NATIONAL QUALITY FORUM

Driving measurable health improvements together

Measure Applications Partnership 2021-2022 Considerations for Implementing Measures in Federal Programs: Clinician, Hospital, and Post-Acute Care Long-Term Care

Final Report

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1. *EXECUTIVE SUMMARY*

The Measure Applications Partnership (MAP) provides multistakeholder pre-rulemaking input to the Centers for Medicare & Medicaid Services (CMS) on Measures Under Consideration (MUC) for Medicare payment and reporting programs. During the 2021-2022 cycle, MAP reviewed 44 measures under consideration for 13 federal programs, including several cross-setting measures considered for multiple programs, resulting in 29 unique measures. The cross-setting measures reviewed included a National Healthcare Safety Network measure and Social Drivers of Health measures. MAP submitted recommendations (XLSX) to the United States (U.S.) Department of Health and Human Services (HHS) on February 1, 2022. Of the 44 MUCs, MAP expressed support for 10 measures and conditional support for 32 measures. Of the two measures that MAP did not support, it provided potential mitigation for one measure. Table 1 provides a summary of setting-specific decision categories for review.

Clinician Workgroup Measures	*
Support for Rulemaking	2
Conditional Support for Rulemaking	10
Do Not Support for Rulemaking With Potential for Mitigation	1
Do Not Support for Rulemaking	0
Total Measures	13
Hospital Workgroup Measures	*
Support for Rulemaking	5
Conditional Support for Rulemaking	17
Do Not Support for Rulemaking With Potential for Mitigation	0
Do Not Support for Rulemaking	1
Total Measures	23
Post-Acute Care/Long-Term Care Workgroup Measures	*
Support for Rulemaking	3
Conditional Support for Rulemaking	5
Do Not Support for Rulemaking With Potential for Mitigation	0
Do Not Support for Rulemaking	0
Total Measures	8

Table 1. 2021-2022 MAP MUC Workgroup Recommendations

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MAP's pre-rulemaking recommendations for measures in these programs reflect the MAP Measure Selection Criteria (MSC) and how well the measures address the goals of the program. These goals are determined either through statutory requirements or CMS Program-Specific Measure Needs and Priorities and are reflected in the measures brought forward to MAP for input. The MSC focus on selecting high quality measures that address key national healthcare priorities and seek measures endorsed by the National Quality Forum (NQF), the current consensus-based entity (CBE), whenever possible. Additionally, the MSC evaluate measures that are preferentially digital, meaningful to patients and useful in making best care

choices, support health equity, and reflect a balance of accountability and efficiency to minimize burden to providers/facilities while achieving excellence.

Significant takeaways from the 2021-2022 MUC cycle include MAP's support for the development of health equity-related initiatives across the government programs, the importance of measure stratification to inform the understanding of disparities and to track gaps in care, and MAP's support for an increase in patient-reported outcome performance measures (PRO-PMs). Additionally, the prominent role of cross-setting digital and safety measures in the prevention of critical clinical safety events in the inpatient setting received high recognition. This report will inform members of the healthcare quality community of key issues in measure development across the Hospital, Clinician, and Post-Acute Care/Long-Term Care (PAC/LTC) care settings.

2. *BACKGROUND: MAP STRUCTURE AND COMPOSITION*

MAP operates under a two-tiered structure consisting of a Coordinating Committee along with three setting-specific Workgroups and two Advisory Groups. MAP Workgroups and Advisory Groups are representative of a broad range of stakeholders that have an interest in, or are affected by, the use of quality and efficiency measures. Such stakeholders may include, but are not limited to, health plans, healthcare providers and practitioners, research entities, measure developers, national policymakers, patient advocates, patients and families, purchasers, and employers.

The Coordinating Committee, along with the setting-specific Workgroups and Advisory Groups, consist of organizational members, individual subject-matter experts, and federal agency liaisons.

- Organizational members represent leading stakeholder groups and contribute to a balance of stakeholder interests.
- Individual subject-matter experts add content expertise to critical areas, and their knowledge should help to fill gaps that are not met by the organizational membership.
- Federal liaisons represent government agencies and serve as ex-officio, non-voting members.

2.1. Rural Health Advisory Group

The Rural Health Advisory Group delivers input to the pre-rulemaking process. It reviews all measures under consideration for the relevant pre-rulemaking cycle and highlights measures that may be particularly pertinent to issues in the rural population (e.g., access, costs, or quality issues encountered by rural residents; data collection and/or reporting challenges; and potential unintended consequences for rural providers). The Rural Health Advisory Group helps to accomplish the following tasks:

- Provide input to the MAP Workgroups on the rural health perspective on MUCs during MAP's annual pre-rulemaking process

- Identify rural-relevant gaps in measurement
- Provide recommendations regarding priority rural health issues, including the challenge of low case-volume and access

2.2. Health Equity Advisory Group

During the 2021-2022 MAP cycle, NQF, with CMS funding, launched the Health Equity Advisory Group to ensure that perspectives on health inequities and disparities were adequately considered. The Health Equity Advisory Group reviews all MUCs for the relevant pre-rulemaking cycle and delivers input on measures with a lens to measurement issues affecting health disparities and the 1,000+ U.S. critical access hospitals (CAHs).

The Health Equity Advisory Group provides input on MUCs with the goal of reducing health differences linked with social, economic, or environmental disadvantages. It is charged with accomplishing the following tasks:

- Provide input to the MAP Workgroups on measurement issues affecting health disparities and CAHs on MUCs during MAP's annual pre-rulemaking process
- Identify health disparity gaps in measurement
- Provide recommendations to reduce health differences that are closely linked to social determinants of health (SDOH)

2.3. Clinician Workgroup

The Clinician Workgroup provides recommendations for coordinating clinician performance measurement across federal programs. This is achieved by ensuring the alignment of measures and data sources to reduce duplication and burden, identifying the characteristics of an ideal measure set to promote common goals across programs, and implementing standardized data elements.

The Clinician Workgroup reviewed 13 measures for annual pre-rulemaking input for two programs:

- Merit-Based Incentive Payment System (MIPS)
- Medicare Part C and D Star Ratings Program

The following program did not have any MUCs during this year's pre-rulemaking cycle:

- Medicare Shared Savings Program (SSP)

2.4. Hospital Workgroup

The Hospital Workgroup provides input to the Coordinating Committee on matters related to the selection and coordination of measures for hospitals, including inpatient acute, outpatient, cancer, and psychiatric hospitals.

The Hospital Workgroup reviewed 23 measures for annual pre-rulemaking input on the following programs, with four measures crossing two programs and two measures crossing four programs:

- Hospital Inpatient Quality Reporting Program (Hospital IQR Program)
- Medicare Promoting Interoperability Program for Hospitals
- Hospital Value-Based Purchasing (VBP) Program
- Hospital-Acquired Conditions Reduction Program (HACRP)
- Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

The following programs did not have any MUCs during this year's pre-rulemaking cycle:

- Hospital Outpatient Quality Reporting Program (Hospital OQR Program)
- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Hospital Readmissions Reduction Program (HRRP)
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program

2.5. Post-Acute Care/Long-Term Care Workgroup

The PAC/LTC Workgroup reviews measures for PAC and LTC programs. Its aim is to establish performance measurement alignment across PAC/LTC settings while emphasizing that alignment must be balanced with consideration for the heterogeneity of patient needs across settings.

The PAC/LTC Workgroup reviewed eight measures for annual pre-rulemaking input on the following programs, with one measure crossing three programs:

- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
- Long-Term Care Hospital\ Quality Reporting Program (LTCH QRP)
- Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program

The following programs did not have any MUCs during this year's pre-rulemaking cycle:

- Home Health Quality Reporting Program (HH QRP)
- Hospice Quality Reporting Program (HQRP)

3. *THEMES*

3.1. Overarching Themes

Throughout the 2021-2022 MAP cycle, overarching themes emerged from the Workgroup, Advisory Group, and Coordinating Committee meetings. Measure alignment, health equity, risk adjustment, and patient-reported outcomes (PROs) were common discussion topics heard throughout the cycle, not only from members, but also from public comments.

3.1.1 Improving measure alignment

MAP Workgroup and Committee members expressed a desire to evaluate measure performance across programs. The rates of performance across programs at the clinician level versus the

Accountable Care Organization (ACO) level are of particular interest. The MAP PAC/LTC Workgroup echoed the need for information transfers and not just within the silos of care settings (e.g., hospital to SNF). In the MAP Hospital Workgroup, CMS highlighted the promotion of program alignment with the incorporation of digital measures into the Medicare Promoting Interoperability Program for Hospitals.

3.1.2 Measures for health equity that inspire action

Leveraging quality measures to promote equity is one of the five goals within the CMS Quality Measurement Action Plan. This cycle's addition of the MAP Health Equity Advisory Group further emphasizes the importance of this voice within the MUC process. All Workgroups expressed enthusiasm for the focus on health equity in the 2021 MUC List. Workgroup members encouraged CMS to consider measures for health equity that show strong connections to outcomes or that would ensure action by accountable entities.

The Health Equity Advisory Group agreed that equity needs to be considered throughout the process of measurement development rather than evaluated only at the end of testing and development. It noted that improving health equity will be an iterative process, and decisions should be made with the understanding that measures may need to be fine-tuned over time.

3.1.3 Risk adjustment and stratification of measures

The MAP Workgroup and Advisory Group members emphasized the need for measures that include risk adjustment and stratification. They also expressed a need for clarification from CMS regarding the standardization of collection and meaningful use of data for stratification and the importance of sending results of this information back to facilities.

The Health Equity Advisory Group had a robust discussion involving the stratification of measures. It shared potential categories of stratification, including age, sex, race, ethnicity, English proficiency, gender identity, sexual orientation, visit type, insurance, disability, markers of economic disparities, rurality, setting type, etc. The Health Equity Advisory Group agreed that the goal is not to stratify all measures by all categories, but to stratify where appropriate. It also cautioned that stratification is a critical tool for investigation disparities; nonetheless, further thought is required regarding the incorporation of stratified results into payment programs.

3.1.4 Patient-reported outcome measures

The MAP Workgroup and Advisory Group members commented on the need for person-centered and person-reported goals. They also agreed with the importance of the family/caregiver perspective and patient experience. The MAP PAC/LTC Workgroup noted the definition of quality is different for each individual, and unless that definition is integrated into measurement, individual needs will not be met. Additionally, the Health Equity Advisory Group highlighted the need for translation and validation of patient-reported outcome performance measure (PRO-PM) tools to minimize concerns regarding language, culture, and response bias. The consumer and caregiver voices are the foundation for CMS' Meaningful Measures 2.0 initiative, which helps to steer quality measures that drive value-based care.

3.2. Themes From the Clinician Workgroup

3.2.1 Alignment of the Shared Savings Program with the Alternative Payment Model Performance Pathway

The MAP Clinician Workgroup expressed concern for unintended consequences by reporting on all-payer data in the Medicare SSP, particularly for Federally Qualified Health Centers (FQHCs) or those that care for a disproportionately disadvantaged population. The Workgroup noted that social driver measures would fit well within the SSP.

3.3. Themes From the Hospital Workgroup

3.3.1 Implementation of measures into the Hospital Inpatient Quality Reporting Program before use within the Hospital Value-Based Purchasing Program

The MAP Hospital Workgroup and CMS clarified that by statutory requirement, any measure intended for the VBP Program must be implemented for at least one year in the Hospital IQR Program first. MAP noted that since older versions of the measures are currently implemented in federal programs, it may be helpful for hospitals to receive communications to clarify why performance changes may occur in the future.

3.4. Themes From the Post-Acute Care/Long-Term Care Workgroup

3.4.1 Infection control

Healthcare-associated infections (HAIs) continue to be one of CMS' high priorities for future measure consideration across multiple programs and settings. The topic of infection was discussed throughout the MAP cycle, with attention to the infection measures presented across multiple programs and settings. The MAP PAC/LTC Workgroup noted that the coronavirus disease 2019 (COVID-19) pandemic uncovered an underpreparedness and lack of resources related to infection control. The Workgroup indicated that infection control resources and focus are currently being addressed, specifically for nursing homes; however, these resources have a limited time frame. The Workgroup agreed with the need to align ongoing measurement that reflects overall infection control performance. Safety is a building block within CMS' Meaningful Measures 2.0 initiative.

4. *CONSIDERATIONS FOR SPECIFIC PROGRAMS*

4.1. Clinician Program Measures

4.1.1. *Medicare Part C and D Star Ratings Program*

The Part C and D Star Ratings Program was enacted by the Medicare Prescription Drug Improvement and Modernization Act of 2003, also called the Medicare Modernization Act (MMA). The MMA provided for private health plans known as Medicare Advantage Plans (Part C) and expanded Medicare to include an optional prescription drug benefit (Part D). This is a quality payment program with the goals of public reporting on Medicare Plan Finder (MPF), quality improvement, marketing and enrollment, and financial incentives.

The Star Ratings cover nine domains. The ratings of health plans (Part C) are as follows:

- Staying healthy: screenings, tests, and vaccines
- Managing chronic (long-term) conditions
- Member experience with health plan
- Member complaints and changes in the health plan's performance
- Health plan customer service

The ratings of drug plans (Part D) are as follows:

- Drug plan customer service
- Member complaints and changes in the drug plan's performance
- Member experience with the drug plan
- Drug safety and accuracy of drug

MAP reviewed three MUCs for inclusion in the Medicare Part C and D Star Ratings Program.

Medicare Part C and D Star Ratings Measures:

- MUC2021-053: Concurrent Use of Opioids and Benzodiazepines (COB)
- MUC2021-056: Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)
- MUC2021-066: Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)

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

The *Concurrent Use of Opioids and Benzodiazepines (COB)* measure captures the percentage of Medicare Part D beneficiaries 18 years of age or older with concurrent use of prescription opioids and prescription benzodiazepines during the measurement period.

MAP supported this measure for rulemaking. This CMS CBE-endorsed measure addresses the prevention and treatment of chronic disease, a high-priority area of concern for CMS. The measure has been updated since its initial endorsement in 2018 and has no competing measure that addresses both the same measure focus and same target population. MAP strongly encouraged CMS to monitor potential negative unintended consequences due to the denominator definition.

Patients concurrently using opioids and benzodiazepines are at a higher risk for opioid-related adverse events (e.g., respiratory depression). This measure focuses on monitoring and reducing opioid prescribing with negative outcomes in most patient populations, except for patients with cancer, sickle cell disease, and those in hospice.

The Rural Health Advisory Group identified possible unintended consequences for certain excluded patient populations, concerns about populations that may need high doses of these medications, and concerns regarding the tapering of drugs when deprescribing as common

themes. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified calculation issues due to a lack of stratification as a priority for the measure. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

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

The *Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)* measure captures the percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of two or more unique anticholinergic (ACH) medications during the measurement period.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This measure addresses the polypharmacy of ACH-active medications in older adults, the effective communication and coordination of care, and effective treatment of chronic diseases, which is a high priority for Part D measure consideration. MAP encouraged CMS to monitor potential negative unintended consequences due to the denominator definition raised by the commenters.

This measure focuses on monitoring beneficiaries 65 years of age and older at risk for cognitive decline due to ACH burden, which can lead to an increased risk for hospitalization, falls, and medical utilization, along with a decreased overall quality of life (Rochon et al, 2021).

The Rural Health Advisory Group identified concerns regarding prescribed versus over-the-counter medications and unintended consequences regarding deprescribing appropriately. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified concerns for measure calculation due to the lack of stratification identified. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

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

The *Polypharmacy: Use of Multiple Central Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)* measure captures the percentage of Medicare Part D beneficiaries 65 years of age or older with concurrent use of three or more unique central nervous system (CNS)-active medications during the measurement period.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This measure addresses the polypharmacy of CNS-active medications in older adults and the effective communication and coordination of care, which is a high priority for Part D measure consideration. MAP encouraged CMS to monitor for potential negative unintended consequences due to the denominator definition raised by the commenters.

This measure focuses on identifying individuals who are prescribed multiple CNS-active medications and monitoring them for adverse drug events, including falls and fractures. The

reduced concurrent prescription of three or more CNS-active medications can result in better patient outcomes and quality of life.

The Rural Health Advisory Group identified concerns regarding the data capture of medication use in nursing homes, as well as the distinction between short-stay and long-stay patients. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified a lack of stratification and the potential for reduced unintended consequences through the exclusion of hospice patients and seizure diagnoses. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.1.2. *Merit-Based Incentive Payment System Program*

The MIPS Program was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to consolidate pre-existing Medicare incentive and quality reporting programs for clinicians into a single program. The quality payment program considerations for the MIPS Program include improvement for beneficiary outcomes, increased adoption of advanced alternative payment models (APMs), improved data and information sharing, reduced burden on clinicians, maximized participation, and operational excellence in program implementation. The MIPS Program makes positive and negative payment adjustments for eligible clinicians (ECs) based on their performance in four categories:

- Quality
- Cost
- Promoting interoperability
- Improvement activities

To meet the quality component of the program, individual ECs or groups of ECs choose six measures to report to CMS. One of these measures must be an outcome measure or another high-priority measure. Clinicians can also choose to report a specialty-specific measure set. In the 2021-2022 pre-rulemaking deliberations, MAP reviewed 10 measures for the MIPS Program.

4.1.2.1. **MUC2021-125 Psoriasis – Improvement in Patient-Reported Itch Severity**

The *Psoriasis – Improvement in Patient-Reported Itch Severity* measure captures the percentage of patients ages 18 and older with a diagnosis of psoriasis who have a patient-reported itch severity assessment performed at an initial (index) visit, who score greater than or equal to four, and who achieve a score reduction of two or more points at a follow-up visit.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This MUC is a patient-reported outcome (PRO) for a psoriasis symptom, complementing an existing measure in the set of psoriasis disease activity. This measure would be just the second outcome measure in the MIPS Dermatology set (and just the 12th measure overall), and as a PRO, it is consistent with CMS' Meaningful Measures 2.0 framework.

Psoriasis is a common condition, with some 7.5 million people affected nationwide, leading to millions of clinical visits every year. Chronic pruritis, the symptom assessed in this PRO, has a

significant impact on quality of life and is associated with depression and global distress, among other effects. Patients and providers on a technical expert panel (TEP) agreed that the quality construct measured was actionable, and the measure result could be used to evaluate quality of care. The measure is supported by a clinical guideline, although the evidence supporting the guideline is somewhat weaker, and the minimum clinical impact in the measure is lower than that recommended by the guideline.

The Rural Health Advisory Group identified concerns about the prevalence of psoriasis in rural communities, low population and case minimums for individual providers, and questions regarding how low population sizes for individual providers in rural communities would translate to the statistical methods used by the developer. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified potential data collection issues resulting from a self-reported measure for disadvantaged populations with language and cultural barriers, as well as access issues; decreasing response rates due to the requirement of two assessments among disadvantaged populations; and selection bias in the measure performance as themes for concern. Unintended consequences identified included a disparity in diagnoses and response bias. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.1.2.2. **MUC2021-135 Dermatitis – Improvement in Patient-Reported Itch Severity**

The *Dermatitis – Improvement in Patient-Reported Itch Severity* measure captures the percentage of patients, ages 18 and older, with a diagnosis of dermatitis who have a patient-reported itch severity assessment performed at an initial (index) visit, who score greater than or equal to four, and who achieve a score reduction of two or more points at a follow-up visit.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This MUC is a PRO for a dermatitis symptom. This measure would be just the second outcome measure in the MIPS Dermatology set (and just the 12th measure overall), and as a PRO, it is consistent with CMS' Meaningful Measures 2.0 initiative. MAP was encouraged to see another PRO proposed for this program.

Chronic pruritis, the symptom assessed in this PRO, has a significant impact on quality of life and is associated with depression and global distress, among other effects. Patients and providers on a TEP agreed that the quality construct measured was actionable, and the measure result could be used to evaluate quality of care. The measure is supported by a clinical guideline, although the evidence supporting the guideline is somewhat weaker, and the minimum clinical impact in the measure is lower than that recommended by the guideline.

The Rural Health Advisory Group found no concerns with the measure regarding relative priority or utility, data collection, measure calculation, or unintended consequences. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified concerns regarding data collection and unintended consequences. Cultural barriers and access issues may arise for

disadvantaged populations since this is a self-reported measure. Selection bias in the measure performance among a disadvantaged population may result from a drop-in response rate over two assessments. Lastly, the disparity in diagnoses was identified as a potential issue. The Health Equity Advisory Group recommended this measure be stratified to assess performance based on the population subgroups. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

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

The *Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)* measure captures the percentage of adult patients 18 years of age and older who had an elective primary total hip arthroplasty (THA) or total knee arthroplasty (TKA) during the performance period and who completed both a pre- and postsurgical care goal achievement survey, as well as demonstrated that 75 percent or more of the patient's expectations from surgery were met or exceeded. The pre- and postsurgical surveys assess the patient's main goals and expectations (i.e., pain, physical function, and quality of life) before surgery and the degree to which the expectations were met or exceeded after surgery. The measure will be reported as two risk-adjusted rates stratified by THA and TKA.

MAP did not support this measure for rulemaking, with potential for mitigation. This measure aligns with the goals of the CMS Meaningful Measures 2.0 initiative to "prioritize outcomes and patient reported measures." Person-centered care is achieved through the feedback provided by patients to their care team on their goals and expectations of their joint replacement surgery through completion of pre- and postsurgical surveys. However, the NQF Scientific Methods Panel (SMP) did not pass this measure for sufficient reliability and validity of the measure specifications.

The measure aims to increase patient satisfaction by providing an opportunity for clinicians to incorporate feedback received from patients into a shared decision making model. Successful implementation will lead to management of unrealistic expectations, improved clinical outcomes, increased health service efficiency, and increased health-related business metrics. Two areas of importance to highlight within this measure are the inclusion of risk adjustment areas, such as age, gender, and body mass index (BMI), and the expansion of the patient population to include patients 18 years of age and older for all payers. MAP acknowledged the importance of stratifying the measure to assess performance on this measure based on population subgroups. MAP suggested the following material changes for mitigation: (1) a more broadly implemented survey that is tested beyond one metro area due to equity and rural health issues, (2) testing for reliability and validity, and (3) the administration of the survey in multiple languages with more focus on patient goals.

The Rural Health Advisory Group identified concerns for patient expectations related to goal achievement, the data collection tools of paper versus electronic health record (EHR), a calculation issue of risk adjustment for BMI and the impact on rural communities, and patient selection in rural settings as a potential unintended negative consequence. For complete details

from the Rural Health Advisory Group Virtual Review Meeting, please see the meeting summary. The Health Equity Advisory Group identified concerns regarding data collection, measure calculation, and unintended consequences. Challenges were identified with the completion of both the pre- and post-survey surveys due to the loss of follow-up for disadvantaged populations. There is also disparity regarding who receives THA and TKA and has access to the surgery, further impacting patient selection. Additionally, it was noted that the denominator may not include populations who are unable to return for the post-survey. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please see the meeting summary.

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

The *Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM)* will estimate a clinician- and clinician group-level, risk-standardized improvement rate for PROs following elective primary THA/TKA for Medicare fee-for-service (FFS) patients 65 years of age or older. Substantial clinical benefit (SCB) improvement will be measured by the change in score on the joint-specific PROM instruments, measuring hip or knee pain and functioning from the preoperative assessment (data collected 90 to zero days before surgery) to the postoperative assessment (data collected 300 to 425 days following surgery).

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This PROM addresses the quality priority of patient-centered care in the CMS Meaningful Measures 2.0 framework. The use of the joint-specific PROM instruments incorporate shared decision making in orthopedic surgery and with the potential to improve patient health outcomes. The measure/intervention uses PROs to gather feedback on pain and joint function after THAs and TKAs to impact outcomes that are important to patients. Feedback from a TEP and a Patient Working Group established continued support for additional postsurgical surveys to monitor recovery and encourage high quality care.

Thirty million Americans are affected by degenerative joint disease, which is commonly treated with elective THAs and TKAs. These procedures decrease pain and improve function during the approximately 1 million osteoarthritis-related hospitalizations per year. More specifically, approximately 6 million Americans 65 years of age or older suffer from osteoarthritis, contributing to Medicare costs exceeding 15 billion dollars annually. The frequency and high cost of these procedures provide a solid foundation for the creation of PROM development.

The Rural Health Advisory Group identified concerns regarding obtaining high response rates for follow-up from resource-limited rural providers, the calculation of the average or the changed score of the measure, and lessened recovery for patients due to the physical or manual occupations in rural communities. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified themes such as pre- and postoperative data collection challenges due to access

barriers for certain populations of patients, the lack of stratification for language, and potential selection bias of the population. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.1.2.5. **MUC2021-090 Kidney Health Evaluation**

The *Kidney Health Evaluation* measure captures the percentage of patients ages 18–75 with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) and Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This measure focuses on nephrology and the critical condition of diabetes, both identified as gaps within the MIPS Program and are considered priority areas for future measures. This measure will also replace and improve upon the existing Healthcare Effectiveness Data and Information Set (HEDIS) *Medical Attention for Nephropathy* measure. The measure will encourage the at least annual evaluation of the eGFR and uACR in patients with diabetes to prevent or delay chronic kidney disease (CKD). Early detection can reduce associated health risks of the comorbidity of diabetes and CKD.

The Rural Health Advisory Group identified concerns for whether rural providers would be able to report the measure due to the difficulties of data collection and the limited laboratory capacity in rural settings to complete the testing. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group conducted a robust discussion and found strong support of the use of the 2021 CKD-Epidemiology Collaboration (EPI) eGFR estimation equation, which does not include race. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please see the meeting summary.

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

The *Adult Kidney Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy* measure captures the percentage of patients ages 18 and older with a diagnosis of CKD (stages 1-5, not receiving Renal Replacement Therapy [RRT]) and proteinuria who were prescribed angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy within a 12-month period.

MAP supported this measure for rulemaking. The measure concentrates on nephrology and the critical condition of diabetes, both identified as gaps within the MIPS program and are considered priority areas for future measurement. This CBE-endorsed measure focuses on using clinically recommended CKD therapeutic interventions to treat diabetic kidney disease and nondiabetic kidney diseases with proteinuria (albuminuria). This measure is aimed at increasing the number of patients receiving high quality nephrology care (prescribed ACE inhibitors or ARB therapy) because it decreases the rate of kidney failure, cardiovascular outcomes, and mortality in patients with CKD.

The Rural Health Advisory Group identified concerns for measure calculations with low patient volume in rural settings, thus impacting the reliability/validity of the measure. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified concerns regarding data collection for providers with fewer resources to understand exclusions and concerns regarding access to care and exacerbation of disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

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

The Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma measure captures the percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal, or small bowel carcinoma, biopsy, or resection that contain impression or conclusion of or recommendation for the testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), microsatellite instability (MSI) by DNA-based testing status, or both.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement, and specifically, the review of the upcoming release of the guidelines. The measure addresses the priority area of pathology for patients with colorectal carcinoma, endometrial, gastroesophageal, or small bowel carcinoma. This process measure addresses a gap in biomarker testing for specific cancer types, thus leading to a potential increase in personalized care.

Two to 4 percent of all colorectal carcinomas can be attributed to Lynch syndrome and the detection of defective MMR, or MSI can assist with the proper diagnoses. Support for MMR and MSI testing for the identification of high-risk patients for Lynch syndrome is provided by the American Society for Clinical Pathology (ASCP), the College of American Pathologists (CAP), the Association for Molecular Pathology (AMP), and the American Society of Clinical Oncology (ASCO). A quality gap in the use of MMR/MSI for the detection of four cancer types (i.e., colorectal carcinoma, endometrial, gastroesophageal, and small bowel carcinoma), and the potential utilization of checkpoint blockade therapy will be addressed. This measure will be the first of its kind to be utilized by CMS and will fill a gap in biomarker testing for the MIPS Program. This measure will contribute to the efficient use of resources and promote increased use of personalized patient care and patient choice.

The Rural Health Advisory Group identified concerns regarding data availability for rural providers and the availability of these tests in rural settings. The latter was listed as an unintended consequence but could be a positive consequence. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified concerns regarding disparities within testing access and access to cancer care, as well as an equity concern regarding ongoing treatment/support. Data

collection issues were also noted due to a lack of stratification for this measure. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.1.2.8. **MUC2021-058 Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated With Immune Checkpoint Inhibitors**

The *Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated With Immune Checkpoint Inhibitors* measure captures the percentage of patients, ages 18 and older, with a diagnosis of cancer, on immune checkpoint inhibitor therapy, and with grade 2 or above diarrhea and/or grade 2 or above colitis who have immune checkpoint inhibitor therapy held and corticosteroids or immunosuppressants prescribed or administered.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This newly developed measure addresses the Meaningful Measures area of patient safety. If included, this measure would be the only quality measure in the MIPS Program to address gastrointestinal adverse effects from the use of immune checkpoint inhibitors as part of cancer treatment.

The Rural Health Advisory Group identified concerns for data collection and the availability of data for grading due to chart abstraction. Integration of data from multiple patient care sites was also noted as a concern. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified data collection concerns regarding a small denominator. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.2. Hospital Program Measures

4.2.1. *End-Stage Renal Disease Quality Incentive Program*

The ESRD QIP is a VBP program established to promote high quality services in dialysis facilities treating patients with ESRD. The ESRD QIP was established in accordance with section 1881(h) of the Social Security Act (SSA), added by section 153(c) of the Medicare Improvements for Patients and Providers Act (MIPPA). As of 2012, payments to dialysis facilities are reduced if facilities do not meet or exceed the required total performance score. Payment reductions are on a sliding scale and can amount to a maximum of 2 percent per year. The goals of the ESRD QIP include improvement in the quality of dialysis care and producing better outcomes for dialysis beneficiaries.

MAP reviewed one MUC for inclusion in the ESRD QIP.

4.2.1.1. **MUC2021-101 Standardized Readmission Ratio (SRR) for Dialysis Facilities**

The *Standardized Readmission Ratio (SRR) for Dialysis Facilities* measure indicates the standardized readmission ration (SRR) for a dialysis facility. The SRR is the ratio of the number of observed index discharges from acute-care hospitals to the indicated facility that resulted in an unplanned readmission to an acute care hospital within four to 30 days of discharge to the

expected number of readmissions, given the discharging hospitals and the characteristics of the patients, and is based on a national norm. This measure is based on Medicare-covered dialysis patients and is intended to signal remediable gaps in care coordination or transitions of care.

MAP did not support this measure for rulemaking. This fully developed and specified measure is an updated version of NQF #2496, which is currently included in the ESRD QIP. This measure addresses the high-priority area of care coordination in the ESRD QIP, and the program does not contain any other readmission measures. However, this measure was submitted for CBE endorsement in the spring of 2020 but did not pass on scientific acceptability, specifically on validity, and was not endorsed. MAP noted the importance of the measure topic but echoed the findings of the SMP and highlighted the compelling public comments in opposition of the measure being supported for rulemaking based on the measure's validity and reliability results. MAP also questioned how the measure is impacting the overall program.

The Rural Health Advisory Group highlighted that this measure is crucial for patients; however. the average polling score indicated the Advisory Group was neutral on the suitability of the measure from a rural perspective. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group noted that there are known disparities in kidney care and outcomes, and this measure addressed an important topic. The Advisory Group also indicated this measure may encourage communication and shared accountability between dialysis facilities and hospitals to improve care coordination for patients. For further details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.2.2. *Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program*

Section 3005 of the Affordable Care Act (ACA) added subsections to section 1866 of the SSA and established the PCHQR Program for hospitals referred to as PPS-Exempt Cancer Hospitals or PCHs. These hospitals (currently, 11 have been granted with this distinction by CMS) are excluded from payment under the Inpatient Prospective Payment System (IPPS). The PCHQR Program is a voluntary quality reporting program: There are no payment implications for these hospitals, and data are published on the Provider Data Catalog (PDC) website. The PCHQR Program is intended to encourage hospitals and clinicians to improve the quality of care, to share information, and to learn from each other's experiences and best practices.

MAP reviewed one MUC for inclusion in the PCHQR program.

4.2.2.1. **MUC2021-091 Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer**

The *Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer* measure indicates the percentage of female patients ages 18 to 70 with stage I (T1c) through stage III human epidermal growth factor receptor 2 (HER2) positive breast cancer for whom appropriate treatment is initiated.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. MAP indicated this measure does not align with the 2021 Program-Specific Measure Needs and Priorities for these programs: PRO-PMs, Care Coordination, and Behavioral Health. However, this measure does align with the CMS Meaningful Measures framework because it is an electronic clinical quality measure (eCQM) and may support greater access to life-saving diagnostics and therapies during the COVID-19 public health emergency (PHE) and beyond.

This measure aims to identify the percentage of female patients ages 18 to 70 with stage I (T1c) through stage III HER2 positive breast cancer for whom appropriate treatment is initiated. Although this measure has undergone measure score reliability and validity testing, validity testing of the critical data elements (e.g., numerator, denominator) should be considered due to MAP's expressed concern that the measure may not pass in a CBE endorsement review. The measure does not currently have CBE endorsement.

The Rural Health Advisory Group noted that the measure could be difficult for rural providers if they do not typically treat cancer and are not familiar with the extensive treatments. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group noted the important topic of this measure. However, it noted that measures that restrict measurement based on sex or gender (e.g., "percentage of female patients") are exclusionary and do not include transgender or nonbinary patients despite relevance. The Health Equity Advisory Group expressed equity concern regarding this measure, as these populations are frequently left out of the healthcare system, and transgender women are at higher risk of breast cancer than cisgender men. It also noted that differential screening and diagnosis for breast cancer is a known disparity, with Black women being 40 percent more likely to die from breast cancer than White women. The Health Equity Advisory Group suggested stratifying this measure by factors such as race, ethnicity, education, insurance status, and federal poverty level. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.2.3. *Hospital Inpatient Quality Reporting Program*

The Hospital IQR Program is a pay-for-reporting and public reporting program established by section 501(b) of the MMA of 2003 and expanded by the Deficit Reduction Act (DRA) of 2005. This program requires hospitals paid under the IPPS to report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. Hospitals that do not participate or participate but fail to meet program requirements receive a one-fourth reduction of the applicable percentage increase in their annual payment update. The program aims to make progress towards paying providers based on quality rather than quantity of care and to provide consumers information about hospital quality to make informed choices about care. The data are publicly reported on the CMS Care Compare website.

MAP reviewed three MUCs for inclusion in the Hospital IQR Program.

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

The *Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)* measure estimates days spent in acute care within 30 days of discharge from an inpatient hospitalization for acute myocardial infarction (AMI). This measure is intended to capture the quality-of-care transitions provided to discharged patients hospitalized with AMI by collectively measuring a set of adverse acute-care outcomes that can occur post-discharge: (1) emergency department (ED) visits, (2) observation stays, and (3) unplanned readmissions at any time during the 30 days post-discharge. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm (PRA). Days spent in each care setting are aggregated for the 30 days post-discharge with a minimum of half-day increments.

MAP supported this measure for rulemaking. The MUC totals the ED visits, observation stays, and readmissions for patients 30 days after discharge from inpatient care following AMI. This measure is currently included in the Hospital IQR Program; the MUC updates the minimum admissions threshold, strengthening the reliability of the measure result. This measure distinguishes itself both for its condition specificity and the inclusion of other health care visits beyond hospital readmissions.

Nearly 4 percent of all Medicare costs are attributable to AMI hospitalizations, an indicator of the prevalence and impact of this clinical condition. Hospital performance in treating and discharging patients with AMI varies considerably, with the outliers yielding hundreds of EDACs for patients relative to their peers. Widespread improvement on this measure would have a significant impact on both costs to the healthcare system and the number of patients experiencing unplanned hospital visits.

The Rural Health Advisory Group noted the measure was appropriate but not necessarily rural-relevant, considering that a patient in the rural setting would be transferred to a hospital that could accommodate a necessary procedure. For complete details, refer to the Rural Health Advisory Group meeting summary. The Health Equity Advisory Group noted that this measure is risk-adjusted but not adjusted for social factors, such as the facility's proportion of patients with low socioeconomic status (SES). It suggested that stratification to identify disparities could be helpful, as well as considering whether the risk adjustment model should be updated to include social risk factors. For complete details of the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.2.3.2. **MUC2021-106 Hospital Commitment to Health Equity**

The *Hospital Commitment to Health Equity* measure assesses promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes. Among Medicare beneficiaries, individuals of racial and ethnic minority as well as individuals with limited English proficiency or disabilities often receive lower quality of care and have higher rates of readmission and complications than beneficiaries without these characteristics. Strong and

consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. This measure assesses whether the hospital has developed a plan to address health equity issues, has collected and analyzed the data needed to act on that plan, and has evaluated its progress towards attaining its objectives. MAP suggested that the information in this measure should be collected by national survey bodies and quality collaboratives while an improved outcome measure is created. MAP also noted that the structure of this measure aligns with potential inclusion in the VBP Program versus the Hospital IQR Program. MAP suggested the following conditions for support in addition to CBE endorsement: (1) committing to look at outcomes in the future, (2) providing more clarity on the measure and supplementing interpretations with results, and (3) verifying attestation provided by the accountable entities.

Reducing healthcare disparities would represent a substantial benefit to the overall quality of care. However, the literature currently does not closely link this measure to clinical outcomes; likewise, a performance gap at the individual hospital level on these specific structural elements has not been established in the literature. In summary, there is insufficient information present to evaluate the potential impact of this measure on the quality of care.

The Rural Health Advisory Group agreed that the measure for the promotion of health equity is crucial. However, concern was raised due the lack of evidence in the literature that links the elements of the measure to clinical outcomes. For complete details from the Rural Health Advisory Group Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group noted, while evaluating the measure as-is, that it would suggest future additions to the measure, including items pertaining to data transparency, accessibility, and disability. The Advisory Group also expressed concern that items included in the measure are not linked to meaningful improvement in process or outcomes and the need for standardized information for stratification. For complete details from the Health Equity Advisory Group Review Meeting, please refer to the meeting summary.

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

The *Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Knee Arthroplasty (THA/TKA)* measure estimates hospital-level, risk-standardized payments for an elective primary total THA/TKA episode of care, starting with an inpatient admission to a short-term, acute-care facility and extending 90 days post-admission for Medicare FFS patients who are 65 years of age or older.

MAP conditionally supported this measure for rulemaking, pending CBE Standing Committee review of the 26 codes added to the mechanical complication's definition. This fully developed and tested measure addresses risk-standardized payment for elective THA and TKA. The developer cites evidence that the risk-standardized payment at the hospital level has a median of $22,408, and the mean ± standard deviation (SD) risk-standardized hospital payment is

$23,686 ± $2,655. This variation demonstrates a range of performance and opportunities for improvement. No other measure in the Hospital IQR Program addresses payment for elective THA and TKA.

As of 2010, over 370,000 THAs and 600,000 TKAs have been performed annually. This recently updated measure was designed to be used with harmonized complications and readmissions measures and aspires to drive quality improvement in care coordination and post-acute costs and resource use. A previous version of the measure has been active in the Hospital IQR Program since 2018.

The Rural Health Advisory Group expressed concern regarding the potential unintended consequence of patient selection by some facilities where the patients could not be cared for. For complete details from the Rural Health Advisory Group Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group expressed concern that lower cost of care could result from rationing of care, and this measure could encourage underutilization if it is not tied to additional quality measures to understand the context. The Advisory Group also noted that under-resourced communities could perform poorly if access to home care and other services are limited and/or expensive. For complete details from the Health Equity Advisory Group Review Meeting, please refer to the meeting summary.

4.2.4. *Hospital Cross-Cutting Measures*

4.2.4.1. **MUC2021-118 Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)**

The *Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)* measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to 90 days post-date of the index admission (i.e., the admission included in the measure cohort).

4.2.4.1.1. **HOSPITAL INPATIENT QUALITY REPORTING PROGRAM**

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported this measure for rulemaking, pending CBE Standing Committee review of the 26 codes added to the mechanical complication's definition. This fully developed and specified measure addresses a critical and preventable safety event in the hospital inpatient setting. The measure is currently used in the Hospital VBP Program, was previously active in the Hospital IQR Program, and has been expanded to include 26 codes to the mechanical complication’s definition. The measure is otherwise identical to the previous version of the measure. MAP noted the importance of communicating the rationale for the updated measure, as trending performance across the two measure specifications may be challenging.

As of 2010, over 370,000 THAs and 600,000 TKAs have been performed annually. Of these procedures, complications for patients related to anesthesia, comorbidities, and allergic reactions pose a significant quality challenge. During NQF endorsement review, the developers

provided three-year, hospital-level, RSCRs from April 1, 2016 to March 31, 2019 using Medicare administrative claims data (n= 962,744 admissions). The RSCRs had a mean of 2.5 percent and ranged from 1.2 to 10.6 percent in the study cohort. The median risk-standardized rate was 2.4 percent. These data demonstrate a wide range of performance and opportunities for improvement in patient care.

The Rural Health Advisory Group noted that the measure had no negative impact on rural providers. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated a neutral impact on health disparities. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.1.2. HOSPITAL VALUE-BASED PURCHASING PROGRAM

The Hospital VBP Program is a pay-for-performance program established by Section 3001(a) of the ACA, under which value-based incentive payments are made each fiscal year (FY) to hospitals meeting performance standards established for a performance period for the school FY. The amount equal to 2 percent of base operating Medicare severity diagnosis-related group (MS-DRG) is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments. The program strives to improve healthcare quality by realigning hospitals' financial incentives and providing incentive payments to hospitals that meet or exceed performance standards.

For the Hospital VBP Program, MAP conditionally supported this measure for rulemaking, pending CBE Standing Committee review of the 26 codes added to the mechanical complication's definition. This fully developed and specified measure addresses a critical and preventable safety event in the Hospital VBP Program. The measure is currently in use and has been expanded to include 26 codes to the mechanical complication's definition. The measure is otherwise identical to the existing measure in Hospital VBP Program.

As of 2010, over 370,000 THAs and 600,000 TKAs have been performed annually. Of these procedures, complications for patients related to anesthesia, comorbidities, and allergic reactions pose a significant quality challenge. During NQF endorsement review, the developers provided three-year, hospital-level RSCRs from April 1, 2016 to March 31, 2019 using Medicare administrative claims data (n= 962,744 admissions). The RSCRs had a mean of 2.5 percent and ranged from 1.2 to 10.6 percent in the study cohort. The median risk-standardized rate was 2.4 percent. These data demonstrate a wide range of performance and opportunities for improvement in patient care.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated a neutral impact

on health disparities. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.2. **MUC2021-131 Medicare Spending per Beneficiary (MSPB)**

The *Medicare Spending per Beneficiary (MSPB)* measure evaluates hospitals' efficiency relative to the efficiency of the national median hospital and assesses the cost to Medicare for Part A and Part B services performed by hospitals and other healthcare providers during an MSPB Hospital episode, which is composed of the periods three days prior to, during, and 30 days following a patient's hospital stay. The measure is not condition-specific and uses standardized prices when measuring costs. Eligible beneficiary populations include beneficiaries enrolled in Medicare Parts A and B who were discharged between January 1 and December 1 in a calendar year from short-term acute hospitals paid under the IPPS.

4.2.4.2.1. **HOSPITAL INPATIENT QUALITY REPORTING PROGRAM**

For the Hospital IQR Program previously described (section 4.2.3.), MAP supported this measure for rulemaking. The *Medicare Spending per Beneficiary* measure was removed from the Hospital IQR Program at the beginning of 2020 to reduce duplication with measures in the Hospital VBP Program, in which it was retained. By statutory requirement, all measures entering the Hospital VBP Program must be implemented for at least one year prior in the Hospital IQR Program. Endorsement of this measure was retained during the last review cycle in June of 2021.

Performance data from prior years of implementation of this measure indicate a substantial opportunity for improvement: There is a considerable range in costs for episodes of care across U.S. hospitals. This measure, one of the only cost measures used in federal quality program reporting, will continue to incentivize hospitals to identify methods of cost savings, such as care coordination and patient safety initiatives to reduce the number of costly adverse events.

The Rural Health Advisory Group noted that the measure could potentially exclude critical access and rural hospitals. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated a neutral impact on health disparities. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.2.2. **HOSPITAL VALUE-BASED PURCHASING PROGRAM**

For the Hospital VBP Program previously described (section 4.2.4.1.2.), MAP supported this measure for rulemaking. This MUC is a methodological refinement to the *Medicare Spending per Beneficiary* measure currently in the Hospital VBP program per statutory requirement. The updated measure now equally weighs all attributed episodes in the hospital's final performance score, expands the coverage of included episodes by allowing readmissions to trigger new episodes, and updates the risk adjustment model to account for the differences in expected costs for episodes that are triggered by readmissions.

Performance data from prior years of implementation of this measure indicate a substantial opportunity for improvement: There is a considerable range in costs for episodes of care across U.S. hospitals. This measure, one of the only cost measures used in federal quality program reporting, will continue to incentivize hospitals to identify methods of cost savings, such as care coordination and patient safety initiatives to reduce the number of costly adverse events.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated a neutral impact on health disparities. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.3. **MUC2021-084 Hospital Harm – Opioid-Related Adverse Events**

The *Hospital Harm – Opioid-Related Adverse Events* measure assesses the proportion of inpatient hospital encounters in which patients ages 18 or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event, and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.

4.2.4.3.1. **HOSPITAL INPATIENT QUALITY REPORTING PROGRAM**

For the Hospital IQR Program previously described (section 4.2.3.), MAP supported this measure for rulemaking. This fully developed and specified measure addresses a critical and preventable safety event in the Hospital IQR Program. The program does not currently include a measure that addresses opioid-related adverse events (ORAEs) and subsequent administration of naloxone in the inpatient setting. This measure was submitted for endorsement review to the Patient Safety Standing Committee for the 2021 spring cycle and received CBE endorsement.

This measure identifies hospital inpatient ORAEs in which patients are administered an opioid antagonist (naloxone) within 12 hours. Opioids have been identified among the drugs most commonly associated with adverse drug events, and ORAEs may be preventable with appropriate medication management, education and training, and patient monitoring.

The Rural Health Advisory Group noted the rural relevance of the measure and the low burden of implementation. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group commented on the potential penalizing of hospitals that treat patients who self-medicate (e.g., patients who also use heroin or other drugs). The Advisory Group also noted that the measure might reinforce bias regarding opioid use for patients of color and could encourage clinical teams to overidentify symptoms as opioid-related adverse events instead of other medical conditions. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.3.2. MEDICARE PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

The Medicare Promoting Interoperability Program for Hospitals (originally established at the Medicare and Medicaid EHR Incentive Programs) is a pay-for-reporting and public reporting program established in 2011 to encourage eligible entities to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT). CMS' three-stage implementation process culminated with the final stage in 2017 focusing on the use of CEHRT to improve health outcomes. Eligible hospitals that fail to meet program requirements, including meeting the clinical quality measure (CQM) requirements, receive a three-fourths reduction on the applicable percentage increase. The program' name change in 2018 propelled the focus on interoperability and improving patient access to health information.

For the Medicare Promoting Interoperability Program for Hospitals, MAP supported this measure for rulemaking. This fully developed and specified measure addresses a critical and preventable safety event in the Medicare Promoting Interoperability Program for Hospitals. The program does not currently include a measure that addresses ORAEs and subsequent administration of naloxone in the inpatient setting. The measure was submitted for endorsement review to the Patient Safety Standing Committee during the 2021 spring cycle and received CBE endorsement.

This measure identifies hospital inpatient ORAEs in which patients are administered an opioid antagonist (naloxone) within 12 hours. Opioids have been identified among the drugs most commonly associated with adverse drug events, and ORAEs may be preventable with appropriate medication management, education and training, and patient monitoring.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group had no program-specific comments regarding this measure and was neutral on this measure's impact on health disparities. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.4. MUC2021-104 Hospital Harm – Severe Obstetric Complications eCQM

The *Hospital Harm – Severe Obstetric Complications eCQM* measure indicates the proportion of patients with severe obstetric complications, which occur during the inpatient delivery hospitalization.

4.2.4.4.1. HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported this measure for rulemaking, pending successful completion of testing and CBE endorsement. This newly developed measure is an outcome eCQM and a high-priority area for the Hospital IQR Program, and it addresses the Meaningful Measures area of patient safety. If included, this measure would be the only outcome measure in the Hospital IQR Program that directly measures maternal morbidity and obstetric complications. MAP did raise concerns about the sample size for the testing of the measure.

Severe maternal morbidity (SMM) rates have increased from 49.5 to 139.7 per 10,000 deliveries in the U.S. from 1993 to 2017, and racial disparities in SMM persist (225.7 per 10,000 deliveries in non-Hispanic Black individuals versus 104.7 per 10,000 deliveries in non-Hispanic White individuals). Complications are also associated with a higher risk of infant death. However, an estimated 40.5 percent of pregnancy-related deaths, 45.5 percent of near-miss morbidities, and 16.7 percent of other severe morbidities are preventable. This measure collects data on severe obstetric complications and patient outcomes to inform quality improvement efforts in maternal care.

The Rural Health Advisory Group noted that rural communities tend to have a higher obstetric-related mortality rate, and this measure does not consider population prevalence. It agreed that the measure was suitable for use with rural providers. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group appreciated that the measure's language was not restricted to females but included all pregnant patients. It suggested stratifying this measure by federal poverty level, race/ethnicity, and insurance status to identify and track disparities across different populations. It also emphasized that this information is important to help identify opportunities for improvement (e.g., increasing access to prenatal care and improved communication, especially with people of color). For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.4.2. MEDICARE PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

For the Medicare Promoting Interoperability Program for Hospitals previously described (section 4.2.4.3.2.), MAP conditionally supported this measure for rulemaking, pending successful completion of testing and CBE endorsement. This newly developed measure is an outcome eCQM addressing the Meaningful Measures area of patient safety. As an eCQM, the measure promotes meaningful use of CEHRT. If included, this measure would be the only outcome measure in the Medicare Promoting Interoperability Program for Hospitals that addresses maternal health and obstetric complications. MAP did raise concerns about the sample size for the testing of the measure.

SMM rates have increased from 49.5 to 139.7 per 10,000 deliveries in the U.S. from 1993 to 2017, and racial disparities in SMM persist (225.7 per 10,000 deliveries in non-Hispanic Black individuals versus 104.7 per 10,000 deliveries in non-Hispanic White individuals). Complications are also associated with a higher risk of infant death. However, an estimated 40.5 percent of pregnancy-related deaths, 45.5 percent of near-miss morbidities, and 16.7 percent of other severe morbidities are preventable. This measure collects data on severe obstetric complications and patient outcomes to inform quality improvement efforts in maternal care.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group also had no program-specific comments for this measure. For a complete review of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.5. MUC2021-100 National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

The *National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure* tracks the development of new bacteremia and fungemia among patients already admitted to acute-care hospitals using algorithmic determinations from data sources widely available in EHRs. This measure includes many healthcare-associated infections not currently under surveillance by the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). Ongoing surveillance also requires minimal data collection burden for users.

4.2.4.5.1. HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported this measure, pending CBE endorsement. This measure tracks the number of hospital-onset bacteremia or fungemia (HOB) infections, indicated by positive test results, among inpatients but excludes those present on admission or for which no treatment was administered. Although this measure does not address any of the Hospital IQR Program measurement priorities, it does correspond to the Patient Safety focus within CMS' Meaningful Measures 2.0 framework. A 2020 decision to reduce the number of measures in the program saw the removal of several infection surveillance measures; this MUC is conceptually very similar to those measures.

MAP expressed concern about unintended consequences and a lack of family and caregiver input in the development process and noted a need to plan for small rural health provider adaptations moving forward.

This MUC tracks a group of very common, and potentially lethal, hospital-acquired infections. Hospitalizations in which these conditions were identified were nearly twice as expensive as the average hospital stay, indicating that high-resource utilization is needed to treat these conditions. Despite the common and costly nature of these infections, studies and surveys estimate that the hospital can prevent nearly half of these infections. Incentivizing the adoption of infection control practices that would reduce the incidence of these conditions would present a substantial benefit to both patients and the healthcare system.

The Rural Health Advisory Group noted the potential difficulty of predicting the denominator and the number of infections, given low case-volume challenges. For complete details from the Rural Health Advisory Group Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated some potential for a positive impact or reducing health disparities. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.5.2. HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

The HACRP is a pay-for-performance and public reporting program established by Section 1886(p)(6)(B) of the SSA. The worst-performing 25 percent of hospitals in the program, as determined by the measures in the program, will have their Medicare payments reduced by 1

percent. The program aims to encourage hospitals to reduce hospital-acquired conditions (HACs) through penalties and to link Medicare payments to healthcare quality in the inpatient hospital setting.

For HACRP, MAP conditionally supported this measure, pending CBE endorsement. This measure tracks the number of HOB infections, indicated by positive test results, among inpatients but excludes those present on admission or for which no treatment was administered. Although this measure does not address any of the Hospital IQR Program measurement priorities, it does correspond to the Patient Safety focus within CMS' Meaningful Measures 2.0 framework. A 2020 decision to reduce the number of measures in the program saw the removal of several infection surveillance measures; this MUC is conceptually very similar to those measures. MAP raised concerns regarding the lack of family and patient input and data collection burden because sepsis requires substantial chart abstraction.

This MUC tracks a group of very common, and potentially lethal, hospital-acquired infections. Hospitalizations in which these conditions were identified were nearly twice as expensive as the average hospital stay, indicating that high-resource utilization is needed to treat these conditions. Despite the common and costly nature of these infections, studies and surveys estimate that the hospital can prevent nearly half of these infections. Incentivizing the adoption of infection control practices that would reduce the incidence of these conditions would present a substantial benefit to both patients and the healthcare system.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated neutral impact on health disparities. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.5.3. PROSPECTIVE PAYMENT SYSTEM-EXEMPT CANCER HOSPITAL QUALITY REPORTING PROGRAM

For the PCHQR Program previously described (section 4.2.2.), MAP conditionally supported this measure, pending CBE endorsement. This measure tracks the number of HOB infections, indicated by positive test results, among inpatients but excludes those present on admission or for which no treatment was administered. Although this measure does not address any of the Hospital IQR Program measurement priorities, it does correspond to the Patient Safety focus within CMS' Meaningful Measures 2.0 framework. A 2020 decision to reduce the number of measures in the program saw the removal of several infection surveillance measures; this MUC is conceptually very similar to those measures. MAP raised concerns regarding the lack of family and patient input and data collection burden because sepsis requires substantial chart abstraction.

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as expensive as the average hospital stay, indicating that high-resource utilization is needed to treat these conditions. Despite the common and costly nature of these infections, studies and surveys estimate that the hospital can prevent nearly half of these infections. Incentivizing the adoption of infection control practices that would reduce the incidence of these conditions would present a substantial benefit to both patients and the healthcare system.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated some potential for a positive impact or reducing health disparities. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.2.4.5.4. MEDICARE PROMOTING INTEROPERABILITY PROGRAM FOR HOSPITALS

For the Medicare Promoting Interoperability Program for Hospitals previously described (section 4.2.4.3.2.), MAP conditionally supported this measure, pending CBE endorsement. This measure tracks the number of HOB infections, indicated by positive test results, among inpatients but excludes those present on admission or for which no treatment was administered. Although this measure does not address any of the Hospital IQR Program measurement priorities, it does correspond to the Patient Safety focus within CMS' Meaningful Measures 2.0 framework. A 2020 decision to reduce the number of measures in the program saw the removal of several infection surveillance measures; this MUC is conceptually very similar to those measures. MAP raised concerns regarding the lack of family and patient input and data collection burden because sepsis requires substantial chart abstraction.

This MUC tracks a group of very common, and potentially lethal, hospital-acquired infections. Hospitalizations in which these conditions were identified were nearly twice as expensive as the average hospital stay, indicating that high-resource utilization is needed to treat these conditions. Despite the common and costly nature of these infections, studies and surveys estimate that the hospital can prevent nearly half of these infections. Incentivizing the adoption of infection control practices that would reduce the incidence of these conditions would present a substantial benefit to both patients and the healthcare system.

The Rural Health Advisory Group had no program-specific comments regarding this measure. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. Due to time constraints, the Health Equity Advisory Group completed polling for this measure via online polling after the meeting ended. Its average poll indicated neutral impact on health disparities. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.3. Post-Acute Care/Long-Term Care Program Measures

4.3.1. *Skilled Nursing Facility Value-Based Purchasing Program*

The SNF VBP Program awards incentive payments to SNFs based on a single all-cause readmission measure, as mandated by the Protecting Access to Medicare Act (PAMA) of 2014. SNFs' performance period risk-standardized readmission rates are compared to their own past performance to calculate an improvement score and the National SNF performance during the baseline period to calculate an achievement score. The higher of the two scores becomes the SNF's performance score.

The Consolidated Appropriations Act of 2021 allows the Secretary of HHS to apply up to nine additional measures, which may include measures focusing on functional status, patient safety, care coordination, or patient experience for payments for services furnished on or after October 1, 2023.

MAP reviewed four MUCs for inclusion in the SNF VBP Program.

4.3.1.1. **MUC2021-124 Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization**

The *Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization* measure estimates the risk-adjusted rate of healthcare-associated infections (HAIs) that are acquired during SNF care and result in hospitalizations. The measure is risk-adjusted to "level the playing field" and to allow comparison of performance based on residents with similar characteristics between SNFs. The one-year measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator) * national observed rate of HAIs. It is important to recognize that HAIs in SNFs are not considered "never events." The goal of this risk-adjusted measure is to identify SNFs that have notably higher rates of HAIs when compared to their peers.

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. MAP noted that the measure adds value to the SNF VBP Program due to the addition of an overall measurement of all HAIs acquired within SNFs requiring hospitalizations and was recently adopted within another PAC/LTC program. The Meaningful Measures 2.0 framework indicates safety as a continued focus of CMS to build value-based care. Infection control and prevention can aid in reducing HAIs within SNFs. There is variation in the performance of this measure within SNFs, and these facilities will have the ability to implement interventions to improve performance.

Patients within SNFs are at greater risk for infection due to increased age, functional decline, and proximity to other patients and healthcare personnel. Evidence indicates 1 in 4 adverse events among SNF patients is attributed to HAIs, and more than half are potentially preventable. Recent claims data indicate a risk-adjusted HAI score of 5.84 percent from 2019 and 6.15 percent from 2018. Moreover, a recently published study indicates that U.S. hospitals saw significant increase in HAIs during 2020, resulting from the COVID-19 pandemic. Education,

monitoring, and feedback on infection rates can aid in reducing HAIs and improving care for patients.

The Rural Health Advisory Group expressed the value of the measure and the importance to reduce HAIs. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group discussed that the risk adjustment of HAI data could make both SNFs with poor performance and the reported data unhelpful for consumers. Specifically, the Advisory Group noted that adjustment for age and sex could pose an equity issue, and sex could be problematic for transgender or nonbinary individuals. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.3.1.2. **MUC2021-137 Total Nursing Hours per Resident Day**

The *Total Nursing Hours per Resident Day* measure indicates the total nursing hours (registered nurse [RN] + licensed practical nurse [LPN] + nurse aide hours) per resident day. The source for total nursing hours is CMS' Payroll-Based Journal (PBJ) system. The denominator for the measure is a count of daily resident census derived from Minimum Data Set (MDS) resident assessments. The measure is case-mix-adjusted based on the distribution of MDS assessments by Resource Utilization Groups, version IV (RUG-IV groups).

MAP conditionally supported this measure for rulemaking, pending CBE endorsement. MAP indicated this measure adds value to the SNF VBP program by adding a measure not currently addressed and aligns across other PAC/LTC programs by working towards the overarching goal of CMS' Meaningful Measures 2.0: value-based care. Per the Consolidated Appropriations Act of 2021, expansion of the measure set will assess the quality of care that SNFs provide to patients. CMS reported that average nursing staffing hours per resident day increased from 3.85 in 2017 Quarter (Q)4 to 4.08 for 2020 Q4. There is variation in the performance of this measure within SNFs, and these facilities will have the ability to address processes to improve staffing.

Patients in SNFs are at greater risk for illness, and staffing can either aid or hinder patients' quality of care. The COVID-19 PHE has brought nursing home staffing to the forefront of an already frequently discussed topic. A recent report from the Office of Inspector General (OIG) on CMS' use of data on nursing home staffing generated recommendations, including taking additional steps to strengthen the oversight of nursing home staff. The developer cited evidence regarding the relationship between higher staffing levels in nursing homes and improved care for patients, which is the strongest relationship with RN staffing.

MAP raised concerns for staffing levels and reimbursement adjustments, particularly a possible financial incentive being created to decrease staffing. MAP questioned the fit of this measure within the program, along with increased staff hours and decreased quality of patient care.

The Rural Health Advisory Group commented on the overall importance of the measure, citing staffing issues across all SNFs but noted that the measure was not rural-specific. For a complete review of the Rural Health Advisory Review Meeting, please refer to the meeting summary. The

Health Equity Advisory Group agreed that the measure addresses an important and relevant topic, noting that staffing remains an issue in SNFs considering the ongoing COVID-19 pandemic. It also felt that this measure could potentially have a positive impact by decreasing health disparities. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

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

The *Discharge to Community Post-Acute Care Measure for Skilled Nursing Facilities (SNF)* estimates the risk-adjusted rate of successful discharge to the community from an SNF with successful discharge to the community, including no unplanned rehospitalizations and no death in the 31 days following SNF discharge. The measure is calculated using the following formula: (risk-adjusted numerator/risk-adjusted denominator) * national observed rate of successful discharges to the community. The measure is calculated using two years of Medicare FFS claims data.

MAP supported this measure for rulemaking. It noted that the measure adds value to the SNF VBP program set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing the same measure. The measure also aligns with CMS' Quality Measurement Action Plan to build value-based care by addressing several goals, including measures focused on key quality domains; aligning measures across programs; prioritizing outcome measures; and implementing measures that reflect social and economic determinants.

The empirical evidence demonstrates that improvement in successful discharge to community rates among PAC patients is possible through modifying provider-led processes and interventions within the PAC setting. With the continuing COVID-19 PHE, the desire and potential need for successful discharges may be necessary to ease healthcare facility burden. The 2018-2019 risk-adjusted measure scores ranged from 7.11 percent to 84.70 percent with a mean risk-adjusted score of 52.55 percent. There is variation in the performance of this measure within SNFs, and these facilities will have the ability to implement interventions to improve performance and care for patients.

The Rural Health Advisory group noted the measure was not risk-adjusted for geographic location or distance from patient to provider. Concern was expressed regarding access to care for patients in rural communities with limited resources and the potential disadvantage for rural providers. For complete details from the Rural Health Advisory Group Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group had a robust discussion about stratification and risk adjustment. It discussed that reporting on this measure may be skewed based on geography, as discharge from facilities located in areas with lower resources may be affected based on factors such as availability of home healthcare, social services, food delivery services, etc. The Advisory Group suggested stratifying the measure by race, ethnicity, language, sexual orientation, gender identity, etc., which could be helpful for identifying disparities. Further discussion occurred regarding not risk-adjusting based on social risk factors, considering

the overall goal is to understand factors that need to be addressed for successful discharge. For complete details of the Health Equity Advisory Review Meeting, please refer to the meeting summary.

4.3.1.4. **MUC2021-095 CoreQ: Short Stay Discharge Measure**

The *CoreQ: Short Stay Discharge Measure* calculates the percentage of individuals discharged in a six-month time period from an SNF, within 100 days of admission, who are satisfied (scoring a three or above on the survey).

MAP supported this measure for rulemaking. It indicated that this measure adds value to the SNF VBP Program set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs by working towards the overarching goal of CMS' Meaningful Measures 2.0: value-based care. Per the Consolidated Appropriations Act of 2021, expansion of the measure set will add measures, including those measuring patient experience. There is a range of variation in the performance with this measure within SNFs, which will allow these facilities the opportunity to implement interventions and processes to improve performance.

In 2016, it was estimated that there were 606,800 short-stay U.S. nursing home patients. As the U.S. population has aged and increased over the years, the estimates have most likely increased. Nursing home data covering 2016 Q1 to 2019 Q4 indicated mean satisfaction rates fluctuated between 77 to 80 percent. The ongoing COVID-19 PHE has brought about even more attention to nursing home patient satisfaction. MAP noted person-centered care, patient experience, and patient satisfaction as focuses of the healthcare community; improvement in these focus areas can help to improve the care for patients.

The Rural Health Advisory Group indicated the measure was applicable to rural settings and not burdensome to implement for providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group cautioned that, as with previously discussed PRO-PMs, disparities may be present in survey completion due to factors such as language barriers or payer type. It noted, however, the data collected in these surveys may help to identify quality disparities with the SNF setting by race or ethnicity and can help to inform quality improvement efforts. Also noted, the exclusion criteria for the measure could exclude vulnerable populations, including patients with a caregiver/guardian and patients with dementia. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

Program Measure Gaps

For the SNF VBP Program, MAP noted the importance of a balance of structure, process, and outcome measures, especially regarding patient experience. MAP commented on the need for information transfer between settings (e.g., hospital to SNF, SNF to home health) and not solely within the silos of care settings.

4.3.2. *Skilled Nursing Facility Quality Reporting Program*

The SNF QRP was established in accordance with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which added section 1899B to the SSA requiring data submission by SNFs. SNFs that submit data under the SNF PPS are required to participate in the SNF QRP, excluding units that are affiliated with CAHs. The IMPACT Act requires measures that address five quality domains, or three measure categories, including resource use, hospitalization, and discharge to the community. Initiated in FY 2018, providers who fail to submit required quality data to CMS will have their annual payment update reduced by two percentage points. SNF QRP data are publicly reported on the Care Compare website with a goal to increase transparency so that patients, families, and caregivers can make informed choices.

MAP reviewed one MUC for inclusion in the SNF QRP.

4.3.2.1. **MUC2021-123 Influenza Vaccination Coverage Among Healthcare Personnel**

The *Influenza Vaccination Coverage Among Healthcare Personnel* measure addresses the percentage of healthcare personnel (HCP) who receive the influenza vaccination.

MAP supported this measure for rulemaking. MAP noted this measure adds value to the SNF QRP set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing the same measure. Vaccination coverage among HCP within SNFs is of importance as seen by the recently adopted *COVID-19 Healthcare Personnel Vaccine* measure. Vaccination coverage among HCP within these facilities can decrease the viral transmission of COVID-19, along with a decrease in morbidity and mortality among patients. There is variation in the performance of this measure within SNFs, and these facilities will have the ability to implement interventions to improve performance.

Influenza affects older adults disproportionately and HCP can aid in this transmission. Estimates of recent years indicate 70 to 85 percent of seasonal flu-related deaths were those 65 years of age and older, and 50 to 70 percent of seasonal flu-related hospitalizations were among the same age group. Recent data from the NHSN show that the influenza vaccination of HCP in long-term acute-care hospitals has a mean of 77.5 percent and a year-over-year actual percentage change of 5.8 percent. Besides increased patient morbidity and mortality, healthcare facility influenza outbreaks lead to longer patient stays. Increased influenza vaccine rates among HCP can help to improve care for patients.

The Rural Health Advisory Group strongly agreed that the measure was suitable for use with rural providers and noted the measure was straightforward, minimally burdensome, and of clinical value. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group discussed that influenza vaccinations are a public health priority and noted that Black and Indigenous populations have higher rates of hospitalization and death and lower rates of influenza vaccination. The Health Equity Advisory Group felt that this measure could potentially have a positive impact by decreasing health disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

Program Measure Gaps

The discussion of gaps within SNF QRP included PROMs. MAP agreed that person-centered and person-reported goals are important, along with the family and caregiver perspective. It noted that the definition of quality is different for each individual, and unless that is integrated into measurement, individual needs will not be met. MAP included mental health, specifically isolation; loneliness; and depression as potential program measure gaps. It further noted the heightened issues of mental health during the COVID-19 pandemic. MAP commented that pain management may be a measure to consider, noting the large number of factors that involve pain within this population. It also noted that the COVID-19 pandemic uncovered underpreparedness and a lack of resources related to infection control. MAP noted the need to align ongoing measurement that reflects overall infection control performance.

4.4. Cross-Setting Measures

4.4.1. **MUC2021-098 National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides Difficile Infection Outcome Measure**

The *National Healthcare Safety Network (NHSN) Healthcare-Associated Clostridioides Difficile Infection Outcome Measure* was reviewed in several PAC/LTC and Hospital programs. The measure tracks the development of new Clostridioides difficile (C. difficile) infections (CDIs) among patients already admitted to healthcare facilities using algorithmic determinations from data sources widely available in EHRs. This measure improves on the original measure by requiring both microbiologic evidence of C. difficile in stool and evidence of antimicrobial treatment.

4.4.1.1. **Long-Term Care Hospital Quality Reporting Program**

The LTCH QRP was established in accordance with section 1886(m) of the SSA, as amended by Section 3004(a) of the ACA. The LTCH QRP applies to all designated LTCH facilities under the Medicare program with the goal of furnishing extended medical care to individuals with clinically complex problems (e.g., multiple acute or chronic conditions needing hospital-level care for relatively extended periods of greater than 25 days). Data sources for LTCH QRP measures include Medicare FFS claims, the CDC's NHSN data submissions, and the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) assessment data.

MAP conditionally supported this measure, pending CBE endorsement and successful testing of reliability and validity. This MUC would modify the existing healthcare-associated (HA)-CDI surveillance measure in the LTCH QRP by only counting cases in which there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, counting a case based on a positive test only, which may have led to a historical undercounting of observed HA-CDI. This updated measure is consistent with the program's priority to measure HAIs and the Meaningful Measures 2.0 area of Patient Safety.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of LTC hospitals on the existing HA-CDI measure shows considerable variation in performance: The 20th percentile of performance for

LTC hospitals was 0.094 infections observed/expected compared with an 80th percentile performance of 0.687 infections observed/expected. Nevertheless, this performance has improved by 60 percent over the past five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group provided no program-specific comments for this measure but determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to have some potential for a positive impact or reducing health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.2. **Inpatient Rehabilitation Facility Quality Reporting Program**

The IRF QRP was established in accordance with section 1886(j) of the SSA as amended by section 3004(b) of the ACA. IRFs that receive the IRF PPS are required to participate in the IRF QRP (e.g., IRF hospitals, IRF units that are co-located with affiliated acute-care facilities, and IRF units affiliated with CAHs). The goal of the IRF QRP is to address the rehabilitation needs of the individuals, including improved functional status and the achievement of the successful return to the community post-discharge. Data sources for IRF QRP measures include Medicare FFS claims, the CDC's NHSN data submissions, and Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessment data.

MAP conditionally supported this measure, pending CBE endorsement and successful testing of reliability and validity. This MUC would modify the existing HA-CDI surveillance measure in the IRF QRP by only counting cases in which there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, such as counting a case based on a positive test only, which may have led to a historical undercounting of observed HA-CDI. This updated measure is consistent with the program's priority to measure HAIs and the Meaningful Measures 2.0 area of Patient Safety.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of IRFs on the existing HA-CDI measure shows considerable variation in performance: The 20th percentile of performance for IRFs was 0.00 infections observed/expected compared with an 80th percentile performance of 0.878 infections observed/expected. Nevertheless, this performance has improved by 48 percent over the prior five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group provided no program-specific comments for this measure but determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to have some

potential for a positive impact on health equity by decreasing health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.3. **Skilled Nursing Facility Quality Reporting Program**

For the SNF QRP previously described (section 4.3.2.), MAP conditionally supported this measure, pending CBE endorsement and successful testing of reliability and validity. The measure adds value to the SNF QRP set by adding a measure not currently addressed within the program, and this measure aligns with other PAC/LTC programs utilizing a similar measure. The updated specifications of this HA-CDI measure are intended to mitigate unintended consequences by only counting those cases in which there is evidence of both a positive test for CDI and a treatment administered, which may have led to a historical undercounting of observed HA-CDIs. HAIs are of importance to SNFs as seen by the recently adopted *SNF HAIs Requiring Hospitalizations* measure. Measuring HAIs remains a high priority for the SNF QRP, and safety is a CMS Meaningful Measures 2.0 focus.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of LTC hospitals on the existing HA-CDI measure shows considerable variation in performance: The 20th percentile of performance for LTC hospitals was 0.094 infections observed/expected compared with an 80th percentile performance of 0.687 infections observed/expected. Nevertheless, this performance has improved by 60 percent over the past five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group provided no program-specific comments for this measure but determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to have some potential for a positive impact on health equity by decreasing health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.4. **Hospital Inpatient Quality Reporting Program**

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported this measure for rulemaking, pending CBE endorsement and the resolution of duplication concerns by CMS. This updated measure is intended to capture HA-CDIs more precisely than the existing similar measure in other hospital programs by only counting those infections among inpatients who have both a positive laboratory test and evidence of treatment. Although this measure does not address any of the Hospital IQR Program measurement priorities, it does correspond to the Patient Safety focus within CMS' Meaningful Measures 2.0 framework. A 2018 decision to reduce the number of measures in the program saw the removal of this

measure at the beginning of 2021. This MUC is conceptually very similar to the removed measure.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of acute-care hospitals on the existing HACDI measure shows considerable variation in performance: The 20th percentile of performance for acute-care hospitals was 0.182 infections observed/expected compared with an 80th percentile performance of 0.762 infections observed/expected. Nevertheless, this performance has improved by 48 percent over the past five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group noted low-case volume as a potential challenge for measure calculation and reporting. It also determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to potentially have a neutral impact on health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.5. **Hospital-Acquired Condition Reduction Program**

The HACRP was established in accordance with section 1886(p)(6)(B) of the SSA. The goal of the HACRP is to encourage hospitals to reduce HACs through penalties and link Medicare payments to healthcare quality in the inpatient hospital setting. CMS evaluates overall hospital performance annually by calculating total HAC scores to determine which hospitals have scores greater than the 75th percentile. Data for the HACRP's six quality measures are gathered from one claims-based *Patient Safety and Adverse Events Composite* measure (CMS PSI 90) and five chart-abstracted measures of HAIs submitted to the CDC's NHSN.

MAP conditionally supported this measure for rulemaking pending CBE endorsement and the resolution of duplication concerns by CMS. This MUC would modify the existing HA-CDI surveillance measure in the HACRP by only counting cases in which there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, such as counting a case based on a positive test only, which may have led to a historical undercounting of observed HA-CDIs. This updated measure is consistent with the program's priority to measure HAIs and the Meaningful Measures 2.0 area of Patient Safety.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of LTC hospitals on the existing HA-CDI measure shows considerable variation in performance: The 20th percentile of performance for acute-care hospitals was 0.182 infections observed/expected compared with an 80th percentile performance of 0.762 infections observed/expected. Nevertheless, this performance has improved by 48 percent over the past five years, considering that the quality measure has

incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group noted low case-volume as a potential challenge for measure calculation and reporting, such as the Hospital IQR Program. It also determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to potentially have a neutral impact on health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.6. **Protective Payment System-Exempt Cancer Hospital Quality Reporting Program**

For the PCHQR Program previously described (section 4.2.2.), MAP conditionally supported this measure for rulemaking pending CBE endorsement and the resolution of duplication concerns by CMS. This MUC would modify the existing HA-CDI surveillance measure in the PCHQR by only counting cases in which there was evidence of both a positive test and treatment. This may mitigate potential unintended consequences from the current measure's design, such as counting a case based on a positive test only, which may have led to a historical undercounting of observed HA-CDI. This updated measure is consistent with the Meaningful Measures 2.0 area of Patient Safety.

An HA-CDI infection has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of LTC hospitals on the existing HA-CDI measure shows considerable variation in performance: In 2019, nearly a third of reporting PPS-exempt cancer hospitals had a Standardized Infection Ratio (SIR) higher than the national average. Nevertheless, the national performance across all reporting facilities has improved by 48 percent over the past five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group provided no program-specific comments for this measure but determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to have some potential for a positive impact on health equity by decreasing health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.1.7. **Medicare Promoting Interoperability Program for Hospitals**

For the Medicare Promoting Interoperability Program for Hospitals previously described (section 4.2.4.3.2.), MAP focused its review of the measure solely on its specifications and appropriateness for the program. This updated measure is intended to capture HA-CDIs more

precisely than the existing similar measure in other hospital programs by only counting those infections among inpatients who have both a positive laboratory test and evidence of treatment. This measure is a digital measure. A decision to reduce the number of measures in the program saw the removal of several infection surveillance measures, including this measure in 2021. This MUC is conceptually very similar to the removed measure. MAP conditionally supported this measure for rulemaking, pending CBE endorsement.

An HA-CDI has serious potential consequences for patients, including death. Nearly 114,000 HA-CDIs were reported to the CDC in 2020. The performance of acute-care hospitals on the existing HA-CDI measure shows considerable variation in performance: The 20th percentile of performance for acute-care hospitals was 0.182 infections observed/expected compared with an 80th percentile performance of 0.762 infections observed/expected. Nevertheless, this performance has improved by 48 percent over the past five years, considering that the quality measure has incentivized the implementation of hand hygiene, isolation, and other protocols recommended by CDC guidelines.

The Rural Health Advisory Group provided no program-specific comments for this measure but determined through polling that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group found this measure to have some potential for a positive impact on health equity by decreasing health disparities. It completed polling for this measure via online polling due to time constraints within the original virtual meeting. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.2. MUC2021-136 Screening for Social Drivers of Health

4.4.2.1. Merit-Based Incentive Payment System

For the MIPS Program previously described (section 4.1.2.), MAP conditionally supported this measure for rulemaking, pending CBE endorsement and successful testing of the measure's reliability and validity. This measure assesses the rate at which providers screen their adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. As the first screening measure to address SDOH and healthcare equity, this measure is consistent with CMS' Meaningful Measures 2.0 priority areas and the priorities of the MIPS program to advance health equity. This measure addresses a significant performance gap, in which 84 percent of physician offices do not screen for all five needs, even though approximately one-third of patients would screen positive for one or more social needs. This measure is consistent with recent guidelines from the American Academy of Family Practitioners (AAFP), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force (USPSTF); these guidelines are inspired by research that shows that health outcomes are largely driven by SDOH, and screening for health needs can help clinicians connect their patients to social services to ameliorate those needs.

MAP raised other concerns, including alignment with data standards, especially gravity, and the identification of food, housing, and transportation as priority SDOH domains for terminology and interoperability alignment. Furthermore, utilities (as a subset of material hardship/financial insecurity) and intimate partner violence are among the domains included in subsequent domain reviews. Additionally, concerns were raised regarding the testing of reliability and validity of the measure itself, not necessarily the instruments, which has already been done. Lastly, the unintended burden on patients to provide information to multiple providers and the availability of resources to address needs were identified.

MAP proposed the following conditions for support in addition to CBE endorsement: (1) additional details on how potential tools map to the individual drivers, as well as best practices; (2) what resources may be available to assist patients; and (3) alignment with data standards, particularly the Gravity project.

The Rural Health Advisory Group identified concerns regarding standardized data sets and data collection for SDOH. It also identified concerns regarding the capture of a positive screen without the appropriate resources available to support the patient's needs. Polling of the Rural Health Advisory Group determined the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group identified concerns for alignment regarding data capture and standardization, the need for stratification by disability, and patient and provider frustrations regarding available resources to address the positive responses. Polling results of the Health Equity Advisory Group found the measure to have some potential for a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.2.2. **Hospital Inpatient Quality Reporting Program**

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported the measure for rulemaking pending CBE endorsement. This measure assesses the rate at which providers screen their adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. As the first screening measure to address SDOH and healthcare equity, this measure is consistent with CMS' Meaningful Measures 2.0 priority areas.

This measure addresses a significant performance gap, in which 84 percent of physician offices do not screen for all five needs, despite the fact that approximately one-third of patients would screen positive for one or more social needs. This measure is consistent with recent guidelines from AAFP, AAP, and USPSTF; these guidelines are inspired by research that shows that health outcomes are largely driven by SDOH. Screening for health needs can help connect patients to social services to ameliorate those needs.

The Rural Health Advisory Group expressed concern about how data would be collected and the burden this may create for admission or discharge settings as well as for the scientific acceptability of the measure. It also expressed that potential unintended consequences could

occur if data are collected without follow-up to appropriate community resources. However, it was also noted that the topic of social drivers of health is critical, and measurement must start somewhere. Polling of the Rural Health Advisory Group indicated that the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group noted concerns about the standardization of screening tools, stratification of results, and the need for clear and specific definitions and consistent methodology. It reiterated concerns about the identification of needs without follow-up action but acknowledged the importance of beginning to collect these data. It was noted that the burden of collecting data for this measure may be lesser at the hospital level than at the clinician level. Polling results of the Health Equity Advisory Group found the measure to have some potential for a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.3. MUC2021-134 Screen Positive Rate for Social Drivers of Health

4.4.3.1. Merit-Based Incentive Payment System

For the MIPS Program previously described (section 4.1.2.), MAP conditionally supported the measure for rulemaking pending CBE endorsement. An additional suggested condition was the results of MUC2021-134 not being used to penalize or criticize healthcare providers under the MIPS or IQR programs. This measure assesses the percentage of patients who screened positive for health-related social needs (HRSNs). It would be the first in the MIPS Program to specifically address screening for health equity, which is consistent with both the program goals and a Meaningful Measures priority. MAP explored potential ambiguity on the definition of the measure, noting that providers should not be penalized for having a higher screen positive rate for social drivers of health. CMS and the developer clarified that MUC2021-134 and MUC2021-136 were used together to document screening and the positivity rate from the screening, and these two measures do not compare providers based on differences in positive screening rates. Several MAP members encouraged CMS to examine MUC2021-134 and MUC2021-136 together while also acknowledging that the current MIPS Program allows providers to choose individual measures, and thus, these two measures may not always be selected together.

The measure ultimately seeks to bridge patients who screened positive for HRSNs with community navigation services and an individualized action plan from the beneficiary to resolve HRSNs identified by the screening. MAP noted that using this measure to document positive screen rates for social drivers of health is an important first step to addressing important social drivers of health outcomes and may be used to stratify other data, leading to the reallocation of financial resources in the future.

The Rural Health Advisory Group identified concerns regarding standardized data sets and data collection for SDOH, concerns for the appropriate resources available to support the patient needs, and concerns for the impact of this measure on payment to providers. Polling of the Rural Health Advisory Group determined the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer

to the meeting summary. The Health Equity Advisory Group identified concerns regarding how the results of the measure would correlate to quality of care as well as concerns regarding the variability of the measure to be able to compare across programs or entities. Polling results of the Health Equity Advisory Group found the measure to have some potential for a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

4.4.3.2. **Hospital Inpatient Quality Reporting Program**

For the Hospital IQR Program previously described (section 4.2.3.), MAP conditionally supported this MUC. Conditions for support are contingent upon CBE endorsement to address reliability and validity concerns. This measure assesses the percentage of patients who screened positive for HRSNs. It would be the first measure in the Hospital IQR Program to specifically address screening for SDOH, which is consistent with a Meaningful Measures 2.0 priority.

The measure ultimately seeks to bridge patients who screened positive for HRSNs with community navigation services and an individualized action plan from the beneficiary to resolve HRSNs identified by the screening. However, the screening measure does not contain any data or requirements to ensure this follow-up. MAP expressed concern that the positivity rate may be challenging for consumers to interpret when publicly reported.

The Rural Health Advisory Group identified similar concerns to those outlined for MUC2021-136 and noted concern regarding the impact of the measure on payment. Polling of the Rural Health Advisory Group determined the measure was suitable for use with rural providers. For complete details from the Rural Health Advisory Group Virtual Review Meeting, please refer to the meeting summary. The Health Equity Advisory Group raised concerns about the intent and performance interpretation of the measure and reiterated comments similar to MUC2021-136 regarding the standardization of tools and unintended consequences. Polling results of the Health Equity Advisory Group found the measure to have some potential for a positive impact on health equity by decreasing health disparities. For complete details from the Health Equity Advisory Group Virtual Review Meeting, please refer to the meeting summary.

5. CONCLUSION

The recommendations submitted by MAP aim to improve the quality, safety, and value of U.S. healthcare through federal healthcare payment and public reporting programs. MAP convened representatives from quality measurement, research and improvement, purchasers, public/community health agencies, health professionals, health plans, consumers, and suppliers. The balance of diverse stakeholder interests ensured the federal government received varied and thoughtful input on performance measure selection. The 2021-2022 MAP cycle involved approximately 150 healthcare leaders and experts representing nearly 90 private-sector organizations, as well as liaisons from seven federal agencies. As the ecosystem of quality measurement drives ahead, discussions involving health equity, person-centered care, measure alignment, and stratification will continue. MAP looks forward to the forum of those discussions.

APPENDIX A: MAP ROSTERS AND NQF STAFF

Coordinating Committee

CO-CHAIRS (VOTING)

Charles Khan, III, MPH

Misty Roberts, RN, MSN, CPHQ, PMP

ORGANIZATIONAL MEMBERS (VOTING)

American Academy of Hospice and Palliative Medicine
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American Association on Health and Disability
Clarke Ross, DPA

American College of Physicians
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American Health Care Association
David Gifford, MD, MPH

American Medical Association
Michael Suk, MD, JD, MPH, MBA

American Nurses Association
Katie Boston-Leary, PhD, MBA, MHA, RN, NEA-BC

America's Health Insurance Plans
Elizabeth Goodman, JD, MSW, DrPH

AmeriHealth Caritas
Parul Mistry, MD, MA

BlueCross BlueShield Association
Carol Peden, MB ChB, MD, FRCA, FFICM, MPH

Covered California
Margareta Brandt, MPH

HCA Healthcare
Kacie Kleja, MBA, MS, CHDA

The Joint Commission

David W. Baker, MD, MPH, FACP

The Leapfrog Group
Leah Binder, MA, MGA

National Committee for Quality Assurance
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National Patient Advocate Foundation
Rebecca Kirch, JD

Network for Regional Healthcare Improvement
Julie Sonier, MPA

Patient Family Centered Care Partners
Libby Hoy

Purchaser Business Group on Health
Emma Hoo

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

Dan Culica, MD, PhD

Janice Tufte

Ronald Walters, MD, MBA, MHA

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Agency for Healthcare Research and Quality
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Centers for Disease Control and Prevention
Arjun Srinivasan, MD

Centers for Medicare & Medicaid Services
Michelle Schreiber, MD

Office of the National Coordinator for Health Information Technology
David Hunt, MD, FACS

Clinician Workgroup

CO-CHAIRS (VOTING)

Rob Fields, MD

Diane Padden, PhD, CRNP, FAANP

ORGANIZATIONAL MEMBERS (VOTING)

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American College of Cardiology
Geoffrey Rose, MS, MPH

American College of Radiology
David J. Seidenwurm, MD, FACR

Blue Cross Blue Shield of Massachusetts
Wei Ying, MD, MS, MBA

Consumer's Checkbook
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Council of Medical Specialty Societies
Helen Burstin, MD, MPH, FACP

Genentech
Donald Nichols, PhD

HealthPartners, Inc.
Beth Averback, MD

Kaiser Permanente
Wendolyn Gozansky, MD, MPH

Louise Batz Patient Safety Foundation
Kathleen Stevens, RN, EdD, ANEF, FAAN

Magellan Health, Inc.
Louis Parrott, MD, PhD

OCHIN, Inc.
Scott Fields, MD, MHA

Patient Safety Action Network
Yanling Yu, PhD

Pharmacy Quality Alliance
Lisa Hines, PharmD

Purchaser Business Group on Health

Rachel Brodie

St. Louis Area Business Health Coalition
Louise Probst

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

Nishant Anand, MD, FACEP

William Fleischman, MD, MHS

Stephanie Fry, MHS

Amy Nguyen Howell, MD, MBA, FAAFP

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Centers for Disease Control and Prevention
Peter Briss, MD, MPH

Centers for Medicare & Medicaid Services
Michelle Schreiber, MD

Health Resources and Services Administration
Girma Alemu, MD, MPH

Hospital Workgroup

CO-CHAIRS (VOTING)

Akin Demehin, MPH

R. Sean Morrison, MD

ORGANIZATIONAL MEMBERS (VOTING)

America's Essential Hospitals
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American Case Management Association
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American Society of Anesthesiologists
Vilma Joseph, MD

American Society of Health-System Pharmacists
Anna Legreid Dopp, PharmD
Association of American Medical Colleges
Janis Orlowski, MD, MACP

City of Hope
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Dialysis Patient Citizens
Jackson Williams, JD, MPA

Greater New York Hospital Association
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Henry Ford Health System
Santosh Mudiraj, MBBS, MPH

Kidney Care Partners
Donna Bednarski, RN, MSN, ANP-BC, CNN

Medtronic
Karen Shehade, CHIE, MBA, MHP, PA-C

Memphis Business Group on Health
Cristie Upshaw Travis, MSHA

National Association for Behavioral Healthcare
Frank Ghinassi, PhD, ABPP

Premier Healthcare Alliance
Aisha Pittman, MPH

Press Ganey
Tejal Gandhi, MD, MPH, CPPS

Project Patient Care
Martin Hatlie, JD

Service Employees International Union
Sarah Nolan, MPA

Society for Maternal-Fetal Medicine
Kelly Gibson, MD

Stratis Health
Jennifer Lundblad, PhD, MBA

University of Pittsburgh Medical Center Health Plan
Janice Donis, RN, MSN

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

Richard Gelb, MA

Suellen Shea, MSN, RN-BC, CPHQ, CPPS, LSSGB

Lindsey Wisham, MPA

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Agency for Healthcare Research and Quality
Unfilled

Centers for Disease Control and Prevention
Andrea Benin, MD

Centers for Medicare & Medicaid Services
Michelle Schreiber, MD

PAC/LTC Workgroup

CO-CHAIRS (VOTING)

Gerri Lamb, PhD, RN, FAAN

Kurt Merkelz, MD, CMD

ORGANIZATIONAL MEMBERS (VOTING)

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American Academy of Physical Medicine and Rehabilitation
Kurtis Hoppe, MD

American Geriatrics Society
Debra Saliba, MD, MPH
American Occupational Therapy Association
Pamela Roberts, PhD, OTR/L, SCFES, FAOTA, CPHQ, FNAP, FACRM

American Physical Therapy Association
Alice Bell, PT, DPT

ATW Health Solutions
Knitasha Washington, DHA, MHA, FACHE

Encompass Health Corporation
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Kindred Healthcare
Mary Van de Kamp, MS/CCC-SLP

LeadingAge
Janine Finck-Boyle, MBA/HCA, LNHA

National Hospice and Palliative Care Organization
Ben Marcantonio, MS, MEd, LMFT

National Partnership for Healthcare and Hospice Innovation
Larry Atkins, PhD

National Pressure Injury Advisory Panel
Jill Cox, PhD, RN, APN-c, CWOCN, FAAN

National Transitions of Care Coalition
James Lett, MD, CMD

Special Needs Plan Alliance
Jolie Harris, DNS, RN, CAS

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

Dan Andersen, PhD

David Andrews, PhD

Terrie Black, DNP, MBA, CRRN, FAHA, FAAN

Sarah Livesay, DNP, APRN, ACNP-BC, ACNS-BC

Paul Mulhausen, MD, MHS

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Centers for Disease Control and Prevention
Andrew Geller, MD

Centers for Medicare & Medicaid Services
Alan Levitt, MD

Office of National Coordinator for Health Information Technology
Brenda Akinnagbe, MPH

Rural Health Advisory Group

CO-CHAIRS (VOTING)

Keith Mueller, PhD

Kimberly Rask, MD, PhD, FACP

ORGANIZATIONAL MEMBERS (VOTING)

American Academy of Family Physicians
Jorge Duchicela, MD, FAAFP

American Academy of Physician Assistants
Stacy Scroggins, DMSc, PA-C

American College of Emergency Physicians
Anisha Turner, MD

American Hospital Association
Stephen Tahta, MD

American Society of Health-System Pharmacists
Rena Sackett, PharmD, BCPS

LifePoint Health
Sandi Hyde, BSME, MSPS

Michigan Center for Rural Health
Crystal Barter, MS

Minnesota Community Measurement
Collette Cole, RN, BSN, CPHQ
National Association of Rural Health Clinics
Bill Finerfrock

National Rural Health Association
Brock Slabach, MPH, FACHE

National Rural Letter Carriers' Association (NRLCA)
Cameron Deml

Truven Health Analytics LLC / IBM Watson Health Company
Perry Payne, MD, JD, MPP

UnitedHealth Group
Rhonda Robinson Beale, MD

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

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Rev. Bruce Hanson

Karen James, PhD, MS

Cody Mullen, PhD

Jessica Schumacher, PhD, MS

Ana Verzone, MS, APRN, FNP, DNP, CNM

Holly Wolff, MHA

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Federal Office of Rural Health Policy, Health Resources and Services Administration
Craig Caplan, MA

Indian Health Services
Susy Postal, MD

Center for Medicare & Medicaid Innovation, Centers for Medicare & Medicaid Services
Emily Moore, MPH, FACHE

Health Equity Advisory Group

CO-CHAIRS (VOTING)

Rebekah Angove, PhD

Laurie Zephyrin, MD, MPH, MBA

ORGANIZATIONAL MEMBERS (VOTING)

Aetna
Joy Bland, DBH, RN, CCM, CPHQ

American Medical Association
Karthik Sivashanker, MD, MPH, CPPS

American Nurses Association
Roberta Waite, EDD, PMHCNS, RN, MSN, ANEF, FAAN

American Society of Health-System Pharmacists
Lanita White, PharmD

America's Essential Hospitals
Kirsten Bibbins-Domingo, PhD, MD, MAS

Beth Israel Lahey Health
Leonor Fernandez, MD

Fenway Health
Chris Grasso, MPH

IBM Watson Health
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Kentuckiana
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National Committee for Quality Assurance
Sarah Shih, MPH

National Health Law Program
David Machledt, PhD

Patient Safety Action Network
Alicia Cole

Planned Parenthood Federation of America
Tala Mansi, MPA

The SCAN Foundation
Sarita Mohanty, MD, MPH, MBA

Vizient
Beth Godsey, MSPA, MBA

INDIVIDUAL SUBJECT-MATTER EXPERTS (VOTING)

Emily Almeda-Lopez, MPP

Susannah Bernheim, MD, MHS

Damien Cabezas, MPH, MSW

Mark Friedberg, MD, MPP

Jeff Huebner, MD

Gerald Nebeker, PhD, FAAIDD

J. Nwando Olayiwola, MD, MPH, FAAFP

Nneka Sederstrom, PhD, MPH, MA, FCCP, FCCM

Cardinale Smith, MD, PhD

Melony Sorbero, PhD, MPH

Jason Suh, MD

FEDERAL GOVERNMENT LIAISONS (NON-VOTING)

Centers for Medicare & Medicaid Services
Robert Morgan

Health Resources & Services Administration
Sarah Potter, MS

Office of Minority Health
Meagan Khau, MHA

Office of National Coordinator of Health Information Technology
David Hunt, MD, FACS

Veterans Health Administration
Leslie Hausmann, PhD

NQF Staff

Tricia Elliott, DHA, MBA, CPHQ, FNAHQ
Senior Managing Director, Measurement Science & Application

Jenna Williams-Bader, MPH
Senior Director, Measurement Science & Application

Matthew Pickering, PharmD
Senior Director, Measurement Science & Application

Chelsea Lynch, MPH, MSN, RN, CIC
Director, Emerging Initiatives

Katie Berryman, MPAP, PMP
Director, Project Management, Program Operations

Udara Perera, DrPHc, MPH
Senior Manager, Emerging Initiatives

Amy Guo, MS
Manager, Emerging Initiatives

Ivory Harding, MS
Manager, Measurement Science & Application

Rebecca Payne, MPH
Manager, Emerging Initiatives

Susanne Young, MPH
Manager, Measurement Science & Application

Ashlan Ruth, BS IE
Project Manager, Measurement Science & Application

Victoria Freire, MPH, CHES®
Analyst, Measurement Science & Application

Joelencia LeFlore
Associate, Measurement Science & Application

Gus Zimmerman, MPP
Associate, Measurement Science & Application

Taroon Amin, PhD, MPH
Consultant