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Measure Applications Partnership (MAP) Health Equity Advisory Group: 2022-2023 Measures Under Consideration (MUC) Review Meeting

Meeting Summary
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Meeting Summary

Measure Applications Partnership (MAP) Health Equity Advisory Group 2022-2023 Measures Under Consideration (MUC) Review Meeting – Day One

The National Quality Forum (NQF) convened a two-day, public virtual meeting for members of the Measure Applications Partnership (MAP) Health Equity Advisory Group on December 6, 2022, and December 7, 2022. The purpose of the meeting was to review and provide input on measures under consideration (MUCs) for the MAP hospital, post-acute care/long-term care (PAC/LTC), and clinician programs with a health equity lens. There were 173 attendees at this meeting, including MAP members, NQF staff, government representatives, measure developers and stewards, and members of the public.

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

Jenna Williams-Bader, NQF Senior Director, welcomed participants to day one of the Health Equity Advisory Group 2022-2023 Measure Under Consideration (MUC) Review Meeting and reviewed housekeeping reminders and the day one agenda (listed below).

- Centers for Medicare & Medicaid Services (CMS) Opening Remarks
- Overview of MAP Health Equity Advisory Group Pre-Rulemaking Approach
- Review of Measures Under Consideration (MUCs)
    - Chronic Condition Management and Prevention Care Measures
    - Renal Measures
    - Health Equity Measures
    - Patient Experience Measures
    - COVID-19 Measures
    - Eye Care Measures
- Preview of Day Two

Ms. Williams-Bader invited Dr. Dana Gelb Safran, NQF President and CEO, to provide opening remarks to the meeting participants.

Dr. Safran welcomed participants to the Health Equity Advisory Group 2022-2023 MUC Review Meeting. Dr. Safran noted that this is an unprecedented time where the nation is paying increased attention to health equity and emphasized that the work of the Advisory Group is essential to helping realize CMS and NQF's vision of consistent, high-quality care for every person in every community. Dr. Safran thanked MAP members and federal liaisons for their participation and thanked co-chairs for their leadership.

Ms. Williams-Bader invited MAP Health Equity Advisory Group co-chairs, Dr. Rebekah Angove and Dr. Laurie Zephyrin, to provide opening remarks. Dr. Angove expressed gratitude for the opportunity to help

lead the group and thanked participants for their attendance. Dr. Zephyrin thanked MAP members and emphasized the critical nature of this work.

Tricia Elliott, NQF Vice President, facilitated introductions and disclosures of interest (DOIs) from members of the MAP Health Equity Advisory Group. 22 of 33 MAP members were present (see Appendix A for detailed attendance). The following disclosures of interest (DOIs) were offered:

- A MAP member disclosed that their team was involved in the development of MUC2022-043 and -052 and recused themselves from discussion on these measures.
- A MAP member disclosed that their team was involved in the development of MUC2022-026, -027, -028, -030, -050, -053, -055, -057, -058, -066, -067, and -081, and recused themselves from discussion of these measures.
- A MAP member disclosed that they sat on the technical expert panel (TEP) that helped inform the development of MUC2022-058.
- A MAP member disclosed that they received funding from the National Institutes of Health (NIH) to explore the role of implicit bias on outcomes for patients with cancer.

Dr. Elliott reminded MAP that conflicts of interest should be declared before the meeting, and any undisclosed conflicts of interest or biased conduct can be reported to the co-chairs or NQF staff.

Ms. Williams-Bader recognized the NQF team and Centers for Medicare & Medicaid Services (CMS) staff supporting the MAP Health Equity Advisory Group activities. Ms. Williams-Bader then reviewed the meeting objectives for day one:

- Review the MAP pre-rulemaking approach and Advisory Group process
- Review and provide input on the MUCs for the MAP hospital, PAC/LTC, and clinician programs with a health equity lens

CMS Opening Remarks

Dr. Tiffany Wiggins, Medical Officer and Clinical Lead for Health Equity, Maternity Care Quality, and Cross-Cutting Measurement Initiatives at the Quality Measurement and Value-Based Incentives Group (QMVIG) at the Center for Clinical Standards & Quality (CCSQ) at CMS, welcomed participants to the meeting and thanked NQF staff and MAP members for their participation. Dr. Wiggins emphasized that a system of quality and safety is reliant on care that is equitable. Dr. Wiggins stated that CMS looks forward to the input of the Advisory Group on measures to be used in various value-based quality programs. Dr. Wiggins stated that the Advisory Group has the opportunity to influence the actions of the healthcare system while also supporting accountability and transparency. Dr. Wiggins stated that CMS seeks to ensure that measures are meaningful to patients and consumers, and that the Advisory Group gives a voice to these stakeholders. Dr. Wiggins emphasized that while the final decision lies with CMS, the input of the Advisory Group is valuable.

Dr. Wiggins proceeded to review the six strategic pillars that guide CMS' work to advance health equity, the five priority areas which comprise the CMS Framework for Health Equity, and the CMS National Quality Strategy goals. Dr. Wiggins stated that while all quality measures should address health equity, MAP will review several equity-specific measures during the current MUC cycle. Dr. Wiggins reviewed strategic priority areas for measure alignment within and across programs and shared considerations for

future measure priorities.

MAP Health Equity Advisory Group 2022-2023 Pre-Rulemaking Activities

Ms. Williams-Bader provided an overview of the MAP Health Equity Advisory Group charge and the role of the Advisory Group within the pre-rulemaking process. The Advisory Group will review each of the measures on the MUC List and provide input on measurement issues related to health disparities and critical access hospitals (CAHs) that may be relevant if the MUCs are used in federal programs, as well as discuss whether measures support the overall goal to reduce health disparities closely linked with social, economic, or environmental disadvantages.

Ms. Williams-Bader shared that the feedback from the MAP Health Equity Advisory Group virtual review meeting will be provided to the Coordinating Committee by incorporating a qualitative summary on each measure's potential impact on health disparities into the preliminary analysis documents. A verbal summary of the MAP Health Equity Advisory Group's discussion will also be shared for each measure under consideration at the setting-specific Workgroup meetings on December 12 (MAP PAC/LTC), December 13-14 (MAP Hospital), and December 15-16 (MAP Clinician).

Ms. Williams-Bader shared the following five-step process for discussion:

1. NQF staff describe the measure group for MAP discussion
2. The lead discussants summarize the measure group and offer initial thoughts
3. MAP members discuss the measure group and provide feedback on the following questions:
    - Could this measure group support the advancement of health equity, and if so, how? Could this measure group support measurement of critical access hospitals, and if so, how?
    - What data collection and/or reporting challenges related to health disparities could exist for this measure group? What challenges could exist for critical access hospitals?
    - When adjusting for health disparities, what methodological problems of calculating measure performance could exist for this measure group? What problems could exist for critical access hospitals?
    - What potential unintended consequences related to health disparities could exist if this measure was included in specific programs? What potential unintended consequences could exist for critical access hospitals?
4. MAP members identify any measures within the measure group for which the issues discussed do not apply
5. If any measures are identified, MAP members provide feedback on questions used during measure group discussion. Measure developers will respond to questions on the specifications of the measure and NQF staff will respond to questions on the preliminary analysis.

Before concluding the discussion of the pre-rulemaking process, Ms. Williams-Bader opened the floor for MAP members to ask questions. At this time, two questions and two comments were raised:

- A MAP member asked if the content of the meeting would be shared with the Workgroups in the form of a written summary. Ms. Williams-Bader responded that due to time constraints, NQF staff do not have an opportunity to provide a written summary to the Workgroups and that Workgroups will instead receive a verbal summary from NQF staff. Dr. Elliott added that NQF staff will compose a written summary to capture the content of the meeting but noted that it will not be available in time for the Workgroup meetings.

- A MAP member asked if NQF staff could share the lead discussant list. NQF staff directed the MAP member to the lead discussant list.
- A MAP member expressed frustration at the compressed agenda of the two-day meeting and stated that it makes the work of the Health Equity Advisory Group feel "marginal." Ms. Williams-Bader acknowledged the compressed timeline and stated that the MAP process is bookended by two federally-mandated deadlines on December 1 and February 1.
- A MAP member raised the issue of measure stratification since measures will be reviewed in groups, rather than individually. Dr. Elliott responded that the Advisory Group could explore the measure specifications of individual measures as needed. Dr. Elliott added that the Advisory Group would have the opportunity to discuss global themes, including those related to measure stratification, at the end of day two.

Measures Under Consideration

Chronic Condition Management and Prevention Care Measures

Udara Perera, NQF Director, stated that MAP members would begin discussion with the measures under consideration for chronic condition management and prevention care. Ms. Perera introduced the measures in this group:

- **MUC2022-043:** Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans (*Part C and D Star Ratings [Medicare])*
- **MUC2022-048:** Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized instrument (*MIPS [Merit-based Incentive Payment System])*
- **MUC2022-065:** Preventive Care and Wellness (composite) *(MIPS)*
- **MUC2022-125:** Gains in Patient Activation Measure (PAM) Scores at 12 Months *(MIPS)*

Dr. Angove then opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. No comments were offered by lead discussants.

Dr. Angove opened the floor for MAP members to discuss the measure group. MAP members requested that these four measures be discussed individually.

MUC2022-048: Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized instrument (MIPS)

A MAP member asked the measure developers to clarify if the basis of the measures in this group differs according to race and ethnicity, noting that CVD risk calculators may have different validity for different groups. The developer for MUC2022-048 stated that this measure incorporates 18 elements, including race and ethnicity. The MAP member also asked what analyses have been completed to understand the impact of including race and ethnicity in MUC2022-048. The developer responded that the measure uses a validated risk-assessment tool that, according to testing data, identifies high-risk patients 93 percent of the time. The developer added that the measure was tested and implemented at three hospitals including one at the University of Tennessee, where the population is 25 percent Black. The developer stated that in patient interviews, Black patients expressed that clinicians were more likely to listen to them as a result of the screening tool used in the measure.

A MAP member asked if MUC2022-048 had been tested in addition to the standardized instrument the measure uses for assessment. The developer responded that the measure itself has been tested, and that reliability and validity data are included in the MUC submission.

A MAP member commented that MUC2022-048 appears important for health equity, but reporting may pose a challenge.

MUC2022-043: Kidney Health Evaluation for Patients with Diabetes (KED) - Health Plans (Part C and D Star Ratings [Medicare])

Multiple MAP members expressed concerns regarding health equity for MUC2022-043 due to the ongoing use of race in calculating estimated glomerular filtration rate (eGFR), which leads to underdiagnosis of chronic kidney disease (CKD) among Black Americans.

Two MAP members suggested that implementation of the measure should wait until the universal adoption of race-neutral eGFR. Similarly, another MAP member expressed feeling comfortable about MUC2022-048, -065, and -125 contingent upon stratification efforts but uncomfortable about moving forward with MUC2022-043 until the issue of using race in eGFR calculation is addressed. The measure developer responded that they are currently collaborating with the National Kidney Foundation and working on adding race-neutral codes to address this issue. The developer noted, however, that the measure still includes older codes that use race in calculating eGFR. The developer also commented that although the current measure does not stratify by race or ethnicity, there are plans to do so for future kidney measures. A MAP member expressed reassurance that this correction is being incorporated into the measure.

A MAP member asked if MUC2022-043 should be removed from the program while the specifications are reworked. A CMS representative responded that because the measure is not currently in use, there is no need to remove it from the Medicare Part C and D Star Ratings Program. The CMS representative added that the measure is not currently in use in any other CMS quality reporting program.

MUC2022-065: Preventive Care and Wellness (composite) (MIPS)

A MAP member noted that MUC2022-065 was not supported for rulemaking in the previous MUC cycle and questioned if this composite measure is as useful as individual measures. Another MAP member expressed agreement and commented that because the measure only applies to the primary care setting, screenings that occur in specialty-care settings could be missed. The measure steward responded that if this composite measure were implemented, individual measures would be removed in order to avoid duplication. The steward added that the plan is to obtain both a composite score and set of individual scores for each component so that issues related to specific measure components can be identified.

A MAP member asked for clarification on whether stratified, individual components of MUC2022-065 will be shared as part of public reporting. The measure steward responded that the stratified components will be shared with providers to support internal quality improvement efforts, but there may be challenges publicly reporting on components of the composite measure due to low sample sizes and anonymity concerns. CMS has not yet finalized the specific data that will be shared on the Care Compare site for public reporting.

A MAP member commented that numerator four of MUC2022-065 is missing fecal immunochemical test (FIT) and that it should be listed separately from the fecal occult blood test (FOBT) and fecal immunochemical DNA test (FIT-DNA) per the guidelines set forth by the American Cancer Society,

Centers for Disease Control and Prevention (CDC), and U.S. Preventive Services Task Force (USPSTF). The developer responded that they would discuss this with the steward to ensure that this composite measure aligns with the individual program measures. A CMS representative stated that an update on this matter will be provided to NQF staff as soon as possible.

After the meeting, a CMS representative confirmed that FIT tests are considered evidence of FOBT within this measure; patients who had a FIT test along with a stool DNA test during the measurement period or in the two years prior to the measurement period would meet the criteria for numerator four.

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

A MAP member asked whether safety net providers are at an increased risk of performing poorly on MUC2022-125. The steward responded that providers are evaluated based on improvement in score rather than baseline scores. The MAP member asked whether economic barriers affect improvement. The steward responded that during measure testing, change in activation was observed across all socioeconomic (SES) strata, and that there is no evidence to suggest that people with low SES will not improve.

For MUC2022-125, a MAP member asked if the measure developer planned to report the measure stratified by demographic characteristics, and expressed concerns about the measure's potential to exacerbate health disparities. The measure developer responded that the measure is not stratified according to demographic characteristics and emphasized that testing data show that all people are able to improve.

Group Discussion: Chronic Condition Management and Prevention Care Measures

Before concluding this section, a MAP member commented that the measure group appears important for health equity. Another MAP member expressed comfort in supporting this group of measures and commented that all measures in the group appeared either beneficial or neutral to health equity, with the caveat that the addition of stratification by race and ethnicity and the resolution of the eGFR code transition are needed to strengthen MUC2022-043.

Renal Measures

Ms. Perera introduced the renal measures under consideration:

- **MUC 2022-060:** First Year Standardized Waitlist Ratio (FYSWR) *(MIPS)*
- **MUC 2022-063:** Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW) *(MIPS)*
- **MUC 2022-075:** Standardized Modality Switch Ratio for Incident Dialysis Patients (SMoSR) *(ESRD QIP [End-Stage Renal Disease Quality Incentive Program])*
- **MUC2022-076:** Standardized Fistula Rate for Incident Patients *(ESRD QIP)*
- **MUC2022-079:** Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities *(ESRD QIP)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant stated that these measures are disparities-sensitive and important for health equity. A lead discussant asked the measure developer to provide methodological clarity on each measure in the group before opening the discussion to the Advisory Group. The measure developer provided a brief overview of each measure, including information related to risk adjustment.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. MAP members requested individual discussion of MUC2022-079 and -075.

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

A MAP member asked if dialysis centers with an increased need to send patients to the emergency department (ED) due to limited resources will be disproportionately impacted by MUC2022-079. A CMS representative responded that the purpose of the measure is to incentivize dialysis centers to maintain overall health of the patient and to prevent the need for emergency care. The measure developer responded that while disparities in access to non-emergency outpatient care exist, this is just one of many factors that contribute to the quality of care provided by a dialysis center. The measure developer noted that there is a wide performance range among facilities located in both high and low SES areas. The developer stated that in their opinion, adjusting for SES would permit facilities in low SES areas to provide poor quality of care. The measure developer provided alternatives to risk adjustment, including stratification by the Area Deprivation Index (ADI) and by the proportion of dually eligible patients. The measure developer noted that such stratification was performed for MUC2022-079.

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

A MAP member asked if MUC2022-075 considers disparities in the ability for patients to perform home dialysis due to factors such as limited health literacy and a lack of clean water. A CMS representative responded that the measure incentivizes providers to discuss what is needed to perform home dialysis with their patients. The measure developer stated that in their opinion, the primary barrier to initiation of home dialysis is the failure of clinicians to educate patients from certain sub-populations. The measure developer added that the TEP that assisted with the development of MUC2022-075 was in consensus that racial and ethnic differences in home dialysis rates transcend SES, and advised the developer not to risk adjust for SES.

Regarding MUC2022-075, a MAP member commented that some patients may not be counseled to receive home dialysis due to upstream factors.

Group Discussion: Renal Measures

A MAP member asked if the measures in this group can track racial and ethnic disparities. The measure developer responded that facility-level results can be stratified by factors such as race and ethnicity. Another MAP member commented that it would be helpful to stratify data by race and ethnicity. Another MAP member expressed agreement.

A MAP member asked for clarification regarding how measures are developed in general. A CMS representative responded that CMS continuously examines issues related to health equity and considers what measures may be needed to address disparities. The CMS representative noted that because development is a multiyear process, measures may appear reactive rather than proactive.

Health Equity Measures

Ms. Perera introduced the next group of measures under consideration. Ms. Perera noted that while all measures are intended to promote equity, health equity is the primary focus of these measures:

- **MUC2022-027:** Facility Commitment to Health Equity *(ESRD QIP, IPFQR [Inpatient Psychiatric Facility Quality Reporting Program], PCHQRP [Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program])*

- **MUC2022-050:** Screen Positive Rate for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-053:** Screening for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-058:** Hospital Disparity Index (HDI) *(Hospital IQR [Hospital Inpatient Quality Reporting Program])*
- **MUC2022-098:** Connection to Community Service Provider *(MIPS)*
- **MUC2022-111:** Resolution of At Least 1 Health-Related Social Need *(MIPS)*

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant commented that these measures are intended to serve as indicators for health equity, but may exacerbate inequities. The discussant reiterated that MUC2022-050 and MUC2022-053 were recommended for the Merit-based Incentive Payment System (MIPS) Program and Hospital Inpatient Quality Reporting (IQR) Program as part of the MAP Health Equity Advisory Group's discussion last year, and their concerns with the measures still remain. The discussant also noted that MUC2022-058, MUC2022-098, and MUC2022-111 are new measures with limited testing data, and that MUC2022-050, MUC2022-053, MUC2022-098, and MUC2022-111 do not specify standardized screening tools. The discussant commented that the measures should also be aligned with ongoing Gravity Project and United States Core Data for Interoperability (USCDI) standards for uniformity.

Another lead discussant commented that these measures rely heavily on USPSTF recommendations on screening for health-related social needs related to domestic violence for women, and that providers and patients indicated in surveys that screening information is actionable and helpful. The discussant also commented that the group includes two measures that address commitment and conditions at the hospital level (MUC2022-027 and MUC2022-058), and the remaining four measures seem to "nest" in order to assess the following stages:

- How many patients are screened?
- Of those who are screened, how many have a need identified?
- Of those with needs identified, how many are connected to additional services?
- Overall, how many patients have their health-related social needs met?

The discussant noted that an unintended consequence of these measures may be identification of needs that providers are unable to help address. The discussant also asked the measure stewards to address how these measures should be interpreted independently of each other, since the percentage of people with a resolved health-related social need is dependent on earlier steps in the process (e.g., how many patients were screened), and not all of these measures may be included in the final program. The discussant noted that for one of the organizational competencies for MUC2022-027 (collection of reliable and valid demographic data on a majority of patients), most Medicare and Medicaid patients have race and ethnicity data collected by the state and asked whether facilities are expected to collect this information separately or if they can use federal program data; the discussant also noted that collecting for a majority of patients is not necessarily a high enough bar to help with stratification. Finally, the discussant noted that MUC2022-058 requires additional information on what subgroups are affected most by disparities in order to be actionable, and suggested that the information should be shared publicly for accountability purposes.

Dr. Wiggins shared that these measures are being considered across a variety of programs and care settings with the understanding that patients navigate the healthcare system as a whole; this is why, for example, MUC2022-027, MUC2022-050, and MUC2022-053 are being expanded outside of the inpatient

hospital setting to end-stage renal disease (ESRD) facilities, inpatient psychiatric facilities, and cancer hospitals. CMS is proposing this comprehensive, aligned approach in the spirit of whole-person care and understanding inequities that underly the healthcare system. Dr. Wiggins noted that CMS hopes to encourage intentional collection of self-reported data and drivers of health, and in the future determine variables that are appropriate to stratify, report, and link to payment programs. A measure developer also commented that these measures are intended to signal the importance of data collection without being too prescriptive on the exact process, given differences in workflow between settings and facilities.

Dr. Angove proposed that the group discuss these measures in five smaller groups as follows: overall questions about the measure group; questions on MUC2022-058; questions on MUC2022-027; questions on MUC2022-050 and MUC2022-053; and questions on MUC2022-098 and MUC2022-111. MAP members agreed that this was appropriate, and Dr. Angove opened the floor for MAP members to discuss the measure group.

Group Discussion: Health Equity Measures

A MAP member commented that there is confusion among providers about what information CMS is asking them to report on their patients, and emphasized the need for clear definitions within these measures. The member recognized that developers are trying to avoid being too prescriptive on how to collect demographic data, but noted that unclear definitions can create additional work for hospitals. The MAP member also commented that hospitals are being asked to report Z codes focused on social drivers of health, and asked how these codes are used in the group of measures. Finally, the MAP member noted that these measures hold providers responsible for an area where their locus of control is limited, and other constituents bear responsibility for helping address systemic community challenges. Another MAP member agreed with these comments and added that providers have limited bandwidth to address these concerns, especially in the wake of the COVID-19 public health emergency.

A MAP member emphasized that stakeholders need to implement social determinants of health (SDOH) measures thoughtfully and suggested a stepwise approach to implementing these measures. The member also asked CMS for clarification on the intended use, timeline, and trajectory of this measure group, noting that at least one measure (MUC2022-058) is currently confidentially reported to providers and moving the measure to a public reporting program is a major change in the intent and use of the measure. Dr. Wiggins shared that stakeholders will need to take an approach of shared accountability and responsibility to effectively address health inequities. Dr. Wiggins reiterated SDOH has a substantial impact on clinical outcomes, and that the locus of control for these measures lies with multiple stakeholders, including providers. The intent of measuring these factors is to equip hospitals to respond to the needs that patients may present with, and CMS welcomes any additional feedback on how they can best equip clinicians to participate in these efforts. A MAP member agreed that there is a shared responsibility to address social needs, and noted that while provider bandwidth is limited, team-based care (e.g., social workers, community health workers, doulas) can help address bandwidth concerns. Another MAP member also agreed and noted that the question of who is responsible for addressing social needs is distinct from the question of whether clinicians can be a bridge point to connect patients with critical social resources.

MUC2022-058: Hospital Disparity Index (HDI) (Hospital IQR)

A MAP member asked for the clinical rationale and evidence justifying why readmissions were chosen as the only source of information on hospital disparities. The measure developer shared that the measure concept was to build an initial index that would accumulate many separate disparity measures into a

single overall score; and CMS is already sharing information about disparities to hospitals confidentially for the readmission measures. The current measure uses readmissions because it is a topic with known disparities familiar to hospitals, but the measure may be expanded to metrics outside of readmissions in the future. The MAP member commented that until the index is expanded, it should be called the "Hospital Readmission Disparity Index" so as not to imply a broader index. Another MAP member agreed.

A MAP member noted that readmissions can be affected by factors outside the clinician's control, including living circumstances and patient choices. The member commented that this measure does not help clinicians identify specific actions for improvement and does not help identify specific patient populations or processes that clinicians should focus on. Because of the lack of specific information, this measure could mask or confound existing health equity challenges. Another MAP member agreed that this composite measure does not provide clear, actionable information for quality improvement; they supported the continued confidential reporting of individual disparities to hospitals. The MAP member also added that this measure may be difficult to interpret for patients looking at the measure as part of public reporting, especially given stratification by imputed data for race and ethnicity rather than the gold standard of self-reported data; two other MAP members agreed with this comment.

A MAP member commented that the measure combines both a within-hospital disparity (difference in readmissions between dual-eligible and non-dual-eligible patients within the same hospital) and across-hospital disparity (readmission rate for dual-eligible patients only) into one score and this poses a validity problem. The MAP member commented that including the across-hospital metric functionally adjusts for factors that affect the outcome of interest and does not help identify inequities (e.g., a hospital with high average performance but high inequity within the hospital could still score well on this index, despite contributing to inequities). Another MAP member asked whether there is a minimum number of patients required to be included in the index, given concerns with reliability; the developer clarified that the index does not require reporting on every disparity measure, and that the across-hospital metric is included to ensure that the index does not reward small gaps that result from all groups at a hospital having poor outcomes. A MAP member shared that they understand why the measure includes the across-hospital metric, but suggested that the two metrics be reported separately for clearer interpretation; three MAP members agreed with this comment.

A MAP member asked for additional information on the risk adjustment model for this measure. The measure developer shared that this measure adjusts for all substantial claims-based comorbidities and uses the same adjustments used in the original readmissions measures used in this measure (NQF #0505, #2515, #1891, #0330, #0506, #1551, and #1789).

A MAP member asked to what degree potential error in classification using the Medicare Bayesian Improved Surname Geocoding (MBISG) method could impact the validity of this measure. The member commented that they are uncomfortable that an algorithm is being used to infer classification based on surname geocoding. Another MAP member shared that MBSIG has high accuracy when compared to self-reported race and ethnicity data for White, Black, Asian/Pacific Islander, and Hispanic patients, with a c-statistic ranging from 0.94 to 0.97.

A MAP member asked whether CMS plans to test this measure as an index measure, noting that the readmissions components have been tested separately but the overall measure has not been tested. The developer shared that there is ongoing testing and evaluation of the composite measure. The member commented that testing and evaluation of this measure should be completed before the measure is implemented into any programs.

MUC2022-027: Facility Commitment to Health Equity (ESRD QIP, IPFQR, PCHQRP)

A MAP member noted that the wording of this measure is vague given differences in organizational structures, but it addresses important aspects that organizations should address to promote health equity. The member added that the measure does not track improvement over time, but represents an important first step in the longer process of addressing equity throughout the healthcare system.

A MAP member commented that this measure may be a "checkbox measure" as written, and reiterated that consistent definitions and interpretation of the domains within these measures is important so that stakeholders are able to make accurate performance comparisons and understand areas for improvement.

A MAP member commented that this measure was addressed by the MAP Health Equity Advisory Group for use in the Hospital IQR program. The member shared that, as commented last year, this measure is important but does not necessarily reflect quality of care; the measure also places burden upon providers to collect data on five domains that are not strongly linked to patient outcomes by existing evidence.

MUC2022-050: Screen Positive Rate for Social Drivers of Health (ESRD QIP, IPFQR, PCHQRP) and MUC2022-053: Screening for Social Drivers of Health (ESRD QIP, IPFQR, PCHQRP)

A MAP member asked whether MUC2022-050 and MUC2022-053 are already reported as part of the MIPS program. A CMS representative shared that these measures are not yet implemented in MIPS; however, a measure similar to MUC2022-053 will be included in MIPS reporting for 2023.

A MAP member asked whether there is a minimum duration of the relationship with the provider or facility for a patient to be included in the denominator for MUC2022-050. The measure developer shared that there is no minimum duration specified, and the measure can apply to any stay where a patient has received established care. The member commented that the screen positive rate is useful for providers to understand their context, but the rate is not helpful for public reporting. The member also noted that with no minimum duration, there may not have been sufficient time for some providers to address SDOH; if this measure is used for purposes other than internal quality improvement, there could be potential for unintended consequences or misinterpretation. Dr. Wiggins clarified that the screen positive rate from MUC2022-050 is informational and will be used to help focus resources; MUC2022-050 will be used in pay-for-reporting, not in pay-for-performance.

MAP members asked whether these measures will be reported publicly, noting that reporting a high screen positive rate could be stigmatizing for facilities. A MAP member noted that there is no clear "good rate" for these measures. Another member added that as with patient safety information, facilities are reluctant to publish their rates, but systems who are tracking and reporting patient safety incidents typically have better outcomes for their patients. A CMS representative noted that these measures are proposed for pay-for-reporting, and they would need to be used in programs for more than a year before they could be moved into the Hospital Value-Based Purchasing (HVBP) Program or pay-for-performance programs.

A MAP member commented that standardizing a screening approach or tool for these measures is important, and that the screen positive rate is helpful for understanding and interpreting outcomes (e.g., future use in risk adjustment models). The MAP member agreed that measures addressing the overall idea of screening are important, and expanding MUC2022-050 and MUC2022-053 to additional settings will contribute to health equity.

MAP members asked whether this screening rate is calculated on a yearly basis, and how frequently clinicians are expected to screen; the measure developer confirmed that the screening measure is reported annually, and the expectation is that screening occur with each admission for planned care. A MAP member commented that these measures address five fundamental areas for health equity that are not being consistently addressed, and agreed that these should be incorporated into clinician interviews with patients. However, the member expressed concerns with the effect on the patient-clinician relationship if implemented without any flexibility (e.g., contributing to "checklist" nature of relationships in healthcare, dehumanizing patients by screening repeatedly for social needs without referring them to services). Another member agreed, commenting that screening could be traumatic if asked repeatedly, in a way that is not culturally sensitive, or when there is not a strong relationship between the patient and provider. A MAP member asked if the screening measure incorporates components to assess whether organizations were able to meet the social need or refer patients to other resources; the developer clarified that at this time, the measure only addresses the initial screening. However, future versions of the measure may include additional components related to access to community resources.

A MAP member commented that when interpreting the results of these measures, stakeholders should be mindful of differences in willingness to self-report social needs between different population subgroups (based on race, ethnicity, and geography). The member suggested that sharing research and data based on the first year of results could provide helpful context.

A MAP member noted that the screening measure screens for "health-related social needs" rather than "social drivers of health." Dr. Wiggins shared that the wording used in this measure is intended to broadly capture factors including not only health-related social needs, but other factors linked to health outcomes. Dr. Wiggins shared a Health Affairs article addressing ongoing work on the language used to address this topic (e.g., "determinants" may be construed as stigmatizing), acknowledged that the words used to describe health equity matter, and noted that CMS will continue to follow the conversation around respectful and precise language and adjust wording accordingly.

MUC2022-098: Connection to Community Service Provider (MIPS) and MUC2022-111: Resolution of At Least 1 Health-Related Social Need (MIPS)

MAP members asked whether MUC2022-098 compels facilities to refer patients to external service providers in the community, or whether healthcare providers can provide services in-house. The measure developer clarified that the measure allows for in-house services to count towards the measure, as they conceptualize the healthcare institution itself as a community provider. A MAP member asked whether a food pharmacy would count as a referral; the developer confirmed this would be included in the measure.

A MAP member commented that for MUC2022-098, facilities will have discrepancies in implementation; some facilities have invested in infrastructure and labor-intensive software to help address SDOH, while other facilities are interested in community partnerships but have not been able to develop them. Since different facilities will have different abilities to refer to community-based organizations, providers with limited resources may be inadvertently penalized. Another member agreed, noting that this measure is intended for clinician-level reporting in MIPS and there can be a wide gap in readiness for this measure between solo practitioners and clinicians who are part of a larger health system with more connections to community resources. A representative from CMS reminded the group that the measures a clinician reports for the MIPS program is up to the clinician, and participants can choose to report six measures from a group of 198 measures; if clinicians are not ready to implement this measure, they are not

required to report on it. A MAP member noted that since the measure is affected by resources available in the community, it would be helpful to provide future analyses on differences between providers who report on this measure versus providers who do not report on this measure; providers may only choose to report when they have community resources available, limiting the usefulness of this measure. Another MAP member agreed, commenting that this measure helps stakeholders start to understand the referral process and resource needs without coercing providers into reporting, but the overall results will be affected by selection bias and need to be interpreted carefully. The member also commented that the stratification by race is helpful and recommended that more measures consider stratification.

A MAP member commented that MUC2022-111 does not have a clear definition for "resolution" of social needs (e.g., it is not clear if moving a patient from severe to mild food insecurity counts as "resolution").

A MAP member noted that MUC2022-098 uses a 60-day timeframe to connect patients to services and asked why this timeframe was chosen, as well as any implications for feasibility. The measure developer shared that the 60-day timeframe was chosen based on feedback from their clinician advisory group, who felt that this timeframe was reasonable based on the types of services provided and potential delays (e.g., backlog at housing agencies).

A MAP member commented that MUC2022-098 does not specify the screening tool that should be used to identify social needs. The member recommended that the developers be more prescriptive before these measures are rolled out and clinicians invest resources and time into implementation, in order to ensure that providers are screening uniformly. The measure developer shared that the five health-related social needs represented in the measure were chosen based on the topic areas addressed in previous screening measures, and the domains have been addressed by the Gravity Project and USCDI in terms of interoperability and consensus on importance and actionability. However, there has been no broad consensus on a single screening tool that should be used to assess these topic areas.

A MAP member asked whether MUC2022-098 has been tested and implemented at the clinician level or if it was only tested with community health organizations. The measure developer shared that this measure was tested as part of the Center for Medicare & Medicaid Innovation (CMMI)'s five-year Accountable Health Communities project, where 54 percent of provider groups who participated were primary care providers; however, the measure was tested among practices rather than individual providers.

A MAP member asked how the phrase, "had contact with" in MUC2022-098 is defined. The developer clarified that contact is measured by direct report from a patient, or indication through an electronic referral platform that the service provider made contact with the patient; this measure intentionally addresses contact with the service provider, one step beyond providers sharing a list of resources to patients. Another MAP member commented that community organizations are increasingly stressed by inflation and other issues, which may affect their ability to respond to patients, but they support this measure despite the challenges.

Patient Experience Measures

Ms. Perera introduced the patient experience measures under consideration:

- **MUC2022-014:** Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood *(MIPS)*

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

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. Prior to the discussion, the lead discussant disclosed that they sat on the TEP that helped to inform the development of MUC2022-014. The lead discussant commented that MUC2022-014 is an attempt to include a patient-reported outcome measure (PROM) in the palliative care setting. The lead discussant noted that while MUC2022-014 appears to support health equity, the measure was only tested in English. The measure developer responded that the survey materials for the measure are available in Spanish, but Spanish language materials were not tested during measure development. Finally, the lead discussant noted that MUC2022-120 is exclusively for use in the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQRP); because only eight facilities are enrolled in this program, the lead discussant commented that MUC2022-120 does not encompass all cancer patients and may not be broadly generalizable.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. MAP members requested that these three measures be discussed individually.

MUC2022-014: Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (MIPS)

A MAP member commented that MUC2022-014 seemed important for health equity and expressed that stratified results would be valuable to measure health disparities. Another MAP member expressed agreement.

A MAP member asked if MUC2022-014 included patients' experience of feeling heard and understood by their oncology team. The measure developer responded that the measure is specified for palliative care only.

A MAP member commented that the scope of MUC2022-014 may be limited since some sub-populations experience greater barriers to accessing specialty care.

A MAP member expressed support for the inclusion of patient-reported outcome-based performance measures (PRO-PMs) on the MUC List, such as MUC2022-014.

For MUC2022-014, a MAP member asked about potential unintended consequences should providers choose not to refer to palliative care those patients who may be more likely to evaluate their experience more negatively. The measure developer responded that they recommend survey vendors to perform patient sampling to avoid bias in terms of which patients are referred to palliative care.

A MAP member asked how MUC2022-014 can assess for potential non-response bias. The measure developer responded that during measure testing, non-respondents were slightly younger on average, and were slightly less likely to be White compared to respondents. The measure developer stated that non-response due to race will require further exploration in the future.

MUC2022-078: Psychiatric Inpatient Experience Measurement (IPFQR)

A MAP member expressed concern that "treatment effectiveness" as used in MUC2022-078 lacked specificity.

For MUC2022-078, a MAP member expressed concern regarding the potential burden imposed on patients to complete the survey. The measure steward responded that patients take the survey in-facility, taking around ten minutes to complete. Another MAP member added that despite the potential for survey fatigue, providers should seek to ensure that responses truly represent the diversity of their patient population.

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

For MUC2022-120, a MAP member asked about the purpose of including patients who die from cancer while receiving care at the reporting hospital in the measure. Another MAP member commented that they had the same question and stated that goals of care should be set upstream. The measure steward responded that the inclusion of patients who die is intended for future use in the ambulatory setting and is meant to help identify which patients are high-risk, which remains difficult at this time.

For MUC2022-120, a MAP member asked how the measure will be assessed. The measure developer responded that the measure will be assessed using the electronic health record (EHR).

COVID-19 Measures

Ms. Perera introduced the COVID-19 measures under consideration:

- **MUC2022-052:** Adult COVID-19 Vaccination Status *(MIPS)*
- **MUC2022-084:** COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) *(ASCQR [Ambulatory Surgical Center Quality Reporting Program], Hospital IQR, Hospital OQR [Hospital Outpatient Quality Reporting Program], IPFQR, IRF QRP [Inpatient Rehabilitation Facility Quality Reporting Program], LTCH QRP [Long-Term Care Hospital Quality Reporting Program], PCHQRP, SNF QRP [Skilled Nursing Facility Quality Reporting Program])*
- **MUC2022-089:** COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(IRF QRP)*
- **MUC2022-090:** COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(HH QRP [Home Health Quality Reporting Program])*
- **MUC2022-091:** COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(LTCH QRP)*
- **MUC2022-092:** COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date *(SNF QRP)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant shared that they do not have any major equity concerns with this group of measures, but as with all measures, the data should be collected in a way that is actionable for providers to address inequities.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. A MAP member asked for clarification on denominator exclusions for individuals who have not received the COVID-19 vaccine for medical, religious, or other reasons. Measure developers clarified that MUC2022-052 excludes patients who have received hospice services or patients who have any contraindication to the vaccine as documented by a clinician. MUC2022-084 excludes patients with Food and Drug Administration (FDA) contraindications (e.g., severe allergic reactions) and does not include any denominator exceptions. MUC2022-089, MUC2022-090, MUC2022-091, and MUC2022-092 do not have any exclusions; during development of the measure, patients and caregivers expressed that a raw rate of vaccination is easiest to interpret and is valuable to inform decision-making. A MAP member commented that the percentage of true contraindications for the COVID-19 vaccine is low, and the lack of exclusions on these measures makes sense to avoid varying interpretations of valid contraindications. Another MAP member

recognized that clinicians can choose which measures to report for MIPS, but vaccine hesitancy and vaccination rates vary by race and ethnicity and clinicians could have low performance on COVID-19 measures even after coaching and patient education.

A MAP member asked whether measures MUC2022-089, -090, -91, and -092 require patients to receive the bivalent vaccine in order to be considered "up to date"; the developer clarified that the definition is based on current CDC guidance, which includes patients who have received the bivalent booster. Another MAP member asked for clarification on whether the definition of "up to date" for MUC2022-084 requires boosters or whether recent primary series vaccinations are also counted, noting that there may be differences in level of protection from the primary series versus boosters tailored to currently circulating COVID-19 strains. The developer shared that individuals who have received a primary series vaccination in the past two months would still be considered "up to date."

A MAP member commented that this group of measures addresses an important topic, but CMS has not included any measures that address COVID-19 in congregate home- and community-based service (HCBS) settings which experienced the same workforce shortages, risks, and transmission issues as institutional settings (e.g., skilled nursing, home health, etc.). A developer shared that MUC2022-052 does partially address clinician-level accountability for congregate settings, but does not directly address Medicaid programs; measure and program structures often coincide with CMS' payment structures, which can contribute to gaps in resource prioritization. Another developer shared that MUC2022-089, -090, -091, and -092 are assessment-based and directed at post-acute care settings, but there have been broader discussions about developing versions of these measures for other settings including HCBS.

A MAP member commented that MUC2022-084 was previously in the Hospital IQR program but is planned to be added to the HVBP Program and Hospital-Acquired Condition Reduction Program (HACRP), and asked why this measure is being shifted to use in pay-for-performance programs. The developer clarified that CMS is no longer considering MUC2022-084 for HVBP or HACRP.

A MAP member asked whether this group of measures will be stratified by demographic factors. Measure developers clarified that none of these measures will include stratification or risk adjustment. The developer of MUC2022-052 shared that they chose not to stratify MUC2022-052 due to concerns about small numbers for individual providers or small practices participating in MIPS; they may consider stratification in future iterations, especially given concerns about geographic differences in access, but will not stratify at this time given these small number concerns and limited evidence base and testing data for this measure. The developer of MUC2022-084 shared that they chose not to stratify for similar reasons, and much of the data used for the measure is submitted at an aggregate rather than an individual level, but they may consider stratification in future versions of the measure. Finally, the developer of MUC2022-089, -090, -091, and -092 shared that they are beginning to collect information about SDOH as part of their assessments, including data outside of race, ethnicity, and dual eligibility status.

Eye Care Measures

Ms. Perera introduced the eye care measures under consideration:

- **MUC 2022-114:** Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy *(MIPS)*
- **MUC 2022-115:** Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up *(MIPS)*
- **MUC 2022-116:** Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage

Appropriate Examination and Follow-up *(MIPS)*

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. Lead discussants shared that the measures in this group fill important quality gaps within the MIPS program and expressed no concerns regarding negative unintended consequences to health equity. A lead discussant also shared that research findings show that communities of color experience vision loss at higher rates and receive intervention/surgical procedures at lower rates compared to Whites.

Dr. Angove opened the floor for MAP members to discuss the measure group. A MAP member stated that based upon the comments provided by lead discussants, it seemed that the measures in the group are positive or at least neutral regarding their impact on health equity. Another MAP member expressed agreement.

Preview of Day Two

Ms. Williams-Bader provided a preview of day two of the Health Equity Advisory Group 2022-2023 MUC Review Meeting. Before concluding the preview of day two, Ms. Williams-Bader opened the floor for questions. No questions were raised.

Adjourn

Ms. Williams-Bader closed the meeting.

Measure Applications Partnership (MAP) Health Equity Advisory Group 2022-2023 Measures Under Consideration (MUC) Review Meeting – Day Two

Welcome, Preview of Day Two, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the Health Equity Advisory Group 2022-2023 MUC Review Meeting, thanked participants for their attendance, and reviewed the ground rules and the day two agenda (listed below). There were 146 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
  - Behavioral Health Measures
  - Patient Safety Measures
  - Outcome Measures – Readmissions, Mortality, and Unplanned Hospitalizations
  - Structural (Hospital/Surgery) Measures
  - Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures
  - Cost Measures
  - Functional Outcome Measures
  - Staffing Measure
- Discussion of Broad Themes
- Opportunity for Public Comment
- Next Steps
- Adjourn

Ms. Williams-Bader turned the meeting to Ms. Elliott for a roll call of Health Equity Advisory Group membership. 23 of 33 MAP members were present (see Appendix B for detailed attendance).

Measures Under Consideration

Behavioral Health Measures

Ms. Perera introduced the behavioral health measures under consideration:

- **MUC2022-122:** Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder *(MIPS)*
- **MUC2022-127:** Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk *(MIPS)*
- **MUC2022-131:** Reduction in Suicidal Ideation or Behavior Symptoms *(MIPS)*

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. No comments were offered by lead discussants.

Dr. Angove opened the floor for MAP members to discuss the measure group. A MAP member asked for further clarification on how MUC2022-122 and MUC2022-131 are related or overlap. A CMS representative shared that both of these measures broadly address behavioral health, rather than

focusing on a single condition (e.g., depression-specific measures), and these measures fill a gap area for the MIPS portfolio. The measure developer added that these two measures could be used by the same site and they have some overlap, but they ultimately measure different constructs; patients can have reduced symptoms (MUC2022-131) without experiencing an improvement in their overall functioning (MUC2022-122).

A MAP member commented that patients who return to their provider for follow-up visits may generally be in better condition than patients who do not return for further care, and asked whether the measure accounts for selection bias. The developer shared that some individuals may not return because their condition has worsened, but other individuals may not return because they have improved and do not believe they need additional care, so performance likely balances out.

A MAP member asked for additional information on disparities in performance for this group of measures. The developer for MUC2022-122 shared that younger patients tended to present with higher baseline rates of functioning than older patients, and therefore experienced smaller changes in functioning over time; race and ethnicity data was limited and there may be potential for disparities in this area. MUC2022-131 also demonstrated disparities by age, with younger patients more likely to present with higher scores for suicidal behavior and more room for improvement, and disparities based on serious mental illness, with patients with psychotic or bipolar disorders experiencing lower rates of improvement. For MUC2022-127, older patients had lower rates of initiation, review, or update of a suicide safety plan. Males were more likely to have suicide safety plan initiation, and measure completion was lower for females. A MAP member commented that this measure group fills an important gap and is disparities-sensitive, and suggested users consider stratification by age, illness severity, gender, race, and ethnicity, as well as prioritize obtaining complete demographic data for the population.

A MAP member asked whether there are potential measure reliability concerns for these measures when stratifying by race, given small denominator sizes and racial variation by CAH geography. The developer acknowledged that small sample sizes could be a concern for certain subgroups when stratifying by race and ethnicity.

A MAP member asked for additional details on potential changes to workflow for clinicians who report on these measures, and asked whether there are potential disparities associated with measure implementation. The developer shared that most EHRs have implemented the suicide safety plan and suicide assessment tools directly in their systems. The assessment tools are also freely available as a paper version, and solo practices and small groups were able to implement the measure during testing. The member commented that low-resource systems would likely use the paper version of the tools, leading to increased burden (e.g., manually entering data) and discrepancies in workflow.

A MAP member asked whether telehealth care was widely used during testing of MUC2022-122, given that testing occurred during the COVID-19 public health emergency and telehealth may be less available now. The developer shared that some testing data was collected from telehealth visits, but data collection started prior to COVID-19 and the majority of data was not from telehealth visits.

A MAP member asked whether there was any evidence of disparities based on preferred language, and whether there were any accommodations for individuals with limited English proficiency. The developer shared that there were no reports of sites being unable to use the instrument due to language issues, and added that the tools addressing suicide safety plan and functioning have been translated to other languages including Spanish. Another member commented that providers working in areas with lower

health literacy or limited English proficiency could experience greater reporting burden, as a provider may need to help a patient fill out the form during the visit.

Patient Safety Measures

Ms. Perera introduced the patient safety measures under consideration:

- **MUC2022-007:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician and Clinician Group Level) *(MIPS)*
- **MUC2022-018:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) *(Hospital IQR)*
- **MUC2022-020:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Outpatient) *(Hospital OQR)*
- **MUC2022-024:** Hospital Harm – Acute Kidney Injury *(Hospital IQR, Medicare Promoting Interoperability Program [Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals])*
- **MUC2022-035:** Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) *(SNF VBP [Skilled Nursing Facility Value-Based Purchasing Program])*
- **MUC2022-064:** Hospital Harm – Pressure Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-082:** Severe Sepsis and Septic Shock: Management Bundle *(HVBP)*

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant commented that the measures appear actionable for providers and expressed support for the measure group. The lead discussant added that the measures provide the opportunity to elucidate health disparities. Another lead discussant noted that the measure group does not appear to pose any unintended negative consequences to persons with disabilities.

A lead discussant asked if there exists a version of MUC2022-020 for pediatric patients. The measure steward responded that there is a similar measure currently in use for pediatric patients that is less detailed, and that the developer plans to develop a more robust measure in the future based on MUC2022-020.

Regarding MUC2022-007, -018, and -020, a lead discussant asked whether melanin in the skin is related to inadequate image quality. A representative from the Office of the National Coordinator for Health Information Technology (ONC) responded that because CT images are captured below the skin, melanin does not affect image quality.

Dr. Angove opened the floor for MAP members to discuss the measure group. MAP members discussed MUC2022-007, -018, and -020 as a group, as well as individually discussing MUC2022-082.

MUC2022-007, MUC2022-018, and MUC2022-020: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) In Adults (MIPS, Hospital IQR, Hospital OQR)

A MAP member commented that MUC2022-007, -018, and -020 have the capacity to support health equity. However, the MAP member noted that these measures employ a size-adjusted radiation dose value and expressed concern that some sub-populations may receive higher radiation doses due to obesity rate differentials and thereby, may incur an increased risk for cancer. The MAP member also

expressed concern that the denominators have exclusions for missing size-adjusted radiation dose, which could impact health equity. The measure steward responded that the purpose of including size-adjusted radiation dose in the measures is to account for case mix in the size of patients. The measure steward stated that to date, there are no recorded differences across demographic characteristics (e.g., race, ethnicity, sex, SES) and radiation dosage. Additionally, the measure steward commented that instances of missing size-adjusted radiation dose data are very uncommon, as CT images measure actual image size.

Regarding MUC-007, -018, and -020, a MAP member asked whether it is possible to standardize radiation doses. The measure developer responded that the purpose of these three measures is to incentivize providers to decrease radiation doses and provide standardization across providers.

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

A MAP member raised that the data collection requirements of MUC2022-082 could pose a burden for providers. Another MAP member expressed agreement.

Outcome Measures – Readmissions, Mortality, and Unplanned Hospitalizations

Ms. Perera introduced the outcome measures under consideration related to readmissions, mortality, and unplanned hospitalizations:

- **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)*
- **MUC2022-099:** Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure *(SNF VBP)*
- **MUC2022-113:** Number of hospitalizations per 1,000 long-stay resident days *(SNF VBP)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant commented that MUC2022-055 and MUC2022-057 are existing measures that are being expanded to be more inclusive (including Medicare Advantage patients in addition to fee-for-service patients), and MUC2022-099 is being expanded to include readmissions throughout the entirety of the nursing home stay instead of within a 30-day period. MUC2022-113 is an existing measure being proposed for inclusion in additional programs, but it does not have any additional specification changes. The lead discussant shared that expanding the patient population captured by these measures is beneficial from an equity perspective, and that these measures address important patient outcomes. The lead discussant also suggested that stratifying by race, ethnicity, and dual eligibility status could provide helpful information on disparities, but this information was not provided by the developer.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. A MAP member commented that the expansion of MUC2022-055 and MUC2022-057 to the Medicare Advantage population is positive, but cautioned that some states have not expanded Medicare; beyond the clinician's control, the surrounding political environment could affect measure performance. Another member agreed that expanding the denominators of MUC2022-055 and MUC2022-057 advances health equity, especially regarding managed care, and added that these measures should be stratified by race and ethnicity.

A MAP member commented that readmissions measures can sometimes over-incentivize reduced readmissions, to the detriment of certain groups, and asked whether there are complementary measures in the Hospital IQR program and Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) that capture this risk. The developer for MUC2022-099 shared that there are complementary measures in the SNF VBP program on discharge-to-community and post-discharge readmissions; should a SNF discharge a patient prior to a readmission, these measures in SNF VBP and QRP would capture this. The member asked whether there is any risk for delayed re-hospitalization from facilities looking to improve performance on this measure. The developer for MUC2022-055 noted that CMS does collect measures such as the Excess Days in Acute Care measures which also capture emergency department and observation stays.

A MAP member expressed concern that readmissions measures can penalize health systems that provide care for a disproportionate number of disadvantaged groups, including low-income patients and patients of color. The member asked whether the measures in this group are risk-adjusted for these factors. The measure developers confirmed that MUC2022-055, MUC2022-057, MUC2022-099 (adjusted for status of patients), and MUC2022-113 (adjusted for age, sex, race, ethnicity) are all risk-adjusted. MUC2022-055 is stratified by race, ethnicity, and dual eligibility. The developers explored risk adjustment using social risk factors for MUC2022-099, but found that dually eligible residents tend to have better outcomes than non-duals; other adjustments did not seem to impact provider scores. The developer of MUC2022-055 and MUC2022-057 also clarified that these measures are not currently stratified by language, since there is no consistent source of information on language for Medicare Advantage patients.

MAP members discussed that stratifying rather than risk adjusting could be appropriate to clearly understand differences in performance; risk adjustment can be used as a helpful tool but can have unintended consequences, which may need to be addressed in payment structures rather than measure specifications themselves. A MAP member reiterated the importance of considering how stakeholders other than clinicians can help support improvements on these measures, as there may be opportunities to leverage other stakeholders to improve patient outcomes.

A MAP member asked whether risk adjustment fairly addresses differences in readmission due to refused treatment. The member shared an example from the COVID-19 pandemic, where Black patients were refused readmission to the hospital due to falsely high oximeter readings; risk adjustment would not fully capture that these patients were refused care due to faulty equipment. The developer shared that MUC2022-055 and MUC2022-057 are risk-adjusted for the patient's condition during initial admission only, not readmission, and overall hospital-wide readmission rates are higher for Black patients after risk adjustment, but acknowledged this is an interesting example of inequity in admissions that they will consider exploring in the future.

A MAP member asked if the measures in this group are already publicly reported, and if so in what form. Developers confirmed that MUC2022-055 and MUC2022-057 are expansions of existing precursor measures that are already in reporting programs; if these expansions are adopted into Hospital IQR, they would be reported publicly at the hospital level on Care Compare. The newly proposed hybrid mortality measure is in voluntary reporting now and will begin mandatory reporting in 2025. MUC2022-099 is not currently being reported. MUC2022-113 is publicly reported on Care Compare and is also used in the Nursing Home Five-Star Quality Rating System.

The member commented that, in general, that the method of reporting (e.g., confidential reporting to hospital versus public accountability) has equity implications. The member emphasized that public

accountability is important to get the resources to address problems, and discouraged stakeholders from holding data back from public reporting on the assumption that members of the public would be unable to interpret the data. The member also made a general comment that it is difficult to assess compound inequities by stratifying across multiple demographic categories and it could be methodologically challenging or impossible for some measures.

Structural (Hospital/Surgery) Measures

Ms. Perera introduced the structural (hospital/surgery) measures under consideration:

- **MUC2022-028:** ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) *(ASCQR)*
- **MUC2022-030:** Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) *(Hospital OQR)*
- **MUC2022-032:** Geriatrics Surgical Measure *(Hospital IQR)*
- **MUC2022-112:** Geriatrics Hospital Measure *(Hospital IQR)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant noted that a previous version of MUC2022-030 was included in the Hospital Outpatient Quality Reporting (OQR) Program but was removed in 2018 because the measure burden outweighed benefits to public reporting. The lead discussant raised that there is ongoing discussion regarding the use of volume as a proxy for quality, and expressed that MUC2022-030 should not be re-introduced if there is no evidence linking volume with quality. Another lead discussant expressed concerns regarding the use of volume as a proxy for quality and commented that public reporting of these measures could significantly impact health equity.

Regarding MUC2022-032 and -112, a lead discussant commented that these may pose an administrative burden and expressed that these measures do not appear to support health equity due to a paucity of research evidence. Another lead discussant also raised that this reporting burden could impact the quality of care for those patients not assessed by the measures and thereby lead to a health equity issue.

A lead discussant stated that systems-level measures, such as MUC2022-032 and -112, are a great approach to improve quality and avoid disparities. However, another lead discussant expressed that the Hospital Commitment to Health Equity measure adopted by CMS in August 2022 for calendar year (CY) 2023 more adequately assesses health equity, and questioned how MUC2022-032 and -112 would contribute to the measure set.

Regarding MUC2022-032 and -112, a measure developer commented that because older adults are a disadvantaged group, these measures seek to address equity of care for this group. The measure developer added that while these two measures address equity, further refinement may be needed to address other aspects of diversity within the older adult population. Another member of the measure developer team for MUC2022-032 and -112 clarified that within each domain of both measures, it states that hospitals agree to capture and stratify additional data related to race, gender, SES, and other SDOH. Another member of the measure developer team commented that the purpose of the measure group is to drive improvements in care by highlighting health inequities.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. MAP members

discussed MUC2022-028 and -030 as a pair, as well as MUC2022-032 and -112 as a pair.

MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (ASCQR) and MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (Hospital OQR)

For MUC2022-028 and -030, a MAP member asked if measure developers considered collecting patient demographic data in order to understand differences in receipt of care by setting (i.e., ambulatory surgical center [ASC] versus hospital outpatient department [HOPD]). The measure developer responded that these measures do not collect demographic data and instead, an aggregate count is collected.

Regarding the relationship between quality and volume, the measure developer commented that procedure-specific information is not publicly available at this time, and that these measures promote transparency and quality for consumers.

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

A MAP member questioned the helpfulness of MUC2022-032 and -112 as patient-facing measures when there are a multitude of surgery measures already in use. The MAP member noted that these MUCs include 12 different factors, which could confuse or misrepresent quality to consumers. The measure developer responded that the purpose of these two measures is to provide understandable measures for consumers that encompasses many aspects of care. Another measure developer commented that MUC2022-032 and -112 add to the set of outcomes measures. A MAP member commented that they were glad to see SDOH as one of the domains included in these measures, in addition to patient-centered goals.

A MAP member commented that the data burden imposed by MUC2022-032 and -112 may contribute to health inequities among facilities with fewer resources. The developer responded that the purpose of these measures is to incentivize facilities to achieve high quality of care without specifying the resources needed. Additionally, the measure developer added the measures assess aspects of care that are not resource intensive.

Finally, a MAP member commented that MUC2022-112 seems like an accreditation or certification process.

Rural Emergency Hospital Quality Reporting Program (REHQRP) Measures

Ms. Perera introduced the Rural Emergency Hospital Quality Reporting Program (REHQRP) measures under consideration:

- **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

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant noted that REHQRP is a newly established program; the Rural Emergency Hospital (REH) designation is a new provider type that will allow CMS to pay for emergency and hospital outpatient care in rural areas

starting in January 2023. Another lead discussant added that as opposed to CAHs which have a 72-hour maximum stay, REHs have a 24-hour maximum stay. A lead discussant noted that many of the measures in this group were previously in the Hospital OQR Program; a CMS representative confirmed that these measures are currently in the program and hospitals eligible to convert to REHs are already reporting data on these measures.

Discussants noted that MUC2022-066 and MUC2022-067 are strong measures but may discourage surgeons from operating on patients with higher risk for readmission; MUC2022-039 may be a function of provider characteristics or other aspects of the emergency department that are not directly linked to quality of care; and MUC2022-081 did not pass endorsement but addresses a potential equity concern of differential exposure to contrast materials and radiation (as was discussed with the Patient Safety measure group).

Dr. Angove opened the floor for MAP members to discuss the measure group. A MAP member agreed that MUC2022-066 could impact clinicians' willingness to perform procedures on certain populations, but noted that elderly patients are at higher risk for perforation and suggested that the measure could be framed as advancing equity by improving patient safety for this higher-risk group. The member also encouraged that this group of measures be stratified by race, ethnicity, and gender.

A MAP member asked for additional information on the factors used for risk adjustment of MUC2022-066 and MUC2022-067. A CMS representative shared that MUC2022-066, -067, and -081 are Medicare fee-for-service based and will be stratified by dual eligibility in confidential hospital reports; the developer added that MUC2022-066 adjusts for 16 variables (age categories, age categorized-arrhythmia interaction, twelve comorbidity variables, two surgical variables) and MUC2022-067 adjusts for age, comorbidities, body system operated on, and relative value unit of the procedure.

Cost Measures

Ms. Perera introduced the cost measures under consideration:

- **MUC2022-097:** Low Back Pain *(MIPS)*
- **MUC2022-100:** Emergency Medicine *(MIPS)*
- **MUC2022-101:** Depression *(MIPS)*
- **MUC2022-106:** Heart Failure *(MIPS)*
- **MUC2022-129:** Psychoses and Related Conditions *(MIPS)*

Dr. Angove opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. Lead discussants highlighted that by incentivizing providers to reduce costs, these measures could lead to the receipt of substandard quality of care for some sub-populations. A lead discussant commented that there may be a need to monitor for this concern, particularly among underserved populations.

A lead discussant added that whereas many existing MIPS measures focus on specific procedures or tests, the measures in this group focus on episodes of care, and noted this difference as positive. A lead discussant also noted that some of the measures adjust for provider specialty and expressed concern that this could mask differences in access to specialty care.

A lead discussant noted that only some of the measures in this group include social risk adjustment, and asked for justification from the measure developer. In response, the measure developer stated that the decision whether to perform social risk adjustment was based on a systematic approach that

determined if disparities in spending occurred due to patient-level or provider-level factors. The measure developer added that social risk adjustment was performed in instances where disparities in spending were attributable to patient-level factors.

Dr. Angove opened the floor for MAP members to discuss the measure group.

A MAP member expressed overall concern regarding MUC2022-129, stating that the measure could exacerbate health disparities due to a shortage of psychiatrists in the Medicare program. The measure developer responded that similar concerns were expressed when the measure was submitted in a previous MUC cycle. Since then, the measure developer commented that they made improvements to the measure by incorporating the input of clinical experts, professional societies, and patients and their families. The measure developer stated that the episode length has been reduced and that testing shows the measure is highly reliable at both the clinician-individual and clinician-group levels.

A MAP member asked why the measures assess costs incurred during an episode of care when the measures will be attributed to individual providers in the MIPS program. The developer responded that the costs captured by the measures in the group are those from downstream consequences, in addition to the initial episode of care. Another MAP member followed up to ask how the measures take into account downstream care costs. The measure developer responded that the measures assess costs incurred during the treatment and monitoring periods. The developer stated that these two periods vary by condition.

For MUC2022-097 and -101, a MAP member raised that some patients may not have access to certain health care services such as physical therapy or mental/behavioral health services. The MAP member asked the measure developer to clarify how the risk adjustment used in each measure accounts for this. The developer responded that all measures in the group use a standard risk adjustment that accounts for variables such as the hierarchical condition categories (HCCs); each measure then receives a measure-specific risk adjustment based on feedback from clinical experts, patients, and families. For MUC2022-097 and -101, the developer stated that testing data show that both rural and urban providers perform similar on cost (i.e., no systematic differences in performance were observed). The developer also added that adjustment for dual eligible status should prevent penalizing providers who disproportionately serve vulnerable patients.

For MUC2022-101 and -129, a MAP member asked if the measure developers observed differences by geographic location during testing. The measure developer responded that geographic variation was analyzed for both measures and that the availability of mental health services was studied specifically for MUC2022-129. The measure developer stated that no statistically significant differences were observed for either metric, and added that their data demonstrates that providers can perform well on both measures regardless of the patient population served.

A MAP member asked if MUC2022-129 captures all costs for dual enrollees. The measure developer responded that the measure only includes Medicare Parts A and B; no Medicaid costs are included.

Functional Outcome Measures

Ms. Perera introduced the functional outcome measures under consideration:

- **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)*

- **MUC2022-083:** Cross-Setting Discharge Function Score *(IRF QRP)*
- **MUC2022-085:** Cross-Setting Discharge Function Score *(HH QRP)*
- **MUC2022-086:** Cross-Setting Discharge Function Score *(SNF QRP, SNF VBP)*
- **MUC2022-087:** Cross-Setting Discharge Function Score *(LTCH QRP)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. A lead discussant highlighted that MUC2022-026 is risk-adjusted by mental health, health literacy, and total painful joint count; it is a rate of improvement rather than an average to avoid encouraging providers to solely treat patients with less severe symptoms. The lead discussant also noted that the preliminary analysis noted that this measure accounts for non-response bias but asked that the developer provide additional detail. The lead discussant noted that during last year's discussion of THA/TKA measures, the group noted that there could be disparities in access to these procedures, but these are not the focus of this particular measure. The discussant also noted that MUC2022-083, -085, -086, and -087 are risk-adjusted by setting and commented that one potential unintended consequence could be selective enrollment of patients with less severe symptoms. Another lead discussant concurred with these comments and added that they would like additional information on how the specific change in score thresholds were chosen for MUC2022-026, as well as whether there are any data collection challenges for MUC2022-083, -085, -086, and -087.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group. In response to the lead discussants' questions, the measure developer shared that the non-response adjustment for MUC2022-026 was developed with statistical experts and uses weighting with a propensity model that includes race and socioeconomic status, which are two factors known to be associated with non-response to patient-reported outcomes. The developer also shared that the specific change thresholds were established based on a literature review, specifically Stephen Lyman et al.'s development of the Hip Dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR.) and the Knee Injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR.) scores. These are anchored in patient satisfaction following a total hip or knee replacement, and represent patients' expectation of "substantial clinical benefit." A MAP member asked what type of patients were solicited to determine this range, and whether there could be a difference in expected change based on patient demographics; the developer shared that the patient population was similar to that from the original HOOS/KOOS, JR. work, but Lyman's work used a two-year follow-up period and the developer used a 10-14 month follow-up period.

A MAP member commented again that upstream of THA/TKA procedures, there may be other disparities that contribute to the types of patients who receive THA/TKA surgery. The developer noted that the population used in measure testing was reflective of the population that receives elective THA/TKA, but acknowledged that there are ongoing issues with access to these procedures for minority populations.

In response to a lead discussant's question, a CMS representative shared that MUC2022-083, -084, -086, and -087 are calculated using data that is collected across all setting assessment instruments; the representative also noted that these cross-setting discharge function score measures are mandated by CMS' Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

In response to a lead discussant's comment on potential unintended consequences of MUC2022-083, -084, -086, and -087, a developer noted that these measures' risk adjustment models (clinical covariates

common across settings, but adjusted to the items and considerations specific to each setting) can help prevent providers from selecting patients that will achieve higher scores. The measures are also constructed so that performance is not based on raw scores, but whether patients are meeting or exceeding expected scores.

Staffing Measure

Ms. Perera introduced the staffing measure under consideration:

- **MUC2022-126:** Total nursing staff turnover *(SNF VBP)*

Dr. Zephyrin opened the web meeting to allow for public comment. No public comments were offered.

Ms. Perera invited lead discussants to provide comments on the measure group. No comments were offered by lead discussants.

Dr. Zephyrin opened the floor for MAP members to discuss the measure group.

A MAP member raised that staffing shortages are especially prevalent in HCBS in addition to long-term care facilities. The MAP member expressed concern that health equity may be impacted based on how the measure is used and interpreted and expressed a desire for the measure to be stratified according to factors such as geography, race, and ethnicity. A CMS representative responded that CMS believes that this new measure can improve health equity by understanding where gaps in performance exist. A CMS representative acknowledged that while staffing shortages exist, facilities should strive to reduce staff turnover. The MAP member responded that the measure would help advance health equity.

Discussion of Broad Themes

Dr. Angove stated that the Advisory Group would now discuss the broad themes that emerged over the past two days. Dr. Angove explained that the goal of this discussion is to identify overarching health equity considerations that the Workgroups should consider, but not necessarily solve these issues.

NQF staff shared a preliminary list of themes noted over the past two days (below):

- Risk adjustment as a potential health equity issue
- EHR versus paper burden for smaller providers
- Workflow burden for smaller providers
- Difference in the burden of filling out surveys/etc. for providers serving patients with limited health literacy, limited English proficiency, etc.
- "Checklist" measures
- Data-intensive measures and reporting burdens
- Stratified reporting
- Measure use (public reporting versus internal use)
- Workforce considerations
- Accuracy and availability of underlying data

Dr. Angove opened the discussion to the Advisory Group and invited members to comment further on the themes that emerged throughout the two-day discussion.

A MAP member raised that the underlying data that are the basis for stratification are often incomplete or contain errors. The member suggested that the data collection and analysis efforts would benefit from national guidance.

A MAP member raised issues on workforce capacity. The member noted that because underserved populations face even greater barriers to accessing care, it is crucial to ensure that quality measures place as little burden on front-line clinicians as possible. A second MAP member expressed agreement. A third MAP member agreed and added that documentation requirements for all healthcare personnel have increased.

A MAP member commented that in addition to race, ethnicity, and dual eligibility status, there is a continued need to risk adjust for social risk factors despite a paucity of evidence. A second MAP member expressed agreement, while a third cautioned that not all measures should be risk-adjusted.

Regarding risk adjustment, a MAP member raised that there is a need to distinguish between whether a measure invites the promotion of health equity versus avoidance of certain populations. In order to promote health equity, the member emphasized that measures must be actionable for providers. Another MAP member suggested that in the future, the MUC submission should require measure developers to provide a more comprehensive explanation on their use of risk adjustment or lack thereof. Furthermore, a MAP member highlighted that standardization of reporting systems is needed to appropriately aggregate data for risk adjustment analyses.

A MAP member raised the impact of measure use on health equity (i.e., public reporting versus internal use for quality improvement). Similarly, another MAP member emphasized that the use of measures – not the measures themselves – determines their overall impact. Consequently, the member suggested the development of measure-use principles or "guardrails." A fourth MAP member agreed.

A MAP member commented that as part of the MUC submission, measure developers should disclose potential health equity concerns and suggest "guardrails" to prevent inequities. Furthermore, the member stated that developers should provide suggestions on the use and disuse of their measure. Another member agreed and commented that this approach would help prioritize health equity and create better measures.

Regarding patient reported outcomes (PROs), a MAP member raised the issue of representativeness (i.e., who is likely to respond and who is not likely to respond). Similarly, another member suggested that the MUC submission require measure developers to address how their measure engages persons with limited English proficiency and persons with disabilities. The member emphasized that this is especially important for PROs and survey-based measures, and that such persons would likely appreciate the opportunity to share their experience of care. Finally, the member added that if measure developers were to address representativeness in this manner, it could help limit burden imposed on providers.

A MAP member questioned when providers should receive data that suggest the existence of health disparities. Specifically, the member pointed to the example of MUC2022-057, which is not stratified by language since this data is not collected consistently among Medicare Advantage patients.

Two MAP members raised the issue of "checklist" measures (i.e., attestation measures) that do not initiate meaningful changes to quality of care. Similarly, another member expressed that measures such as MUC2022-039 which use volume as a proxy for quality seem to be "data for data's sake."

Dr. Angove asked MAP members to reflect on why provider burden can impact health equity. A MAP member commented that there is a greater burden placed on providers who serve patients who may require additional assistance completing surveys, including persons with low literacy and limited English proficiency. A second MAP member raised that smaller providers may experience more difficulty

implementing and collecting data for more complex measures due to fewer resources. Furthermore, a third MAP member pointed out that in addition to CAHs and REHs, safety net providers often have lower case volumes and may be disproportionately burdened due to limited resources.

A MAP member commented on the usefulness of stratified reporting data and suggested that measure developers provide MAP members with stratified national performance data in future MUC cycles. Another MAP member agreed and emphasized the general need for stratified reporting of data. The member noted that the verbal comments from measure developers regarding stratified data during the meeting were very helpful and requested that such information be included in written documents in the future.

A MAP member raised the use of managed care plans in addressing quality of care for Medicare and Medicaid patients. The MAP member commented that although there was no discussion of managed care plans during the meeting, this is a future area that MAP should explore.

Finally, a MAP member emphasized the need for a standard lexicon throughout the discussion and pointed out an earlier conversation on distinguishing between health-related social needs and SDOH.

Opportunity for Public Comment

Ms. Williams-Bader opened the web meeting to allow for public comment. At this time, one member of the public provided the following comments:

- The member of the public noted that burden for both the patient and the provider was a consistent theme throughout the discussion.
- The member of the public highlighted the ongoing discussion of stratification versus risk adjustment, and suggested that stratification should be used as the "default" in the presentation of information in order to promote transparency.
- The member of the public raised the issue of how measures are used (i.e., public reporting versus internal use) and commented that CMS should explore how payment can be leveraged to support social needs.
- The member of the public highlighted the ongoing discussion of upstream equity issues and suggested that complementary measures could be implemented to assess those patients who cannot seek care.
- The member of the public suggested that CMS make the public comment portal for written comments available sooner.

Next Steps

Ms. Williams-Bader shared the timeline of upcoming MAP activities, including the Rural Health Advisory Group Review Meeting (December 8-9), PAC/LTC Workgroup Review Meeting (December 12), Hospital Workgroup Review Meeting (December 13-14), and Clinician Workgroup Review Meeting (December 15-16). Ms. Williams-Bader noted that all meetings are open to the public and Health Equity Advisory Group members are welcome to attend. Ms. Williams-Bader shared that the second public commenting period on the MUC List 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. Finally, Ms. Williams-Bader directed members to the applicable MAP resources, including the MAP Health Equity Advisory Group webpage and Advisory Group email address (MAPHealthEquity@qualityforum.org).

Ms. Williams-Bader turned the meeting to the Advisory Group co-chairs and CMS colleagues for closing remarks. Dr. Zephyrin thanked the group for their insights and participation. Dr. Angove expressed appreciation for the group's professionalism and patience and thanked the NQF staff.

Dr. Wiggins expressed appreciation for the group's participation and emphasized that for care to be high-quality, it must be equitable. Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) and Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG) at CMS, thanked NQF staff, the Advisory Group co-chairs, and CMS contractors and staff. Dr. Schreiber noted that risk adjustment and stratification is an ongoing area of investigation at CMS and that CMS is working to expand organization-wide access to comprehensive, patient-level data. Finally, Dr. Schreiber expressed excitement for the upcoming MAP meetings.

Adjourn

Ms. Williams-Bader closed the meeting.

Appendix A: MAP Health Equity Advisory Group Attendance – Day One

The following members of the MAP Health Equity Advisory Group were in attendance on day one of the meeting on December 6th, 2022:

Organizational Members

- American Medical Association
- American Nurses Association
- America's Essential Hospitals
- Beth Israel Lahey Health
- Merative
- National Committee for Quality Assurance
- National Health Law Program
- Patient Safety Action Network
- The SCAN Foundation
- Vizient

Individual Subject Matter Experts

- Rebekah Angove, PhD
- Susannah Bernheim, MD, MHS
- Mark Friedberg, MD, MPP
- Jeff Huebner, MD
- Gerald Nebeker, PhD, FAAIDD
- Cardinale Smith, MD, PhD
- Melony Sorbero, PhD, MPH
- Jason Suh, MD
- Laurie Zephyrin, MD, MPH, MBA

Federal Liaisons

- Centers for Medicare & Medicaid Services
- Health Resources & Services Administration (HRSA)
- Veterans Health Administration (VHA)

Appendix B: MAP Health Equity Advisory Group Attendance – Day Two

The following members of the MAP Health Equity Advisory Group were in attendance on day two of the meeting on December 7, 2022:

Organizational Members

- American Medical Association
- America's Essential Hospitals
- Beth Israel Lahey Health
- Kentuckiana Health Collaborative
- Merative
- National Committee for Quality Assurance
- National Health Law Program
- Patient Safety Action Network
- The SCAN Foundation
- Vizient

Individual Subject Matter Experts

- Rebekah Angove, PhD
- Susannah Bernheim, MD, MHS
- Mark Friedberg, MD, MPP
- Jeff Huebner, MD
- Gerald Nebeker, PhD, FAAIDD
- Cardinale Smith, MD, PhD
- Melony Sorbero, PhD, MPH
- Jason Suh, MD
- Laurie Zephyrin, MD, MPH, MBA

Federal Liaisons

- Centers for Medicare & Medicaid Services (CMS)
- Health Resources & Services Administration (HRSA)
- Office of the National Coordinator for Health Information Technology (ONC)
- Veterans Health Administration (VHA)