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Meeting Summary

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

Meeting Summary
December 23, 2022

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Measure Applications Partnership Rural Health Advisory Group 2022-2023 Measures Under Consideration Review Meeting – Day One

The National Quality Forum (NQF) convened a two-day, public web meeting on behalf of the Centers for Medicare and Medicaid Services (CMS) for members of the Measure Applications Partnership (MAP) Rural Health Advisory Group on December 8 and 9, 2022. The purpose of the meeting was to review and provide input with a rural health lens on measures under consideration (MUCs) for the MAP hospital, post-acute care/long-term care (PAC/LTC), and clinician programs. There were 119 attendees at the meeting, including MAP members, NQF staff, government representatives, measure developers and stewards, and members of the public.

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

Jenna Williams-Bader, NQF Senior Director, welcomed participants to day one of the Rural Health Advisory Group 2022-2023 MUC Review Meeting and reviewed the meeting ground rules, housekeeping reminders, and agenda for the meeting. Ms. Williams-Bader invited Dr. Dana Gelb Safran, NQF President and Chief Executive Officer (CEO), to provide opening remarks.

Dr. Safran noted that the Rural Health Advisory Group launched in 2017 as part of the 2017-2018 MUC cycle, marking this year as its fifth anniversary. Dr. Safran noted that individuals who reside in rural areas are often particularly vulnerable with respect to health status, health behaviors, sociodemographic status, and access to care. Dr. Safran emphasized that in the current MAP cycle, the Rural Health Advisory Group has an essential role in providing key feedback on measures considered for the new Rural Emergency Hospital Quality Reporting Program (REH QRP) beginning in 2023. Dr. Safran thanked the Advisory Group, co-chairs, CMS representatives, and NQF staff for their time and meaningful contributions during this MUC cycle.

Ms. Williams-Bader invited the Rural Health Advisory Group co-chairs, Dr. Kimberly Rask and Dr. Keith Mueller, to provide opening remarks. The co-chairs recognized the importance of this work and thanked MAP members for their time and commitment.

Dr. Tricia Elliott, NQF Vice President, facilitated introductions and disclosures of interest from the MAP Rural Health Advisory Group members. A total of 11 of 22 Advisory Group members were present (see Appendix A for detailed attendance). No conflicts of interest were identified for the Advisory Group.

Ms. Williams-Bader also introduced the NQF team and CMS staff supporting the MAP Rural Health Advisory Group activities and reviewed the meeting objectives:

- Review the MAP pre-rulemaking approach and Advisory Group process; and
- Review and provide input on the measures under consideration (MUCs) for the Measure Applications Partnership (MAP) hospital, post-acute care/long-term care (PAC/LTC), and clinician programs from the rural health perspective.

CMS Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards and Quality (CCSQ), and Group Director of the Quality Measurement and Value-based Incentives Group (QMVIG) at CMS, thanked everyone involved with the MAP Rural Health Advisory Group. Dr. Schreiber stated that CMS is committed to aligning measures and programs (e.g., Medicare fee-for-service, Medicare Shared Savings Program (MSSP), Medicaid) to achieve a cohesive quality strategy and measures that are closely aligned.

Dr. Schreiber emphasized the importance of the charge to the Rural Health Advisory Group members to push these goals forward.

Dr. Schreiber reviewed CMS' National Quality Strategy (NQS) goals: to ensure the best, safest, and most effective care for all individuals and to enable a responsive, equitable, and resilient healthcare system. Dr. Schreiber emphasized the cross-agency work that is taking place to ensure alignment across agencies as well as alignment in measures used across payers. Dr. Schreiber reviewed a set of clinical areas that CMS has identified as strategic priorities (such as maternal health, diabetes, wellness, and prevention, etc.) as well as six cross-cutting priorities (such as equity, safety, resilience, etc.). Dr. Schreiber also identified considerations for future measure priorities, with an emphasis on ensuring the alignment of measures, as CMS looks to fill gaps in their measurement portfolio.

Overview of Pre-Rulemaking Approach

Ms. Williams-Bader provided an overview of the role of the MAP Rural Health Advisory Group in the pre-rulemaking process. The MAP Rural Health Advisory Group is charged with providing rural perspectives on the measures under consideration to the setting-specific MAP Workgroups and Committees. The MAP Rural Health Advisory Group also addresses priority rural health issues, such as low case-volume.

Ms. Williams-Bader stated that a verbal summary of the MAP Rural Health Advisory Group's discussion would be shared for each measure under consideration at the setting-specific Workgroup meetings for MAP PAC/LTC (December 12), MAP Hospital (December 13-14), and MAP Clinician (December 15-16).

Ms. Williams-Bader then shared the process for discussing groups of measures under consideration:

1. NQF staff describe the measure group for MAP discussion
2. The lead discussants summarize the measure group and offer initial thoughts
3. The Advisory Group discusses the measure group and provides feedback on the following questions:
    a. Could this measure group support better care for rural residents in terms of access, cost, or quality, and if so, how?
    b. What data collection and/or reporting challenges could exist for rural providers for this measure group?
    c. For small rural facilities, what methodological problems of calculating measure performance could exist for this measure group?
    d. What potential unintended consequences could exist for rural health providers or rural health populations if measures in this group were included in specific programs?
4. After discussion of the measure group, MAP members identify any measures for which the issues discussed do not apply
5. If any measures are identified, MAP members will provide feedback on questions used during the measure group discussion. Measure developers will respond to questions on measure specifications and NQF staff will respond to questions on the preliminary analyses

Measures Under Consideration

Chronic Condition Management and Preventive Care Measures

Tamara Funk, NQF Director, opened the discussion by introducing the measures under consideration for chronic condition management and preventive care:

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

Dr. Rask opened the discussion to receive public comments on the measures. No public comments were offered.

Ms. Funk asked the lead discussants to provide comments on this group of measures. A lead discussant shared that the measures would improve access to healthcare, healthcare costs, and healthcare quality for rural residents and invited further discussion to better understand how each measure may impact the rural setting.

Group Discussion: Chronic Condition Management and Preventive Care Measures

A MAP member highlighted that measures focused on prevention and better management of chronic care conditions reduce the need for specialty services and access to specialists. The member emphasized that in rural communities there are issues with the availability of services and access to specialists and was therefore in support of this group of measures.

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

A MAP member shared the importance of this measure for screening patients, particularly in a rural setting. The MAP member highlighted that obstetric care services are limited in rural areas and noted examples of fragmented care, such as one provider administering the initial examination at 20 weeks of gestation and a different provider managing the delivery in a completely different setting. The MAP member stated that the denominator was appropriate and did not raise a concern for these types of co-management or limited obstetrical care situations. Another member of the Advisory Group highlighted the need for risk assessment with the potential for follow-up.

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

A MAP member stated that screening for colorectal cancer is often a challenge in rural areas due to limited offerings and geographic issues such as the costs of time and travel for a patient to undergo a colonoscopy, but that the measure provided a sufficient amount of latitude in obtaining the adequacy of screening. The MAP member noted no unintended consequences and stated that the measure was sound.

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

A MAP member shared concerns about potential unintended consequences with the measure, highlighting that PAM scores may differ in populations that have limited resources which may in turn impact patients' attitudes, motivations, behaviors, and outcomes in seeking healthcare. Another MAP member agreed with the concern and shared that when using PAM scores, it is important to be familiar with the population. A MAP member expressed a concern about the cost of using the tool.

A CMS representative replied that the PAM tool will be publicly available to ensure mitigation of any cost barriers and to make the tool easier to use. Another CMS representative highlighted that the MIPS program allows clinicians to select measures, and clinicians may select this measure or not select this measure.

A federal liaison asked whether this measure is being considered for inclusion as part of the MIPS Value Pathways (MVPs) and expressed concerns with that possibility due to the unintended consequences, as well as concerns about sampling. A CMS representative responded that it had not yet been determined whether to include it in an MVP, but that even in an MVP the clinician has a choice of which measures to report. CMS highlighted that MIPS intends to provide clinicians with an inventory of measures to choose.

The measure developer responded to the concerns about unintended consequences for PAM scores, clarifying that the measure is about gains in activation. A low activation score at the outset does not necessarily disadvantage the provider and in fact, those patients with low initial activation scores tend to move up the scale the fastest over time, potentially giving an advantage to those providers. A MAP member acknowledged this clarification but provided examples of contextual barriers specific to rural settings that may impede patients' abilities to have better attitudes, motivation, behaviors, and outcomes that are out of the control of both patient and provider. The measure developer acknowledged the concern and responded that having the measurement allows clinicians to know where patients are beginning to help them move forward, and to find ways to work with the patient to mitigate the effects of structural barriers.

Renal Measures

Ms. Funk introduced the renal measures for discussion:

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

Dr. Mueller opened the discussion to public comments. No public comments were offered.

Ms. Funk invited the lead discussants to introduce the renal measures. No lead discussants were present, so a CMS representative briefly reviewed each of the measures. The CMS representative shared that MUC2022-060 intends to help incentivize providers to get patients in their first year of dialysis to sign onto the waitlist for kidney transplants. MUC2022-063 measures the percentage of prevalent patients waitlisted and waitlisted in active status. The CMS representative emphasized that these measures aim to keep patients in active status while on the kidney transplant waitlist. The CMS representative shared that MUC2022-075 looks at the ratio of switching from an in-center modality to a home modality in the first year of dialysis, which can be especially important for patients in a rural setting for whom regular travel to a dialysis facility can be quite burdensome. MUC2022-076 focuses on patients' decisions about vascular access in their first year of dialysis and whether a patient will choose to get an arterial venous fistula in the first year with support from their providers. Lastly, the CMS representative shared that MUC2022-079 is intended to encourage facilities to take a comprehensive approach by trying to prevent unscheduled emergency department (ED) visits for dialysis patients. Such

visits are often related to dialysis complications that are secondary to their dialysis.

Mr. Mueller then opened the discussion for MAP members to comment on the renal measures.

Group Discussion: Renal Measures

A MAP member shared concerns about the unintended consequences with these measures, specifically regarding access for MUC2022-076 and MUC2022-079, inquiring whether barriers to access in rural communities, such as the availability of surgeons in rural facilities, may potentially disadvantage rural providers.

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

A federal liaison raised a concern about not including patient preference in the standardized modality switch ratio. CMS representatives shared that there has not been an effective way to account for patients' preferences in the modality switch ratio. CMS also commented that there is overall low usage of home dialysis within the United States which is likely to be more reflective of lack of access than low uptake by patient choice, or by failure to consider patient choice. CMS further explained that the scoring for this measure is based on a risk-adjusted statistical model that identifies extreme outliers, as compared to the rest of the dialysis facilities in the United States, to identify facilities that have the lowest uptake of home modalities. While patient choice may be a factor driving this low uptake, it is the responsibility of dialysis facilities to both educate and facilitate patients about a transition to home dialysis.

A federal liaison inquired about the validity of MUC2022-075 since the measure went through the endorsement process and passed NQF's Scientific Methods Panel review but did not pass Standing Committee review. The Renal Standing Committee expressed concerns with the lack of sociodemographic factors in the measure, which a CMS representative stated was intentional. In addition, the Renal Standing Committee questioned the use of a modality switch ratio instead of a standard rate for home dialysis use. The CMS representative clarified that the modality switch ratio for this measure was also intentional given that roughly 40 percent of dialysis facilities do not offer home dialysis.

MUC2022-076: Standardized Fistula Rate for Incident Patients (ESRD QIP)

A CMS representative noted the Renal Standing Committee's concern with the performance gap of the measure for those who receive a fistula among incident patients in the first year. The CMS representative highlighted that there is still a broad range in variation of performance in facilities and believes the Renal Standing Committee conflated average performance after one year on dialysis and missed the fact that there was still a large variation in overall facility performance. A representative from CMS responded to this comment that since the standardized fistula rate is measured during the first year of dialysis, the intention for MUC2022-076 is to help providers determine if the fistula is the correct care path, to set a time for the appropriate surgery, or to make other arrangements.

Rural Emergency Hospital Quality Reporting Program Measures

Ms. Funk introduced the Rural Emergency Hospital Quality Reporting Program (REH QRP) measures:

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

Dr. Rask opened the discussion for public comment. A member of the public identified MUC2022-039 as a measure they have been able to use to identify wait times in rural ED settings.

Ms. Funk invited the lead discussants to offer introductory comments. One lead discussant shared that in their experience consulting for rural trauma centers, challenges exist related to transportation, the availability of ambulance services, and overworked providers. The lead discussant shared that patients are transported often between care facilities to access the appropriate care, which can mean moving them to urban trauma centers. The lead discussant highlighted that wait times for trauma patients were a significant issue, stating that in many counties it can take four to six hours to arrange a facility transport from a local agency (which are often unavailable) and rural centers may inappropriately use services like air travel because it is the only transportation mode available. Lastly, the lead discussant noted that for the computed tomography (CT) measures, a CT with contrast material is more beneficial than a CT without contrast material because the information captured with contrast material can help to determine the next line of care.

CMS provided opening remarks for the measures as well. Dr. Schreiber noted that as a new quality program, the REH QRP intends to be pay-for-reporting, meaning organizations are only penalized if they do not report the measures at all. Dr. Schreiber added that CMS will work to improve the measures with more information captured on how these measures perform in rural emergency hospitals and the potential challenges they pose.

A CMS representative reviewed MUC2022-039, sharing the measure has been reported since 2013 in the Hospital Outpatient Quality Reporting (OQR) Program and has widespread support across stakeholders. The CMS representative noted the performance is calculated for the measure using chart-abstracted data and captures a continuous variable over time (initial arrival of the patient to when the patient is discharged). The measure includes separate data elements for patients that do not have a psychiatric or mental health diagnosis and patients that do have a principal psychiatric diagnosis.

For the next measure, MUC2022-066, a CMS representative highlighted the importance of this measure for the REH QRP due to timeframes for travel and distance for care. The CMS representative reviewed that the data for this measure are obtained through administrative claims and enrollment data. The measure is in the Hospital OQR Program and has been publicly reported since 2017 and has been endorsed since 2020. The CMS representative noted that this measure will increase effective communication and care coordination for low-risk coloscopies.

The CMS representative noted that CMS is considering adding MUC2022-067 to the REH QRP and noted the measure has been in use in the Hospital OQR Program since 2017. The representative also noted that the measure is endorsed. The CMS representative noted that MUC2022-067 is risk-adjusted using patient-level demographics in patient health, level status, and clinical conditions. CMS highlighted that this measure provides opportunities for improved care and lower rates of adverse events, following any outpatient or surgical procedure.

Lastly, the CMS representative shared that MUC2022-081 has been implemented in the Hospital OQR Program since 2010. The representative noted that since this measure is being considered for a new provider type, there is limited data to address safety in this area for the REH QRP. The CMS representative highlighted that this measure is intended to align with current clinical guidance at rural hospitals while avoiding the potentially harmful effects of unnecessary radiation and contrast exposure.

The CMS representative concluded that all the measures are currently in the Hospital OQR Program and hospitals eligible to convert to rural emergency hospital status already have publicly reported data for

these measures.

A MAP member suggested that public-facing data could be analyzed to inform interventions around workforce or transportation issues, for example, before reporting it publicly so that results can then be shared alongside efforts to resolve challenges.

MUC2022-039: Median Time from emergency department (ED) Arrival to ED Departure for Discharged ED Patients

A MAP member asked about exclusion criteria, specifically whether patients transferred to another facility are excluded, or if they are included and able to be stratified. The measure developer clarified that data about patients who are transferred to another facility is collected but not reported. The measure developer further clarified that patients are stratified by those discharged to a home setting with a mental health diagnosis, discharged to a home setting without a mental health diagnosis, and patients transferred from a hospital to another acute care facility (but noted the rate for patients who are transferred is not reported). Another MAP member noted that an important difference between rural trauma and urban trauma is the inability to get to care, and MAP members additionally cited weather challenges and transport safety as common issues.

A comment raised in the chat asked about the impact of hospital size for reporting the results. The measure developer stated that measure is publicly reported on Care Compare for two of the stratifications (discharged with current mental health diagnosis or discharged with no current mental health diagnosis), and split by median minutes based on ED volume – low, medium, high, and very high. Median minutes among hospitals with low ED volume is slightly lower across both publicly reported stratifications. The developer noted the third stratification is not currently publicly reported. The developer also noted this measure is particularly well-suited to REH QRP settings because it is limited to patients transferred into acute facilities, and since rural settings often do not have acute inpatient beds the trauma patients would be captured in this stratification. The MAP member suggested that transferred outpatients are a high-risk quality issue, noting that the ED dwell time while working to transfer a critical patient is one of the most important issues in the mortality of patients in rural trauma settings. A MAP member raised the concern that reporting data on transferred patients may disproportionately disadvantage hospitals.

A MAP member noted that rural EDs are not staffed as well as urban EDs, so in a time-sensitive emergency, low staffing would impact a patient's wait time for a service. The member stated that reporting this measure in REH QRP will be helpful to analyze rural factors. A CMS representative responded that there is a statutory requirement that rural emergency hospital EDs be staffed all times with providers able to identify life-threatening emergencies, administer cardiopulmonary resuscitation (CPR), and effectively communicate a patient's events, as well as to have another provider on call at all times, and a practitioner able to be onsite within 30 to 60 minutes in all areas not considered 'frontier' areas.

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

A MAP member asked about the inclusion of any hospital visit versus a hospital visit related to the colonoscopy within seven days of the colonoscopy in the measure. A CMS representative clarified that the measure is not limited to admissions related to complications. The measure does use exclusion criteria in the denominator for high-risk surgeries performed in the same timeframe as a colonoscopy, and exclusions in the numerator for planned admissions.

Patient Experience Measures

Ms. Funk introduced the patient experience measures for discussion:

- **MUC2022-014:** Ambulatory palliative care patients' experience of feeling heard and understood *(MIPS)*
- **MUC2022-078:** Psychiatric Inpatient Experience Measurement *(IPFQR [Inpatient Psychiatric Facility Quality Reporting Program])*
- **MUC2022-120:** Documentation of Goals of Care Discussions Among Cancer Patients *(PCHQRP [Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program])*

Dr. Mueller opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to provide introductory comments on the measures. A lead discussant provided positive remarks about the measure set overall and emphasized that MUC2022-014 showed more applicability to the rural care setting as it focused on ambulatory care patients and their experience with palliative care. The discussant noted that both MUC2022-078 and MUC2022-120 are less suited to the rural setting, noting lower volume in rural facilities, and specifically referencing the limited number of inpatient psychiatric hospitals in rural settings. The lead discussant also shared concerns about MUC2022-120, that the measure may be burdensome to hospital systems who lack the infrastructure to collect the data, even if data are in structured fields.

Another lead discussant also shared positive remarks about the measure set and noted that the measures aligned with the Meaningful Measurement Initiative 2.0. The lead discussant shared from personal experience how these three measures are particularly relevant to rural settings, demonstrating the potential impact on patient experiences and outcomes, particularly MUC2022-014. The lead discussant noted that currently inpatient psychiatric facilities are excluded from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and emphasized the importance of MUC2022-078 as a result. The discussant highlighted four critical areas to improve patient-reported outcomes in behavioral health: the treatment team, the nursing presence, treatment outcomes, and the healing environment. Lastly, the discussant shared that MUC2022-120 is especially critical in rural areas because patients often travel long distances for quality cancer care, and goal setting is an outcome that helps patients and families find answers and determine how to manage their situation.

MUC2022-078: Psychiatric Inpatient Experience Measurement (IPFQR)

A federal liaison stated support for this measure but shared a concern about the response rate. The measure developer acknowledged this as a potential challenge but replied that this was examined in testing and response rates 24 hours prior to discharge were significantly different from response rates post-discharge. The developer noted that they were able to obtain a much higher response rate from patients surveyed 24 hours prior to discharge while rates were lower post-discharge.

A MAP member raised concerns about selection bias for this measure since it is collected right before discharge and inquired how the measure developers ensured the sample is representative of the population. The measure developer shared the two-step process they used to mitigate selection bias of randomly sampling data from the group who completed the survey and comparing it to the entire population. The measure developer found no statistically significant difference between the sample and the full data set.

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

MAP members expressed concerns about the cost to implement and maintain the collection of feedback from patients and noted that since there are fewer providers in rural settings, this measure then puts a

larger burden on those providers. A MAP member also emphasized the importance of documentation to ensure the capture of the goals of care, and to help move measurement toward patient-reported outcomes.

MAP members discussed how data would be used within MUC2022-120, including the feasibility of data collection and capturing findings. A CMS representative responded that the inclusion of discrete fields is intended to prompt providers when recording goals with their patients, provide a centralized location for providers to access the information, and help facilities obtain the data efficiently using electronic queries. Lastly, the CMS representative noted that hospitals using Cerner, EPIC, and Allscripts could implement the measure, and hospitals that did not have the initial infrastructure were able to adopt the measure within a two-year timeframe.

COVID-19 Measures

Ms. Funk introduced the COVID-19 measures:

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

Dr. Rask opened the discussion for public comment. A member of the public highlighted that the administration of the COVID-19 vaccine in rural settings requires a system of support from larger health systems, commercial pharmacies, and government agencies. The commenter emphasized that providers should not be held accountable for MUC2022-052 since their performance on the measure is not an accurate assessment of the quality of care provided, and the clinician's proper role in the process is to recommend, not administer, vaccines.

Ms. Funk invited the lead discussants to provide introductory comments on the measures. The first lead discussant had no comments or concerns for the patient-specific measures because they can be recorded in an electronic medical record (EMR). A second lead discussant contrasted this with the high burden of MUC2022-084 because small rural hospitals may not have employee health software; therefore, data collection presents a challenge as it takes resources to track down and capture this data from providers in a rural setting. The discussant noted a recommendation from providers to include this measure in the setting where the COVID-19 vaccines and boosters are administered.

A CMS representative acknowledged the challenge of getting adequate documentation across settings and emphasized CMS' goal to ensure the measures do not present a burden on the provider.

Group Discussion: COVID-19 Measures

A MAP member shared that their organization collaborated with skilled nursing facilities to raise their staff and resident vaccination rates; however, the member acknowledged challenges to getting an accurate count in rural settings given the high turnover rate among staff combined with changes among

residents. MAP members also discussed the variance in COVID vaccination rates across states due to differences in state-level vaccination policies. Dr. Schreiber acknowledged the challenges in rural settings but shared that the tracking of vaccination rates has been well established based on tracking of other immunizations. Dr. Schreiber also highlighted that the importance of capturing this data outweighs the challenges of data collection and emphasized the importance of vaccination from a public health perspective.

MAP members discussed the high burden level of documentation in rural hospitals. A representative from the Centers for Disease Control and Prevention (CDC) explained the model used for the COVID-19 vaccination is based on the model used for the influenza vaccination. The CDC representative shared that as COVID-19 becomes increasingly seasonal, the COVID-19 model would eventually evolve to capture seasonal vaccination (as is done for influenza). MAP members noted a need for a more streamlined approach for data collection, citing challenges to the current physical vaccination card system implemented in some states.

For MUC2022-089, MUC2022-090, MUC2022-091, and MUC2022-092 a MAP member raised a question about the definition of "up-to-date" as the pandemic shifts over time. A CMS representative responded that these measures use the CDC definition, which currently includes a completed primary series of vaccines and, when eligible, the most recent booster. The representative noted that this measure is an update to a previous measure that only focused on those who had received a primary vaccination series.

Eye Measures

Ms. Funk introduced the eye measures for discussion:

- **MUC 2022-114:** Appropriate screening and plan of care for elevated intraocular pressure following intravitreal or periocular steroid therapy *(MIPS)*
- **MUC 2022-115:** Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up *(MIPS)*
- **MUC 2022-116:** Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up *(MIPS)*

Dr. Mueller opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to provide introductory comments on the measures. A lead discussant shared concerns about the low volume of testing for MUC2022-114 as testing looked at only 500 patients among 17 physicians. The measure developer noted the importance of screening for the complication, but that there is no threshold for the volume of testing. The lead discussant also shared concerns for MUC2022-115, in which the testing showed little opportunity for improvement and no significant amount of variation. Lastly, the lead discussant noted that MUC2022-116 demonstrated a strong measure construct, with clear variation and an opportunity for improvement. The discussant stated that of all three measures, they find MUC2022-116 to be the most feasible for rural settings.

A CMS representative highlighted that retinal specialists are an ophthalmology subspecialty. The CMS representative highlighted that the implementation of these measures will help assess the performance of providers and the quality of services for these conditions.

Preview of Day Two

Ms. Williams-Bader provided a preview of day two of the Rural Health Advisory Group 2022-2023 MUC Review Meeting and thanked the members for their engagement. Ms. Williams-Bader adjourned the meeting for the day.

Measure Applications Partnership Rural Health Advisory Group 2022-2023 MUC Review Meeting 2022-2023 – Day Two

There were 143 attendees at the meeting, including Advisory Group members, NQF staff, government representatives, measure developers and stewards, and members of the public.

Welcome, Preview of Day Two, and Roll Call

Ms. Williams-Bader welcomed participants to day two of the Rural Health Advisory Group 2022-2023 MUC Review Meeting on December 9, 2022, and reviewed housekeeping reminders and the day two agenda. Dr. Elliott completed roll call for Advisory Group attendance. Nineteen of 22 Advisory Group members were present (see Appendix B for detailed attendance).

Measures Under Consideration

Behavioral Health Measures

Ms. Funk introduced the Behavioral Health measures:

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

Dr. Rask opened the discussion for public comment. No public comments were offered.

Ms. Funk briefly reviewed the discussion questions for consideration by the MAP Advisory Group before prompting the lead discussants to give introductory comments for the behavioral health measures.

For this group of measures, the lead discussants noted transportation barriers when transferring patients between rural and urban facilities, challenges around follow-up with patients and those lost to follow-up, and the availability and accessibility of critical information across settings in the EMR. In addition, there were concerns about how to measure the intended data over time and the feasibility of implementation. A CMS representative noted that this group of measures aims to capture mental health conditions beyond singularly screening for depression, adding more information on behavioral health conditions to the current measure set that can be used for improvement by providers and facilities.

MUC2022-122: Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder (MIPS)

A CMS representative noted that this measure is a survey between the patient and provider. MAP members asked for clarification on how this measure defines improvement. CMS shared that improvement is defined as a positive change in an individual's level of function, and then maintaining that level of function without getting worse.

MAP members discussed rural-specific barriers, specifically challenges related to resources (e.g., limited time and staffing challenges), noting that providers in rural settings tend to take on multiple roles and therefore experience time constraints. MAP members also discussed the limitations of this measure, including the modality by which data for this measure is collected and that this may present challenges

as it translates to rural settings or for telehealth. A MAP member shared that the instruments used in telehealth might cause validity issues when asked verbally as compared to self-reporting data using a paper format. CMS and the measure developers shared that some literature supports the measure's validity in a telehealth setting by using a patient portal or app option to complete self-report surveys.

MUC2022-127: Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk (MIPS)

A CMS representative noted that this is a follow-up measure that can be incorporated in a telehealth setting. Both a CMS representative and the measure developer clarified that this measure would be in the patient's medical record and could therefore follow the patient across care settings.

A federal liaison shared that they have implemented initiatives for mental health screening using telehealth. A CMS representative highlighted that the measures fill gaps for behavioral and mental health measures that primarily only focus on depression. The measure developer shared that during beta testing they did not have any difficulties with the measure's feasibility and its ability to be captured in multiple behavioral health care settings.

MAP members discussed general constraints on time and resources in rural settings and listed staffing limitations as a challenge that might reduce the capacity for follow-ups. However, MAP members appreciated the flexibility of this measure, emphasizing the importance of flexibility in rural contexts where patients are more likely to experience fragmented care. MAP members also noted the importance of interoperability, to ensure the measure can be feasibly used across settings and in various electronic health records (EHRs). MAP members identified a concern that the measures are partially dependent on the patient interacting with the healthcare system (e.g., coming to appointments and treatments). They further explained that since the measures are submitted for MIPS, the provider might not select these measures due to them being dependent on the patient's access to the healthcare system, thereby putting them at higher risk for not meeting the measure. MAP members shared that they appreciated the low volume parameters for using this measure since many rural providers occupy multiple roles and it would not be feasible for them to use this measure.

MUC2022-131: Reduction in Suicidal Ideation or Behavior Symptoms (MIPS)

A CMS representative noted this measure is also a follow-up measure.

Similar to MUC2022-127, MAP members discussed challenges in the rural setting related to time, resources, and staffing. MAP members also discussed the burden of follow-up measures and noted that patient retention presents a persistent challenge in rural settings. Also, similar to MUC2022-127, MAP members emphasized the importance of flexibility for this measure as it is recorded in the EHR and can therefore be accessed across settings.

Patient Safety Measures

Ms. Funk introduced the patient safety measures:

- **MUC2022-007:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults *(Clinician and Clinician Group Level) (MIPS)*
- **MUC2022-018:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults *(Hospital Level – Inpatient) (Hospital IQR)*
- **MUC2022-020:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults *(Hospital Level – Outpatient) (Hospital OQR)*
- **MUC2022-035:** Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) *(SNF VBP)*

- **MUC2022-064:** Hospital Harm - Pressure Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-024:** Hospital Harm- Acute Kidney Injury *(Hospital IQR, Medicare Promoting Interoperability Program)*
- **MUC2022-082:** Severe Sepsis and Septic Shock: Management Bundle *(HVBP)*

Dr. Rask opened the discussion for public comment. In response to a public query in the chat, CMS confirmed that MUC2022-082 is proposed for inclusion in the HVBP program in the next reporting year. No additional comments were offered.

Ms. Funk asked the lead discussants to provide introductory comments. The lead discussants noted the importance of patient safety but raised concerns around potential data collection burden for MUC2022-035, MUC2022-064, and MUC2022-024. The lead discussants also noted the need for educational patient-facing materials in rural settings for these same measures. MAP members discussed patient safety measures from the rural perspective, echoing themes of burden of reporting, limited resources, and staffing constraints affecting these measures. A lead discussant noted that while MUC2022-035 is not an eCQM, there is no additional burden on staff for data collection of this measure.

A lead discussant noted that for MUC2022-064 and MUC2022-024, although these measures are eCQMs, modifications to the workflow may still be necessary to document the data, and subsequently additional education around these modifications. A CMS representative acknowledged challenges around data collection and noted the opportunity to further improve the measures. Dr. Schreiber added that the goal of these measures is to give providers timely feedback and support facilities' understanding of a "total harm picture" with the goal of improvement.

Group Discussion: MUC2022-007, MUC2022-018, and MUC2022-020

A lead discussant noted that these measures are potentially meaningful in rural settings if the data can be feasibly extracted, but that staff may need educational materials or trainings. The measure developer noted that guidance and educational materials are publicly available and highlighted that the software is designed to collect data while minimizing the burden on providers.

One MAP member noted barriers to accessing the appropriate scanners for the procedure in rural settings. A MAP member raised the potential opportunity for education around dosage to reduce these events and stated the need to reduce the number of consecutive scans. The MAP member suggested implementing a protocol to help reduce scans without reducing efficacy. Another MAP member noted that the use of software to provide information (e.g., patient's size on the CT scan, scales appropriate for patients) improves the diagnostic accuracy, decisions on appropriate scans, and meaningfully reduces doses.

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

A lead discussant noted that because this measure is not an eCQM it poses a potential data collection challenge. A CMS representative acknowledged the challenges of this measure and expressed a continuous effort to improve measurement in this area, and that an eCQM is in process. The CMS representative also noted that this measure is already used in another program and is a proposed addition to the HVBP program.

A MAP member highlighted the importance of this measure to the lives of patients, and specifically for patients in rural settings. MAP members noted that rural settings often have less staff and acknowledged that since this measure is labor intensive in terms of data collection and abstraction, rural facilities may be more burdened. In addition, more staff training is needed on how to identify sepsis, and the importance of doing so. A CMS representative shared that they are currently working on adding

another sepsis measure that can help mitigate the collection burden of this specific measure. Dr. Schreiber acknowledged the concern about the abstraction burden of this measure in rural settings but highlighted that this measure is already required reporting as part of the Hospital Inpatient Quality Reporting (IQR) Program and many critical access hospitals and rural hospitals already report it. CMS is adding this measure to the HVBP program because of the importance of sepsis and sepsis reporting. A MAP member also highlighted the importance of available and accessible patient-facing sepsis educational materials for rural populations.

Health Equity Measures

Ms. Funk introduced the health equity measures:

- **MUC2022-027:** Facility Commitment to Health Equity *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-050:** Screen Positive Rate for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-053:** Screening for Social Drivers of Health *(ESRD QIP, IPFQR, PCHQRP)*
- **MUC2022-058:** Hospital Disparity Index (HDI) *(Hospital IQR)*
- **MUC2022-098:** Connection to Community Service Provider *(MIPS)*
- **MUC2022-111:** Resolution of At Least 1 Health-Related Social Need *(MIPS)*

Dr. Rask opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to give introductory comments. The lead discussants all emphasized the importance of these measures to promote both access and quality. The lead discussants also raised challenges related to limited availability of resources in rural settings for implementation and the simultaneous disproportionate impact of various health equity issues on rural communities, including transportation barriers or minimal resources to support interpersonal safety.

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

For MUC2022-050 and MUC2022-053, a MAP member raised concerns about reporting demographics in rural areas, where underrepresented minority groups may be fewer and therefore pose a challenge to case volume for reporting in this measure. The measure developer noted the intent of these measures is to be a starting point to learn, understand, and build on information about social drivers of health. The measure developer acknowledged the limited resources in rural areas and stated that these measures are intended to identify where gaps exist for future improvements.

Another MAP member emphasized the barriers to access, such as isolation, that is exacerbated by transportation barriers and lack of access to providers. The MAP member stated that these barriers are often amplified in rural areas, so although these measures will be important to understand the barriers, the differences in rural settings should be highlighted. MAP members also discussed the importance of building trust with patients, especially in rural communities, and suggested a greater emphasis on public facing materials to generate patient buy-in.

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

A MAP member asked if this measure would be publicly reported. The MAP member noted that it can be challenging for rural settings to be part of the HDI while also addressing disparities. Dr. Schreiber clarified this measure would not initially be available for public display and would be used by CMS to look at the performance of hospitals in total; however, the information would be made public at some point. The MAP member agreed with the delay before making measure scores public to allow hospitals time to respond, and to ensure trust is maintained between the hospital and the community. Dr.

Schreiber acknowledged the importance for facilities to have advanced notice and stated the intentions of CMS to continue sending confidential reports to facilities that are more in-depth and highlight equity issues.

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

A MAP member emphasized that for both MUC2022-098 and MUC2022-111, isolated rural and remote environments are often resource-limited but do have the capacity to address core or supplemental health-related social needs compared to urban centers. The MAP member was appreciative that the numerator of MUC2022-098 incorporated state, territorial, and local agencies. The MAP member encouraged integration of local needs with broader support for both measures. In response to discussion about rural underrepresentation in the measures, the measure developer stated that they strongly encourage stratification for this measure.

A MAP member noted that barriers to these measures includes not only transportation to access these services, but also knowledge on both the patient and provider side of available services. The measure developer acknowledged these concerns for rural settings, but also shared the importance of these measures in helping to identify current barriers and where resources are needed to better serve the population.

Outcomes – Readmission, Mortality, and Unplanned Hospitalization Measures

Ms. Funk introduced the outcomes – readmission, mortality, and unplanned hospitalization measures:

- **MUC2022-055:** Hybrid Hospital-Wide All-Cause Risk Standardized Readmission Measure *(Hospital IQR)*
- **MUC2022-057:** Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure *(Hospital IQR)*
- **MUC2022-099:** Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure *(SNF VBP)*
- **MUC2022-113:** Number of hospitalizations per 1,000 long-stay resident days *(SNF VBP)*

Dr. Mueller reviewed the guidelines for public comment and opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to give introductory comments. The lead discussant commented on the availability of data for these measures, noting the expansion of data sources for a few of the measures and raising challenges with volume that may impact other measures.

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

The lead discussant noted the expansion of data sources to include Medicare Advantage patients would be beneficial in the rural setting. A MAP member positively responded to the expansion of data for these measures to include Medicare Advantage patients.

MUC2022-099: Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure (SNF VBP)

The lead discussant raised a challenge with potentially low case volume for this measure in a rural setting. The measure developer addressed the comment, noting that during testing this measure performed more favorably in rural settings and therefore the developer did not foresee a disadvantage

for the rural setting. The measure developer also highlighted that this measure is statutorily mandated and is seeking to move programs to the SNF VBP program.

MUC2022-113: Number of hospitalizations per 1,000 long-stay resident days (SNF VBP)

The measure developer noted this measure has been collected since 2015. The measure developer also highlighted the importance of this measure for long-stay residents, in which there are few measures and therefore limited data available.

Structural (Hospital/Surgery) Measures

Ms. Funk introduced the structural (hospital/surgery) measures:

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

Dr. Rask reviewed the guidelines for public comment and opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to give introductory comments. A lead discussant raised concern around the burden of data collection, particularly for MUC2022-030. Another lead discussant highlighted the potential disproportionate impact that having volume as a singular measure might have in rural settings. The lead discussant also raised potential ceiling effects for both measures MUC2022-032 and MUC2022-112.

Group Discussion: MUC2022-028: ASC Facility Volume Data on Selected Surgical Procedures (formerly ASC-7) (ASCQR) and MUC2022-030: Hospital Outpatient Department Volume Data on Selected Outpatient Surgical Procedures (formerly OP-26) (Hospital OQR)

The measure developer shared that these measures is voluntary measures for critical access hospitals, and that there is a low burden to collect data for these measures. The measure developer also noted that because the volume of reporting from critical access hospitals is low, it is likely that more complicated procedures will not be performed in critical access hospitals. With the reported data, patients would be able to determine which facilities offer various procedures and make informed decisions for where to access care.

The measure developer emphasized the importance of these measures to help inform the public to help informed decision-making.

MAP members highlighted the importance of the availability of MUC2022-028 and consistency across settings to inform patient options. Dr. Schreiber elevated CMS' goals to improve consistency of care across settings.

Dr. Rask brought forward a comment from the chat about MUC2022-030, noting that for rural relevance, there were a total of 726 rural facilities, and that this information was available in the final rule for the calendar year 2023.

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

A CMS representative noted the importance to build a framework for age-friendly measures in the rural setting. A measure developer shared that in testing the measure, no hospital topped out in either measure.

A MAP member commented that these measures are critical for care as the older population grows larger. However, the MAP member noted that often rural settings lag non-rural settings and highlighted a difference in incentives in rural settings and urban settings.

The measure developer also noted that the measures were intended to translate across settings and to be guided by the needs of the patient, particularly as it relates to older patients undergoing surgery. MAP members again emphasized the importance of centering the patient's goals in health care services.

The measure developer raised MUC2022-112 to understand what is important to the patient and use the information to better provide care services. MAP members discussed the importance of centering the patient's goals in care services.

Cost Measures

Ms. Funk introduced the cost measures:

- **MUC2022-097:** Low back pain *(MIPS)*
- **MUC2022-100:** Emergency medicine *(MIPS)*
- **MUC2022-101:** Depression *(MIPS)*
- **MUC2022-106:** Heart failure *(MIPS)*
- **MUC2022-129:** Psychoses and Related Conditions *(MIPS)*

Dr. Mueller opened the discussion for public comment. No public comments were offered.

No lead discussants were present, so Ms. Funk invited CMS and the measure developer to provide introductory comments.

Group Discussion: Cost Measures

The measure developer described the measures' goal of assessing the use of resources to help balance cost with quality as each of the measures follows the episode of care and a physician's role in the patient's care journey. Additionally, a CMS representative noted that since the measures use claims data and are calculated by CMS, there is no additional burden to providers.

The MAP members raised concerns about the use of resources in rural settings as compared to their use in urban settings. The measure developer acknowledged the concern but noted that in testing, rural settings tended to perform better on the measure. A MAP member asked if performance could be followed during the year, but the measure developer clarified that since the measure uses claims data, data is only available after the performance period and could not be tracked in real time.

Functional Outcome Measures

Ms. Funk introduced the functional outcome measures:

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

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

Dr. Rask opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to give introductory comments. The lead discussants highlighted the similarity across measures MUC2022-083, MUC2022-085, MUC2022-086, and MUC2022-087 with slight differences across provider types, noting these measures fill current gaps and should not place any additional burden on providers. The lead discussants raised concerns for MUC2022-026 regarding access to outpatient and telehealth services in rural setting.

The measure developer noted that across these measures, rural providers tended to have higher scores than urban providers. The MAP members agreed that consistency in measures across settings is needed to improve transparency and cross-comparison.

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

A MAP member asked for clarification on whether there were post-operative issues related to access to physical therapy (PT) that might contribute to varied success in rural versus urban settings. Another MAP member noted the difference between in-person and virtual physical therapy, especially relevant to rural environments, and asked if this could be considered in the case-mix adjustment. The measure developer replied that the risk adjustment model addresses unintended consequences and controls for numerous patient characteristics and takes into account differences in settings and differences in assessments. The measure developer also noted that telehealth is available under the current waiver and those patients are included in the measure. Implementation of a virtual environment has not been observed and cannot be recorded or directly addressed through the case mix. MAP members also noted the importance of alignment in functional outcome measures across care settings.

Staffing Measure

Ms. Funk introduced the final measure in the 2022-2023 MUC cycle, a staffing measure:

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

Dr. Mueller opened the discussion for public comment. No public comments were offered.

Ms. Funk invited the lead discussants to give introductory comments. The lead discussants emphasized the importance of reducing turnover for continuity of care and to maintain high quality healthcare. Lead discussants noted that rural areas consistently experience challenges in the recruitment and retention of staff, which may disadvantage them in this measure.

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

A CMS representative explained that this measure is intended to complement another staffing measure in the VBP program that looks at staffing levels. This measure examines retention to understand stability and quality.

MAP members recognized the importance of continuity of care, particularly in the rural setting. MAP members noted unique barriers to staffing in rural settings and emphasized the importance of being thoughtful with staffing measures to mitigate these challenges. A MAP member raised concerns that this

measure may have an unintentional consequence of creating a feedback loop in which low staffing and turnover impact funding, which, in turn, continues to impact staffing and turnover.

The measure developer acknowledged the challenges unique to rural settings with this measure, but also emphasized its importance both as a complement to the staffing level measure and to better understand staff turnover.

Discussion of Broad Themes

Dr. Rask reviewed several broad themes captured across the two days of discussion:

- Not enough patients for stratification
- Lack of resources for rural health communities
- Barriers to access including transportation

Dr. Rask opened the discussion to the MAP members to discuss additional themes. The MAP members added the following themes:

- System level considerations
- Fragmentation of care
- Smaller workforce and higher burden on staff
- Broadband access and the impact on telehealth options
    - Face to face care has a different set of barriers and requires separate resources in comparison to telehealth services
- The patient voice is critical and central in all aspects of health care quality
- EHR limitations for data extraction
- Data burden on smaller providers with limited resources
- Timeliness of care and care pathways

Opportunity for Public Comment

Ms. Williams-Bader opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Ms. Williams-Bader shared a timeline for upcoming MAP activities, including PAC/LTC Workgroup Review Meeting (December 12), Hospital Workgroup Review Meeting (December 13-14), and Clinician Workgroup Review Meeting (December 15-16), and noted that all meetings are open to the public and that Rural Health Advisory Group members are welcome to attend. Ms. Williams-Bader shared that the public commenting period on the Workgroup recommendations will run from January 6 through January 12, 2023. Ms. Williams-Bader stated that the Coordinating Committee will meet January 24-25, and that the final recommendations spreadsheet will be published by February 1. Ms. Williams-Bader shared links to MAP resources and provided closing remarks thanking the MAP members, co-chairs, CMS representatives, and measure developers.

Dr. Tiffany Wiggins, Medical Officer and Clinical Lead for Health Equity, Maternity Care Quality, and Cross-Cutting Measurement Initiatives at the Quality Measurement and Value-Based Incentives Group (QMVIG) at the Center for Clinical Standards & Quality (CCSQ) at CMS, shared brief closing remarks, emphasizing the importance of equity as a strategic goal in the pursuit of quality improvement in healthcare. Dr. Wiggins also acknowledged this Advisory Group's role in elevating the rural health perspective, a previously underrepresented perspective in healthcare quality. Dr. Wiggins thanked the MAP members, co-chairs, CMS representatives and measure developers for their robust and thoughtful conversation.

Adjourn

Ms. Williams-Bader adjourned the meeting.

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

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

Organizational Members

- American Academy of Family Physicians
- American Academy of PAs (AAPA)
- American Heart Association
- LifePoint Health
- Minnesota Community Measurement
- Trauma Center Association of America

Individual Subject Matter Experts

- Kimberly Rask, MD, PhD, FACP
- Keith Mueller, PhD
- Rosie Bartell
- Cody Mullen, PhD Traci Sellers-Pullen, RN, MSOl, CCM

Federal Government Liaisons

- Federal Office of Rural Health Policy
- Center for Medicare & Medicaid Innovation, Centers for Medicare & Medicaid Services
- Indian Health Services
- Department of Veteran Affairs

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

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

Organizational Members

- American Academy of Family Physicians
- American Academy of PAs (AAPA)
- American Society of Health-System Pharmacists
- LifePoint Health
- Michigan Center for Rural Health
- Minnesota Community Measurement
- Trauma Center Association of America
- UnitedHealth Group

Individual Subject Matter Experts

- Kimberly Rask, MD, PhD, FACP
- Keith Mueller, PhD
- Rosie Bartell
- Rev. Bruce Hansen
- Cody Mullen, PhD
- Traci Sellers-Pullen, RN, MSOl, CCM
- Jessica Schumacher, PhD, MS

Federal Government Liaisons

- Federal Office of Rural Health Policy
- Center for Medicare & Medicaid Innovation, Centers for Medicare & Medicaid Services
- Department of Veteran Affairs