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Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup: 2022-2023 Measures Under Consideration (MUC) Review Meeting

Meeting Summary
December 29, 2022

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Meeting Summary

Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) 2022-2023 Measures Under Consideration (MUC) Review Meeting

The National Quality Forum (NQF) convened a public web meeting, on behalf of the Centers for Medicare & Medicaid Services (CMS), for members of the Measure Applications Partnership (MAP) Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup on December 12, 2022. The purpose of the meeting was for the MAP PAC/LTC Workgroup to review and provide recommendations for the 2022-2023 Measures Under Consideration (MUC) proposed for CMS PAC/LTC programs. There were 100 attendees at this meeting including MAP PAC/LTC Workgroup members, NQF staff, government representatives, and members of the public.

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

Jenna Williams-Bader, senior director, NQF, welcomed participants to the MAP PAC/LTC 2022-2023 Measures Under Consideration web meeting, and reviewed housekeeping reminders, meeting ground rules and the meeting agenda. Ms. Williams-Bader then invited NQF leadership to provide opening remarks. Dr. Dana Gelb Safran, president & CEO, NQF, provided opening remarks to the PAC/LTC Workgroup. Following Dr. Safran, opening remarks were provided by the PAC/LTC Workgroup co-chairs, Mary Ellen DeBardeleben and Dr. Kurt Merkelz.

Dr. Tricia Elliott, vice president, NQF, performed roll call and disclosures of interest (DOIs). Of the 17 organizational members, 15 attended the meeting. In addition, there were two co-chairs, and two subject matter experts, totaling 19 voting members. Sixteen members was the minimum quorum for voting. One PAC/LTC Workgroup member disclosed that their organization was involved in the technical expert panel (TEP) for the patient COVID-19 vaccine measure. Another PAC/LTC Workgroup member disclosed participation in the TEP for the patient COVID-19 vaccine measure. These two disclosures were deemed not to be a direct conflict, therefore no recusals from measure voting were necessary. The full attendance details are available in Appendix A. Dr. Elliott also introduced the nonvoting federal government liaisons.

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

1. Review the MAP PAC/LTC Workgroup programs
2. Provide an overview of the MAP decision categories and voting process
3. Review and provide input on the measures under consideration (MUCs) for the MAP PAC/LTC programs
4. Identify measure gaps for the MAP PAC/LTC programs

Centers for Medicare & Medicaid Services Opening Remarks

Dr. Michelle Schreiber, Deputy Director of the Center for Clinical Standards & Quality (CCSQ) for CMS and the Group Director for the Quality Measurement and Value-Based Incentives Group (QMVIG), welcomed participants to the meeting. Dr. Schreiber thanked the participants, the Advisory Groups, CMS representatives, and federal partners for their input in the meeting. Dr. Schreiber shared CMS'

future strategies and the quality measures that are being evaluated. Dr. Schreiber also reviewed CMS' national quality strategy goals, targets that are standardized across all CMS programs, and priority areas that align with the measures and goals.

Overview of MAP PAC/LTC Workgroup and CMS Programs

Jenna Williams-Bader, senior director, NQF, provided an overview of the pre-rulemaking approach for the measures under consideration (MUC). Ms. Williams-Bader reminded the group that the charge of the Workgroup was to provide recommendations on matters related to the selection and coordination of measures for post-acute care (PAC) and long-term care (LTC) programs. Ms. Williams-Bader reviewed the program type, incentive structure and program goals of the CMS programs: Home Health Quality Reporting Program (HH QRP), Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), Long-Term Care Hospital Quality Reporting Program (LTCH QRP), Skilled Nursing Facility Quality Reporting Program (SNF QRP), and Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP).

Overview of Decision Categories and Voting Process

Ms. Williams-Bader provided an overview of the pre-rulemaking approach for the measures under consideration (MUC). Ms. Bader-Williams reviewed the MUC decision categories: Support for Rulemaking, Conditional Support for Rulemaking, Do Not Support for Rulemaking with Potential for Mitigation, and Do Not Support for Rulemaking. Ms. Williams-Bader noted that the decision categories were standardized for consistency and the Workgroups must reach a decision on every measure under consideration accompanied with a rationale for the decision. Ms. Williams-Bader reviewed that for the Workgroup to reach quorum, 66 percent of the voting members of the Workgroup must be present virtually for live voting, and quorum was present. Ms. Williams-Bader shared that MAP has established a consensus threshold of greater than or equal to 60 percent of voting participants voting for a decision category and a minimum of 60 percent of the quorum figure voting positively for a decision category. Ms. Williams-Bader provided an overview on the voting process which starts with NQF staff providing an overview of the measure with the preliminary recommendation, CMS presenting contextual background on the MUC, and lead discussants providing their findings. Ms. Williams-Bader continued that the co-chairs then open for discussion among the Workgroup and end with the Workgroup voting on the acceptance of the preliminary analysis recommendation. Ms. Williams-Bader noted that further discussion and voting on the measure under consideration will occur if less than 60 percent of the Workgroup accepts the preliminary analysis recommendation and then NQF will tally the votes. Ms. Williams-Bader paused for questions and a member of the Workgroup asked what group reviews measures that receive Conditional Support for Rulemaking, pending endorsement by a consensus-based entity (CBE). Ms. Williams-Bader shared that organizations such as NQF and other consensus-based entities review measures for endorsement. Dr. Elliott added that NQF's endorsement and maintenance process is different from MAP and measures are reviewed through various cycles to achieve endorsement. Ms. Williams-Bader led a test vote for the Workgroup so the Workgroup would be familiar with the voting process going forward.

Measures Under Consideration

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

Udara Perera, director, NQF, introduced the SNF VBP measure section and the four measures included in the section.

- **MUC2022-035:** Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)

- **MUC2022-099:** Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure
- **MUC2022-113:** Number of hospitalizations per 1,000 long-stay resident days
- **MUC2022-126:** Total nursing staff turnover

Public Comment

Ms. DeBardeleben provided instructions to meeting attendees on the public commenting process before opening the meeting for public comment. Dr. Schreiber noted the Consolidated Appropriations Act, 2021 (CAA) authorized the Department of Health and Human Services' (HHS) secretary to expand SNF VBP from one measure to a maximum of 10 measures. A MAP member asked for clarification on which measure is currently in SNF VBP, and Dr. Schreiber responded that it is an all-cause hospital readmissions measure. Another MAP member noted there were three other measures finalized in the FY2023 rule for addition to SNF VBP. A CMS representative shared the following finalized measure information: 1. Skilled Nursing Facility (SNF) Hospital Acquired Infection, 2. Total Nurse Staffing, and 3. Discharge to Community. No public comments were presented during the commenting period.

MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera presented a summary of the six public comments received during the public comment period, of which four were in favor of the measure and two were not in support of the measure. Ms. Perera noted those comments in favor indicated falls were largely preventable injuries and monitoring falls could facilitate quality processes to minimize falls. Ms. Perera further noted comments on refinements to the measure called for shortening the measure look-back period to incentivize improvement. Ms. Perera noted the comments not in support of the measure indicated the measure was not risk-adjusted, questioned the appropriateness of the measure for the program, and noted the measure was not a calculation of the rate of falls, but rather the rate of patients who fall. Dr. Elliott noted the Health Equity Advisory Group indicated no issues from an equity perspective, and the measure fills a gap. Dr. Elliott noted the Rural Health Advisory Group expressed concern of the potential for higher rates for this measure in rural communities due to staffing shortages. Dr. Elliott further noted a Rural Health Advisory Group lead discussant indicated the measure utilizes the minimum data set (MDS) so there is no additional burden associated with data collection.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. A CMS representative noted that CMS considers the measure fills a measure gap in patient safety. The CMS representative indicated the measure has been in the Nursing Home Quality Initiative program since 2010. The CMS representative further noted the measure shows a wide range of scores across facilities demonstrating there is room for improvement.

A lead discussant stated support for the measure. Another lead discussant indicated the measure is NQF-endorsed and utilized in other programs. This lead discussant further stated the measure is a long-stay measure and questioned whether the SNF VBP should be used to improve long-stay resident care. The lead discussant asked what would happen to those facilities that provide only acute care and not long-stay care. The lead discussant also noted a written public comment by an organization about what constitutes a major fracture and whether this would include, for instance, the fracture of a finger.

Ms. DeBardeleben opened the meeting for Workgroup discussion. A MAP member asked how the MDS is set up to decipher head injury, joint, or other major injury. The MAP member asked if there had been any testing to look at claims or a quality look at the data. The measure developer noted testing indicated

the MDS as a data element had high validity and the subset correlation was also high. The measure developer indicated that the MDS would capture more falls with major injury than other data sources.

A MAP member questioned whether the 275-day look back period is the right amount of time. The MAP member noted the look back period is challenging as the event can stay on a facility record for 12 to 18 months and questioned if a different timeframe would be better. The MAP member asked CMS to comment more about a long-stay measure applying to Medicare payments for a value-based program. A CMS representative noted the design of the SNF VBP is such that if the measure does not have significant volume, the measure would not be counted. The CMS representative further noted most SNF residents are long stay so if they had an injury and went to the hospital, they will be covered by Medicare. A MAP member noted it appeared, according to the documentation, the developer put effort into determining what was a stable measure and 275 days is three quarters of one year. The MAP member asked the measure developer to comment on the look back period. The measure developer agreed the look back period was in consideration of SNF VBP payment updates that are completed on an annual basis. There was further discussion from a few MAP members regarding the look back period and its potential to have the [fall] event on the facility record for 12 to 18 months. A MAP member noted one of the goals of the measure is to incentivize staff to improve their actions and if so, staff need to see the results of those actions. The measure developer indicated the MDS for SNF VBP is designed for yearly update and feedback will be taken into future consideration.

A MAP member indicated there may be a question when it comes to an injury, for instance whether a head injury caused a fall, or the fall caused the head injury. This MAP member also stated the notification and transfer of information about falls can be difficult for the facility to ascertain. The MAP member further stated the measure is not a true fall rate, but the percentage of patients who fall and the way it is collected on the MDS makes it difficult to decipher the actual fall rate. A CMS representative responded with appreciation of the comments on the look back period.

A MAP member requested feedback on the preliminary analysis statement about the potential for unintended consequences from the increased use of physical or chemical restraints to reduce falls. A CMS representative noted there are measures currently in programs designed to capture data on physical and chemical restraints. The measure developer acknowledged the potential for unintended consequences of increased use of physical or chemical restraints, but those will be monitored. The measure developer further noted the current physical restraint measure has a low national average. Another MAP member noted the use of these [fall] measures in the nursing homes where they are employed. This MAP member indicated the short-stay measure was topped out in their nursing homes, but the long-stay measure continued to demonstrate opportunities for improvement. The MAP member further commented on the concern for restraints with the most concern for chemical restraints, but that the concern is low.

Ms. DeBardeleben moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Support for Rulemaking” for measure MUC2022-113. A MAP member asked for clarification of whether the adoption of this measure would replace the current measure in the program. A CMS representative noted this measure would not replace the current measure. Ms. DeBardeleben reminded the Workgroup of the four MAP decision categories. Ms. Williams-Bader confirmed the meeting is at quorum. Voting results were as follows: Yes – 14, No – 6, and percentage voting Yes – 70 percent. Full voting results are available in Appendix B.

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

Ms. Perera introduced the next measure and reviewed the measure information including the measure

description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were four public comments received during the public comment period, all in favor of the measure. Ms. Perera reported public comments that noted the measure would add value and that the value would outweigh the burden of data collection but also noted the measure correlates highly with an all-cause admission measure. Dr. Elliott reported the Health Equity Advisory Group expressed that expanding the denominator would advance health equity. Dr. Elliott reported the Rural Health Advisory Group noted the measure was tested in the rural health setting and data did not show any disadvantages to rural settings. Dr. Elliott also reported the Rural Health Advisory Group noted there may be a low volume issue for this measure.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. A CMS representative noted adding this measure to the program would meet the statute mandate to replace the current SNF readmission measure. The CMS representative noted a prior version of the measure has been in the program since 2016. The CMS representative further noted substantive updates to the measure included refinements to improve measure reliability and changing the readmission observation window to align with specifications of PPR measures to avoid duplicate counting of readmission events.

A lead discussant stated they had anticipated this measure's replacement. The lead discussant noted agreement with the refinement to assess two years of claims data and noted this change addresses the low volume concern. This lead discussant also stated they like that the measure is not overlapping with SNF QRP but agreed endorsement would be important for the measure. This lead discussant stated the Medicare Payment Advisory Commission (MedPAC) did an analysis of the VBP program as it stood today, and its concern may continue even with this measure as it does not account for social risk factors. This lead discussant further noted the analysis showed a disadvantage to nursing homes that serve dual eligibles. This lead discussant also stated the need to keep in mind long COVID and where this population will fit into the potentially preventable readmission measure in the future. This lead discussant noted written public comments stated the measure is based on hospital claims data and those diagnoses are not always accurate. Lastly, this lead discussant voiced support in general for the measure. The second lead discussant stated they had no additional comments to share. The third lead discussant agreed with the summary of the first lead discussant and echoed this was an improvement over the previous measure. This lead discussant noted the desire for CMS to implement the measure before endorsement is completed. This lead discussant stated concern that the measure only includes a fee-for-service population and recognized the challenge with a claims-based measure.

Ms. DeBardeleben opened the meeting for Workgroup discussion. Dr. Schreiber clarified CMS has the discretion to implement measures into programs prior to endorsement. The measure developer reported that dual eligibles perform better at the stay level than non-duals so if added to the risk adjustment, facilities would score worse for those who treat a high proportion of duals. The measure developer further reported when adding dual status, race, and area deprivation index (ADI) to the risk adjustment model, there was still a high correlation between the scores with and without the SRS. The measure developer responded to a question that patient level data for this measure is not available to SNFs at this time. A CMS representative confirmed patient level data is not available at this time. A MAP member noted, for all claims-based measures, it was difficult for facilities to make meaningful change due to the two-year rolling rate and a lack of information regarding the coding. The MAP member further noted with the focus on health equity, it was even more important to see patient level data including social determinants of health (SDOH) factors to initiate improvement change on these measures. There were MAP member comments in agreement with the need for patient level data. A CMS representative acknowledged the patient level data comments and suggestions.

Ms. DeBardeleben moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-099 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 19, No – 1, and percentage voting Yes – 95 percent. Full voting results are available in Appendix B.

MUC2022-113: Number of hospitalizations per 1,000 long-stay resident days

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were four public comments received for this measure, of which three were in favor of the measure and one was not in support of the measure. Ms. Perera indicated a comment was submitted that provided reliability testing information details that were not included in the MUC submission information. Ms. Perera noted comments on refinements to the measure asked about risk adjustment that was performed and questioned the appropriateness of the measure in the program. Ms. Perera also noted comments not in support of the measure included the measure was not endorsed, not appropriate for the VBP, and not a measure of post-acute care. Dr. Elliott reported the Health Equity Advisory Group expressed expanding the denominator would advance health equity. Dr. Elliott also reported, not necessarily specific to just this measure, that the Health Equity Advisory Group discussed stratification of measures, including this one. Dr. Elliott reported the Rural Health Advisory Group had a concern about reliability with small numbers. Ms. Perera turned the meeting over to CMS for any further clarification on the measure.

A CMS representative noted this measure has been in use since 2015 and is used in the Five-Star Quality Rating System. The CMS representative reported hospitalizations among long-stay residents can be disruptive and burdensome, and there have been numerous interventions initiated to reduce hospitalizations for residents. The CMS representative further reported that the measure is appropriate for the program and will improve quality in the long-term setting. Lastly, the CMS representative stated the measure has good validity based on its relationship between lower hospitalization rates and better performance compared to other measures in the Five-Star Quality Rating System.

A lead discussant stated general support for the measure, noted the literature reports hospital stays are not good for these residents, and this data is already used in other arenas such as Care Compare. The second lead discussant asked for clarification on what was considered an unplanned hospitalization. This lead discussant noted one of the references from 2010 was old supporting a lack of clinicians on-site but acknowledged it may still be true today and noted COVID-19 has completely changed the world regarding caregiver support. The third lead discussant disclosed they worked with CMS from 2013 to 2021 on a demonstration project to study avoidable hospitalizations. This lead discussant noted the project worked to define planned and unplanned hospitalizations. This lead discussant further noted that parts of the measure have been tested and used in Care Compare. This lead discussant stated agreement with conditional support for the measure.

Ms. DeBardeleben opened the meeting for Workgroup discussion. A CMS representative responded to the question about the definition of unplanned hospitalizations. The CMS representative clarified the measure is an all-cause hospitalization measure and further noted scheduled surgeries are excluded, but hospitalizations are not differentiated in terms of avoidable or not. The CMS representative reported that generally hospitalizations are not good for nursing home residents and there are SNF interventions that can be done to provide care without having to transfer a resident.

A MAP member commented that some patients nearing the end of life who were having difficulty with a hospice decision may cycle back and forth from the hospital and questioned whether they were

excluded. The MAP member also questioned whether patients who leave the facility for a non-facility stay, such as a holiday stay with family, would be counted. A CMS representative acknowledged any time a resident left the SNF to go to an inpatient facility the resident would be counted. A measure developer answered the question regarding a resident returning home for a holiday stay and those days outside the facility would not be counted. There was discussion from several MAP members acknowledging the difficulty of a facility managing and tracking what would happen to a resident while they were outside the facility, such as home. The CMS representative noted this was a long-stay measure and the idea of a long-stay resident would go home for a visit is extremely rare.

Ms. DeBardeleben moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-113 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 19, No – 2, and percentage voting Yes – 90. Full voting results are available in Appendix B.

MUC2022-126: Total nursing staff turnover

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were six public comments received on this measure, of which four were in favor of the measure and two were not in support of the measure. Ms. Perera noted a comment was submitted that provided reliability testing information details that were not included in the MUC submission information. Ms. Perera noted comments in support of the measure indicated therapy practitioners were a critical part of the SNF care team. Ms. Perera also noted comments on refinements to the measure indicated importance of a turnover measure but mentioned the measure as written does not measure the right things. The comment noted the measure could have unintended consequences if used in the VBP as it could penalize a SNF for efforts to staff adequately to provide quality care. Ms. Perera noted comments not in support of the measure indicated the measure was not endorsed and not appropriate for the VBP. Dr. Elliott reported the Health Equity Advisory Group expressed the importance of this measure to advance health equity, however, they expressed concerns about the equity implications due to caregiver shortages. Dr. Elliott also reported the Health Equity Advisory Group noted analysis of the geographic area of impact for staff shortages and turnover is important. Dr. Elliott reported the Rural Health Advisory Group expressed concerns regarding rural staffing challenges' impact on this measure may be disproportionate to the urban settings.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. A CMS representative noted the reporting of total staff turnover at the beginning of 2022 and the ability to provide the information through the payroll based journal (PBJ) nurse staffing data set. The CMS representative also noted reliability testing on the measure used random split half correlation and the correlation for the overall SNF sample indicated very good or good reliability.

A lead discussant stated their organization had unanimous support for the measure and staffing is essential within a facility. This lead discussant acknowledged the current difficulties in the [staffing] market related to benefits and pay. The second lead discussant expressed agreement with the first discussant and stated strong support of a staffing measure. This lead discussant also noted an association between staff turnover and quality. This lead discussant further noted certified nursing assistants (CNAs) express how important continuity of care and relationship building is to patients. This lead discussant noted the measure developer's statement about a potential unintended consequence of facilities terminating employees before they reach the 120-day threshold but noted this was highly unlikely. This lead discussant noted the desire to see this measure stratified by job categories, specifically pulling out CNA data as that turnover rate is most likely much higher. This lead discussant

also indicated there is evidence that facilities can make a difference in retaining staff including training and mentorship.

There was a public commenter who questioned how healthcare students were factored into this measure as they are a vital portion of the workforce. A CMS representative responded that if the student meets the criteria for the denominator and then subsequently the numerator, they would be included. The CMS representative further noted it does depend on if these students are being paid as that is one of the criteria for the collection of staffing data.

Ms. DeBardeleben opened the meeting for Workgroup discussion. A MAP member acknowledged staff turnover is an important measure but questioned if the measure as written is measuring what it was intended to measure and furthermore it sets up the potential for unintended consequences. The MAP member stated the definition included agency staff but questioned whether it should be employed staff as those are the individuals working on a regular basis. The MAP member also questioned the inclusion of staff on maternity leave or foreign-born staff who take extended vacations, all of whom intend to return to work. This MAP member stated lack of support for the measure, even with the condition of endorsement. A CMS representative commented on the numerator definition of 60 days, stating after looking at definitions of 60 or 90 days there was not a meaningful difference. The CMS representative commented that in regard to agency staff the perspective of the resident was one of most importance and it represented a disruption in the continuity of care. Another MAP member stated to consider an agency nurse the same as a full or part time nurse is risky to running a facility. The MAP member further stated there was a benefit to filling positions with employed staff who were committed to the facility. A CMS representative stated that the measure was looking at more than a year's worth of data and those staff who leave and come back do not have a meaningful impact on the measure.

A MAP member questioned the unintended consequences of penalizing a facility for using agency staff to meet resident needs if they are unable to hire staff with the given workforce shortages. A CMS representative responded that they do not see this measure working in isolation, but in conjunction with the current staffing level measure. The CMS representative also responded to a prior comment regarding the inclusion of nurse administrators in the measure. The CMS representative noted the inclusion of directors of nursing and charge nurses within the measure, but there was a separate measure for administrator turnover. Another CMS representative noted the SNF VBP is looking to align with the Care Compare measures. A MAP member commented that it was important to view this measure through the eyes of the resident with assessment of staff consistency and improvement of care.

Ms. DeBardeleben moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-126 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 17, No – 4, and percentage voting Yes – 81 percent. Full voting results are available in Appendix B.

New Cross-Cutting Function Measure

Ms. Perera provided an overview of the new cross-cutting function measure section and the four measures included in the section.

- **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)*

Public Comment

Ms. DeBardeleben opened the meeting for public comment. A commenter shared concern that for a discharge function score it was a limited measure of select motor function, therefore recommended being cautious to penalize facilities on a narrow score of outcome benefit that can have consequences such as barrier to access in a PAC setting. Another commenter inquired how the calculation would address patients who are deemed unsafe to attempt one or more of the measure function items at admission. The commenter continued that after collaborating with analytical experts in the IRF field, there was concern that the range of expected discharge scores would need to be large if a typical accuracy threshold was used therefore, it may be difficult to offer valid measurement of IRF quality performance on this measure.

MUC2022-083: Cross-Setting Discharge Function Score (IRF QRP)

Ms. Perera prefaced the measure overview by noting that once a vote was conducted for the measure for IRF QRP, the Workgroup had the opportunity to decide whether to carry over the vote from this measure into other programs being considered. Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera presented a summary of the four public comments received for this measure, of which two were in favor of the measure and two were not in support of the measure. Ms. Perera noted those comments in favor indicated the measure has good reliability and validity, is risk-adjusted, and feasible to implement. Ms. Perera noted the comments not in support of the measure indicated concerns about the validity and usability of the measure and noted that more details are needed on how CMS plans to calculate overall expected discharge for ten separate functional items, such as eating and oral hygiene. Dr. Elliott summarized that the Health Equity Advisory Group focused on data collection and that data was already reported by facilities. Dr. Elliott noted the Rural Health Advisory Group expressed variability and gaps in care. Dr. Elliott also noted the Rural Health Advisory Group stated there is a data collection tool currently in place, so there would be no additional burden associated with collection.

Ms. Perera then turned the meeting over to CMS for any clarifying comments on the measure. A CMS representative noted there are eight outcome measures and two process measures addressing functional status across all PAC programs which are not cross-setting in nature nor topped out. The CMS representative further noted the measure utilized a standard set of assessment items that are common to the programs to evaluate patient functional status without additional provider burden and the measure captures dimensions of function, mobility, and self-care in a single measure.

A lead discussant shared concerns about the validity and usability of the measure. The lead discussant noted that discrepancies were found in the way discharge scores are currently calculated for certain measures, such as the percentage of patients who are at or above expected ability to care for themselves and move around at time of discharge. The lead discussant shared that it may be premature to move to an expanded discharge function score as the proposed measure would require a wide range of expected discharge scores if a typical accuracy threshold was used. The lead discussant continued that the technical report provided a table, comparing the standard recoding and imputation discrepancies for the suggested [OASIS section] GG items for the measure and the data demonstrated that the imputation measure method was not as valid for sit to stand and the walk 50 feet GG items, leading to concerns about those two items being added. The lead discussant shared another comment suggesting that the term wheelchair bound be replaced with wheelchair user or person who uses a wheelchair in this and any other relevant measure language. The lead discussant asked for clarification on the count of items, especially if the patient is scored NA on admission and on discharge for walking ten feet and walking 50 feet with two turns.

Another lead discussant agreed with the first lead discussant's comments and shared this measure has a range of gaps; therefore, it may be beneficial to further clarify the measure. The lead discussant inquired about clarification on the admission question that was mentioned in the public comment. The lead discussant expanded on the functional assessment data that is covered in different denominators across different PAC settings, therefore, if this is supposed to be a cross-cutting measure, there is concern that the IRF has Medicare A and C, SNF has Medicare A, and LTCH has all of them. The lead discussant noted there is concern the denominator would be different across different settings.

The third lead discussant noted the measure is an important outcome and could do something across settings which is important to CMS. The lead discussant noted that the measure is limited in the expected discharge function score, how it is calculated, and whether the operating statistics around it are valid and predictable. The lead discussant shared that the measure elements are valuable but there needs to be clarification on the purpose of the score and how it is calculated.

Ms. DeBardeleben opened the meeting for Workgroup discussion. A CMS representative shared the measure developer would answer questions regarding the discrepancy in discharge score and how it is calculated for the IRF setting. The measure developer noted it might refer to corrections that have been made on existing measures in terms of specification or calculation by contractors who calculate the scores on existing measures which were corrected. The developer shared that the proposed measure is similar to existing measures in the IRF, SNF, and LTCH QRPs where the discharge scores on multiple functional outcome items at discharge are summed into an overall index, and that index is risk-adjusted for a similar calculation on the admission score as well as a wide array of clinical comorbidities. The developer stated that if a patient is not assessed because it is clinically counter-indicated or not assessed at admission or discharge, rather than using simple imputation which is currently used to treat all such cases as most dependent and coded to one, this measure would use existing information on the same clinical covariance as well as any assessments on other items. The developer noted a large range of observed scores across facilities, therefore the findings of a large range of expected scores is consistent with the measure. The developer further noted that they observed expected correlations between this measure and existing function measures, as well as with other measures, such as discharge to community. The developer emphasized excellent reliability of the measure and good predictive validity; both the item scores as well as the model fits of the measures.

Ms. DeBardeleben shared the questions from the chat one by one. A MAP member asked how the measure will account for patients who are deemed not safe to attempt one or more of the measure function items at admission, such as sit to stand. The developer responded that when there is an ANA or NA code to an activity not assessed on any one item on admission, the score would be imputed based on a statistical imputation model that uses all the clinical covariance as well as any valid responses to any of the other items. The developer stated for example, sit to stand is NA and is not assessed, but walking ten feet is, or in a more typical result, rolling might be assessed, even though the sit to stand is not assessed, therefore that is imputed. The developer continued that the imputed score is used in conjunction with any other observed score, if the roll in bed is a one, most dependent, the imputed score is computed and then summed with all the other items into the overall admission score.

A MAP member commented from the chat that the IRF and SNF QRP programs have competing measures that are collected and calculated in a similar manner, a discharge self-care score, and a discharge mobility score, with items included in this measure may be highly correlated with each other. The MAP member inquired whether consideration for this measure would lead to the retirement of other existing functional measures in the programs. A CMS representative responded that the other four functional measures in the SNF QRP and the IRF QRP were adopted through the rulemaking process. The

CMS representative continued that if any of the measures were discontinued, they would go through the rulemaking process as well.

Ms. DeBardeleben shared the second part of that question was about how certain items are highly correlated with each other. The measure developer addressed that in conversation with the TEP they discussed items that could be removed because of high correlation, and chose to remove for example, sitting to lying because it was deemed by the experts to be not marginally informative, and was shown to be highly correlated with items that were retained. The developer added that the correlation between the items showed a good internal consistency of the overall index. A MAP member wanted further clarification on whether there would be an automatic review of other existing competing measures to avoid duplication if this moves forward for rulemaking. A CMS representative shared the goal for this measure is to replace a topped-out process measure and the items used to create the measure are already being collected, therefore it does not add to provider burden. The CMS representative added that it may be a similar process to remove other measures, for example, within SNF and IRF.

Another CMS representative clarified the measure is a cross-setting measure that meets the IMPACT Act requirement for a cross-setting measure across the four post-acute care programs. The current measures in IRF and SNF, the discharge self-care and mobility measures, and the change self-care mobility measures do not meet the IMPACT Act requirements as they are not collected across all four settings. The CMS representative continued that this measure could potentially allow CMS to consider moving from a process measure to an outcome measure to satisfy the IMPACT Act requirement. The CMS representative added that any of those setting-specific function items could be considered in the future for removal based on CMS goals, and those would go through the rulemaking process; therefore, there would be an opportunity to comment at that time. Dr. Schreiber added that CMS will try to retire other measures in future rulewriting when introducing new measures as there is no intent to create duplication of measures or additional burden.

A MAP member asked if there was a reason why sit to stand and walk 50 feet with two turns continue to count in the ten assessment items even though they had a negative value when comparing the recode versus imputation method. The MAP member also asked if there was any consideration to assess other items or how the score was input for these items. A measure developer clarified that it was based on additional analyses performed on how patients performed at discharge based on being classified as “ones” on admission. The developer found that the imputation of the performance of such patients was much closer when using imputation rather than always imputing them as the most dependent. The developer continued that there were individual items that vary by setting where that distance is smaller when just imputing those scores as “ones.” The developer further noted that it does not invalidate the overall approach across the entire item set and for all items imputed, the methodology is the same for consistency in all clinical covariates used in that setting, as well as all other items available in that setting, noting it is the most comprehensive approach to imputation overall. The developer concluded that in all models they found high predictive validity as well as overall lower error and bias relative to the impute as one methodology that can be used for the index of both admission and discharge course.

A MAP member asked if the patient scores NA for both walking items whether they are both replaced with something else. A developer responded that for patients that score NA on walking on both items at admission and discharge, meaning that there is no indication the patient does walk during the stay, that then the wheel item is used. The developer shared that the wheel item is used twice which is similar to how measures are currently addressed. The developer continued that they multiply its weight in the overall index by two for patients who use a wheelchair to get the overall index measured on the same

scale as for patients who walk. The developer added that the note about language regarding patients who use wheelchairs is appreciated and will be reviewed with respect for patients.

A MAP member inquired about the voting process and whether it would be more appropriate to have all discussions for each measure first before voting on the measures to ensure everyone has the chance to share comments. Ms. Perera shared that the Workgroup has the option to carry over the vote, however, the measures can be discussed for each specific program and then the measure be voted upon if one or more Workgroup members voice concerns on carrying over the vote. Ms. Perera added that comments can be provided for the varying measures, even if it does not affect the voting decision.

A MAP member shared a concern that there are issues that impact the measure itself regardless of the setting; therefore, it is more efficient to conduct one vote as this is a cross-setting measure. Other MAP members concurred. Ms. Williams-Bader appreciated the feedback and shared that NQF staff will discuss and get back to the Workgroup on best practice. Ms. DeBardeleben clarified that any MAP member could request that the measures be discussed separately after this vote.

A MAP member shared that current language excludes patients for which the discharge destination indicates the patient had a medical emergency from the denominator. The MAP member inquired if current language could be expanded to ensure it captures all forms of unexpected discharges, including secondary discharges. A measure developer shared that each setting is limited to the responses available on the assessment which identify exclusions, therefore discharge from medical emergencies do not get additional information about such discharges. Ms. DeBardeleben inquired for clarification on what is included in the medical emergency discharge destination. The developer responded that it is a discharge destination that includes discharge to acute care hospital or emergency room but that the language varies between settings. Ms. DeBardeleben shared that it would be beneficial to include what codes are going to be excluded from the denominator for each setting in the measure. The developer agreed and added that the full specifications, where the individual item responses are specified to be completely transparent, would be similar to a typical user manual.

Another MAP member shared hesitancies with expected discharge summation of discharge scores and ten items as predicted by the admission scores on those items plus some covariates that are put into a model. The MAP member shared that clarification is needed to understand how the score is determined and what the score represents therefore, this meeting offers an opportunity to explore how different settings are performing and could help implement a performance improvement plan using the data from the model. A measure developer explained that there are two sets of NQF-endorsed measures that are currently used in IRF and SNF, and a similar version used in LTCH for ventilator patients, and the change in these discharge measures are virtually identical in that the risk-adjusters include admission score on set items. The developer continued that, currently, the mobility items available in that setting, summed up available self-care items, and then separately in IRF and SNF. The items that are not assessed are summed up through simple imputation which is the admission score. The square of the admission score is taken and a whole set of covariates: age, primary medical condition, HCCs, cognitive function, communication impairment, incontinence, history of falls, pressure ulcers, and more, are specified. The developer further noted that the details are provided in the submissions; clinical comorbidities and the mission score are used to risk adjust the measure. The developer continued that for the change function, the difference between the discharge score and the admission score is taken and that is what is being predicted. For the discharge measure, the difference between the discharge score and those measures are highly correlated, because the same specification with a slight change to what is predicted and then the difference is primarily how those measures are reported. The discharge function scores and the proportion of patients at the provider level where their observed discharge

function met or exceeded their expected discharge function based on where they started, and all their clinical comorbidities is what is reported.

Ms. DeBardeleben stated a comment that was made earlier that the measure may have similar calculations, however, the denominators vary by setting. Ms. DeBardeleben further stated for example, IRF collect Medicare A and C, SNF collects Medicare Part A only, and LTCH collects this on all patients. Ms. DeBardeleben stated that the variation in patients and data collection undermines the ability of the measure to be truly cross-setting. A developer shared that these measures are similar to all existing QRP measures that rely on assessments. The developer continued that they capture as much of the assessed population as is clinically reasonable and do not attempt to reduce the reportability and actionability of these measures. A MAP member added that only 10 percent of the SNF population is Medicare and 53 percent in IRF, which demonstrates that what is assessed in each setting can vary widely based on what is assessed and collected. A representative from CMS noted that CMS will begin to collect data on all patients, regardless of payer, beginning October 1, 2024, and January 1, 2025, for the home health setting.

A measure developer reminded the Workgroup that the IMPACT Act mandated reporting of measures within the function domain and the existing measure is a process measure which is collected through all the assessment items that have been collected amongst the different settings. The measure developer shared that the plan is to develop a cross-setting, functional status outcome measure across the PAC settings and across a wide variety of patients. The developer shared that the residents admitted within these settings range from those who are not going to improve much at all to those who are going to improve significantly. The measure developer added that the expected score concept is to try to develop measures that have the expected score at the end and to have measures that demonstrate how providers are doing at meeting that expected score. The measure developer shared that this type of concept is already within the setting-specific measures that come to MAP and have been finalized within programs. The measure developer clarified that nothing new is added to the items that are already being collected and are used to calculate the measures within the settings. The developer shared that the most judicious set of items were applied for a wide range of patients that are in these settings. The measure developer noted that they are trying to build a better measure, a measure that can be applied across all these settings. The measure developer further noted that the expected score concept should apply to any admission, whether it is a Medicare admissions or Medicare Advantage, as it is all risk-adjusted.

A MAP member inquired about what formulas are used to determine imputation for the metrics from the technical report. The member shared that many hospitals have identified discrepancies from the challenging calculations for the current metrics around self-care and mobility with the maximum and calculating those adds another level on top. The MAP member shared they would like further clarification of what that formula is to be able to ensure that the imputations are being calculated correctly. A CMS representative noted what the measure developer shared earlier about the measure specification documents providing greater details on how the imputation methods are used and calculated from measures. A measure developer concurred that all the measures included in QRP, the manuals and preliminary technical documentation would provide full detail and transparency on how the measure is calculated which includes the details of both the imputation and risk adjustment methodology. The developer added that the imputation approach is similar to the risk adjustment approach with the difference that it is done on an item-by-item level and including other items, which is all other GG items available in that setting for risk adjustment. The measure developer concluded that rather than being a linear model, it is an ordered probate model which is used to estimate one of the six possible values that each GG item can take.

A MAP member appreciated that the Workgroup is trying to move towards cross-cutting measures, toward population health improvement and outcomes around population health. The member noticed that the measure is applied to both home health and facility-based care. The member stated there are some specific nuances and underpinnings that individualize to these two constructs of care, the processes and workflows are different in these care settings. The MAP member noted making these measures actionable, allowing the measures to become implemented while focusing on care coordination, and interoperability. The member requested that as these measures are developed, tested, and passed through the rulemaking process, the data is shared in an effective, meaningful, timely manner across care settings. A CMS representative shared that one thing to consider is that the measure is not intended to compare one provider to another, that values are compared within programs and not between programs. The representative noted that there is a measure that captures change, using the same assessments and predicts value, which allows for consistency through the programs.

A MAP member questioned whether it would be more appropriate to consider this measure for QRP for a period before it gets considered for a value-based purchasing program rather than at the same time. A CMS representative shared that the proposed measure is better than the current functional measure and functional measures are key areas in the SNF setting. The representative shared that the data elements have been used consistently over time and imputation is just a refinement or an improvement, therefore CMS recommends moving forward with the SNF VBP and QRP programs.

A MAP member shared a concern that the provider may not be able to discern what issue the individual may be struggling with and how to improve the situation when the measure is rolled into a single performance score. Other MAP members agreed with this concern. A measure developer responded that the alternative would be to use individual items and some level of summarization that is useful from both the customer and TEP perspective. The developer continued that the TEP strongly agreed with combining self-care and mobility in this measure. The measure developer noted that some existing measures do allow providers to separate the two disciplines; therefore, the proposed measure serves to use as many cross-setting standardized items as possible, in every available setting. The measure developer noted that it does not remove the ability of providers, where additional information is available, to make use of those measures.

Another MAP member built upon a previous comment about measures being similar but not being compared to one another on the Care Compare sites, that in a cross-setting indicator, program settings would be compared as to their success and meeting their functional goals. A CMS representative noted that the proposed measure is a cross-setting measure, and it is not compared across settings rather compared within settings' providers and patients' functional abilities.

Ms. DeBardeleben shared the last comment from a MAP member in the chat that the existing process measure assumes equivalence, and the resulting percentage is probably reported. The MAP member continued that with this measure being cross-setting, using the percentage to meet or exceed, would potentially create equivalence to the consumer that similar outcomes at discharge may be available in each setting. The member noted that even at the actual discharge functional values, they would be significantly different. Ms. DeBardeleben referred to NQF staff for next steps.

Ms. Perera thanked the co-chair and noted the Workgroup was running close on time for measures in this section but wanted to circle back to a member comment about discussing the measures and providing comments on each of the programs before moving to a vote. Ms. Perera asked the Workgroup by a show of hands if they would prefer to talk about each program for which this measure is being considered for, and then take a vote at the end for all the programs. A MAP member asked for

clarification on what other voting process there was aside from the proposed voting process. Ms. Perera clarified that the original process was to vote on the measure for IRF QRP, and then to let the Workgroup decide whether to carry that vote forward for each program for which the measure is considered. After Workgroup discussion, Ms. Perera clarified that the MAP Workgroup would be voting for them as a group unless a member would like to vote on the measure for each program individually. Ms. Perera shared that with majority decision, the Workgroup will take comments for each of the programs for which this measure is being considered and vote at the end of the discussion. Ms. DeBardeleben noted that comments for all measures will be taken and voted on as one set, but any one member can request to pull out measures and vote separately.

Ms. DeBardeleben moved the Workgroup to vote, "Conditional Support for Rulemaking," for measure MUC2022-083 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Full voting results are available in Appendix B.

MUC2022-085: Cross-Setting Discharge Function Score (HH QRP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were five public comments received on this measure, of which three were in favor of the measure and two were not in support of the measure. Ms. Perera noted comments in support of the measure indicated the measure has good reliability and validity, is risk-adjusted and feasible to implement. Ms. Perera also noted comments on refinements to the measure indicated that the state of Pennsylvania must enact and adhere to required education and corrective action processes rather than placing common laypersons caring for loved ones in federal criminal prosecution. Ms. Perera noted comments not in support of the measure indicated the measure was too complicated and easy to game based on the expected function. Dr. Elliott reported the Health Equity Advisory Group expressed the importance of data collection and data already collected, reported by the entities. Dr. Elliott also reported that the Rural Health Advisory Group noted significant variability, reflecting gaps in care data collection from the rural health perspective. Dr. Elliott reported the Rural Health Advisory Group further noted that there is already a data collection tool and no additional burden. Ms. Perera turned the meeting over to CMS for any further clarification on the measure.

A CMS representative noted the comments from the previous measure and further noted this measure is in a different setting, therefore there are exclusion criteria that are different across settings. The CMS representative added that the setting is accounted for when adjusted for risk.

A lead discussant noted that there are some duplicative measures in home health and that could lead to unintended consequences for agencies to identify certain patients for enrollment. The lead discussant further noted that this measure is an opportunity for other data collection and an opportunity for interdisciplinary team members to plan comprehensively from the plan of care perspective. The lead discussant concluded that their organization supports conditional support for rulemaking. Another lead discussant concurred with the previous lead discussant that the group has addressed duplicate measures, potential selection bias, and CMS addressed these concerns in the shared materials.

Ms. DeBardeleben referred to a prior comment made by a MAP member that asked how the measure accounts for patients who enter home health for maintenance or stabilization care and are not expected to improve. A CMS representative noted that the discharge function score is based upon the patient at admission, therefore if the functional status of the patient is not expected to change at admission, the calculation adjusts accordingly. A measure developer shared that the measure is composed of four steps: imputation of NA results, sum of discharge and admission score, prediction of summed up

discharge score to get expected discharge score, and the number of episodes for each home health agency, respectively. The developer expanded that the episodes contribute to the numerator for the calculation of the final score. The developer shared that out of the steps listed, the third step is relevant to this comment, where the risk adjustment model predicts the expected discharge score. The measure developer shared that there can be the case that the expected discharge score is lower than or equal to the admission score, therefore the only requirement for an episode to contribute to the numerator is for the episode to end at a functional status at discharge that is potentially the same or lower than the expected discharge score.

A MAP member shared a concern for the ability to game the measure results and if there is anything in the model that eliminates subjectivity. The member expanded with an example in the MDS that there is some aspect of judgement in how the expected improvement is noted. The developer noted that in home health, admission source and living arrangement, information recorded at admission are used to predict discharge data from previously submitted data; therefore, obtaining an observed discharge score and an observed admission score. The measure developer noted that a correlation is created between the characteristics at admission and the discharge score for each episode. The measure developer noted that while it is possible that home health could influence the coefficients used to estimate on historical data which would cause the risk adjustment models to be potentially invalid for first future use. The developer further noted, however, there are 12,000 home health agencies making it unlikely that that would be the case thus, concerns about gaming the measure are addressed by the risk adjustment model. Another measure developer emphasized that providers are not asked to provide the expected score, rather the expected score is determined by initial functional items and other comorbidities. A CMS representative added that an assessment is completed at admission and discharge and the proposed measure has potential to perform better than previous assessments due to the prediction with risk adjustment rather than a straight comparison without risk adjustment. A measure developer noted that there may be concern about the third column in the assessment where the provider sets a goal for the patient. The developer clarified that the column is not used for any current functional outcome measures, including the proposed measure.

A MAP member inquired about the level of data exchange, how the discharge score is affected, and the documentation process if a patient were to move from one facility setting to another, such as going from an IRF facility to a SNF facility. A CMS representative shared that each provider would assess the patient for their facility, therefore there may be a difference between admission and discharge scores due to arrival and discharge from the initial facility to the next facility who would have new admission and discharge scores. The CMS representative continued that the providers would transmit information in the patient charts as normal from one provider to the next and the difference would be the way the patient is assessed at each facility. The MAP member inquired whether there would be an acceptable delay, while maintaining accuracy, in the calculation of the score when patients are transferred between facilities. A CMS representative noted that the facilities follow the requirements of the assessment for each facility, for example, SNF facilities have a certain timeframe that the assessment and MDS must be completed and IRF facilities have certain requirements for discharge. A measure developer clarified that the measure is cross-setting and is consistent across all settings therefore it is not trying to compare the care that the patient receives in an IRF facility to the care they may receive in a SNF facility, rather the care received is compared from a IRF facility to another IRF facility and the same can be applied to the other settings. Ms. DeBardeleben commented that the denominators are likely to be different across settings to reduce cross comparison and to adjust risks to the specific setting. A measure developer noted that the scores are adjusted based on the setting with the goal of being aligned across the settings where appropriate.

The Workgroup decided to carry over the vote, "Conditional Support for Rulemaking," from the previous measure (MUC2022-083) for MUC2022-085 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Full voting results are available in Appendix B.

MUC2022-086: Cross-Setting Discharge Function Score (SNF QRP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were five public comments received on this measure, of which three were in favor of the measure and two were not in support of the measure. Ms. Perera noted comments in support of the measure indicated the measure has good reliability and validity, is risk-adjusted and feasible to implement. Ms. Perera also noted comments on refinements to the measure indicated that the state of Pennsylvania must enact and adhere to required education and corrective action processes rather than placing common laypersons caring for loved ones in federal criminal prosecution. Ms. Perera noted comments not in support of the measure indicated the measure was too complicated and easy to game based on the expected function. Dr. Elliott reported the comments for this measure are similar to prior discussions. Ms. Perera turned the meeting over to CMS for any further clarification on the measure. CMS representatives did not have additional comments.

A lead discussant shared their support for an outcome measure and cross-setting measure. The discussant thanked the other members of the Workgroup for their clarifying questions on the developer perspective of the measure and shared that the measure has the potential for positive change.

Another lead discussant thanked the Workgroup members, developers, and CMS representatives for feedback. The discussant shared that there may still be complications for the facilities to improve but based on the discussion, it seems the scores are calculating some individual by element scores which is an improvement. The discussant shared that if there is a way for the data to be shared with providers, it would help simplify the administrative burden which adds to the goal of improving quality and delivering value. A CMS representative noted this measure is intended to address problems with existing functional measures and potentially replace a topped-out process functional assessment measure. A measure developer added that the expectation is based on risk adjustment, not on any claims of expectation from the provider, and the measure controls for function at admission through statistical imputations which should reduce the ability to game the measure.

A MAP member asked if the same analysis is done at each setting, with the same set of comorbidities or assessed elements. A CMS representative responded that the risk adjustment is similar across the settings but accounts for specific clinical conditions. The member thanked the Workgroup for the explanation on GG and asked if there are any considerations to not do testing, of a new or revised measure, in the value-based purchasing perspective and rather in the quality reporting perspective to increase data collection. A CMS representative shared that the value-based settings adopt measures already adopted within a quality reporting program. Another CMS representative added that data has already been calculated and tested for QRP, therefore there is no high expectation of change. The representative noted the measure from QRP would be similar, if not the same, for SNF VBP. Another MAP member added that the measure may be better tested through QRP before implementing in VBP, as it would give providers time to deliberate and understand the new reports and measures before being held accountable. A CMS representative noted that Congress recommended a cross-setting measure due to there being multiple individual measures in the past, which would then help standardize assessments through the IMPACT Act. The CMS representative added that having a function score in the SNF VBP helps assess care coordination, patient safety, and eventually, patient satisfaction.

A MAP member asked about the difference between the function of this measure compared to the topped-out measure that is being proposed for replacement. A CMS representative shared that there are measures in IRF, SNF, and LTCH that observe changing mobility in patients requiring ventilator support, that they are not process measures, and they do not meet the IMPACT Act requirements. The representative continued that the current measure replaces a measure in the programs that is an IMPACT Act-required measure. Another CMS representative shared that the logic does not align to do non-cross cutting measures for VBP if there are cross-cutting measures in place for the QRP. The CMS representative noted the goal of the measure is to align a cross-cutting measure across programs.

Ms. DeBardeleben raised a question about the time frame to retire existing measures to avoid redundancy and measurement. A CMS representative restated that the measure evaluates function and is designed to be an improvement on a topped-out process measure and to satisfy IMPACT Act requirements by moving to an outcome measure. The CMS representative continued that the proposed measure is not designed to be a replacement for the other four measures in SNF QRP, two change measures and two discharge function measures. The CMS representative noted that there is not a concrete deadline in place for the measure removal process as it must go through the rulemaking process.

A MAP member commented that the QRP would hold SNFs accountable for reporting performance on this measure and to make sure that reporting is done well before holding them accountable for performance. The MAP member asked if this measure is already applied in Home Health and IRF. A CMS representative clarified that it is the SNF VBP, and the programs are already reporting these measures and evaluating patients using assessments that have been used for years. The CMS representative clarified that the same data is being collected and being applied differently with these measures, which is an improvement. The MAP member added they would like clarification as to whether it would be possible to work out any issues with the measure before applying it to other settings. Another MAP member concurred with the comment and asked what the benefit is of submitting the measure to the other programs if the measure is holding those submitting to QRP accountable. A CMS representative noted that the assessments are submitted once, and no additional assessment is needed.

The Workgroup agreed to carry over the vote, “Conditional Support for Rulemaking,” from the previous measure (MUC2022-083) for MUC2022-086 for SNF QRP, with the condition of endorsement by a CBE. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Full voting results are available in Appendix B.

MUC2022-086: Cross-Setting Discharge Function Score (SNF VBP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were two public comments received on this measure, of which one was in favor of the measure, and one was not in support of the measure. Ms. Perera noted comments not in support of the measure indicated the measure was too complicated and easy to game based on the expected function. Dr. Elliott reported the comments for this measure are similar to prior discussions.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. A CMS representative shared that the elements for the function have been established, therefore there no changes in measure collection and the assessments are the same. Another CMS representative added that all GG items in this measure are being collected on the assessment instruments, therefore there are no new items.

A lead discussant emphasized the value of assessment of functional status and that goals should be captured in the assessment. The lead discussant inquired about whether there would be a summary that would answer the statements posed at the beginning of the measure discussion.

The Workgroup agreed to carry over the vote, "Conditional Support for Rulemaking," from the previous measure (MUC2022-083) for MUC2022-086 for SNF VBP, with the condition of endorsement by a CBE. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Complete voting results are available in Appendix B.

MUC2022-087: Cross-Setting Discharge Function Score (LTCH QRP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there was one comment in support of the measure and no comments were provided. Dr. Elliott reported there were no new comments from the Advisory Groups.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. CMS representatives had no new additional comments.

A lead discussant shared their support for this cross-setting measure and reinforced that the measure is replacing a topped-out measure and it is important to have functional outcome measures to compare within settings.

A MAP member asked for clarification if the measure is new to the LTCH setting and if the LTCH setting has other existing process measures. A CMS representative shared that this measure is intended to replace a topped-out functional assessment measure and that the LTCH setting has an outcome measure that measures the change in mobility among patients requiring ventilator support. A measure developer added that the outcome measure was a requirement that would now be a cross-setting functional status outcome measure for all patients in the LTCH setting, including ventilator patients.

The Workgroup agreed to carry over the vote, "Conditional Support for Rulemaking," from the previous measure (MUC2022-083) for MUC2022-087 with the condition of endorsement by a CBE. Voting results were as follows: Yes – 15, No – 5, and percentage voting Yes – 75 percent. Complete voting results are available in Appendix B.

New Cross-Cutting COVID-19 Measure

Prior to the start of the discussion of the COVID-19 measures, Ms. Williams-Bader clarified the meeting process for the rest of the day. She explained that the Workgroup will discuss and vote on the first measure, NQF staff will ask if the Workgroup opposes the carryover of the votes to the next measure/setting, and then there will be discussion plus vote on the remaining settings if the votes are not carried over.

Udara Perera, director, NQF, introduced the new cross-cutting COVID-19 measure section and the four measures included in the section.

- **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)*
- **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)*

Public Comment

Dr. Merkelz reminded the meeting attendees of the public commenting process before opening the meeting for public comment. A member of the public stated that although this is an important issue, they did not think the measure was appropriate for QRP programs as QRP has financial implications. The commenter also noted that the definition of "up-to-date" keeps changing and there has been no review of the validity and reliability of the measure. Another public commenter agreed with the prior commenter and further expressed worry that facilities will be accountable if residents refuse the vaccine. Another public commenter stated that the vaccine may be detrimental to IRF patients during their short stay. There was another comment in agreement with the first public commenter.

MUC2022-089: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (IRF QRP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera presented a summary of the five public comments received for this measure, of which three were in favor of the measure and two were not in support of the measure. Ms. Perera stated comments in favor of the measure noted that although this measure does not specifically include hospice and palliative care (HCP), HCP patients may spend time in a [facility] and this quality measure can help patients decide on which facility to choose; and that patient engagement is critical at this stage of the pandemic where the best available information indicates COVID-19 variants will continue to require additional boosters to avert COVID-19 case surges. Ms. Perera stated comments on refinements to the measure called for fewer specific criteria for denominator inclusion and for numerator inclusion that provides more flexibility over time, as well as more flexibility for adaptation to local circumstances. Ms. Perera stated comments not in support of the measure noted the measure will simply reflect COVID-19 vaccination and booster-related uptake rates in the IRFs' general community and will not capture any meaningful differences across IRFs in the same geographic areas. Lastly, Ms. Perera stated comments not in support also noted that IRFs do not have immediate or ongoing access to COVID-19 vaccines and/or boosters and will have difficulty affecting this measure. Dr. Elliott stated the Health Equity Advisory Group expressed concerns about vaccine hesitancy due to cultural norms. Dr. Elliott stated the Rural Health Advisory Group noted it was an important measure in rural health communities.

Ms. Perera turned the meeting over to CMS for any further clarification on the measure. Dr. Schreiber commented, in general, on this measure for all settings and noted this as a high priority topic for not only CMS, but for the country as it continues to face COVID-19. Dr. Schreiber stated that for CMS this is a foundation to mitigate COVID-19 and severe illness, to which a large degree of patients in these facilities are at risk. Dr. Schreiber reminded the meeting attendees that these are reporting programs and there is no financial penalty unless the facility does not report at all. Dr. Schreiber further noted this information is important for consumer choice and providers have an opportunity to influence their patients, especially for those patients in the facility. Dr. Schreiber also noted, from an equity perspective this is important as these are high risk patients who have frequently been undeserved in the past. Another CMS representative noted that PAC providers are in a unique position to leverage their care processes to increase vaccination coverage in their settings to protect patients and prevent negative outcomes.

A lead discussant noted agreement with the importance of a public health measure, but was not sure there will be a distinction in the facility to participate. This lead discussant stated agreement with the public comment regarding a potential impact on a patient's ability to participate in therapy.

Dr. Merkelz opened the meeting for Workgroup discussion. A MAP member questioned the inclusion of

cultural norms and religious exclusions in the measure. Another MAP member commented that the average length of stay in an IRF is 12 days and post-vaccine symptoms could impact a patient's three hour per day therapy requirement with detriment to the therapeutic intervention. This MAP member further commented that the influenza vaccine was discontinued in the IRF setting and wondered if this would be the same case for this measure. Another MAP member commented positively on the inclusion of a cross-cutting measure but questioned how refusals will be handled in the measure. This MAP member also asked the developer to comment on how the National Healthcare Safety Network (NHSN) will handle this measure. A MAP member noted support for reporting COVID-19 vaccines but questioned a scenario that may lead to patient selection or obstruction to transition of care. There were further MAP member comments about residents who refuse the vaccine, refuse to report to the facility, or those who are unable to respond.

Dr. Schreiber responded that the measure is a raw rate, so there are no exclusions besides those who are allergic to some component of the vaccine. Dr. Schreiber noted that CMS does not post community rates of vaccination, so a consumer who is looking at a facility would not know the rates. Dr. Schreiber also noted 12 days is not a short amount of time when there is a patient the facility deals with each day. Dr. Schreiber stated NHSN is highly reliable, and the reporting system used by CMS and CDC in nearly every facility type with few exceptions. A CMS representative commented that the assessment item does not require proof of vaccination and attestation from the patient as well. The measure developer confirmed that no proof of vaccination documentation is required for this measure and all sources will be accepted including patient interview or proxy response. The measure developer further clarified, although there is currently vaccination information in NHSN, this measure would not use that information. The measure developer noted the concern with the measure obstructing or reducing is one they do not want to happen and noted during testing providers shared that they were already asking patients about vaccination status. A CMS representative clarified comments that this measure will capture all nursing home stays, not just short stays. The measure developer noted the viability of the measure with the use of the up-to-date definition.

Dr. Merkelz asked for clarification about earlier comments regarding the time of vaccination status reported and those patients who may not be able to report for themselves for various reasons such as dementia. The measure developer responded that the item will be measured at discharge and that proof of vaccination is not required, even verbal reports from family will be accepted.

A MAP member stated support for the basic measure concept but questioned whether future changes in recommendations with boosters would affect the measure. Dr. Schreiber stated that was why the measure was written with the up-to-date definition, so the measure would consider any future changes. Another MAP member questioned whether this measure could have unintended consequences of increased disparities in access to services for those not vaccinated, for instance not accepted into a long-term facility due to lack of vaccination. Dr. Schreiber noted acknowledgement of the comment and hoped that a facility would not turn away a patient due to vaccination status. Dr. Schreiber further noted in many cases these are the most vulnerable population to COVID-19 and those who have not had access to the vaccination. A CMS representative commented with a correction to an earlier statement regarding which patients will be assessed for this measure and it will only be short-stay SNF patients, not long-stay patients.

A MAP member noted their comments would carry over to other settings, so in the interest of time noted comments for home heath as well. The MAP member stated that this measure, like other vaccinations, would help public health. The MAP member also stated conversations clinicians have with patients about one vaccine can have a ripple effect to other needed vaccines. The MAP member noted

concern regarding data exchange in the home health setting and to some extent in the facility setting. The MAP member suggested the need for a central data repository or the ability to access data that may be available to the public at some point. Another MAP member noted their participation in a TEP for the COVID-19 patient level vaccination measure and further noted that many of the issues raised by the Workgroup were also raised in the TEP. The MAP member asked why this measure is quarterly and not measured yearly like the influenza measure. Dr. Schreiber answered that generally the influenza window of time is shorter, usually September to March. Dr. Schreiber noted that it may be more burdensome to keep track of patients for an entire year to report. Dr. Schreiber further noted the CDC has yet to announce whether the COVID-19 vaccine will be seasonal. The measure developer stated the importance of the vaccine data collection is also to gather and analyze patient level data. The measure developer further stated this data will enable providers to develop strategies and engagement approaches to improve vaccination. A MAP member commented that most patients admitted to an IRF setting come from an acute setting and thus have already been encouraged to receive vaccination. The MAP member further commented that there is little the IRF provider could do to increase vaccination status. Dr. Schreiber responded that healthcare is a continuum and every contact along the continuum provides an opportunity to encourage vaccination. Dr. Schreiber further noted the average 12-day IRF length of stay is generally more time than a patient stays in a hospital setting. The MAP member noted that the influenza vaccine that was retired did not have rates that varied much, and this may be the case with the COVID-19 measure in the IRF setting as well.

A MAP member requested the measure be voted on separately for each program. The MAP member clarified an earlier comment that short- and long-stay patients are in the same facility, but this measure is only reporting data for short-stay residents. This MAP member further noted that this measure is not getting at the safety issue and is not giving consumers the information they need to know.

Dr. Merkelz reminded the Workgroup that the vote is for the IRF setting and moved the Workgroup to vote on acceptance of the NQF staff recommendation, “Conditional Support for Rulemaking” for measure MUC2022-089 with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 11, No – 8, and percentage voting Yes – 58 percent. The Workgroup did not reach consensus. Dr. Merkelz suggested to the Workgroup the decision category of “Do Not Support with Potential for Mitigation.” Ms. Williams-Bader confirmed there would need to be mitigation strategies indicated for this voting category. A MAP member asked for clarification on who would provide the mitigation strategies. Ms. Williams-Bader confirmed those strategies were to come from the Workgroup. Dr. Merkelz noted there were no mitigation strategies. Dr. Merkelz moved the Workgroup to vote on, “Do Not Support for Rulemaking” for measure MUC2022-089. Voting results were as follows: Yes – 12, No – 8, and percentage voting Yes – 60 percent. The Workgroup reached consensus. Full voting results are available in Appendix B.

MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (HH QRP)

Following the vote, Ms. Perera asked the Workgroup if they would like to move the votes forward to the next program, HH QRP. There were objections to moving the votes forward. A MAP member noted they were uncomfortable with moving the decision category of, “Do Not Support for Rulemaking” forward. The MAP member stated respect for the vaccine issues in a short-stay IRF but noted COVID-19 is still the third leading cause of death in the United States. The MAP member further noted a New York Times article about the vulnerability of the elderly and disabled, stating once the measure moves away from short-term stays they saw no relevance to the argument against the vaccine measure. There were a few more MAP members who agreed with not moving the “Do Not Support for Rulemaking” votes forward.

A MAP member asked for clarification that if the measure is not adopted if consumers would not have

access to vaccination information in any manner. Dr. Schreiber answered yes, consumers would not receive the information. Another MAP member questioned the lag time of almost a year on Care Compare and whether that data would have value.

Ms. Williams-Bader asked MAP members if anyone had any new comments to make regarding the measure in the HH QRP. A MAP member stated support for the vaccination measure and noted that all providers of all types have a role to play in improving vaccination rates. Another MAP member noted concern that home health providers cannot supply the vaccine and because it is not a facility there is not an exposure concern.

Dr. Merkelz moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-090 with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 11, No – 9, and percentage voting Yes – 55 percent. The Workgroup did not reach consensus. Ms. Perera asked the Workgroup if there were any mitigation strategies for this measure. Dr. Merkelz also asked the Workgroup if there were any mitigation strategies to suggest for this measure and noted there were none. Dr. Merkelz moved the Workgroup to vote on, "Do Not Support for Rulemaking" for measure MUC2022-090. Voting results were as follows: Yes – 12, No – 8, and percentage voting Yes – 60 percent. The Workgroup reached consensus. Full voting results are available in Appendix B.

A MAP member asked for clarification on the voting process and voting categories. Ms. Perera and Ms. Williams-Bader reviewed the categories and the process, including if the Workgroup does not reach consensus on all voting categories.

MUC2022-091: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (LTCH QRP)

Ms. Perera asked the Workgroup if there were any new comments or questions for the measure in the LTCH QRP. Dr. Merkelz also asked if MAP members had any new comments to add for this measure. There were no comments stated.

Dr. Merkelz moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-091 with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 10, No – 10, and percentage voting Yes – 50 percent. The Workgroup did not reach consensus. Dr. Merkelz stated if there were no new mitigation strategies the Workgroup will move to vote on, "Do Not Support for Rulemaking" for measure MUC2022-091. Voting results were as follows: Yes – 12, No – 8, and percentage voting Yes – 60 percent. The Workgroup reached consensus. Full voting results are available in Appendix B.

MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (SNF QRP)

Ms. Perera asked the Workgroup if there were any new comments or questions for the measure in SNF QRP. A CMS representative stated there were no new comments. A MAP member noted support for the measure and stated they could have stated support for the measure in the prior setting as well. The MAP member noted agreement with the comments made by Dr. Schreiber and others in support of the measure. This MAP member stated if healthcare workers are being asked to be vaccinated, the vaccination status of residents should at least be reported.

Dr. Merkelz moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-092 with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows:

Yes – 11, No – 9, and percentage voting Yes – 55 percent. The Workgroup did not reach consensus. Dr. Merkelz moved the Workgroup to vote on, "Do Not Support for Rulemaking" for measure MUC2022-092. Voting results were as follows: Yes – 11, No – 8, and percentage voting Yes – 58 percent. Dr. Merkelz moved the Workgroup to vote on, "Support for Rulemaking" for measure MUC2022-092. Voting results were as follows: Yes – 8, No – 11, and percentage voting Yes – 42 percent. Dr. Merkelz moved the Workgroup to vote on, "Do Not Support for Rulemaking with Potential for Mitigation" for measure MUC2022-092. Voting results were as follows: Yes – 5, No – 13, and percentage voting Yes – 28 percent. The Workgroup did not reach consensus on any of the four decision categories. The NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-092 will become the Workgroup recommendation and it will be noted for the MAP Coordinating Committee review during their review meeting. Full voting results are available in Appendix B.

Revised Cross-Cutting COVID-19 Measure

Ms. Perera provided an overview of the revised cross-cutting COVID-19 measure section and the three measures included in this section.

- **MUC2022-084**: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) *(IRF QRP)*
- **MUC2022-084**: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) *(LTCH QRP)*
- **MUC2022-084**: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision) *(SNF QRP)*

Public Comment

Dr. Merkelz opened the meeting for public comment. No public comments were made.

MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel HCP (2022 revision) (IRF QRP)

Ms. Perera introduced the measure and reviewed the measure information including the measure description, level of analysis, risk adjustment, stratification, program submitted to, and summary of the NQF staff preliminary analysis. Ms. Perera noted there were three public comments received for this measure, of which one was in favor of the measure and two were not in support of the measure. Ms. Perera indicated a comment was submitted that the measure would provide a challenge for administration and facilities for staffing purposes. Dr. Elliott shared that the Advisory Group comments applied for all three settings. Dr. Elliott noted the Health Equity Advisory Group stated importance for the COVID-19 measures. Dr. Elliott noted the Rural Health Advisory Group indicated difficulty collecting data and documenting the results.

Ms. Perera then turned the meeting over to CMS for any clarifying comments on the measure. A CMS program lead noted the measure is an important public health issue, is currently in use and is being updated with new recommendations, and introduced the CDC representative to discuss the measure.

A CDC representative stated that healthcare personnel vaccination remains critically important to personal health and patient safety, ensuring an adequate workforce to care for the patients, and used in conjunction with other infection control measures to protect patients. The CDC representative stated that MUC2022-84 aligns with most recent CDC recommendations for the best measure of protection from COVID-19. The CDC representative provided an overview on additional items: the NHSN rolled out up-to-date vaccination as part of weekly reporting from healthcare facilities, which represented 85 percent of the patient rehabilitation facilities and 92 percent of SNF facilities in NHSN were reporting up-to-date vaccination data. The representative shared that the CDC has established scientific acceptability

testing which will be incorporated into quality measure submission for endorsement submission. The representative noted that CDC intends to submit a document in January 2023 for the re-specified NQF measure #3636 Healthcare Personnel COVID-19 Vaccination Coverage. The CDC representative further noted that validity testing from the third quarter of 2022 has shown a medium correlation with the NQF-endorsed primary vaccination measure and reliability testing using a signal-to-noise analysis suggests the measure has excellent reliability.

A lead discussant shared that their organization supports efforts to promote a fully vaccinated community, including the healthcare workforce; however, the proposed measure fails to offer any additional value to the IRF QRP and would create significant administrative burden. As previously discussed, the lead discussant noted concern with the data lags on Care Compare and the high likelihood that the data reported at the time of a patient's stay may not reflect the current rate of personnel vaccination. This lead discussant also noted implementation challenges for data reporting, specifically those staff not employed by the facility, such as volunteers. This lead discussant further noted the high rates of contested penalties tied to the existing provider measure due to recognized issues in the CDC tracking system. The lead discussant suggested the technical issues be addressed before changes are made to the reporting requirements.

Another lead discussant shared that there is some difficulty following up-to-date data, matching that to vaccination records, and determining what is the current vaccination status of healthcare providers, especially for the providers outside of one's own organization.

A MAP member asked for clarification on gathering up-to-date information after the April 1, 2022, data collection requirements, primary series of vaccination and booster. The MAP member inquired whether the measure follows the requirements from the April 1, 2022, definition or whether up-to-date applies more generally.

A MAP member asked for clarification on whether the definition of healthcare has changed from when the data was collected. A CMS representative responded that reporting was made optional for contractors and non-employees. The representative continued that CDC had received feedback that they should consider making reporting mandatory but based on feedback received during the Workgroup meeting, there would be challenges in burden associated with required reporting by those contractors and non-employees. The CDC representative clarified the definition of healthcare vaccination was up-to-date at the time of MUC documentation in May 2022 and re-emphasized that has since changed. The CDC representative noted that the measure addresses up-to-date vaccination at the beginning of the first day of the quarter which would be data collected from July through September. The CDC representative shared that the CDC did not require remote employees to report vaccination status as it was burdensome to collect the data. The CDC representative added that NQF #4431 covers a six-month period that would be easier for facilities to identify the target population than the current reporting, which is submitted weekly and accumulated an average quarterly for the up-to-date vaccination data, allowing it to be more dynamic.

A MAP member shared that there are limitations to being able to ask employees to receive the COVID vaccine and collect their vaccination status, based on laws in Virginia and other states. The MAP member asked how limitations will be reconciled in facilities without creating disparities. A CDC representative shared that this is a measure that currently exists in these programs and is not requiring anyone to become vaccinated, rather to simply report status. A MAP member added that not all facilities would be able to meet the measure requirements, which would be a disadvantage. Another MAP member added that there is a similar issue with previous measures as there may be cultural decisions or religious exemptions about not receiving the vaccine which is an important issue to

consider. Another MAP member encouraged CDC to align measure collection in the NHSN with the measure itself. The member added that when the measure was released, the numerator and denominator were the IRF wide rate for healthcare personnel and data was required to be collected by the manufacturer in the NHSN which is burdensome and caused providers to get detailed in the reporting process. The MAP member suggested allowing the providers to have leeway to make changes before the system is updated.

Dr. Merkelz moved the Workgroup to vote on acceptance of the NQF staff recommendation, "Conditional Support for Rulemaking" for measure MUC2022-084 IRF QRP with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 14, No – 3, and percentage voting Yes – 82 percent. Full voting results are available in Appendix B.

Ms. Perera asked the Workgroup if they would like to move this vote forward to the two remaining programs for which this measure is being considered. With no objections from the Workgroup, the vote conducted for MUC2022-084 IRF QRP will stand for the other two programs as well. Ms. Perera concluded the discission for the measures under consideration.

MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel HCP (2022 revision) (LTCH QRP)

The Workgroup agreed to carry over the vote, "Conditional Support for Rulemaking," from the previous measure (MUC2022-084 IRF QRP) for MUC2022-84 for LTCH QRP, with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 14, No – 3, and percentage voting Yes – 82 percent. Full voting results are available in Appendix B.

MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel HCP (2022 revision) (SNF QRP)

The Workgroup agreed to carry over the vote, "Conditional Support for Rulemaking," from the previous measure (MUC2022-084 IRF QRP) for MUC2022-84 for SNF QRP, with the conditions of testing indicating the measure is reliable and valid, and endorsement by a CBE. Voting results were as follows: Yes – 14, No – 3, and percentage voting Yes – 82 percent. Full voting results are available in Appendix B.

MAP PAC/LTC Programs Measure Gaps

Due to meeting time constraints, Ms. Williams-Bader recommended skipping the discussion on measure gaps. The co-chairs supported this suggestion and moved to public comment.

Opportunity for Public Comment

Ms. Williams-Bader introduced public comment. A member of the public expressed particular thanks to NQF, the co-chairs, and the Workgroup. A MAP member inquired whether it would be possible to have longer meetings in the future or have access to meeting materials for a longer period before scheduled meetings. Ms. Williams-Bader shared that meeting materials cannot be released before the release of the MUC List, however, NQF strives to provide MAP members with as much time as possible with the materials.

Next Steps

Ms. Williams-Bader summarized the next steps for MAP. Ms. Williams-Bader shared the timeline for upcoming MAP activities, that there are MAP Workgroup meetings all week and there will be an opportunity for public comment on Workgroup recommendations from January 6, 2023, to January 12, 2023. Ms. Williams-Bader noted the MAP Coordinating Committee will review the measures and make

final recommendations in late January and NQF will submit a spreadsheet of final recommendations to HHS by February 1, 2023.

Ms. Williams-Bader concluded the meeting by sharing MAP resources and NQF MAP contact information. Ms. Williams-Bader thanked the co-chairs and asked them and Dr. Schreiber for any closing remarks. Dr. Merkelz thanked CDC representatives, Dr. Schreiber, and members of CMS, and NQF for their time. Ms. DeBardeleben thanked the measure developers, CMS, CDC, and all other engaged stakeholders for the discussion and time dedicated to the meeting. Ms. DeBardeleben reminded the Workgroup of the second commenting period happening from January 6 to 12, 2023. Dr. Schreiber thanked the Workgroup, co-chairs, and NQF for their input on measures as it helps decision making in what is put forward into rulewriting. Ms. Williams-Bader thanked the Workgroup for reviewing all the measures and making recommendations for the measures to be put forward and adjourned the meeting.

Appendix A: MAP PAC/LTC Workgroup Attendance (Voting Only)

The following members of the MAP PAC/LTC Workgroup were in attendance:

Co-chairs

- Mary Ellen DeBardeleben, MBA, MPH, CJCP
- Kurt Merkelz, MD, CMD

Organization Members

- AARP
- Academy of Nutrition and Dietetics
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Physical Medicine and Rehabilitation
- American Geriatrics Society
- American Medical Rehabilitation Providers Association
- American Occupational Therapy Association
- LeadingAge
- National Hospice and Palliative Care Organization
- National Partnership for Healthcare and Hospice Innovation
- National Pressure Injury Advisory Panel
- Service Employees International Union
- SNP Alliance
- The Scan Foundation
- Society for Healthcare Epidemiology of America

Individual Subject Matter Experts

- Gregory Alexander, PhD, RN, FAAN
- Dan Andersen, PhD

Appendix B: Full Voting Results

Some MAP members were unable to attend the entire meeting. The vote totals reflect members present and eligible to vote. Quorum was met and maintained during voting periods.

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)	14 (70)	6 (30)	20 (100)	Support for Rulemaking
MUC2022-099: Skilled Nursing Facility (SNF) Within-Stay (WS) Potentially Preventable Readmissions (PPR) Measure	SNF VBP	19 (95)	1 (5)	20 (100)	Conditional Support for Rulemaking
MUC2022-113: Number of hospitalizations per 1,000 long-stay resident days	SNF VBP	19 (90)	2 (10)	21 (100)	Conditional Support for Rulemaking
MUC2022-126: Total nursing staff turnover	SNF VBP	17 (81)	4 (19)	21 (100)	Conditional Support for Rulemaking
MUC2022-083: Cross-Setting Discharge Function Score	Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)	15 (75)	5 (25)	20 (100)	Conditional Support for Rulemaking
MUC2022-085: Cross-Setting Discharge Function Score	Home Health Quality Reporting Program (HH QRP)	15 (75)	5 (25)	20 (100)	Conditional Support for Rulemaking
MUC2022-086: Cross-Setting Discharge Function Score	Skilled Nursing Facility Quality Reporting Program (SNF QRP)	15 (75)	5 (25)	20 (100)	Conditional Support for Rulemaking
MUC2022-086: Cross-Setting Discharge Function Score	SNF VBP	12 (63)	7 (37)	19 (100)	Conditional Support for Rulemaking
MUC2022-087: Cross-Setting Discharge Function Score	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	15 (75)	5 (25)	20 (100)	Conditional Support for Rulemaking

Measure	Program	Yes (N/%)	No (N/%)	Total (N/%)	Decision Category
MUC2022-089: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	IRF QRP	11 (58) 12 (60)	8 (42) 8 (40)	19 (100) 20 (100)	Conditional Support for Rulemaking Do Not Support for Rulemaking
MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	HH QRP	11 (55) 12 (60)	9 (45) 8 (40)	20 (100) 20 (100)	Conditional Support for Rulemaking Do Not Support for Rulemaking
MUC2022-091: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	LTCH QRP	10 (50) 12 (60)	10 (50) 8 (40)	20 (100) 20 (100)	Conditional Support for Rulemaking Do Not Support for Rulemaking
MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date*	SNF QRP	11 (55) 11 (58) 8 (42) 5 (28)	9 (45) 8 (42) 11 (58) 13 (72)	20 (100) 19 (100) 19 (100) 18 (100)	Conditional Support for Rulemaking Do Not Support for Rulemaking Support for Rulemaking Do Not Support with Potential for Mitigation
MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision)	IRF QRP	14 (82)	3 (18)	17 (100)	Conditional Support for Rulemaking
MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision)	LTCH QRP	14 (82)	3 (18)	17 (100)	Conditional Support for Rulemaking
MUC2022-084: COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) (2022 revision)	SNF QRP	14 (82)	3 (18)	17 (100)	Conditional Support for Rulemaking

*Consensus not reached by Workgroup