledged some hospitals will not have enough in their groups but that those hospitals can still create a summary.

Another MAP member noted the Health Equity Advisory Group had some concerns about the use of dual eligible patients in the index and asked if the Advisory Group had any suggestions for replacements. Dr. Elliott pointed to earlier comments summarizing the Health Equity Advisory Group's discussion and restated that the Advisory Group wanted a better understanding of how dual eligible patients will be used in the index. Dr. Elliott noted more details of the discussion will be included in the Health Equity Advisory Group meeting summary. The MAP member asked if the Advisory Group had given a recommendation for the measure. Dr. Elliott noted that while Advisory Groups had provided recommendations in the past, NQF decided to focus on the discussion with the Advisory Groups during the current pre-rulemaking cycle. Dr. Elliott also noted that the Advisory Group had some concerns with the use of a composite measure. Another MAP member, whose organization is also a member of the Health Equity Advisory Group, noted that imputation of race and ethnicity was discussed by the Advisory Group, and noted that this data is a new addition to the confidential report. The MAP member noted that the measure may have skipped a few steps in moving to public reporting and rolling the readmission measures all up into one measure and then immediately moving to public reporting. Another MAP member expressed a concern about unintended consequences in interpreting the data provided by the index. The member noted that CMS is currently working with hospitals to understand how hospitals are using the current confidential reports, and asked CMS if they plan to work with patients and families in a similar way to "test" the measure with patients and families before measure

implementation. Dr. Schreiber noted that those concerns are difficult to address without knowing exactly what will be proposed in rulemaking but noted that CMS is being careful with moving the measure forward in a stepwise fashion. A co-chair noted that the market will respond to publicly reported data and that their organization and other community groups will help to contextualize the measure data for patients.

Another co-chair stated that what CMS is attempting to achieve with the measure is extremely difficult. The co-chair noted that there are real gaps in data availability and that measures must make use of the best data they have available. The co-chair acknowledged that the use of imputation for race and ethnicity data is an effort to try and close some of the data gaps. The co-chair noted that in conversations with their organization's members they understand where CMS is trying to go but do not like making statistical estimations about populations that hospitals treat and then using that data for comparative performance purposes. The co-chair noted CMS has acknowledged that the goal is eventually using patient-reported data in these measures. The co-chair noted the potential for unintended consequences when using the measure is significant. The co-chair also raised a question of how well the indirect estimation tool works in estimating demographic and social risk of communities served by hospitals. The co-chair noted that because the measure is in a prototype phase, they would strongly recommend that there is significant field testing, that hospitals have the opportunity to engage, and that patients are involved to find out what they will get out of the measure. The co-chair noted they were hard pressed to support the preliminary analysis recommendation as the measure is a prototype and may give patients and hospitals false comfort or false alarm about their performance in addressing disparities. The co-chair noted they would not limit the index to readmission measures.

A MAP member noted there may be some way for CMS to engage patient groups either through NQF or other forums and give them measure information, perhaps even anonymized hospital data. The MAP member stressed the need to capture what patients think. Dr. Elliott asked a clarifying question if the Workgroup would consider that a condition or more of an implementation consideration. The MAP member noted they were not suggesting testing with patients as a condition, just that they wanted to make sure that patients were included in measure development. Another MAP member noted they would support the use of confidential reports as a condition or mitigation. Ms. Williams-Bader noted that since the measure is planned for public reporting, that that would be more of a mitigation than a condition. Dr. Schreiber agreed. A co-chair asked for clarification if the member was asking for confidential reporting or confidential reports during field testing. A co-chair clarified that their comment was referring to more intensive confidential reporting prior to the full measure implementation.

Mr. Demehin moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Conditional Support for Rulemaking," for measure MUC2022-058. Conditions for support of this measure are testing indicating the measure is reliable and valid, including testing with low volume hospitals which do not have all seven readmission rates calculated and may have small numbers of the targeted groups, and endorsement by a consensus-based entity (CBE). Voting results were as follows: Yes – 12, No – 6, and percentage voting Yes – 67 percent. Complete voting results are in Appendix B.

## Hybrid Readmission and Mortality Measures

Dr. Elliott provided an overview of the hybrid readmission and mortality measures included in the section.

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

### *Public Comment*

Mr. Hatlie opened the meeting to allow for public comment. There were no comments.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff preliminary analysis recommendation. Dr. Elliott presented a summary of the four public comments received during the public comment period, three of which were supportive of the measure and one which was supportive of the measure under certain conditions. Dr. Elliott noted that commenters requested that CMS test the hybrid approach using existing condition-specific mortality measures prior to implementation, as these types of measures are more actionable and allow hospitals to drill down to understand opportunities for improvement and requested that CMS consider including SDOH in the risk model to better account for external factors that may impact a hospital's performance. Dr. Elliott noted the Health Equity Advisory Group discussed that the measure is a re-specification of the current measure which is stratified for hospitals and that results are provided confidentially by both dual-eligibility and by race and ethnicity. Dr. Elliott noted the Rural Health Advisory Group stated that the measure is based on administrative data and has been expanded to include Medicare Advantage beneficiaries which would improve the ability of rural hospitals to report as Medicare Advantage is a high percentage in rural communities.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. Dr. Schreiber noted the measure has been in use for a long time, but that CMS is bringing the measure back through MAP as it now contains Medicare Advantage data. A CMS representative noted the measure was developed to identify facilities that are performing better or worse based on case mix and that the measure addresses care coordination. The CMS representative also noted the benefit of the change of the measure is the ability to include more hospitals in the program. The CMS representative concluded by noting the measure is endorsed.

A lead discussant noted they were very supportive of the measure. Another lead discussant asked if social determinants were included in the measure. Dr. Schreiber noted they were not in this measure but pointed to the previous index measure which includes them. The lead discussant noted they also supported the measure.

Mr. Hatlie opened the meeting for Workgroup discussion. Several MAP members expressed appreciation for the inclusion of Medicare Advantage beneficiaries in the measure. A MAP member asked if other measures had been expanded to include the Medicare Advantage population and if that would be a future direction for condition-specific measures. Dr. Schreiber noted that is a potential direction for future measure development. A co-chair asked if the inclusion of Medicare Advantage patients had gone through the NQF endorsement process. A CMS representative indicated that the version of the measure which includes Medicare Advantage patients is currently going through the NQF endorsement process. A co-chair stated they agreed that including Medicare Advantage is a step in the right direction.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-055. Voting results were as follows: Yes – 16, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

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

Dr. Elliott introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and the NQF staff

preliminary analysis recommendation. Dr. Elliott presented a summary of the three public comments received during the public comment period, two of which were supportive of the measure and one which was supportive of the measure under certain conditions. Dr. Elliott noted that commenters requested that CMS test the hybrid approach using existing condition-specific mortality measures prior to implementation, as these types of measures are more actionable and allow hospitals to drill down to understand opportunities for improvement and requested that CMS consider including SDOH in the risk model to better account for external factors that may impact a hospital's performance. Dr. Elliott noted the Health Equity Advisory Group discussed expanding the denominators of these measures (especially with regards to managed care) and stated the measures should be prioritized for stratification by race and ethnicity. Dr. Elliott noted the Rural Health Advisory Group stated that the measure is based on administrative data and has been expanded to include Medicare Advantage beneficiaries which would improve the ability of rural hospitals to report as Medicare Advantage is a high percentage in rural communities.

Dr. Elliott then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted the measure is being brought back with an expanded cohort including Medicare Advantage beneficiaries and the measure is scheduled to be implemented for the fiscal year 2027 payment cycle. The CMS representative noted all other measure specifications will remain the same except for the addition of Medicare Advantage beneficiaries. The CMS representative also noted the measure addresses CMS high priority areas of preventative and treatment practices as well as safety in the Hospital IQR program. The CMS representative concluded by noting that measuring hospital-wide mortality can ensure other efforts to reduce negative outcomes, such as readmissions or utilization, are not causing any unintended consequences.

A lead discussant noted they had similar comments for this measure as their comments on MUC2022-055 and appreciated the clarification that there would be no additional burden related with this measure. Another lead discussant had no additional comments on this measure.

Mr. Hatlie opened the meeting for Workgroup discussion. A MAP member expressed appreciation that the measure is being added and noted agreement that mortality is a meaningful outcome to patients and providers. Other MAP members expressed agreement with the addition of Medicare Advantage patients to the measure in the chat.

Mr. Hatlie moved the Workgroup to vote on acceptance of the NQF staff recommendation of "Support for Rulemaking," for measure MUC2022-057. Voting results were as follows: Yes – 16, No – 2, and percentage voting Yes – 89 percent. Complete voting results are in Appendix B.

## MAP Hospital Programs Measure Gaps

Ms. Williams-Bader opened the discussion on measure gaps in programs covered by the MAP Hospital Workgroup. A co-chair noted that the Workgroup had made progress in filling several gaps during this cycle, that they welcomed attention to patient safety, equity, aging as a vulnerable population in this MUC List, and that cross-continuum spread was another strength this cycle. A MAP member agreed with the co-chair that this cycle's process filled a lot of gaps. The MAP member also noted that the key to future measure development will be to end data challenges and include Medicare Advantage beneficiaries in measures where appropriate. Several MAP members expressed agreement with that comment in the chat. Another MAP member stated in chat that wonderful discussions were had during this meeting and that the meeting was very informative and showed a lot of steps in the right direction. A different MAP member stated in the chat that they were glad to see that as care shifts to outpatient settings and ASCs, the measures are following. Another MAP member stated they enjoyed learning from

everyone during the meeting and that measurement is being pushed forward to move in an ever-changing direction. The MAP member also stated they appreciated the time and effort spent to develop measures for the cycle. A co-chair closed the discussion by stating they were happy to see a focus on health equity and the use of the EHR to assist hospitals in quality measurement. The co-chair stated that the MUC List was a nice list of measures. The co-chair also expressed appreciation and thanks for the Workgroup's engagement during the meeting.

## Opportunity for Public Comment

Ms. Williams-Bader opened the meeting to allow for public comment. There were no comments.

## Next Steps

Ms. Williams-Bader shared the timeline of upcoming MAP activities, including the Clinician Workgroup Review Meeting (December 15-16). Ms. Williams-Bader shared that the second public commenting period on the Workgroup recommendations will run from January 6, 2023, through January 12, 2023. Ms. Williams-Bader stated that the Coordinating Committee will meet January 24-25, and that the final recommendations spreadsheet will be published by February 1, 2023. Ms. Williams-Bader noted the Coordinating Committee meeting is open to the public and Hospital Workgroup members are welcome to attend. Finally, Ms. Williams-Bader directed members to the applicable MAP resources, including the MAP Hospital Workgroup webpage and Workgroup email address (MAPHospital@qualityforum.org). Ms. Williams-Bader then turned the floor over to Dr. Schreiber for closing remarks.

Dr. Schreiber thanked all participants for their comments and engagement over the past two days of the meeting. Dr. Schreiber noted that she hoped the Workgroup could see how the National Quality Strategy is being operationalized in the measures brought forward for consideration. Dr. Schreiber noted that CMS continues to seek to increase their transparency and level of engagement and noted that CMS would welcome feedback at any time. Dr. Schreiber noted additional opportunities for interested stakeholders to get involved in quality measurement, including the National Leadership Alliance for Safety as well as Yale's call for a TEP on their patient safety measures. Dr. Schreiber closed by extending her thanks to MAP members, NQF staff, the co-chairs, CMS staff participants, and measure developers for their preparation and individual contributions to a very successful meeting.

Ms. Williams-Bader then thanked Mr. Hatlie for serving as an acting co-chair during the meeting and turned the meeting over to the co-chairs for closing remarks. Mr. Hatlie noted that he really enjoyed his experience and felt supported by both NQF staff and Mr. Demehin, and extended thanks to both. Mr. Demehin expressed his appreciation for Mr. Hatlie's leadership during the meeting and thanked all participants for a productive meeting.

## Adjourn

Ms. Williams-Bader closed the meeting.

## Appendix A: MAP Hospital Workgroup Attendance (Voting Only)

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

### Day 1

***Co-chairs***

- Akin Demehin, MPH
- Martin Hatlie, JD (Acting)

***Organization Members***

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- Cigna HealthCare
- City of Hope
- Kidney Care Partners
- Medtronic
- Mothers Against Medical Error
- National Association for Behavioral Healthcare
- Premier Healthcare Alliance
- Press Ganey Associates
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

***Individual Subject Matter Experts***

- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB
- Jennifer Wills, MPA

### Day 2

***Co-chairs***

- Akin Demehin, MPH
- Martin Hatlie, JD (Acting)

***Organization Members***

- America's Essential Hospitals
- American Society of Anesthesiologists
- American Society of Health-System Pharmacists
- Association of American Medical Colleges
- Cigna HealthCare
- City of Hope
- Dialysis Patient Citizens
- Kidney Care Partners
- Medtronic
- Mothers Against Medical Error
- National Association for Behavioral Healthcare

- Premier Healthcare Alliance
- Press Ganey Associates
- Society for Maternal-Fetal Medicine
- Stratis Health
- UPMC Health Plan

***Individual Subject Matter Experts***

- Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB
- Jennifer Wills, MPA

## 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 during voting periods.

| Measure | Program | Yes (N/%) | No (N/%) | Total (N/%) | Decision Category |
|---|---|---|---|---|---|
| MUC2022-078: Psychiatric Inpatient Experience Measurement | IPFQR | 16 (84%) | 3 (16%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-120: Documentation of Goals of Care Discussions Among Cancer Patients | PCHQRP | 16 (89%) | 2 (11%) | 18 (100%) | Conditional Support for Rulemaking |
| MUC2022-082: Severe Sepsis and Septic Shock: Management Bundle | HVBP | 6 (32%)<br><br>12 (63%) | 13 (68%)<br><br>7 (37%) | 19 (100%)<br><br>19 (100%) | Support for Rulemaking<br><br>Conditional Support for Rulemaking |
| MUC2022-018: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) | Hospital IQR | 19 (100%) | 0 (0%) | 19 (100%) | Support for Rulemaking |
| MUC2022-020: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) | Hospital OQR | 18 (95%) | 1 (5%) | 19 (100%) | Support for Rulemaking |
| MUC2022-064: Hospital Harm - Pressure Injury | Hospital IQR | 18 (100%) | 0 (0%) | 18 (100%) | Conditional Support for Rulemaking |
| MUC2022-064: Hospital Harm - Pressure Injury | Medicare Promoting Interoperability Program | 18 (100%) | 0 (0%) | 18 (100%) | Conditional Support for Rulemaking |
| MUC2022-024: Hospital Harm - Acute Kidney Injury | Hospital IQR | 16 (89%) | 2 (11%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-024: Hospital Harm - Acute Kidney Injury | Medicare Promoting Interoperability Program | 16 (89%) | 2 (11%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) | ASCQR | 11 (61%) | 7 (39%) | 18 (100%) | Conditional Support for Rulemaking |

| Measure | Program | Yes (N/%) | No (N/%) | Total (N/%) | Decision Category |
|---|---|---|---|---|---|
| MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) | Hospital OQR | 11 (61%) | 7 (39%) | 18 (100%) | Conditional Support for Rulemaking |
| MUC2022-039: Median Time from emergency department (ED) Arrival to ED Departure for Discharged ED Patients | REHQRP | 10 (63%) | 6 (37%) | 16 (100%) | Do Not Support for Rulemaking |
| MUC2022-066: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy | REHQRP | 11 (73%) | 4 (27%) | 15 (100%) | Support for Rulemaking |
| MUC2022-067: Risk-standardized hospital visits within 7 days after hospital outpatient surgery | REHQRP | 14 (82%) | 3 (18%) | 17 (100%) | Support for Rulemaking |
| MUC2022-081: Abdomen Computed Tomography (CT) Use of Contrast Material | REHQRP | 15 (88%) | 2 (12%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | ASCQR | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | Hospital IQR | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | Hospital OQR | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | IPFQR | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | PCHQRP | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | ESRD QIP | 16 (94%) | 1 (6%) | 17 (100%) | Conditional Support for Rulemaking |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | HACRP | N/A | N/A | N/A | Workgroup did not have a vote for this program |
| MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) | HVBP | N/A | N/A | N/A | Workgroup did not have a vote for this program |
| MUC2022-075: Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) | ESRD QIP | 18 (90%) | 2 (10%) | 20 (100%) | Do Not Support for Rulemaking with Potential for Mitigation |

| Measure | Program | Yes (N/%) | No (N/%) | Total (N/%) | Decision Category |
|---|---|---|---|---|---|
| MUC2022-076: Standardized Fistula Rate for Incident Patients | ESRD QIP | 20 (100%) | 0 (0%) | 20 (100%) | Do Not Support for Rulemaking with Potential for Mitigation |
| MUC2022-079: Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities | ESRD QIP | 18 (90%) | 2 (10%) | 20 (100%) | Support for Rulemaking |
| MUC2022-125: Gains in Patient Activation Measure (PAM) Scores at 12 Months | ESRD QIP | 13 (65%) | 7 (35%) | 20 (100%) | Support for Rulemaking |
| MUC2022-026: Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty | ASCQR | 19 (95%) | 1 (5%) | 20 (100%) | Support for Rulemaking |
| MUC2022-026: Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty | Hospital OQR | 19 (95%) | 1 (5%) | 20 (100%) | Support for Rulemaking |
| MUC2022-032: Geriatrics Surgical Measure | Hospital IQR | 9 (47%)<br>7 (39%)<br>12 (67%) | 10 (53%)<br>11 (61%)<br>6 (33%) | 19 (100%)<br>18 (100%)<br>18 (100%) | Do Not Support for Rulemaking<br>Support for Rulemaking<br>Conditional Support for Rulemaking |
| MUC2022-112: Geriatrics Hospital Measure | Hospital IQR | 9 (50%)<br>16 (84%) | 9 (50%)<br>3 (16%) | 18 (100%)<br>19 (100%) | Conditional Support for Rulemaking<br>Do Not Support for Rulemaking with Potential for Mitigation |
| MUC2022-053: Screening for Social Drivers of Health | ESRD QIP | 17 (85%) | 3 (15%) | 20 (100%) | Conditional Support for Rulemaking |
| MUC2022-053: Screening for Social Drivers of Health | IPFQR | 17 (85%) | 3 (15%) | 20 (100%) | Conditional Support for Rulemaking |
| MUC2022-053: Screening for Social Drivers of Health | PCHQRP | 17 (85%) | 3 (15%) | 20 (100%) | Conditional Support for Rulemaking |

| Measure | Program | Yes (N/%) | No (N/%) | Total (N/%) | Decision Category |
|---|---|---|---|---|---|
| MUC2022-050: Screen Positive Rate for Social Drivers of Health | ESRD QIP | 14 (74%) | 5 (26%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-050: Screen Positive Rate for Social Drivers of Health | IPFQR | 14 (74%) | 5 (26%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-050: Screen Positive Rate for Social Drivers of Health | PCHQRP | 14 (74%) | 5 (26%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-027: Facility Commitment to Health Equity | ESRD QIP | 17 (89%) | 2 (11%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-027: Facility Commitment to Health Equity | IPFQR | 17 (89%) | 2 (11%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-027: Facility Commitment to Health Equity | PCHQRP | 17 (89%) | 2 (11%) | 19 (100%) | Conditional Support for Rulemaking |
| MUC2022-058: Hospital Disparity Index (HDI) | Hospital IQR | 12 (67%) | 6 (33%) | 18 (100%) | Conditional Support for Rulemaking |
| MUC2022-055: Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure | Hospital IQR | 16 (89%) | 2 (11%) | 18 (100%) | Support for Rulemaking |
| MUC2022-057: Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure | Hospital IQR | 16 (89%) | 2 (11%) | 18 (100%) | Support for Rulemaking |