NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Measure Applications Partnership Health Equity Advisory Group Virtual Review Meeting

The National Quality Forum (NQF) convened a public virtual meeting for members of the Measure Applications Partnership (MAP) Health Equity Advisory Group on December 9, 2021. There were 286 attendees at the meeting, including Advisory Group 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

Chelsea Lynch, NQF Director, welcomed participants to the web meeting and reviewed housekeeping reminders and the meeting agenda. Ms. Lynch introduced Tricia Elliott, NQF Senior Managing Director, and MAP Health Equity Advisory Group co-chairs, Dr. Rebekah Angove and Dr. Laurie Zephyrin, to provide opening remarks.

Ms. Lynch and Victoria Freire, NQF Analyst, facilitated introductions and disclosures of interest from members of the MAP Health Equity Advisory Group. 27 of 28 Advisory Group members were present (see Appendix A for detailed attendance). One Advisory Group member disclosed that their team was involved of the development of MUC2021-104, MUC2021-106, MUC2021-107, MUC2021-118, MUC2021-120, MUC2021-122, and recused themselves from discussion on these measures. Ms. Lynch reminded the Advisory Group that conflicts of interest should be declared during the meeting, and any undisclosed conflicts of interest or biased conduct can be reported to the co-chairs or NQF staff.

Ms. Lynch introduced the NQF team and Centers for Medicare & Medicaid Services (CMS) staff supporting the MAP Health Equity Advisory Group activities.

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director for Quality and Value at CMS, welcomed the Advisory Group to the meeting. Dr. Schreiber noted that the Health Equity Advisory Group is the first group to provide broad perspectives on health equity related to the Measures Under Consideration (MUC) List. Dr. Schreiber also emphasized the current administration's commitment to promote equity and enact programs that help reduce health disparities, which were highlighted during the COVID-19 pandemic. As part of this commitment, the administration continues to consider cross-governmental opportunities to enact permanent programs to facilitate lasting change. Dr. Schreiber shared that the Health Equity Advisory Group will review measures under consideration in a range of settings (clinician, hospital, and post-acute care/long-term care), and CMS looks forward to hearing any feedback or suggested action steps related to these measures. Dr. Schreiber also noted that many of the measure stewards were in attendance and available to answer questions during the meeting. Dr. Schreiber thanked the Advisory Group in advance for their input as part of this important initiative.

Overview of Pre-Rulemaking Approach

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

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

1. NQF staff describes the program in which the measure is being proposed.
2. The lead discussants will summarize the measure and offer initial thoughts about inclusion of the measure into the program.
3. Advisory Group discusses each measure and provides feedback on:
    - relative priority in terms of advancing health equity for all;
    - data collection and/or reporting challenges regarding health disparities;
    - methodological problems of calculating performance measures adjusting for health disparities; and
    - potential unintended consequences related to health disparities if the measure is included in specific programs.
4. Advisory Group takes a poll on the potential impact on health disparities if the measure is included within a specific program. The poll scores range from 1-5, or from negative impact/increasing disparities to positive impact/reducing disparities.
5. Advisory Group discusses gap areas in measurement relevant to health disparities and critical access hospitals.

Finally, Ms. Guo shared a list of suggested discussion questions for the Advisory Group:

1. What aspects of health equity do you see this measure advancing (culture, access, outcomes, etc.)?
2. What social determinants of health should be considered related to this measure?
3. If the measure includes stratification or risk adjustment, are there any concerns about how the measure is stratified or risk adjusted from a health equity lens? What additional information would be beneficial to include? If the measure does not include stratification or risk adjustment, what information would be beneficial to include?
4. Would it be beneficial to provide stratification when providing performance feedback for this measure?
5. In what ways could the measure exacerbate disparities or have unintended consequences?
6. What measurement gaps related to health disparities and critical access hospitals are present in the program?

Measures Under Consideration

Merit-Based Incentive Payment System (MIPS) Program Measures

Ms. Lynch shared that the Advisory Group would begin discussion with the measures under consideration for the Merit-Based Incentive Payment System (MIPS) program. Ms. Lynch shared that the MIPS program is a quality payment program with a pay-for-performance structure. MIPS includes independent scores in quality, interoperability, improvement, and cost categories, which are weighted and used to generate a final score used to adjust payment for eligible clinicians. MIPS is intended to improve patient outcomes for fee-for-service Medicare and reward innovative, high-value patient care.

MUC2021-125: Psoriasis – Improvement in Patient-Reported Itch Severity

MAP members noted that reporting on this measure requires collection of data from patients at two points (an initial visit and follow-up), and that high-risk populations who are lost to follow-up may be excluded from the measure calculation. This measure also addresses a condition that may be sensitive to social needs (e.g., populations with housing insecurity may be at elevated risk). In the chat, a MAP member shared there may be a stigma in some Black, Indigenous and People of Color (BIPOC) communities that psoriasis is a common disease that does not need to be managed. Additionally, MAP members noted performance on this measure may be better in populations with higher socioeconomic status (SES), based on ability to pay for specialized treatment.

A MAP member commented that psoriasis-related equity concerns are more severe at the diagnosis stage (psoriasis reported twice as often in White vs. Black or Latino populations, suggesting underdiagnosis), which is not addressed in this measure. CMS shared that this measure was submitted by the American Academy of Dermatology, who shared that this is an important dermatology measure as psoriasis affects 7.5 million patients in the United States.

MAP commented that stratification of this measure may be helpful to understand any existing disparities in performance. Suggested dimensions for stratification included race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and dual eligibility status for Medicare and Medicaid.

MAP members appreciated that this is a patient-reported measure but shared additional considerations for measures that require self-reporting. Patients with disabilities may have difficulty self-reporting on itch severity and a MAP member suggested that the measure might benefit from the option to collect input from a caregiver or parent. MAP members also commented that, in general, patient-reported outcome-based performance measure (PRO-PM) tools should also account for factors including language proficiency and health literacy. A MAP member noted that the tool may not translate well across languages and cultures, sharing an example from another tool (in Korean, a response to “Are you short of breath” might be “I feel tired”); other members agreed that the tool would need to be thoughtfully interpreted and responses should be monitored for potential bias.

MAP members asked whether the Advisory Group could recommend that measure developers provide additional equity-related data for consideration in the future (e.g., measure denominator prevalence across populations). CMS commented that the Advisory Group may have suggestions relevant to all measures (e.g., access concerns upstream of measure under consideration, general recommendations to stratify, general ‘best practices’ for PRO-PMs), and these could be discussed separately later in the day. Advisory Group members agreed with this approach.

The measure steward thanked the Advisory Group for their feedback and shared that they may consider adding the option for a proxy response. The steward also shared that the measure uses three tools that

assess itching, and at least one of these tools has been validated in different languages. The measure includes telehealth codes that could help reduce the burden of follow-up visits, mitigating any patients lost to follow-up. Finally, the steward is in the process of developing a complementary shared decision-making measure that will account for patient choice in determining the plan of treatment.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The poll used a range from 1-5, where a higher score indicates higher potential to improve health equity by reducing health disparities. The average score was 2.7, indicating that the Advisory Group was neutral on the impact on health disparities if this measure is used in MIPS. Additional details of the polling results for each measure under consideration can be found in Appendix B.

MUC2021-135: Dermatitis – Improvement in Patient-Reported Itch Severity

MAP noted that the specifications for MUC2021-135 are almost identical to those for MUC2021-125: Psoriasis – Improvement in Patient-Reported Itch Severity. MAP was in consensus that the concerns for this measure are similar to those discussed for MUC2021-125, although the denominator may be larger for dermatitis compared to psoriasis.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 2.8, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)

MAP members discussed that this is a patient-reported outcome, and that similar concerns as previously discussed (e.g., thoughtful translation to different languages, cultural context of the survey) apply. A member noted that age and cultural background could impact patient responses, as some patients might focus more on their experience with the provider (e.g., "my provider was friendly to me") rather than the outcome of the procedure (e.g., "my knee is still swelling"). Advisory Group members shared concerns that the measure may be intensive, as it requires pre-surgical and post-surgical assessments at two different time points, and high-risk patients who are lost to follow-up will not be included in the measure denominator. Members also asked whether the pre- and post-surveys are patient-centered and whether they include both clinical and non-clinical factors. The developer shared that during development and testing of both electronic and paper-based survey options, focus groups felt that the measure was low-burden and simple to calculate. The developer shared that they believe the measure will improve equity by increasing communication between the provider and patient, and will enhance patient engagement. A MAP member shared that there is potential for this measure to capture patient-specific values and goals related to post-surgical care, but its success will depend on implementation.

A MAP member flagged that there are already disparities by race and ethnicity in initial access to total hip arthroplasty (THA) and total knee arthroplasty (TKA), and that this measure could inadvertently foster unfair selection of patients who the clinician feels will be likely to perform better on the measure. MAP also discussed that the measure is risk adjusted by surgery type, age, gender, and body mass index, but is not risk adjusted or stratified by race, ethnicity, SES, or other factors. The developer shared that the PRO-PM was developed using CMS' guidelines for addressing health equity and needs of disadvantaged patient populations (e.g., guidelines for social risk factors), but quantitative testing around social determinants of health (SDOH) (e.g., race, ethnicity, level of education) did not identify any differences. MAP members noted that this may be related to the previous comment on access to elective procedures (patients with fewer resources for care are unable to access THA/TKA and are not reflected in the denominator for this measure).

An Advisory Group member asked for clarification on whether responses to polling should assume that the measures are stratified and risk adjusted based on Advisory Group recommendations. A co-chair clarified that the group should submit their poll responses based on the assumption that the measures will be used as they are presented without additional stratification or risk adjustment.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 2.6, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)

MAP members appreciated that this measure is a PRO-PM; however, members reiterated their comments on differential access to THA/TKA procedures previously shared during discussion of MUC2021-063. MAP also discussed that the burden of data collection would likely be distributed unevenly across practices, and could pose a greater burden for small practices in areas with limited resources. Members expressed concerns that this measure could encourage surgeons to select for more English-speaking, less socially disadvantaged patients to reduce burden for administering the survey for this measure. The developer shared that this measure assesses threshold level of improvement rather than post-operation status alone; this disincentivizes surgeons from avoiding treatment of patients with greater severity conditions or social risk factors. The developer noted that patients with greater severity (lower baseline score) have greater opportunity for improvement based on the threshold improvement being measured.

As with MUC2021-063, MAP suggested that stratification of this measure by dimensions including race, ethnicity, language, and SES could be helpful for understanding disparities. The developer shared that this measure's risk adjustment model includes social risk factors to account for concerns that non-White, dual-eligible, or low SES patients may have lower response rates.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 2.6, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

MUC2021-090: Kidney Health Evaluation

MAP discussed that glomerular filtration rate (GFR) measurements were previously calculated using separate thresholds (black vs. non-black GFR levels), although there is no medical basis to support this separation. These different thresholds resulted in the underdiagnosis of kidney disease in African American patients. The developer shared that reporting for MUC2021-090 will use a new Chronic Kidney Disease Epidemiology Collaboration estimated glomerular filtration rate (CKD-EPI eGFR) equation that does not include race as a factor.

Representatives from the National Kidney Foundation and American Society of Nephrology shared that removing race from eGFR calculations has been discussed over the past two years, and task force recommendations were released in the fall to recommend use of the race-less eGFR estimation equation. The National Kidney Foundation is working to implement this in all national partner labs.

The developer also highlighted that MUC2021-090 is based on both eGFR and urine albumin-creatinine ratio (uACR), as uACR measurements are underutilized. A member asked for clarification on if this measure is incentivizing laboratories to perform these tests in tandem; the developer shared that this

measure focuses on patients with diabetes (high risk of developing kidney disease) who have had both eGFR and uACR measured once in the 12-month period.

A member commented that if this measure is not already stratified, it would be helpful to stratify by race, ethnicity, language, and other demographics.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 4.2, indicating that the Advisory Group felt this measure has some potential for positive impact by decreasing health disparities.

MUC2021-127: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

MAP discussed that this measure addresses an important clinical area with low performance and disparities in levels of disease, complications, and treatment. MAP discussed that it is unclear if there are disparities in performance for this measure, and stratification may be required to understand any performance gaps. A developer shared that there are no current racial or ethnic disparities in angiotensin converting enzyme inhibitor (ACEI)/angiotensin receptor blocker (ARB) use according to National Health and Nutrition Examination Survey (NHANES) data; MAP members discussed that this could be due to lack of access, undertreatment, and underdiagnosis. The developer also shared that in Optum and Medicare Advantage, ACEI/ARB use may actually be higher in Black and Hispanic patients, but this population is not representative of the community at large. The developer also agreed that disparities persist related to chronic disease control and ability to receive care for low SES patients.

A MAP member raised concerns that this measure is burdensome, as it requires some detailed chart review to provide the information required for the measure calculation. This reporting burden may be more difficult for providers with fewer resources.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 3.1, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

MUC2021-105: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

MAP discussed that biomarker testing is a clinically important measure that is helpful for identifying patients who are responsive to certain immunotherapies. Members flagged that access to testing may be limited by factors including age, race, lack of insurance, dual eligibility, and geography, including distance from academic research centers. The developer agreed that access to testing is an issue but clarified that the measure focuses on pathologist recommendation of testing. The developer shared that the goal of the measure is for patients to be empowered to access their records and follow up with providers if testing is not performed ("my pathologist recommended that this testing be done, who can I follow up with to have this test ordered"), and that in the developer's experience, pathologists in small rural communities and critical access hospitals are building capacity for testing as this measure is introduced.

A MAP member asked whether the measure could disregard patients with lower health literacy or trouble accessing charts and portals. The member noted that the measure's focus on pathologist recommendation, rather than actual testing, could shift responsibility without actually improving outcomes for patients. The developer acknowledged this feedback and explained that the rationale was to avoid penalizing pathologists who work in areas with low access to testing.

A MAP member asked whether pathologist recommendations vary based on knowledge of patient demographics (e.g., race) or patient's comfort level with asking questions. The developer shared that pathologists rarely have access to demographic information in laboratory information systems, so this measure would look for pathologists to perform testing on all patients with the relevant diagnoses.

A MAP member suggested that stratification of the denominator could be helpful.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 2.7, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

MUC2021-058: Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors

MAP members commented that this patient safety measure likely applies to a very small denominator (testing data included 75 patients across seven sites in the reliability testing) and did not identify any major equity implications. A member noted that there is a lack of knowledge among most providers about appropriate management of immune checkpoint inhibitor toxicities and diarrhea, and asked whether the measure will improve outcomes or will penalize physicians in systems where this knowledge is less common. The developer shared that the measure is intended to increase awareness among providers and prescribers as use of immune checkpoint inhibitors increases in facilities outside of academic medical centers.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 3.4, indicating that the Advisory Group was neutral on the measure's impact on health disparities.

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Ms. Lynch shared that the Advisory Group would continue discussion by reviewing the measures under consideration for the Skilled Nursing Facility Quality Reporting Program (SNF QRP). Ms. Lynch noted that SNF QRP is a pay for reporting and public reporting program where skilled nursing facilities (SNFs) that do not submit required quality data will have their annual payment update reduced by two percent. The goal of this program is to increase transparency to help patients make informed choices.

MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel

MAP discussed that influenza vaccinations are a public health priority and noted Black and Indigenous populations have higher rates of hospitalization and death and lower rates of influenza vaccination. MAP discussed that vaccination among healthcare personnel is helpful for protecting patients.

MAP members asked for additional clarification on stratification and treatment of declinations in the numerator and denominator of the measure. The developer shared that the data reported to CMS are only for vaccination coverage, and declination is measured but not reported as part of compliance. Statistics on personnel who have received the vaccine, personnel with medical contraindications, and personnel who have declined the vaccine are all collected and included in the denominator, but only personnel who have received the vaccine count towards coverage in the numerator. The developer also shared that this measure is stratified by personnel type and stratified data is available to individual facilities. The Centers for Disease Control and Prevention (CDC) also publishes state-level influenza vaccination coverage data online, both overall and stratified by personnel type.

The Advisory Group was polled on the potential health equity impact if this measure is used in SNF QRP. The average score was 3.8, indicating that the Advisory Group felt there was some potential for this measure to have a positive impact by decreasing health disparities.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

Ms. Lynch shared the next program for discussion, the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program. SNF VBP is a value-based purchasing program that awards incentive payments to skilled nursing facilities based on improvement and achievement scores on an all-cause readmission measure. The all-cause readmission measure will eventually be replaced with a potentially preventable readmission measure. In addition, up to nine additional measures in topics including functional status, patient safety, care coordination, or patient experience may be applied for services after October 2023. The program is intended to reward value, outcomes, and innovations over volume.

MUC2021-095: CoreQ: Short Stay Discharge Measure

MAP discussed that this is a person-centered measure that incentivizes providers to improve patient satisfaction. Members flagged that, as with previously discussed PRO-PMs, there may be disparities in survey completion due to factors such as language barriers or payer type. However, the data collected in the surveys will help identify quality disparities within the SNF setting by race, ethnicity, etc. and can help inform quality improvement efforts. A MAP member noted that overall satisfaction results are more difficult to act on, compared to more specific questions, and that cultural background could impact patients' interpretation of "satisfaction."

MAP members flagged that the exclusion criteria for the measure could exclude vulnerable populations, including patients with a caregiver/guardian and patients with dementia. The exclusion criteria also include patients discharged to another facility, but transfers could be related to SES.

A MAP member asked whether the measure is risk-adjusted; another member clarified that this measure is not risk-adjusted.

The Advisory Group was polled on the potential health equity impact if this measure is used in SNF VBP. The average score was 3.0, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)

Before discussion, the measure developer provided a brief update from the materials that were originally provided to the Advisory Group. The developer shared that the previously circulated materials were from the measure's NQF endorsement submission in 2019, but these analyses have been updated using more recent data. The developer used several different approaches for the split sample reliability; reliability ranged from 0.78 to 0.88 regardless of approach, consistent with the level recorded during the original endorsement submission.

MAP discussed that reporting on this measure may be skewed based on geography, as discharge from facilities located in areas with lower resources may be affected based on factors such as availability of home health care, social services, food delivery services, etc. Members suggested that stratification by race, ethnicity, language, sexual orientation, gender identity, etc. could be helpful for identifying disparities. A member noted that the measure is stratified by dual eligibility status, but it is unclear if this was done at the population level or if any stratification was done within the nursing home. The developer shared that the measure excludes baseline nursing home residents, as they are likely to have discharges back to the nursing home. The developer also shared that this exclusion helped reduce the

difference in performance between dual eligible and non-dual eligible patients. The developer also shared that there are denominator exclusions for vulnerable subpopulations (e.g., discharges to psychiatric hospitals, disaster alternative care sites or federal hospitals, hospices). A member commented that the group should consider that these exclusions are also ignoring the care experience of vulnerable patients.

MAP members asked for additional detail on the risk adjustment model (social risk factors, including Agency for Healthcare Research and Quality [AHRQ] SES and intellectual or physical disability). The developer shared that SES was included in early testing of the measure. The developer also shared that during testing, non-White patients had slightly higher rates of expected discharge to the community after adjusting for other covariates (age, sex, clinical covariates). This suggests that risk adjusting for race and ethnicity could negatively impact non-White patients, so the developer decided not to use social risk factors in the measure's risk adjustment model.

A MAP member commented that ideally, this measure would not be risk adjusted based on social risk factors. The member commented that the overall goal is to understand the actual rates of discharge and factors that need to be addressed for successful discharge. Members commented that this measure has the potential to increase length of stay for patients.

The Advisory Group was polled on the potential health equity impact if this measure is used in SNF VBP. The average score was 2.9, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

MAP discussed that this measure could be helpful for consumers to identify facilities with higher rates of healthcare-associated infections (HAIs) and inform their healthcare choices. Some HAIs may be averted by increasing staffing, improving communication, or reducing bias, so this measure may serve as an indirect indicator of equity.

MAP members discussed that risk adjustment of HAI data could mask SNFs with poor performance and make the reported data unhelpful for consumers. Members also noted that clinicians in settings where a health problem is more prevalent should also be more equipped to deal with the health problem, especially for the captured population in nursing facilities. Members asked for clarification on the risk adjustment model, and whether it includes SDOH, race, or dual eligibility. The developer shared that the measure is adjusted for age, sex, and original reason for Medicare entitlement, but no other social risk factors (based on the rationale of not setting a lower standard based on social risk factors); other covariates include previous dialysis, previous intensive care unit (ICU) use, and clinical categories (e.g., certain types of surgery and inpatient stays). The developer shared that the measure is intended to strike a balance and highlight poor performance without undue penalization of facilities. MAP members noted that adjusting for age and sex could still pose an equity issue, and sex could be problematic for transgender or nonbinary individuals.

A member asked for further detail about how this measure would be used in the SNF VBP program if it were included. CMS shared that this measure would be included as part of the expanded SNF VBP program, which allows use of up to ten additional measures; if theoretically ten measures were included and all were equally weighted, this individual measure would make up 10% of the overall determination of a SNF's performance score. Based on facility performance, the facility could receive incentive payments that make up for two percent withholding of Medicare fee-for-service payments. The member

asked if the performance score is based on improvement or comparison to other facilities; CMS shared that both improvement and overall achievement are used as part of SNF scoring.

A member also asked whether both risk-adjusted and non-risk-adjusted performance are shared as part of public reporting. CMS shared that they currently publicly report measures that are risk-adjusted for clinical indications and publicly reporting non-risk-adjusted performance would have implications for all measures publicly reported to fairly compare performance.

The Advisory Group was polled on the potential health equity impact if this measure is used in SNF VBP. The average score was 2.9, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-137: Total Nursing Hours Per Resident Day

MAP agreed that the measure addresses an important and relevant topic, but noted that the supporting literature was focused on registered nurse (RN) hours and many SNFs are staffed mainly by licensed practical nurses (LPNs). MAP members noted that staffing remains an issue in SNFs, especially considering the ongoing COVID-19 pandemic. A developer shared that the average ratio of nurses to residents has not significantly increased during the pandemic, since the number of residents in facilities also reduced; a MAP member noted that resident acuity in SNFs remains high.

A MAP member suggested stratification by resident demographics. A member reiterated that this is an important measure to have a baseline to help understand any differences in nursing hours by race, ethnicity, and SES after adjusting for clinical need. Another member noted that communities of color are more concentrated in for-profit SNFs, which have, on average, lower nursing hours. The developer shared that the risk adjustment model for this measure is based on clinical needs only and does not include race, ethnicity, or SES; this is intended to incentivize nursing facilities to provide the appropriate level of care for all residents.

The Advisory Group was polled on the potential health equity impact if this measure is used in SNF VBP. The average score was 3.5, indicating that the Advisory Group felt there was some potential for this measure to have a positive impact by decreasing health disparities.

Cross-Cutting Measures, Part 1

Ms. Lynch shared that the Advisory Group would discuss measures that are being considered for use in multiple federal programs. Ms. Lynch noted that if the Advisory Group is in consensus, members can submit one poll on the measure and carry forward the polling results for all other programs where the measure is being considered.

MUC2021-136: Screening for Social Drivers of Health

MAP noted that this measure and the accompanying measure MUC2021-134 pose an opportunity to include measures explicitly addressing the need for screening and understanding SDOH. Members agreed that collecting this information is a critical first step towards understanding disparities and improving health equity.

MAP members asked for additional information on the standardization recommended within the measure to ensure nationwide screening is uniform. The developer responded that the measure itself would serve as the standard, as any tool used for reporting on this measure would need to align with the specifications and would need to map to the five Driver of Health domains included within the measure. The developer shared many clinics are already screening for SDOH, and once the measure is introduced, it will prompt conversation about the most effective tools to capture this information. A

federal liaison noted that it may be helpful to add social isolation to the list of determinants being considered, especially during the COVID-19 pandemic.

MAP members emphasized that standardization and clarity about the tools used for collecting the measure are critical:

- Clear, specific definitions (e.g., define "beneficiaries who are in the practice") are needed to prevent cherry-picking when reporting and ignoring patients who are not returning to the facilities
- Consistent methodology and wording for screening and documenting responses should be decided before implementing the measure, or data may not be comparable later. Patients may also be uncomfortable having this information documented in their health record.
- If used in an electronic health record (EHR): Federal data standards, aligning with existing standards (Health Level 7 [HL7] Gravity and United States Core Data for Interoperability [USCDI]), and use of SDOH Z codes

MAP members also asked whether the measure encourages screening for the sake of screening, or if it also includes follow-up (e.g., if a screening identifies a patient with food insecurity, are they connected with resources). Members discussed that there is harm to the provider-patient relationship if a provider asks and identifies a need but does not offer any resources. A member noted that there should be training in responding to individual needs as part of screening, with attention to cultural and linguistic needs. Another member noted that some communities may not have any resources available. Other members noted that it is difficult to obtain resources and funding without first collecting data to provide justification.

MAP discussed the resources required for this measure. A member flagged that the frequency of reporting (once, annually, every encounter) was unclear, and noted that SDOH can change rapidly due to treatment costs or personal situation (e.g., employment, childcare, transportation). Members also flagged that systems in areas with greater need may also have higher data collection burden, and that facilities may have difficulty implementing this measure due to varying information technology (IT) systems. The developer shared that thousands of practices are already screening for SDOH; this measure is important for recognizing and incentivizing these practices, as well as further understanding technology and workforce requirements. The developer shared that this measure was designed as a pay for reporting measure to start, but data from this measure can later inform appropriate performance targets and design of other measures around needs resolution and navigation.

Members flagged that it may be helpful to stratify and/or carefully consider how to handle specialty populations (e.g., patients with disabilities; cancer patients).

A member asked for additional information on validation of the measure; the developer shared that the measure was based on Accountable Health Community pilot data from CMS over a five-year period. The domains in the measure were validated both at the item level and the tool level, and had high reliability compared to other tools (Cohen's kappa statistics above 0.6).

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 4.3, indicating that the Advisory Group felt the measure had some potential for positive impact by decreasing health disparities.

The Advisory Group also considered the use of MUC2021-136 in the Hospital Inpatient Quality Reporting (IQR) Program. A member noted that this measure would likely be less burdensome at the hospital level, but patients are more likely to visit a smaller clinician practice instead. Members flagged that screening

may be more comfortable for patients at the clinician level as they may have a closer relationship with their primary care provider instead of a healthcare provider at hospital during an inpatient stay (patients may be scared to provide the information in case it affects the level of care they receive at the hospital, especially stressful if in hospital for an emergency). Other MAP members noted that these trust concerns could also be present with a primary care provider, and some patients might not have an established relationship with a provider and may only have contact with the healthcare system through the hospital. Members noted that screening at both levels could be helpful, especially if interoperable data is shared between providers for an understanding of prior results and actions.

A member expressed concern that safety net hospitals could be penalized or have increased burden compared to other hospitals that treat more privileged populations. Another member asked whether the developer has testing data at both clinician and hospital reporting levels. The developer shared that the measure has been tested in over 600 clinical settings, 40 percent of which are in hospital settings and 54 percent in primary care practices.

The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 4.1, indicating that the Advisory Group felt there was some potential for the measure to have positive impact by decreasing health disparities.

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

MAP members asked for clarification on interpretation of this measure (e.g., is identification of more patients with food insecurity interpreted as “better performance”?) The developer clarified that there are no benchmarks or standards currently set for this measure; performance is tied to whether the actual screen positive rate was reported, not the actual screen positive rate. A member commented that this measure would likely stay as pay for reporting in the future, since health systems would not be able to routinely reduce positive screens for given patients or populations.

A MAP member reiterated that it is important for this measure to use a standardized tool. The member commented that it is difficult to understand if the screening results are meaningful, reliable, and comparable without use of a standardized tool. A member also noted that facilities with more resources may disproportionally identify more needs. A member added that variability due to lack of standardization could have unintended consequences (e.g., results not comparable over time). The developer shared that as part of the testing performed on the measure, the results of screening were reported and used to help validate the measure.

A MAP member reiterated the importance of follow-up after a positive screening.

MAP members flagged that it is important to have more clarity on the intent and purpose of the measure. Providers may have concerns about unintended consequences of visibility to the public about the social needs of the patients they treat. The developer shared that the measure could help explain context for facilities that struggle with quality performance in other areas.

The Advisory Group was polled on the potential health equity impact if this measure is used in MIPS. The average score was 3.7, indicating that the Advisory Group felt there was some potential for this measure to have a positive impact by decreasing health disparities.

The Advisory Group then considered the measure for the Hospital IQR Program. An Advisory Group member asked for additional clarification on the structure of the MIPS program and the Hospital IQR Program, noting that their understanding was that CMS cannot use pay for performance measures, and each measure must have a score subject to public reporting. CMS clarified that MIPS is a pay for performance program, where each measure that is reported must have a score, and Hospital IQR

Program is a pay for reporting program where compliance would be based on if the information has been reported.

There were no additional program-specific comments. The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 3.7, indicating that the Advisory Group felt this measure had some potential to have a positive impact by decreasing health disparities.

MUC2021-084: Hospital Harm – Opioid-Related Adverse Events

MAP discussed that this measure is important for safety, especially as the opioid epidemic continues nationwide, but members were unclear on its implications for equity. One member noted concerns with potentially penalizing hospitals who treat patients who self-medicate (e.g., patients who also use heroin or other drugs). Another member noted that the measure might reinforce bias around opioid use for patients of color and could encourage clinical teams to overidentify symptoms as opioid-related adverse events instead of other medical conditions. This could also reduce prescription of opioids for patients of color, even when needed.

The Advisory Group was polled on the potential health equity impact if this measure is used in the Hospital IQR Program. The average score was 3.2, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

Ms. Lynch shared that MUC2021-084 is also being considered for the Medicare Promoting Interoperability Program for Hospitals. This is a pay for reporting and public reporting program, where eligible hospitals and critical access hospitals that fail to meet program requirements receive a 3/4 reduction of applicable percentage increase. This program is intended to promote interoperability using Certified Electronic Health Record Technology (CEHRT), improving patient and provider access to data.

The Advisory Group was polled on the potential health equity impact if this measure is used in Medicare Promoting Interoperability Program for Hospitals. The average score was 3.3, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

Medicare Parts C & D Star Ratings

Ms. Lynch shared that the next program with measures under consideration was Medicare Parts C & D Star Ratings. This is a quality payment and public reporting program. For Medicare Advantage, the incentive structure is public reporting with quality bonus payments, while stand-alone prescription drug plans have a public reporting incentive structure. The program is intended to provide information about plan quality to inform beneficiaries' choices, as well as incentivize high performing plans.

MUC2021-053: Concurrent Use of Opioids and Benzodiazepines (COB)

MAP discussed that it is important to understand use of opioids and benzodiazepines as it relates to minorities and underserved populations, and this measure could provide valuable data. MAP recommended that this measure be stratified to understand disparities. A MAP member flagged that while it is best practice to avoid concurrent prescriptions, there are still times where it is appropriate; the member noted that this measure could have the unintended consequence of reducing access to treatment, especially for non-White patients who are often undertreated for pain and anxiety.

The Advisory Group was polled on the potential health equity impact if this measure is used in Medicare Parts C & D Star Ratings. The average score was 2.9, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)

MAP discussed that this measure addresses a topic associated with burden among older adults. MAP noted that there is little information available about disparities in this area (e.g., impact of health literacy, language) and that stratifying this measure could be helpful to understand subpopulations that may be impacted by overuse of anticholinergic medications.

The Advisory Group was polled on the potential health equity impact if this measure is used in Medicare Parts C & D Star Ratings. The average score was 3.2, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

MAP discussed that, as with MUC2021-056, this measure could benefit from stratification. This measure excludes patients who were in hospice care and diagnosed with a seizure disorder, but members suggested stratification to understand the impact on patients with mental health diagnoses. A member also noted that this measure is related to risk of falls and could have an important impact on institutionalization for patients with disabilities; the member suggested that stratification by setting could also provide helpful information, as over-medication might be more common in certain settings. A member noted that this measure could also be associated with care coordination (communication, medication reconciliation, etc.)

The Advisory Group was polled on the potential health equity impact if this measure is used in Medicare Parts C & D Star Ratings. The average score was 3.2, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

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

Ms. Lynch shared that the next program under discussion was the End-Stage Renal Disease Quality Incentive Program (ESRD QIP). ESRD QIP is a pay for performance and public reporting program, which reduces payments to dialysis facilities on a sliding scale if they do not meet or exceed a required total performance score (maximum reduction of two percent). This program is intended to improve the quality of dialysis care.

MUC2021-101: Standardized Readmission Ratio (SRR) for Dialysis Facilities

MAP members noted that there are known disparities in kidney care and outcomes, and this measure addresses an important topic. However, the measure failed NQF endorsement due to concerns with validity. NQF's Scientific Methods Panel reviewed the measure and determined that the measure correlations were not adequate for the measure, and the All-Cause Admissions and Readmissions Standing Committee upheld the Scientific Methods Panel's decision. A MAP member commented that this is a chronically ill population that may be readmitted for a variety of reasons; another member commented that the measure excludes patients with more than 12 admissions per year.

A MAP member shared that the measure may encourage communication and shared accountability between dialysis facilities and hospitals to improve care coordination for patients. For example, a clinician might have many Spanish-speaking patients who go to a dialysis facility with no translators; implementing this measure could encourage the dialysis facility to hire additional Spanish speakers to improve communication and understanding of any issues that should be flagged at the hospital to reduce readmissions.

The Advisory Group was polled on the potential health equity impact if this measure is used in ESRD QIP. The average score was 3.4, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

Ms. Lynch shared that the next program under discussion was the Hospital Inpatient Quality Reporting Program (Hospital IQR). The Hospital IQR Program is a pay for reporting and public reporting program, where hospitals that do not participate or fail to meet program requirements receive a 1/4 reduction of the applicable percentage increase in their annual payment update. The program is intended to encourage payment for quality over quantity, and to provide consumers information so that they can make informed choices about their care.

MUC2021-106: Hospital Commitment to Health Equity

MAP noted that this is a structural measure that addresses important items including data collection, data elements, community engagement, and other organizational features that hospitals will need to attest to. MAP noted that, while they are evaluating the measure as-is, they would suggest future additions to the measure including items around data transparency, accessibility, and disability.

MAP members asked whether the data from this measure will eventually be compared to quality-of-care data. The developer shared that this measure is an initial attempt to understand if hospitals are currently performing best practices related to health equity (e.g., establishing an equity plan, collecting and stratifying data, evaluating leadership commitment over time), and to signal that this should be a priority for hospitals. The developer also shared that over time, they would consider adding items to the measure (e.g., educational components), but these would not be included in the initial version of the measure.

MAP members expressed concern that the items included in the measure are not actually linked to meaningful improvements in processes or outcomes, and that hospitals may report high levels of commitment/intent to promote to equity without taking any associated actions (e.g., changing hiring and governance processes, eliciting feedback from patient advisors, creating accessible facilities, hiring translators). A member noted that the measure does include a specific item on stratification by demographic and SDOH variables and use in hospital performance dashboards. The developer shared that they feel the elements set forth in the measure are specific enough to prompt hospitals to take further action. A member commented that this measure is unproven but could potentially improve equity.

MAP also discussed the need for standardized definitions for this measure, including clarity around defining "commitment" and collecting standardized demographic information for stratification.

The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 3.7, indicating that the Advisory Group felt this measure had some potential for positive impact by decreasing health disparities.

MUC2021-122: Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)

MAP discussed that this measure is risk-adjusted but is not adjusted for social factors such as the facility's proportion of patients with low SES. MAP suggested that stratification to identify disparities could be helpful, as well as considering whether the risk adjustment model should be updated to include social risk factors.

The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 3.3, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty (THA/TKA)

MAP discussed that this is a modified version of an existing cost of care measure. Members expressed concerns that lower cost of care could result from rationing of care, and that this measure could encourage underutilization if not tied to additional quality measures to understand context. Members also noted that under-resourced communities could perform poorly if access to home care and other services is limited and/or expensive.

MAP reiterated comments that primary THA/TKA is a primarily elective procedure and may be less accessible to disadvantaged patients. MAP also discussed that primary elective THA/TKA are increasingly likely to be performed in outpatient settings, with younger and healthier patients, so the type of patients who are still receiving THA/TKA procedures in the hospital inpatient setting may be affected.

The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 2.5, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

Ms. Lynch shared that the next program with measures under consideration was the Prospective Payment System-Exempt Cancer Hospital Quality Reporting (PCHQR) program. PCHQR is a voluntary quality reporting program that provides information on 11 cancer hospitals exempt from the Inpatient Prospective Payment System and Inpatient Quality Reporting Program. Data from PCHQR is published on Hospital Compare with the intent to encourage hospitals and clinicians to improve care and share information including best practices.

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

MAP discussed that this measure addresses an important topic. However, MAP noted that measures that restrict measurement based on sex or gender (e.g., "percentage of female patients") are exclusionary and do not include transgender or nonbinary patients despite relevance. This is a significant equity concern for this measure, as these populations are frequently left out of the healthcare system and transgender women are at higher risk of breast cancer than cisgender men.

MAP also noted that differential screening and diagnosis for breast cancer is a known disparity, with Black women 40 percent more likely to die from breast cancer than White women. It may be helpful to consider stratifying this measure by factors including race, ethnicity, education, insurance status, and federal poverty level.

MAP also noted that the definition of "appropriate treatment" lacks specificity and does not consider how treatment is influenced by costs and beneficiary needs and preferences. A member noted that the treatment landscape is changing, and this measure does not specify estrogen and progesterone receptor status, and while the measure may improve use of HER2 therapies it will impact a limited population.

A MAP member commented that since PCHQR is a voluntary reporting program, this measure may be vulnerable to biased reporting.

The Advisory Group was polled on the potential health equity impact if this measure is used in PCHQR. The average score was 2.5, indicating that the Advisory Group was neutral on this measure's impact on health disparities.

Cross-Cutting Measures, Part 2

MUC2021-104: Severe Obstetric Complications eCQM

MAP members discussed that this measure addresses an important clinical area, as rates of severe maternal morbidity are increasing over time in the United States. Racial disparities persist in maternal morbidity, with rates more than twice as high for non-Hispanic Black individuals compared to non-Hispanic White individuals; maternal morbidity is also higher in low-income neighborhoods. Members appreciated that the measure language was not restricted to females but included all pregnant patients.

MAP members suggested stratification of this measure by federal poverty level, race/ethnicity, and insurance status to identify and track disparities across different populations. Members also emphasized that this information is important to help identify opportunities for improvement (e.g., increasing access to prenatal care, improved communication, especially with people of color).

The Advisory Group was polled on the potential health equity impact if this measure is used in Hospital IQR Program. The average score was 4.4, indicating that the Advisory Group felt this measure had some potential for positive impact by decreasing health disparities.

Prior to discussing suitability of this measure for the Medicare Promoting Interoperability Program for Hospitals, CMS shared that this measure is included in this program because it is an electronic clinical quality measure (eCQM) and must be included as part of this program along with the Hospital IQR Program.

There were no program-specific comments. The Advisory Group was in consensus to move the polling results from Hospital IQR Program forward to the Promoting Interoperability program.

Remaining Measures

Ms. Lynch shared that, due to time constraints, polling for the remaining four measures would be conducted via online poll after the meeting. These measures and the programs they are being considered for are listed below, along with the average polling results received after the meeting and associated interpretation. Full voting information can be found in Appendix B.

- MUC2021-118: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
    - Hospital IQR Program: polling average was 3.1, indicating neutral impact on health disparities
    - Hospital VBP Program: polling average was 2.9, indicating neutral impact on health disparities
- MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital
    - Hospital IQR Program: polling average was 2.9, indicating neutral impact on health disparities
    - Hospital VBP Program: polling average was 3.2, indicating neutral impact on health disparities
- MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

    - Hospital-Acquired Condition Reduction Program (HACRP): polling average was 3.4, indicating neutral impact on health disparities
    - Hospital IQR Program: polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
    - Medicare Promoting Interoperability Program for Hospitals: polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
    - PCHQR: polling average was 3.6, indicating some potential for positive impact, or reducing health disparities
    - Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP): polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
    - Long-Term Care Hospital Quality Reporting Program (LTCH QRP): polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
    - SNF QRP: polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
- MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure
    - HACRP: polling average was 3.4, indicating neutral impact on health disparities
    - Hospital IQR Program: polling average was 3.5, indicating some potential for positive impact, or reducing health disparities
    - Medicare Promoting Interoperability Program for Hospitals: polling average was 3.2, indicating neutral impact on health disparities
    - PCHQR: polling average was 3.5, indicating some potential for positive impact, or reducing health disparities

Discussion of Overarching Equity Themes

Dr. Schreiber thanked the Advisory Group once more for their input on the measures under consideration, noting that the discussion will help inform the other MAP Workgroups and CMS when they consider the measure for rulemaking. Dr. Schreiber reminded the Advisory Group that many equity-related initiatives are being discussed across the government (e.g., broadband expansion, maternal safety initiatives to improve postpartum care). CMS hopes to encourage leadership commitment to equity by including it as a structural measure, with the understanding that the Advisory Group would prefer to include additional items in this measure.

Dr. Schreiber noted that the Advisory Group recommended stratification for almost all measures under consideration and asked for any input on recommended factors and methods for stratification. She also stated CMS is considering providing stratified reports on select measure performance for facility-level quality improvement efforts, as well as stratification by race, ethnicity, dual eligibility, area deprivation indices, and zip code. Additionally, CMS is considering use of a health equity system score as part of Medicare Stars. Dr. Schreiber also asked for input on best practices for reflecting cultural and language sensitivity in PRO-PMs, and suggestions for measuring access to care and identifying patients that have not been able to get into the care system. Finally, Dr. Schreiber shared that high-priority topic areas may include maternal health, mental health, kidney care, and sickle cell disease, but welcomed additional feedback.

The co-chairs asked whether there were any suggested changes or additions to a list of common themes and questions compiled during the day's discussion:

- Stratification – when and which measures should be stratified, suggested factors for stratification (SOGI, REL, etc.; inclusive categories; setting)

- Translation and validation of PRO-PM tools to minimize concerns regarding language, culture, response bias
- Which conditions should quality measures focus on?
- What patient populations are used for testing?
- How do we evaluate measures that address important topics, but are impacted by access issues upstream?
- Appropriate use of risk adjustment, and reporting of risk-adjusted vs. non-risk-adjusted data
- How to interpret cost-of-care measures

MAP agreed that equity needs to be considered throughout the process of measure development, rather than evaluated only at the end of testing and development. Intersectionality, or the overlap of multiple demographics, needs to be understood to assess disparities (e.g., BIPOC transgender women likely to have the worst health outcomes); an intersectional lens reflects a holistic, patient-centered view. It is also important to discuss health equity implications of exclusion criteria (who is being excluded, and why?) Members also noted that improving health equity will be an iterative process, and decisions should be made with the understanding that many measures will need to be fine-tuned over time; healthcare practices should start with a small number of equity initiatives and gradually grow from there.

MAP members discussed that prior to discussing stratification, CMS should provide clarification and support around the standardized collection and meaningful use of data for stratification. CMS shared that they are currently discussing what data to collect and when/how to collect it (to avoid patient burden), as well as standardization of data definitions to promote interoperability. USCDI and the Office of the National Coordinator for Health Information Technology (ONC)-ratified Gravity Project initiatives related to standardized data elements will likely become the definitions used by CMS. CMS has also identified the need to build trust with communities and patients before collecting this data due to distrust about how demographic data will be used.

MAP members also shared potential categories for stratification including age, sex, race, ethnicity, English proficiency, gender identity, sexual orientation, visit type, insurance, disability, markers of economic disparities (federal poverty level, ability to pay for care, work disruption, transportation), rurality, setting type, etc. MAP members agreed that the goal is not to stratify all measures by all of these categories (not an effective use of resources), but to stratify where appropriate (inform understanding of disparities, track gaps in care). CMS asked whether Advisory Group members were open to stratifying on items such as census tract, zip code, dual eligibility status, etc. that are readily available, before SDOH data collection has been established. A member suggested that the Behavioral Risk Factor Surveillance System (BRFSS) or the National Equity Atlas could be helpful in assessing population-level social needs. MAP members shared that they sometimes use the area deprivation index (ADI) or social vulnerability index (SVI) and these can be helpful, but these indices do not account for heterogeneity and are not a substitute for individual-level data. A member also shared that, in their experience, they see more consistent disparities based on disability status compared to dual eligibility status.

MAP members cautioned that stratification is a critical tool for investigating disparities, but further thought is required regarding incorporation of stratified results into payment programs (e.g., if you penalize systems based on gaps in care, providers may be incentivized to care for less diverse populations, ultimately reducing access; stratified reporting may pose challenges for low-volume providers, especially if measures are expressed as comparative outcomes or percentages). A member

flagged that the group should consider the equity implications of measures that take away funding from low-resource facilities.

Discussion on Review Process

Ms. Lynch asked the Advisory Group to share feedback on the process used to discuss health equity as it relates to the measures under consideration, as well as the methods for collecting and sharing discussion with the Workgroups (e.g., summary, polling question). Advisory Group members provided the following feedback.

The Advisory Group noted that inclusion of individual measures incurs opportunity cost (resources are used to implement one specific measure instead of its alternative). Since the current MAP Health Equity Advisory Group review process focuses on evaluation of individual measures, it does not allow the Advisory Group to holistically consider the measures and measure gaps across an entire program.

An Advisory Group member commented that it is difficult to separate the intended use vs. properties of a measure itself, and that almost any measure can be used in a way that improves or worsens equity. A MAP member suggested that measures are discussed more broadly for concerns and areas for awareness during implementation; two members agreed with this comment.

MAP members agreed that it would be helpful for developers to submit a summary of common equity-related considerations (e.g., performance stratified by common dimensions; developer-identified limitations of measures). CMS agreed that this information would be a helpful addition to the Measures Management System Blueprint.

A MAP member asked for clarification on whether the group should provide input on whether measures should be adjusted based on social risk; NQF clarified that currently, the group is intended to review the measures as they are provided by the developer.

MAP members shared that additional time between the release of the MUC list and the Health Equity Advisory Group meeting would be helpful, as members had limited time to review the measures. CMS shared that the MUC list is released on December 1 based on statute, and all Advisory Group and Workgroup meetings are scheduled prior to January when rulewriting begins, but they are open to considering other timeframes or meeting iteratively over the course of the year. Advisory Group members agreed that multiple meetings over the course of the year would be helpful and could help frontload some of the content (e.g., building familiarity with the programs).

A member shared that it could be helpful to include “mixed effects” and “not enough information to determine” options in the polling question.

Ms. Lynch thanked the Advisory Group for their input and welcomed any additional feedback via email.

Public Comment

Ms. Lynch opened the web meeting to allow for public comment. Four individuals offered public comments during this period.

One commenter shared strong support for measures MUC2021-136: Screening for Social Drivers of Health and MUC2021-134: Screen Positive Rate for Social Drivers of Health. The commenter shared that these measures are especially important given the Department of Health and Human Services’ commitment to health equity and the need for measurement and federal payment programs to reflect social and economic determinants of health. The commenter noted that there are no other patient-level

SDOH measures that are under consideration during this MAP cycle. The commenter shared that it is crucial to recognize providers who are performing SDOH screening to understand racial and ethnic disparities and encouraged the thoughtful staging and introduction of this measure.

Another commenter also shared support for MUC2021-134 and MUC2021-136. The commenter noted that this is the first time social drivers of health have been recognized in a CMS measure set, and that providers are frustrated by seeing issues that make it difficult for patients, especially patients of color, to achieve optimal health. This is especially burdensome for children and their caregivers. The commenter emphasized that screening helps providers identify these needs, and these measures under consideration will reward providers for screening and assessing positive screening rates. A phased approach will allow clinicians time to plan and build capacity for screening.

A commenter shared that many hospitals and health systems are not practiced in looking at stratified or disaggregated quality data, and that if CMS leads by implementing measures with these elements, hospitals and health systems will follow. The commenter also shared that providers should focus on performance gaps outside of stratifying (e.g., considering what percentage of the patient population is in the denominator, and what portion of the outcome they are responsible for). She encouraged the group to continue considering disaggregation of data and examination of gaps that lead to health inequities.

A commenter highlighted that the nation is focusing on improving equity, but stakeholders have few tools at their disposal. The commenter stated that no measure is perfect, so stakeholders should adopt some standardized measures with the understanding that these measures will evolve over time. The commenter shared support for MUC2021-134 and MUC2021-136, noting that it is important to screen for SDOH and to understand the results at a systems level to guide investment and priorities for quality improvement.

Next Steps

Ms. Freire shared that the initial public commenting period on the MUC list closes on December 9. The Health Equity Advisory Group's meeting will be followed by the setting-specific Workgroup meetings (Clinician, December 14; Hospital, December 15; PAC/LTC, December 16) and Coordinating Committee meeting (January 19, 2022). The second public commenting period on the MUC list will run from December 30, 2021 through January 13, 2022, and the final recommendations of the MAP will be submitted to CMS by February 1, 2022.

Ms. Lynch shared that the NQF staff will follow up with Advisory Group members via email with an offline survey to obtain polling results on the four measures that the Advisory Group was unable to discuss. Ms. Lynch thanked the group for their participation and thanked the co-chairs for their leadership and facilitation; the co-chairs thanked the Advisory Group and expressed excitement for future MAP Health Equity Advisory Group meetings.

Appendix A: MAP Health Equity Advisory Group Attendance

The following members of the MAP Health Equity Advisory Group were in attendance:

Organizational Members

- Aetna
- American Medical Association
- American Nurses Association
- American Society of Health-System Pharmacists
- America's Essential Hospitals
- Beth Israel Lahey Health
- Fenway Health
- IBM Watson
- Kentuckiana Health Collaborative
- National Committee for Quality Assurance
- National Health Law Program
- Patient Safety Action Network
- Planned Parenthood Federation of America
- The SCAN Foundation
- Vizient

Individual Subject Matter Experts

- Rebekah Angove, PhD
- Susannah Bernheim, MD, MHS
- Damien Cabezas, MPH, MSW
- Mark Friedberg, MD, MPP
- Jeff Huebner, MD
- Gerald Nebeker, PhD, FAAIDD
- J. Nwando Olayiwola, MD, MPH, FAAFP
- Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM
- Cardinale Smith, MD, PhD
- Melony Sorbero, PhD, MPH
- Jason Suh, MD
- Laurie Zephyrin, MD, MPH, MBA

Appendix B: Full Voting Results

Interpretation of the average voting scores is as follows:

- 1.0-1.4: Advisory Group felt there was **high potential for negative impact** by increasing health disparities if measure is used in program of interest.
- 1.5-2.4: Advisory Group felt there was **some potential for negative impact** by increasing health disparities if measure is used in program of interest.
- 2.5-3.4: Advisory Group was **neutral on impact** on health disparities if measure is used in program of interest.
- 3.5-4.4: Advisory Group felt there was **some potential for positive impact** by decreasing health disparities if measure is used in program of interest.
- 4.5-5.0: Advisory Group felt there was **high potential for positive impact** by decreasing health disparities if measure is used in program of interest.

Please note that the vote totals may vary due to changes in attendance over the course of the meeting.

Measure Name	Program	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total number of responses	Average vote
MUC2021-125: Psoriasis – Improvement in Patient-Reported Itch Severity	MIPS	0	11	7	4	0	22	2.7
MUC2021-135: Dermatitis – Improvement in Patient-Reported Itch Severity	MIPS	0	11	8	5	0	24	2.8
MUC2021-063: Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)	MIPS	2	9	9	4	0	24	2.6
MUC2021-107: Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)	MIPS	3	8	6	5	0	22	2.6
MUC2021-090: Kidney Health Evaluation	MIPS	0	0	2	15	8	25	4.2
MUC2021-127: Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	MIPS	0	5	10	7	0	22	3.1
MUC2021-105: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma	MIPS	1	8	10	2	1	22	2.7
MUC2021-058: Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors	MIPS	0	0	14	9	0	23	3.4

Measure Name	Program	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total number of responses	Average vote
MUC2021-053: Concurrent Use of Opioids and Benzodiazepines (COB)	Part C & D	0	6	10	4	0	20	2.9
MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)	Part C & D	0	2	14	4	1	21	3.2
MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)	Part C & D	0	2	13	7	0	22	3.2
MUC2021-101: Standardized Readmission Ratio (SRR) for Dialysis Facilities	ESRD QIP	0	2	9	10	0	21	3.4
MUC2021-106: Hospital Commitment to Health Equity	Hospital IQR Program	1	2	3	9	4	19	3.7
MUC2021-122: Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Hospital IQR Program	0	2	9	7	0	18	3.3
MUC2021-120: Hospital-Level, Risk-Standardized Payment Associated with an Episode of Care for Primary Elective Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Hospital IQR Program	0	11	7	1	0	19	2.5
MUC2021-091: Appropriate Treatment for Patients with Stage I (T1c) Through III HER2 Positive Breast Cancer	PCHQR	4	5	3	5	0	17	2.5
MUC2021-123: Influenza Vaccination Coverage Among Healthcare Personnel	SNF QRP	0	0	7	15	2	24	3.8
MUC2021-095: CoreQ: Short Stay Discharge Measure	SNF VBP	0	7	9	8	0	24	3.0
MUC2021-130: Discharge to Community-Post Acute Care Measure for Skilled Nursing Facilities (SNF)	SNF VBP	0	11	5	8	0	24	2.9
MUC2021-124: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization	SNF VBP	2	6	7	5	1	21	2.9
MUC2021-137: Total Nursing Hours Per Resident Day	SNF VBP	0	4	6	10	2	22	3.5
MUC2021-136: Screening for Social Drivers of Health	MIPS	0	1	1	12	10	24	4.3
MUC2021-136: Screening for Social Drivers of Health	Hospital IQR Program	0	2	3	9	10	24	4.1
MUC2021-134: Screen Positive Rate for Social Drivers of Health	MIPS	0	4	3	10	4	21	3.7
MUC2021-134: Screen Positive Rate for Social Drivers of Health	Hospital IQR Program	0	3	5	9	4	21	3.7
MUC2021-084: Hospital Harm – Opioid-Related Adverse Events	Hospital IQR Program	0	3	12	5	1	21	3.2

Measure Name	Program	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total number of responses	Average vote
MUC2021-084: Hospital Harm – Opioid-Related Adverse Events	Medicare Promoting Interoperability Program for Hospitals	0	1	16	5	1	23	3.3
MUC2021-118: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital IQR Program	0	4	6	6	0	16	3.1
MUC2021-118: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital VBP	0	7	3	6	0	16	2.9
MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital	Hospital IQR Program	0	7	4	6	0	17	2.9
MUC2021-131: Medicare Spending Per Beneficiary (MSPB) Hospital	Hospital VBP	0	4	6	7	0	17	3.2
MUC2021-104: Severe Obstetric Complications eCQM	Hospital IQR Program	0	0	0	12	7	19	4.4
MUC2021-104: Severe Obstetric Complications eCQM	Medicare Promoting Interoperability Program for Hospitals	0	0	0	12	7	19	4.4
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	HACRP	0	2	7	8	0	17	3.4
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	Hospital IQR Program	0	2	5	10	0	17	3.5
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	Medicare Promoting Interoperability Program for Hospitals	0	2	5	10	0	17	3.5
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	PCHQR	0	1	6	9	1	17	3.6

Measure Name	Program	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total number of responses	Average vote
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	IRF QRP	0	2	6	8	1	17	3.5
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	LTCH QRP	0	2	5	9	1	17	3.5
MUC2021-098: National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure	SNF QRP	0	2	5	9	1	17	3.5
MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	HACRP	0	2	6	9	0	17	3.4
MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	Hospital IQR Program	0	2	5	10	0	17	3.5
MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	Medicare Promoting Interoperability Program for Hospitals	0	3	7	7	0	17	3.2
MUC2021-100: National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure	PCHQR	0	1	6	10	0	17	3.5