NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Measure Applications Partnership Rural Health Workgroup Virtual Review Meeting

The National Quality Forum (NQF) convened a public virtual meeting for members of the Measure Applications Partnership (MAP) Rural Health Workgroup on January 6, 2021. There were 219 attendees at the meeting, including Workgroup members, NQF staff, government representatives, measure developers and stewards, and members of the public.

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

Chelsea Lynch, NQF Director, welcomed participants to the virtual meeting and reviewed housekeeping reminders, agenda, and objectives for the meeting:

- Review and provide input on measures under consideration for the MAP Clinician, MAP Hospital, and MAP Post-Acute Care/Long-Term Care (PAC/LTC) programs from the rural perspective
- Identify measure gaps for the MAP Clinician, MAP Hospital, and MAP PAC/LTC programs

Ms. Lynch also introduced the NQF team supporting the MAP Rural Health Workgroup activities.

Co-chairs Ira Moscovice and Aaron Garman; Michelle Schreiber, Deputy Director for Quality and Value at the Centers for Medicare and Medicaid Services (CMS); Chris Queram, Interim President and Chief Executive Officer of NQF; and Sheri Winsper, Senior Vice President of Quality Measurement at NQF also provided opening remarks.

Michael Haynie, NQF Senior Managing Director, facilitated introductions and disclosures of interest from members of the MAP Rural Health Workgroup. 20 of 25 Workgroup members were present (see Appendix A for detailed attendance). Ms. Haynie reminded the Workgroup 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.

Overview of Pre-Rulemaking Approach

Udara Perera, NQF Senior Manager, provided an overview of the role of the MAP Rural Health Workgroup in the pre-rulemaking process. The MAP Rural Health Workgroup is charged with providing rural perspectives on the measures under consideration to the setting-specific MAP Workgroups and Committees (MAP Clinician, MAP Hospital, MAP PAC/LTC, and MAP Coordinating Committees). The MAP Rural Health Workgroup also addresses priority rural health issues such as low case-volume.

Ms. Perera shared that the feedback from the MAP Rural Health Workgroup virtual review meeting will be provided to the setting-specific Workgroups by incorporating a qualitative summary and voting results on each measure's suitability for rural use into the preliminary analysis documents. Rural liaisons will also be present at the setting-specific Workgroup meetings on January 11 and January 12 and will represent the group's discussion.

Finally, Ms. Perera shared the process for discussing each measure under consideration:

1. NQF staff describes the program for which the measure is being proposed.
2. NQF staff summarizes the measure and lead discussants offer initial thoughts about inclusion of the measure into the program.
3. Workgroup discusses the measure regarding:
    a. Relative priority/utility in terms of access, cost, or quality issues encountered by rural residents;
    b. Data collection and/or reporting challenges for rural providers;
    c. Methodological problems of calculating performance measures for small rural facilities; and
    d. Potential unintended consequences of inclusion in specific programs.
4. Workgroup votes on agreement that the measure is suitable for use with rural providers within the specific program of interest (score from 1-5, where a 5 reflects agreement that the measure is highly suitable for the program)
5. Workgroup discusses gap areas in measurement relevant to rural residents/providers for the specific program

Ms. Lynch clarified that the voting results from the MAP Rural Health Workgroup will be considered by the setting-specific Workgroups during their discussion, but individual votes from the MAP Rural health Workgroup meeting will not be used in calculations for the setting-specific Workgroup voting. The setting-specific Workgroups will hold a separate vote later to make an overall recommendation on the suitability of the measures (support for rulemaking; conditional support; do not support with potential for mitigation; do not support). Ms. Lynch also asked if Workgroup members had any questions about the process before proceeding. No questions or comments were offered.

Measures Under Consideration

Clinician Programs – Merit-Based Incentive Payment System (MIPS)

Ms. Lynch shared that the Workgroup would begin discussion with the measures under consideration for Clinician programs. For 2020-2021, measures are being considered for use in the Merit-Based Incentive Payment System (MIPS) and the Medicare Shared Savings Program.

Ms. Lynch shared that the MIPS program is a quality payment program. The incentive structure is pay-for-performance and weights quality, interoperability, improvement, and cost categories 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.

MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure

Workgroup members noted that the topic of asthma and chronic obstructive pulmonary disease (COPD) was rural-relevant. However, cost of care for rural providers might exceed those in non-rural areas and access to tools for treating COPD (e.g., access to pulmonary rehabilitation teams, resources for smoking cessation programs) is limited in rural areas. Workgroup members also expressed concern that focusing on costs may result in lower-quality care and asked for further clarification on the definition of an episode.

Dr. Schreiber clarified that cost measures in MIPS are mandated as part of the MIPS statute. While CMS previously used broader categories, such as spending per beneficiary, they are trying to collect more specific information on particular types of care and specific physicians providing that care through the

use of episode-based measures. The measure developer shared that the measure is based on an episode group, which is defined as a unit of comparison that represents a clinically coherent set of medical services for a given condition. The episode group aggregates these items and services for a defined patient cohort to assess the total cost of their care. The measure developer also noted that the cost measures will be interpreted and paired with quality measures on the same conditions.

Workgroup members also asked whether the measure has language addressing the attribution of care by non-physician practitioners (e.g., physician assistants, nurse specialists). The measure developer shared that attribution for this measure is based on billing, and the measure is attributed to a clinician group that billed the trigger services, or an individual clinician within the group that billed 30% or more of the primary care evaluation and management (E&M) with asthma or COPD-related codes.

Workgroup members sought additional clarity on the definition of an asthma-COPD episode and asked whether voting should be postponed. Samuel Stolpe, NQF Senior Director, reminded the Workgroup that the setting-specific Workgroups will make an overall recommendation for the suitability of the measures during the January 11 and 12 meetings and if the MAP Rural Health Workgroup can provide their rural perspective (e.g., noting scarcity of specialists) and provide input on whether the measure is suitable for rural areas, the group can move forward with voting.

The Workgroup voted on the suitability of this measure for use with rural providers in MIPS using a range from 1-5, where a higher score indicates stronger agreement that the measure is suitable for rural providers. The average score was 3.1, indicating that the Workgroup was neutral on the suitability of the measure from a rural perspective.

MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure

Workgroup members shared that this measure might be less applicable for rural providers and low case-volume and measure reliability could be concerns. Again, cost of care in rural areas could be elevated due to limited resources, and measuring cost without pairing with quality measures could result in underutilization of care. Rural providers could also be penalized since cancers are typically identified in more advanced stages in rural settings.

A Workgroup member asked whether services for malignant conditions (e.g., chemotherapy and radiation) that are outside of the rural spectrum would be included in the measure calculation. The measure developer shared that these services are not included in the cost-of-care calculation. A comment was also shared on whether it would be appropriate to extend the 15-day pre-surgery period to 30 days. The developer shared that the measure was developed with input from surgeons who perform colon and rectal resection, who felt that the 15-day period was more appropriate than a 30- or 60-day period for capturing pre-operative testing.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.2, indicating that the Workgroup was neutral on the suitability of the measure from a rural perspective.

MUC20-0017: Diabetes Episode-Based Cost Measure

Workgroup members shared that diabetes was an important and high-priority, common condition for rural settings. Low case-volume seemed unlikely to be a challenge as testing was done with as few as 20 episodes. A Workgroup member also emphasized the importance of social determinants of health and social risk factors related to diabetes. Again, the Workgroup noted that cost of care could be elevated in rural areas and that the cost measures should be paired with quality measures.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a

4.1, indicating that the Workgroup agreed that the measure was suitable for use with rural providers in MIPS.

MUC20-0018: Melanoma Resection Episode-Based Cost Measure

Workgroup members shared that melanoma resection is a relevant and common procedure performed in rural areas with key opportunities for improvement. As with the other cost measures, rural providers may be more likely to exceed national average cost, and cost of care should be paired with quality measures to prevent underutilization.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.8, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in MIPS.

MUC20-0019: Sepsis Episode-Based Cost Measure

Workgroup members shared that a sepsis measure is relevant to rural providers, especially in internal medicine. The measure was noted to be more reliable for clinician groups instead of individual clinicians and might face challenges with lower case-volume in small critical access hospitals. A Workgroup member noted that if transfer costs are included in the cost of care, this could be a concern for rural providers. As with the other cost measures, rural providers could exceed the national average cost, and cost of care should be paired with quality measures.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.5, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in MIPS.

MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System

The Workgroup discussed that heart failure is a significant problem that contributes to admission rates in rural hospitals and is relevant to rural providers. A Workgroup member felt that extending this measure to clinicians from the Accountable Care Organization (ACO) level would make sense for rural providers.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.9, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in MIPS.

MUC20-0040: Intervention for Prediabetes

The Workgroup noted a few concerns with the measure, including the very specific interventions specified in the measure (e.g., recognized diabetes prevention program, referral to a medical nutrition therapy with a registered dietician) that could pose a significant barrier in the rural setting. However, the focus on prediabetes/diabetes is rural-relevant. A Workgroup member shared that implementation of the measure might incentivize providers to set up additional resources for prediabetic and diabetic patients.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.6, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in MIPS.

MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure

The Workgroup discussed that this measure is a patient-reported outcome-based performance

measure. A Workgroup member shared that this looks like a well-tested tool (similar to Consumer Assessment of Healthcare Providers and Systems, or CAHPS survey) but cautioned that it is more a tool than a performance measure, since it does not set a particular target or outcome. A Workgroup member also expressed concern over the wording of the tool, which focuses on physician providers, and noted that this could have the unintended consequence of not measuring the full mix of providers present in rural workforces.

The measure developer shared that the survey wording is based on patient input – while patients recognize the difference between provider types, they prefer to use catch-all words ("doctor" to refer to all clinician types). The developer also shared that there is one element of the measure that overlaps with the CAHPS survey, but the measure also assesses access, care coordination, comprehensiveness, and health goals.

A Workgroup member shared that they strongly support this measure as a rural family physician. They expressed that clinicians can control their performance on this measure, and the measure helps provide feedback on patients' perceived quality of care.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 4.2, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in MIPS.

MUC20-0043: Preventive Care and Wellness (Composite)

The Workgroup noted that this measure combines seven well-established preventive services. A Workgroup member shared that this would pose a low burden for data collection since it combines data from existing measures, and it could serve as a good "report card" summarizing performance for rural providers. A Workgroup member cautioned that aggregating these seven measures could make it more difficult to interpret the final score.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 3.9, indicating that the Workgroup agreed this measure was suitable for use with rural providers in MIPS.

Clinician Programs – Medicare Shared Savings Program

Ms. Lynch shared that the Medicare Shared Savings Program is a voluntary pay-for-performance program that encourages ACOs to coordinate high quality care for Medicare beneficiaries. As part of this program, ACOs report MIPS measures on behalf of clinicians and are scored under the MIPS Alternative Payment Model (APM) scoring standard; eligible clinicians may qualify for a 5% APM incentive payment.

MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions

Workgroup members shared that due to barriers to accessing acute and emergent care settings, rural providers might actually perform better on this measure than other providers. However, a Workgroup member noted that very few rural providers in their state are part of ACOs and provision of home-based care / home health services could be challenging for rural providers.

The Workgroup voted on the suitability of this measure for inclusion in the Medicare Shared Savings Program. The average score was a 3.4, indicating that the Workgroup indicating that the Workgroup was neutral on the suitability of the measure for use in the Medicare Shared Savings Program with rural providers.

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

Nicolette Mehas, NQF Director, shared that in the 2020-2021 pre-rulemaking cycle, measures are being considered for use in the hospital programs End-Stage Renal Disease Quality Incentive Program (ESRD QIP), Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs), Hospital Inpatient Quality Reporting Program (Hospital IQR Program), and Hospital Outpatient Quality Reporting Program (Hospital OQR Program). In addition, COVID-19/SARS-CoV-2 measures will be considered for several other hospital programs.

Dr. Mehas shared that ESRD QIP is a pay-for-performance and public reporting program. Dialysis facilities that do not meet required total performance scores have their payments reduced up to a maximum of 2.0% per year. The goal of the program is to improve the quality of dialysis care and produce better outcomes for beneficiaries.

MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)

The Workgroup discussed that the measure addresses both cost and quality and is unlikely to face low case-volume problems since it is measured at the facility level. The Workgroup also noted that the measure has been improved and can now capture Medicare Advantage beneficiaries. Multiple Workgroup members shared that they think this measure is appropriate for rural health.

The Workgroup voted on the suitability of this measure for inclusion in ESRD QIP. The average score was a 3.7, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in ESRD QIP.

Hospital Programs – Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)

Ms. Lynch shared that the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs) is a pay-for-reporting and public reporting program. In this program, eligible hospitals that fail to meet program requirements receive a three-fourths reduction of the applicable percentage increase. This program is intended to promote interoperability between EHRs and CMS data collection.

MUC20-0032: Global Malnutrition Composite Score

The Workgroup discussed that this measure is an important area of measurement, especially given the impact of COVID-19, food deserts, and other issues. One Workgroup member felt that the measure was achievable in rural hospitals, but another Workgroup member expressed concerns over possible low case-volume (denominator is people over 65 with acute inpatient stays).

The Workgroup voted on the suitability of this measure for inclusion in the Promoting Interoperability program. The average score was a 3.9, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in the Promoting Interoperability program.

Hospital Programs – Hospital Inpatient Quality Reporting Program (Hospital IQR Program)

Dr. Mehas shared that the Hospital IQR Program is a pay-for-reporting and public reporting program. Hospitals that do not participate or fail to meet program requirements receive a one-fourth reduction of the applicable percentage increase in their annual payment update. The program is intended to shift towards paying providers based on quality rather than quantity, as well as provide consumers information about hospital quality to guide their choices about their care.

MUC20-0032: Global Malnutrition Composite Score

A Workgroup member asked for clarification on how this measure will be tied into hospital payments.

Dr. Schreiber clarified that CMS usually introduces new measures into the Hospital IQR program before they are used in more payment-oriented programs such as Hospital Value-Based Purchasing, and that this measure will be used more in the Hospital IQR program but is also listed in Promoting Interoperability for alignment of electronic clinical quality measure (eCQM) sets across programs. A Workgroup member shared that they are in favor of electronic measures for ease of data collection and felt that it was appropriate to include this measure in Hospital IQR for alignment.

The Workgroup voted on the suitability of this measure for inclusion in the Hospital IQR program. The average score was a 3.8, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in the Hospital IQR program.

MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)

The Workgroup discussed that total hip and total knee arthroplasties are the most common orthopedic surgeries. A Workgroup member shared that since these procedures are more commonly shifting towards outpatient and ambulatory services, the threshold of 25 cases might become more of a problem over time as inpatient volume decreases. Dr. Schreiber noted that CMS may consider extending this measure to the Ambulatory Surgical Center Quality Reporting (ASCQR) Program in future. The Workgroup member shared that this would be helpful, but urged CMS to consider expanding to other programs as rural settings are less likely to have outpatient rural surgery centers.

The Workgroup voted on the suitability of this measure for inclusion in the Hospital IQR program. The average score was a 3.1, indicating that the Workgroup was neutral on the suitability of the measure from a rural perspective.

Hospital Programs – Hospital Outpatient Quality Reporting Program (Hospital OQR Program)

Ms. Lynch shared that the Hospital OQR program is a pay-for-reporting and public reporting program. In this program, hospitals that do not report data on the required measures receive a 2.0% reduction in their annual payment update. The Hospital OQR program is intended to provide consumers with information on quality of care to help inform their healthcare decisions, as well as establish a system for collecting and providing quality data to hospitals providing outpatient services.

MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

The Workgroup discussed concerns over the treatment criteria (90-minute time to appropriate treatment from arrival at emergency department) and its reliability and achievability in rural settings due to transportation issues. The measure developer clarified that the measure accounts for different treatment modalities; if the facility is an on-site facility that can perform percutaneous coronary intervention (PCI) the measure is based on PCI treatment, but otherwise fibrinolysis or transfer to a hospital that provides PCI is measured for providers.

The Workgroup voted on the suitability of this measure for inclusion in the Hospital OQR program. The average score was a 3.9, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in the Hospital OQR Program.

MUC20-0005: Breast Screening Recall Rates

The Workgroup discussed that this is an important issue and is unlikely to face low case-volume challenges. However, the measure does not use benchmarks based on a specific clinical guideline. Another Workgroup member commented that the measure is more related to radiology rather than

primary care (as many rural providers may be referring to another group to perform mammograms).

The Workgroup voted on the suitability of this measure for inclusion in the Hospital OQR program. The average score was a 3.4, indicating that the Workgroup was neutral on the suitability of this measure for use with rural providers in the Hospital OQR Program.

PAC/LTC Programs – Hospice Quality Reporting Program (HQRP)

Dr. Mehas shared that the HQRP is a pay-for-reporting and public reporting program. In this program, hospices that do not submit quality data will have their annual payment update reduced by 2% through FY2023 and 4% afterwards. This program is intended to improve pain and system management for hospice patients, providing more patient-centered care in the home environment.

MUC20-0030: Hospice Care Index

The Workgroup discussed that there is more limited access to hospice facilities in rural areas and asked for additional information on testing data and reportability. The measure developer shared that during testing, scores on this measure were similar for rural and urban hospice facilities, and that 85-87% of hospices still met the minimum threshold for reporting on the measure.

The Workgroup voted on the suitability of this measure for inclusion in the HQRP. The average score was a 3.6, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in the HQRP.

PAC/LTC Programs – Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Ms. Lynch shared that the SNF QRP is a pay-for-reporting and public reporting program. In the program, skilled nursing facilities that do not submit required quality data will have their annual payment update reduced by 2%. The program is intended to increase transparency for patients.

MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization

The Workgroup discussed that the topic of reducing healthcare-associated infections in skilled nursing facilities is important. 86% of skilled nursing facilities meet the reporting threshold for 25 cases; while a breakdown of reporting from rural vs. urban providers was not provided, the group did not express concerns over low case-volume. A Workgroup member also shared that since SNF QRP is a pay-for-reporting program, it will allow providers to gain experience without being penalized for performance.

The Workgroup voted on the suitability of this measure for inclusion in the SNF QRP. The average score was a 3.9, indicating that the Workgroup agreed that this measure was suitable for use with rural providers in the SNF QRP.

CMS Presentation on COVID-19 Measures

Ms. Winsper provided introductory remarks for context on NQF's recommendations on the COVID-19 measures. While NQF supports appropriate vaccination for all kinds of illnesses, NQF did not have enough evidence to evaluate how the administration of the COVID-19 vaccines should be measured. In order to maintain the integrity of criteria used to evaluate all of the measures considered during pre-rulemaking, NQF followed the recommendation algorithm, resulting in a preliminary "do not support with mitigation" recommendation. NQF asks that the Workgroup focus on providing feedback to CMS on whether the proposed measures are the best way to evaluate administration of COVID-19 vaccines or if any adjustments are recommended.

Dr. Schreiber also shared the rationale for putting forth the COVID-19 vaccination measures during the 2020-2021 pre-rulemaking cycle. The COVID-19 measures are different from the other measures being

put forth today because testing data on validity and reliability do not exist yet. Despite this, CMS would like to include these measures in programs as soon as possible due to the public health importance of COVID-19 vaccines. However, the measures cannot be included in programs without moving them through the MAP and collecting comments from the Workgroups and from the public, and waiting for the next MAP cycle would introduce another year of delay.

Dr. Schreiber shared that CMS is bringing forward several COVID-19 vaccination measures for consideration, including a measure on vaccination coverage for staff in hospitals, inpatient rehabilitation facilities, etc.; vaccination coverage for patients in ESRD facilities; and vaccination of patients measured at the clinician level. These measures are being developed in cooperation with the Centers for Disease Control and Prevention (CDC). Additional measures on vaccination in SNFs and for patients in hospital settings are not being brought forth at this time because of challenges for data collection and possible contraindications for hospitalized patients.

Alan Levitt, Medical Officer for the Division of Chronic and Post-Acute Care at the Center for Clinical Standards and Quality at CMS, provided descriptions of MUC20-0044: SARS-CoV-2 Vaccination Coverage Among Healthcare Personnel and MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in ESRD Facilities. Dr. Levitt noted similarities to NQF #0431: Influenza Vaccination Coverage Among Healthcare Personnel for these measures. Dr. Schreiber also provided an overview of MUC20-0045: SARS-CoV-2 Vaccination by Clinicians, noting that these measures are designed to be flexible as approved vaccines and guidelines may change before implementation.

The Workgroup did not have any questions or comments on the COVID-19 measures presentation.

COVID-19 Measures Under Consideration

MUC20-0045: CoV-2 Vaccination by Clinicians

The Workgroup discussed that they would feel comfortable using this measure for rural populations after the COVID-19 vaccine has passed emergency use authorization and has received full approval from the Food and Drug Administration (FDA). A Workgroup member shared that the group's concerns about measure validity (e.g., whether the measure can gain endorsement) will be addressed by the broader measurement community, but the Workgroup should specifically provide input if there are certain rural-specific measurement difficulties. The Workgroup shared that the measure was important in rural communities and could encourage distribution and tracking of vaccine distribution in rural communities, and noted that supply chain problems would be resolved by 2022 when the measure would be implemented.

A Workgroup member noted that there is a high degree of pushback on COVID-19 and vaccinations from some patients in rural communities, which might reduce vaccination rates. The measure developer shared that they hope to collect information on who has refused the vaccine, but do not want to penalize clinicians for patient refusals. Therefore, the measure includes exceptions for contraindications and for patient refusal.

The Workgroup voted on the suitability of this measure for inclusion in MIPS. The average score was a 4.0, indicating that the Workgroup agreed that the measure was suitable for use with rural providers in MIPS.

MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities

The Workgroup agreed that patients with ESRD are a high-priority group that should be vaccinated and

it seemed appropriate to measure vaccination in these patients. The Workgroup did not identify any rural-specific problems or disadvantages for rural providers taking the previous measure exclusions into consideration. A Workgroup member asked for clarification on whether this measure would be applied to rural patients visiting any ESRD facility, any patients visiting a rurally-located ESRD facility, or only rural patients in rurally-located ESRD facilities. Another Workgroup member shared that ESRD networks often report on both options together, including both rural patients getting treatment outside the community and rural facilities that provide dialysis to patients in the community.

The Workgroup voted on the suitability of this measure for inclusion in ESRD QIP. The average score was a 4.2, indicating that the Workgroup agreed that the measure was suitable for use with rural providers in ESRD QIP.

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel

The Workgroup agreed that this was an important measure. A Workgroup member noted that many ESRD facilities may have employees that work at multiple facilities, and asked whether the measure accounts for workers who are vaccinated at one facility but also work in another facility. The measure developer shared that the specifications include "vaccination at this facility or elsewhere," so vaccination at another facility would be accounted for in measurement.

The Workgroup voted on the suitability of this measure for inclusion in ESRD QIP. The average score was a 4.1, indicating that the Workgroup agreed that the measure was suitable for use with rural providers in ESRD QIP. The Workgroup was also in consensus to move these voting results forward for the ASCQR, Hospital OQR Program, Hospital IQR Program, Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), Long-Term Care Hospital Quality Reporting Program (LTCH QRP), and SNF QRP. One Workgroup member shared that they liked that ASCQR is pay-for-reporting rather than pay-for-performance, but there were no additional program-specific comments.

Public Comment

Dr. Moscovice and Dr. Garman opened the virtual meeting to allow for public comment.

A member of the public commented that they had concerns about the 15-day pre-surgery period for MUC2020-0016: Colon and Rectal Resection Episode-Based Cost Measure. They stated that this period was too short for the rural setting, and shared that a 30-day window would be more reasonable. The member also commented that they were happy to see patient-reported outcome measures represented in the measures under consideration this year and expressed the importance of recruiting patients and patient advocates to participate in the Workgroup in the coming years.

Ms. Lynch asked whether the Workgroup had any input on measurement gaps in the CMS programs that should be discussed. A Workgroup member re-emphasized that there are gaps in specialist areas including prediabetic education/nutrition and pulmonary rehabilitation in rural communities, but noted that video visits have helped recently helped reduce this gap. However, the Workgroup member did not have a specific CMS program in mind that should address this gap.

A Workgroup member thanked CMS and NQF for reviewing the measures under consideration and expressed that the measures from this cycle were more rural-relevant than measures that have been brought forward in the past.

Next Steps

Amy Guo, NQF Analyst, shared next steps for the MAP work. Ms. Guo noted that the MAP Rural Health Workgroup has completed meetings for the 2020-2021 cycle. Feedback from the review meeting will be integrated into the preliminary analysis documents that will be circulated with the MAP Clinician, MAP Hospital, and MAP PAC/LTC Workgroups prior to their meetings on January 11 and 12. Liaisons from the MAP Rural Health Workgroup will also be present at these meetings to represent the group's discussion. The Coordinating Committee will meet to discuss and finalize recommendations on January 25. The final recommendations of the MAP will be sent to CMS by February 1, and NQF will also release a report in March summarizing the 2020-2021 pre-rulemaking recommendations.

The co-chairs thanked the group for their thoughtful discussion and expressed their interest in working with the MAP Rural Health Workgroup again in the future. CMS thanked the Workgroup for their time and careful consideration of the measures, noted that they would further consider the points raised during discussion, and thanked NQF staff for organizing the meeting. NQF thanked the Workgroup for their time and participation and thanked CMS for their partnership.

Appendix A: MAP Rural Health Workgroup Attendance

The following members of the MAP Rural Health Workgroup were in attendance:

Organizational Members

- Alliant Health Solutions
- American Academy of Family Physicians
- American Academy of Physician Assistants
- American Hospital Association
- American Society of Health-System Pharmacists
- Geisinger Health
- Intermountain Healthcare
- Michigan Center for Rural Health
- Minnesota Community Measurement
- National Rural Health Association
- National Rural Letter Carriers' Association
- RUPRI Center for Rural Health Policy Analysis
- Rural Wisconsin Health Cooperative
- Truven Health Analytics LLC/IBM Watson Health Company

Individual Subject Matter Experts

- Michael Fadden, MD
- John Gale, MS
- Aaron Garman, MD
- Ira Moscovice, PhD
- Jessica Schumacher, PhD
- Ana Verzone, MS, APRN, FNP, CNM

Appendix B: Full Voting Results

Interpretation of the average voting scores is as follows:

- 1.0-1.4: Workgroup **strongly disagreed** that measure was suitable for use with rural providers in program of interest.
- 1.5-2.4: Workgroup **disagreed** that measure was suitable for use with rural providers in program of interest.
- 2.5-3.4: Workgroup was **neutral** on whether the measure was suitable for use with rural providers in program of interest.
- 3.5-4.4: Workgroup **agreed** that measure was suitable for use with rural providers in program of interest.
- 4.5-5.0: Workgroup **strongly agreed** that measure was suitable for use with rural providers in program of interest.

Measure Name	Program	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Total number of votes	Average vote
MUC20-0015: Asthma-Chronic Obstructive Pulmonary Disease (COPD) Episode-Based Cost Measure	MIPS	1	5	5	7	1	19	3.1
MUC20-0016: Colon and Rectal Resection Episode-Based Cost Measure	MIPS	0	6	5	7	1	19	3.2
MUC20-0017: Diabetes Episode-Based Cost Measure	MIPS	0	1	1	13	4	19	4.1
MUC20-0018: Melanoma Resection Episode-Based Cost Measure	MIPS	0	0	4	12	1	17	3.8
MUC20-0019: Sepsis Episode-Based Cost Measure	MIPS	0	2	5	12	0	19	3.5
MUC20-0034: Risk-Standardized Acute Unplanned Cardiovascular-Related Admission Rates for Patients with Heart Failure for the Merit-based Incentive Payment System	MIPS	0	0	1	18	0	19	3.9
MUC20-0040: Intervention for Prediabetes	MIPS	1	3	0	12	2	18	3.6
MUC20-0042: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure	MIPS	0	1	2	8	7	18	4.2
MUC20-0043: Preventive Care and Wellness (Composite)	MIPS	0	2	1	13	3	19	3.9
MUC20-0033: ACO-Level Days at Home for Patients with Complex, Chronic Conditions	Medicare Shared Savings Program	1	1	5	9	0	16	3.4
MUC20-0039: Standardized Hospitalization Ratio for Dialysis Facilities (SHR)	ESRD QIP	0	3	1	11	2	17	3.7

MUC20-0032: Global Malnutrition Composite Score	Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs) Measures	0	0	2	14	0	16	3.9
MUC20-0032: Global Malnutrition Composite Score	Hospital IQR Program	0	1	2	14	1	18	3.8
MUC20-0003: Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	Hospital IQR Program	0	4	8	6	0	18	3.1
MUC20-0004: Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)	Hospital OQR Program	0	0	4	10	3	17	3.9
MUC20-0005: Breast Screening Recall Rates	Hospital OQR Program	1	2	6	9	1	19	3.4
MUC20-0030: Hospice Care Index	HQRP	0	1	5	13	0	19	3.6
MUC20-0002: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization	SNF QRP	1	0	0	15	2	18	3.9
MUC20-0045: CoV-2 Vaccination by Clinicians	MIPS	0	1	1	11	3	16	4.0
MUC20-0048: SARS-CoV-2 Vaccination Coverage for Patients in End-Stage Renal Disease (ESRD) Facilities	ESRD QIP	0	0	1	11	4	16	4.2
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	ESRD QIP	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	ASCQR	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	Hospital OQR Program	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	Hospital IQR Program	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	IPFQR	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	PCHQR	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	IRF QRP	0	0	2	12	3	17	4.1

MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	LTCH QRP	0	0	2	12	3	17	4.1
MUC20-0044: SARS-CoV-2 Vaccination Coverage among Healthcare Personnel	SNF QRP	0	0	2	12	3	17	4.1