Measure Applications Partnership 2021-2022 Considerations for Measure Set Removal in Federal Programs

FINAL REPORT

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Contents

Measure Applications Partnership 2021-2022 Considerations for Measure Set Removal in Federal Programs 1
Contents 2
Executive Summary 3
Introduction 4
Hospital Program Background 5
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program 5
Ambulatory Surgical Center Quality Reporting (ASCQR) Program 6
Hospital Readmissions Reduction Program (HRRP) 6
Hospital Value-Based Purchasing (VBP) Program 7
Hospital Inpatient Quality Reporting (IQR) Program 7
Discussion Themes and Considerations for Program Measures 8
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Miscellaneous Measures 9
Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Tobacco and Alcohol Measures 11
Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures 17
Hospital Readmissions Reduction Program (HRRP) Measures 19
Hospital Value-Based Purchasing (VBP) Program and Hospital Inpatient Quality Reporting (IQR) Program Mortality Measures 22
Hospital Inpatient Quality Reporting (IQR) Program Measures 24
Future Considerations for MSR 26
Appendix A: MAP Roster and NQF Staff 28
2021-2022 Measure Applications Partnership (MAP) Coordinating Committee 28
NQF Staff 30

Executive Summary

- **Measure Applications Partnership (MAP) Coordinating Committee** – Coordinating Committee members repeatedly emphasized the need to approach Measure Set Review (MSR) processes holistically and to examine the role of measures within a program and how they fit with other measures within these programs. Committee members identified MSR as an opportunity to step back from individual measure scrutiny to broadly look at the role of quality measurement and programs in achieving desired health outcomes. Committee members are cognizant that changes to these programs or measures send a message to stakeholders across the care continuum about the MAP's priorities. Additional measures may be needed to provide a person-centered approach to quality expectations that exist today from the patient perspective, and patient input should be sought to identify those measures.
- **Programs and Measures** – Measures that warranted the highest level of strategic discussion were those concerning condition-specific readmission measures versus hospital-wide readmission measurement. Committee members highlighted Hospital Star Ratings Programs, which were the focus of prior NQF reports, indicating that greater focus should be placed on units treating specific conditions in hospitals rather than generic ratings. Committee members noted that the Star Ratings programs do differ significantly from the Hospital Readmissions Reduction Program (HRRP) due to the sensitive nature of readmissions. Further, Committee members noted that hospitals with higher readmission rates may be those that high-acuity patients prefer. Committee members also advised that additional focus should be given to health equity in these measures and suggested stratification of the measures to improve understanding of any differences in readmission rates across populations.
- **Public Comments** – Committee members greatly appreciated the voices of impacted patients and families during public comment and would appreciate the continuation or expansion of these voices. Committee members encouraged increased representation of consumer (e.g., patient, family, and caregiver or advocate) voices, as well as nurses and social workers.
- **Future Considerations** – MSR voting should include gradations of support, possibly in a similar matrix to MAP Pre-Rulemaking voting. Abstention should be allowed; however, Committee members debated its inclusion as a voting category versus a notification process. Measure Review Criteria (MRC) should be amended to evaluate measures as part of the overall set of measures in a program and to explicitly address gaps, to address how a measure diminishes inequities or promotes equity, and to determine whether the measure differentiates between excellence and adequacy of performance.
- More data are needed in advance of measure selection and review. The Committee members suggested trend data, performance data, gaps, variation across subpopulations, endorsement status, measures in the development or implementation pipeline, and any recent literature or initiatives discussing the measures. Additionally, more information should be provided on the context of the programs housing the measures.

Introduction

Since 2011, the Centers for Medicare & Medicaid Services (CMS) has called upon MAP to recommend consensus-based measures most appropriate for public reporting, performance-based payment, quality, and efficiency. One of MAP's key initiatives is to convene multistakeholders for an intensive annual review of the quality measures being considered by CMS for almost 20 federal health programs. In convening MAP, the National Quality Forum (NQF) brings together representatives of Quality Measurement, Research, Purchasers, Providers, Public/Community Health Agencies, Health Professionals, Health Plans, Consumers, and Suppliers. MAP's careful balance of these stakeholder interests ensures that the federal government will receive varied and thoughtful input on performance measure selection.

A December 2020 omnibus appropriations legislation included funding for Medicare Extenders as well as language related to potential activities that the MAP may undertake to review measures for potential removal from federal quality and performance programs regularly assessed by the MAP. Subtitle A—Section 102 of the Consolidated Appropriations Act of 2020 grants the consensus-based entity that provides input on the selection of quality and efficiency measures used in various Medicare programs the authority to provide input on the removal of quality and efficiency measures as well:

INPUT FOR REMOVAL OF MEASURES—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph: "(4) REMOVAL OF MEASURES—The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal."

For the 2021-2022 MAP cycle, NQF has collaborated with CMS and the MAP Coordinating Committee to define a process for MSR. Initiated by CMS, the goal of this effort is to offer a holistic review of quality measures with input from diverse multistakeholders. This cycle will focus on developing a process for review and creating criteria for evaluating measures within federal programs. This process will be implemented on a pilot basis with measures considered only by the MAP Coordinating Committee during the 2021-22 cycle. At the end of the 2022-2023 cycle, the report with the final recommendations and rationale for measure removal from federal programs will also include input from the setting-specific MAP Workgroups and the Rural Health and Health Equity Advisory Groups. The complete Measure Review Process is as follows:

- MSR Education Meeting
- MSR CMS Planning Meeting
- MSR Meeting
- MSR Final Recommendations submitted to CMS

During the MSR Education Meeting on August 9, 2021, Coordinating Committee members were charged with focusing on developing and piloting a process for review, creating criteria for evaluating measures within federal programs, and easing the burden associated with the increased number of performance measures. In order to have a feasible goal during the pilot program, Coordinating Committee members decided to focus MSR on selected hospital programs rather than the complete list of approximately 500 measures. At the end of the meeting, each Coordinating Committee member received an email with a survey link to select 10 measures from the approximately 40 measures within select Hospital programs

provided for review by CMS to recommend for discussion during the two-day virtual MSR Meetings on September 8–9, 2021. NQF staff aggregated these responses, and the aggregate list of the top 22 measures was distributed ahead of the MSR meetings in September. The specific Hospital programs considered are as follows:

- Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
- Ambulatory Surgical Center Quality Reporting (ASCQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing (VBP) Program
- Hospital Inpatient Quality Reporting (Hospital IQR) Program

Hospital Program Background

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

The IPFQR was established under the authority provided by Sections 3401(f) and 10322(a) of the Affordable Care Act amended section 1886(s)(4) of the Social Security Act to require the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units. This act applies to all psychiatric units paid under Medicare's Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

Program Type: Pay for Reporting and Public Reporting

Incentive Structure: Inpatient psychiatric facilities (IPFs) that do not submit data on all required measures receive a 2.0 percent reduction in annual payment update.

Program Goal: Provide consumers with quality-of-care information to make more informed decisions about healthcare options and encourage hospitals and clinicians to improve the quality of inpatient psychiatric care by ensuring that providers are aware of and reporting on best practices.

The IPFQR Miscellaneous measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 2584:** Transition Record With Specified Elements Received by Discharged Patients (Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- **CMIT 1645:** Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification
- **CMIT 2725:** Screening for Metabolic Disorders

The Lead Discussants chosen for this group of measures were AmeriHealth Caritas, The Leapfrog Group, National Patient Advocate Foundation, and the Network for Regional Health Improvement.

The IPFQR Tobacco and Alcohol measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 1677:** Tobacco Use Treatment Provided or Offered
- **CMIT 2588:** Tobacco Use Treatment

- **CMIT 2589:** Tobacco Use Treatment at Discharge
- **CMIT 2590:** Tobacco Use Treatment Provided or Offered at Discharge
- **CMIT 2591:** Alcohol Use Brief Intervention
- **CMIT 2592:** Alcohol Use Brief Intervention Provided or Offered
- **CMIT 5555:** (SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

The Lead Discussants chosen for this group of measures were American College of Physicians, Covered California, The Leapfrog Group, and the Purchaser Business Group on Health.

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

The ASCQR was established under the authority provided by Section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, Title I of the Tax Relief and Health Care Act (TRHCA) of 2006. The statute provides the authority for requiring Ambulatory Surgical Centers (ASCs) paid under the ASC fee schedule (ASCFS) to report on process, structure, outcomes, patient experience of care, efficiency, and costs of care measures.

Program Type: Pay for Reporting and Public Reporting

Incentive Structure: ASCs that do not participate or fail to meet program requirements receive 2.0 percent reduction in annual payment update.

Program Goal: Promote higher quality, more efficient healthcare for Medicare beneficiaries through measurement, and allow consumers to find and compare the quality of care given at ASCs to inform decisions on where to get care.

The ASCQR Measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 1049:** Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery
- **CMIT 1061:** Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- **CMIT 2936:** Normothermia Outcome

The Lead Discussants chosen for this group of measures were HCA Healthcare, National Patient Advocate Foundation, Network for Regional Healthcare Improvement, and the Purchaser Business Group on Health.

Hospital Readmissions Reduction Program (HRRP)

The HRRP is a Medicare VBP program established under Section 1886(q) of the Social Security Act. Under HRRP, CMS reduces payments to subsection (d) hospitals with excess readmissions. The 21st Century Cures Act directs CMS to use a stratified methodology (beginning in fiscal year [FY] 2019) to evaluate a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits.

Program Type: Pay for Performance and Public Reporting

Incentive Structure: Medicare fee-for-service (FFS) base operating diagnosis-related group (DRG) payment rates are reduced for hospitals with excess readmissions. The maximum payment reduction is 3.0 percent.

Program Goal: Reduce excess readmissions in acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), which includes more than three-quarters of all hospitals, and encourage hospitals to improve communication and care coordination efforts to better engage patients and caregivers, with respect to post-discharge planning.

The HRRP Measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 78:** Heart Failure (HF) 30-Day Readmission Rate
- **CMIT 80:** Acute Myocardial Infarction (AMI) 30-Day Readmission Rate
- **CMIT 899:** Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) 30-Day Readmission Rate

The Lead Discussants chosen for this group of measures were the American College of Physicians, HCA Healthcare, and Ronald Walters.

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program was established by Section 3001(a) of the Affordable Care Act, under which value-based incentive payments are made each fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year. The Secretary shall select measures, other than measures of readmissions, for purposes of the Hospital VBP Program. In addition, a cost efficiency measure, currently the *Medicare Spending per Beneficiary* measure, must be included.

Program Type: Pay for Performance

Incentive Structure: The amount equal to 2.0 percent of base operating DRG is withheld from reimbursements of participating hospitals and redistributed to them as incentive payments

Program Goal: Improve healthcare quality by realigning hospitals' financial incentives, and provide incentive payments to hospitals that meet or exceed performance standards

Hospital Inpatient Quality Reporting (IQR) Program

The IQR was established by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and expanded by the Deficit Reduction Act of 2005. Hospitals paid under the IPPS are required to report on measures in the program. Hospitals not included in the Hospital IQR Program, such as critical access hospitals and hospitals located in Puerto Rico and the U.S. Territories, are permitted to participate in voluntary quality reporting. Performance of quality measures are publicly reported on the CMS Care Compare website.

Program Type: Pay for Reporting and Public Reporting

Incentive Structure: Hospitals that do not participate, or that do participate but fail to meet program requirements, receive a one-fourth reduction of the applicable percentage increase in their annual payment update

Program Goal: Progress towards paying providers based on the quality rather than the quantity of care they give patients and to provide consumers information about hospital quality so that they can make informed choices about their care

The VBP and Hospital IQR Program Mortality measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 89:** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following
- Heart Failure (HF) Hospitalization
- **CMIT 86:** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization
- **CMIT 1357:** CMS Death Rate Among Surgical Inpatients With Serious Treatable Complications
- **CMIT 902:** Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke

The Lead Discussants chosen for this group of measures were America's Health Insurance Plans, AmeriHeath Caritas, Janice Tufte, and Ronald Walters.

The Hospital IQR Program Measures selected by the Coordinating Committee for discussion during the MSR are as follows:

- **CMIT 1017:** Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)
- **CMIT 5756:** Exclusive Breast Milk Feeding (eCQM)

The Lead Discussants chosen for this group of measures were the American Health Care Association and Janice Tufte.

Discussion Themes and Considerations for Program Measures

Ms. Tricia Elliott, senior managing director, NQF, reviewed the MSR process and MRC. Ms. Elliott instructed Committee members to share their opinions and thoughts on support for removing measures, referencing any relevant measure removal criteria. Following the discussion, the Committee members were instructed to submit their vote indicating support for removal from the program: "yes" to remove or "no" to not remove. Ms. Elliott reviewed the MRC for the pilot year:

- Measure does not contribute to the overall goal and objectives of the program
- Performance or improvement on the measure does not result in better patient outcomes
- Measure is not NQF endorsed
- Evidence base for the measure has changed, and the measure no longer reflects current evidence
- Measure performance is uniformly high and lacks variation in performance overall and by subpopulation
- Measure is not feasible to implement
- Measure is duplicative of other measures in the program
- Measure has negative unintended consequences

Ms. Misty Roberts, Coordinating Committee co-chair, reiterated two objectives for the process: (1) feedback and recommendations on the measures and (2) feedback on the actual criteria the Committee members found to be meaningful in the evaluation of the measures. Ms. Elliott reminded the Committee that this is a pilot, the process is being tested, and this is more of a poll. NQF is not looking to achieve quorum or percentages, and this poll is designed to gauge the process. Mr. Chip Kahn, Coordinating Committee co-chair, noted he would prefer to aim for the 60 percent mark to make this process meaningful. Committee members agreed in the online chat platform. Ms. Elliott indicated NQF will take note of the exact totals and calculate the percentages.

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Miscellaneous Measures

CMIT 2584: Transition Record With Specified Elements Received by Discharged Patients (Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)

The *Transition Record With Specified Elements Received by Discharged Patients (Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)* measure focuses on the percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge, including, at a minimum, all of the specified elements.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed and the measure being a process measure that does not ensure care coordination with a primary care physician(PCP) or post-discharge behavioral health provider.

General Committee comments focused on the capacity to differentiate measure excellence, burden of collection on relevance to outcome, the ability to improve upon on a measure that matters to patients and families/quality of care, and the reporting level of the facility being a process measure that does not ensure results were acted on or whether there was any integration with the receiving or outpatient provider. A Lead Discussant agreed on the previous sentiments and reported a need to improve upon a measure that matters to patients and families. The discussant suggested that process measures can still remain, but they cannot substitute for the quality of care and do not meet the level of excellence desired.

A Committee member posed a question about other endorsed measures dealing with the process of transition and records accompanying transition. Dr. Michelle Schreiber, a CMS representative, did not think there were any similar measures and noted the measure was meant to determine whether information was transmitted to the patient and next level of care. This Committee member expressed a personal sentiment and example of a family member with mental illness who had experienced several situations of error in the transition of care due to lack of communication. The Committee member indicated the receiving facility or organization typically reports a lack of pertinent records to continue care. Another Committee member asked whether a similar scenario has occurred in which a measure such as this was removed from the inpatient psychiatric setting due to privacy concerns. Dr. Schreiber indicated that no issues have been raised regarding privacy; however, to the prior Committee member's point, CMS was trying to ensure that individuals have the information needed so that care does not fall through the gaps.

CMIT 1645: Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification

The *Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification* measure is focused on the proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History, and Patient Strengths completed; HBIPS-2: Physical Restraint; HBIPS-3: Seclusion; HBIPS-4: Multiple Antipsychotic Medications at Discharge; HBIPS-6: Post Discharge Continuing Care Plan; and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-4 (Patients Discharged on Multiple Antipsychotic Medications).

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement removed, the burden of data collection, and a change in the standard of care.

General Committee comments focused on the measure not being evidence based and the lack of capacity to differentiate measure excellence and adequacy. A Lead Discussant was also concerned about the lack of capacity to differentiate measure excellence and adequacy.

CMIT 2725: Screening for Metabolic Disorders

The *Screening for Metabolic Disorders* measure is focused on the percentage of patients discharged from an IPF with a prescription for one or more routinely scheduled antipsychotic medications for which a structured metabolic screening for four elements was completed in the 12 months prior to discharge either prior to or during the index IPF stay.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of not being NQF endorsed, the measure not being evidence based, and the measure failing to ensure that routine metabolic screening is occurring.

General Committee comments focused on the structure of the measure being process focused, the addition of measure evaluation criteria focused on the distinction between excellence and adequacy, and the annual cholesterol level screening not being aligned with the clinical guidelines to occur every four to six years unless there is heart disease, diabetes, or family history of high cholesterol.

Committee Comments on Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Miscellaneous Measures

Dr. Schreiber posed a question for the Lead Discussants regarding their view on CMIT 2584 and CMIT 1645, specifically if they saw them as patient safety issues to ensure patients and others are receiving records. A Lead Discussant reported that those measures were not flagged for removal by the organization because they do recognize them as a part of the standard of care. The discussant noted that they do recognize NQF endorsement was removed, but the national rate was at 68 percent; therefore, there is still room left for improvement. A Committee member saw the safety value in those measures but did not think the measure would reveal anything about the level of quality. The Committee member also noted that the measure is hard to collect and does not meet standards of a

high value of excellence. The Committee member further noted the measure is good for basic surveillance and accreditation to ensure safety but does not give enough credence to quality.

Another Committee member reported it could go either way; the issue is important because the member lives near a safety-net hospital, and medication can be found dumped on the street by discharged patients. The Committee member also reported that providers found this measure to be burdensome, although the 68 percent rating is high. The Committee member further echoed the issue on quality and believed there could be a better measure. Another Committee member wanted more clarification on other discharge medication documentation that may or may not include antipsychotic measures not included in the portfolio. The Committee member noted the combination of medication is a significant element in the health and wellness of individuals with serious mental illness being discharged from inpatient facilities. If there are similar measures, this Committee member would be fine with the removal of this measure. Dr. Schreiber asked for clarification from Ms. Lauren Lowenstein, another CMS representative. Ms. Lowenstein noted the medication continuation measure is the most closely aligned measure following discharge. The measure looks at whether patients filled a prescription for their medications, including antipsychotics. This measure is broader than the antipsychotic medication measure that does not report the specific type of medications filled. This measure looks at patients who were discharged with major depressive disorder, schizophrenia, or bipolar disorder who have filled at least one evidence-based medication throughout a 30-day discharge window, and the public reporting aggregates those diagnoses and medications. Dr. Schreiber emphasized that CMIT 1645 is focused on being a safety issue concerning individuals who are taking multiple antipsychotic medications. Dr. Schreiber's answer to a Committee member's question about a similar measure was no, but CMS would verify this.

Public Comment on IPFQR Miscellaneous Measures

No public or NQF member comments were provided for these measures.

Polling Results

- **CMIT 2584:** Yes–14, No–3, 82 percent in favor of removal
- **CMIT 1645:** Yes–15, No–2, 88 percent in favor of removal
- **CMIT 2725:** Yes–13, No–3, 81 percent in favor of removal

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program Tobacco and Alcohol Measures

CMIT 1677: Tobacco Use Treatment Provided or Offered

The *Tobacco Use Treatment Provided or Offered* measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided during the hospital stay within the first three days after admission, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment during the hospital stay within the first three days after admission. This measure is intended to be used as part of a set of four linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening, TOB-3 Tobacco Use Treatment Provided or Offered at Discharge, TOB-4 Tobacco Use: Assessing Status After Discharge.)

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, flawed specifications, further clarification needed for definition of "inpatient", and the measure of compliance with standard of care.

General Committee comments focused on specifications insufficiently allowing for alternatives, such as contraindications from medication without classification of "refusal"; exclusion criteria and both numerator and denominator data elements requiring further clarification; the suggestion that tobacco cessation may be better addressed in outpatient settings or in coordination with outpatient settings; and the age cutoff being problematic, as youth also struggle with tobacco use.

A Lead Discussant noted their performance measurement committee reviewed this measure, and it was not supported due to its specifications, evidence, and ability to implement the measure. In terms of specification, a Lead Discussant indicated the results of the measure would not easily identify opportunities for improvement. A Lead Discussant also noted that the numerator, patients receiving counseling and/or receiving pharmacotherapy, is equal to patients refusing either or both. The measure does not touch on knowing which one was noted for a particular patient; therefore, the measure does not allow for alternatives such as contraindications from medication. It appears that would be classified as refusal; therefore, modifications need to be made to the specifications. One of the Lead Discussants mentioned that the specifications are missing key exclusion criteria, including patients who expire during hospitalizations, and contraindications. This Lead Discussant also noted some of the data elements require more clarification, specifically practical counseling in the numerator and cognitive impairment in the denominator. Denominator specification should clearly define what constitutes inpatient status. Another Lead Discussant spoke about evidence and mentioned that developers present evidence of benefits of performing these interventions; however, the evidence is in an outpatient setting, not a hospital. This Lead Discussant noted that facilities and individual physicians could face challenges with implementation, particularly identifying counseling.

Dr. Schreiber reminded the Coordinating Committee of a proposal to remove many of these measures, particularly the first two; however, significant public comments and comments from across the Department of Health and Human Services (HHS) were made as this went into clearance. Removal was not finalized due to this significant feedback. There is evidence that these topics are problems, particularly in the psychiatric patient population, and it was felt by many that these were important interventions for these patients while in these facilities. If CMS re-proposed these for removal, broader conversations would need to take place to gain consensus.

CMIT 2588: Tobacco Use Treatment

The *Tobacco Use Treatment* measure is a subset of measure TOB-2. This measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided during the hospital stay, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment during the hospital stay. This measure is intended to be used as part of a set of four linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-3 Tobacco Use Treatment Provided or Offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, the challenge of collecting data on this measure as part of a set, and the possibility that treatment may be better addressed in an outpatient behavioral health/primary care setting or through outcomes-focused measures in an inpatient setting.

General Committee comments were similar to those listed for CMIT 1677 in that the specifications do not sufficiently allow for alternatives such as contraindications from medication without classification of "refusal"; exclusion criteria and both numerator and denominator data elements require further

clarification; tobacco cessation may be better addressed in outpatient settings or in coordination with outpatient settings; and the age cutoff being problematic, as youth also struggle with tobacco use.

CMIT 2589: Tobacco Use Treatment at Discharge

The *Tobacco Use Treatment at Discharge* measure is a subset of TOB-3a. The measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the U.S. Food and Drug Administration (FDA)-approved tobacco cessation medications. This measure is intended to be used as part of a set of four linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, the challenge in data collection on this measure as part of a set, and the possibility that treatment may be better addressed in an outpatient behavioral health/primary care setting or through outcomes-focused measures in an inpatient setting.

General Committee comments were similar to those listed for CMIT 1677 and CMIT 2588 in that the specifications do not sufficiently allow for alternatives such as contraindications from medication without classification of “refusal”; exclusion criteria and both numerator and denominator data elements require further clarification; tobacco cessation may be better addressed in outpatient settings or in coordination with outpatient settings; and the age cutoff is problematic, as youth also struggle with tobacco use.

CMIT 2590: Tobacco Use Treatment Provided or Offered at Discharge

The *Tobacco Use Treatment Provided or Offered at Discharge* measure is reported as an overall rate, which includes all hospitalized patients 18 years of age an older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. These measures are intended to be used as part of a set of four linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, the challenge in data collection on this measure as part of a set, and the possibility that treatment may be better addressed in an outpatient behavioral health/primary care setting or through outcomes-focused measures in an inpatient setting.

General Committee comments were similar to those listed for CMIT 1677, CMIT 2588, and CMIT 2589 in that the specifications do not sufficiently allow for alternatives such as contraindications from medication without classification of “refusal”; exclusion criteria and both numerator and denominator data elements require further clarification; tobacco cessation may be better addressed in outpatient settings or in coordination with outpatient settings; and the age cutoff is problematic, as youth also struggle with tobacco use.

CMIT 2591: Alcohol Use Brief Intervention

The *Alcohol Use Brief Intervention* measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2) describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, little room for improvement in the measure, high burden of data collection due to chart abstraction, and the potential of undue penalization to rural providers where patients have limited access to counseling services.

General Committee comments focused on the lack of evidence presented supporting the benefits of intervention in outpatient settings, particularly improvements in consumption rates; concern regarding referral to Alcoholics Anonymous not being included in measure specifications; the need to develop more outcome-focused measures; coordination with outpatient settings; inclusion of criteria as a baseline standard; and the lack of standards that should allow excellence differentiation.

A Lead Discussant indicated that although the Alcohol Use Brief Intervention (SUB-2a) represents an important clinical concept, the developers did not present evidence supporting benefits of this intervention in an outpatient setting, particularly improvements in consumption rates. Reiterating another Committee member's comment, this Lead Discussant noted that the measure could unfairly penalize clinicians in rural areas where patients have limited access to counseling or urban issues. Similar to the tobacco measure in which it is either referral or refusal, there is also a problem with this highlighting.

CMIT 2592: Alcohol Use Brief Intervention Provided or Offered

The *Alcohol Use Brief Intervention Provided or Offered* measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2) describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, little room for improvement in the measure, high burden of data collection due to chart abstraction, and treatment possibly being better addressed in an outpatient behavioral health/primary care setting or through outcomes-focused measures in an inpatient setting.

General Committee comments were similar to those for CMIT 2591, referring to the lack of evidence presented supporting the benefits of intervention in an outpatient setting, particularly improvements in consumption rates; concern regarding referral to Alcoholics Anonymous not being included in measure specifications; the need to develop more outcome-focused measures; coordination with outpatient settings; and including criteria as a baseline standard, not standards that should allow excellence differentiation. Additionally, Committee members pointed out the need for evidence for any measure that leads to outcomes.

CMIT 5555: (SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

The *(SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge* measure is reported as an overall rate, which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, difficulty for hospitals to collect data, evidentiary support of alternative treatments, and the possibility that rural health providers may be unfairly penalized due to lack of access.

General Committee comments were similar to those provided for CMIT 2591 and CMIT 2592 in that there is a lack of evidence presented supporting the benefits of intervention in an outpatient setting, particularly improvements in consumption rates; concern regarding referral to Alcoholics Anonymous not being included in measure specifications; the need to develop more outcome-focused measures; coordination with outpatient settings; and including criteria as a baseline standard, not standards that should allow excellence differentiation. Additionally, the Committee pointed out the need for evidence for any measure that leads to outcomes. Several other comments captured the following sentiments: implementation may encourage the overuse of medically assisted therapies; instead of best methods of pharmacotherapy coupled with counseling, the evidence refers mostly to outpatient settings rather than inpatient settings; it is concerning that referrals to Alcoholics Anonymous or a PCP do not currently fulfill numerator requirements; and the numerator specifies FDA-approved medications, while some off-label medications cannot be incorporated.

Committee Comments on Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) Tobacco and Alcohol Measures

A Committee member found it noteworthy that the first two alcohol measures are chart related. Additionally, this committee member found it noteworthy that the composition ofthe third measure may negatively impact rural health providers and urban areas. This Committee member also mentioned that since the third measure is addressing opioids, perhaps the provider is unable to refer the individual, and that is different than refusing. The Committee member also asked for clarification on whether these measures will be electronic and derived from coding. The Committee member also noted that measures without these specifics should be removed. Mr. Kahn asked for clarification from CMS, and Dr. Schreiber noted that CMS will need to take it back for further review.

An individual representing the measure steward noted that these are not perfect measures but related to Dr. Schreiber's earlier comments, which stated that an uptake has occurred in the use of alcohol and tobacco, especially throughout the pandemic. The individual felt that it would be bad timing to remove these measures and agreed with looking at what better measures can be developed in the future. The measure steward noted the following sentiments: the psychiatric setting is a difficult setting to develop

measures in, chart abstraction is burdensome, and electronic health records (EHRs) in this setting are still evolving.

Mr. Kahn noted the concern voiced throughout the meeting about measures lacking in many ways; nevertheless, the Committee is compelled to keep them if they do not have better measures. Mr. Kahn indicated being torn regarding earlier comments from the Lead Discussants about certain measures striving for excellence and other measures just checking the box. Mr. Khan noted the three items of concern include improvement, accountability, and transparency. Another Committee member responded to Mr. Khan's comment about this entire endeavor being reflective of NQF, members, and stakeholders. There is as a credibility test with people who depend on these treatments, services, and supports. If we eliminate entire categories of measures because they are not perfect, what will be done for alcohol and tobacco measures that are documented as a serious issue? These are important public health problems. The Committee member reiterated that Dr. Schreiber already noted that CMS supported treatment with discharge in the alcohol and tobacco area.

Another Committee member reflected on their experience as a measure developer. The Committee member noted that a great deal of discussion has occurred about recognizing excellence; however, there may be some disagreement with this statement. The Committee member continued by stating that during measure development, discussion takes place about the floor or the ceiling. If the floor is not met and the data demonstrate that a huge gap is present, the measure cannot be set at the ceiling. Measure developers need to focus on what is reasonable.

At this point, extensive discussion had occurred among several Committee members who reiterated the earlier references and discussions regarding moving towards better measures. The Committee members noted measures cannot be classified as good simply because they are present and continuously used. A Committee member noted the criteria about moving the needle and unintended consequences. Another Committee member referenced moving towards outcome measures at a slow pace. This Committee member noted that the work of this Committee is trying to influence those decisions.

Dr. Schreiber noted that mental health is a public health emergency and has increased during the pandemic. In the psychiatric population, alcohol and tobacco are even more problematic than they are in the general population. Dr. Schreiber reiterated that the cycle of measures may begin with structural, then proceed to process, and then move to outcome. There is still opportunity to improve in the process, and not all measures are topped out. CMS does believe the needle is moving.

Co-chairs Mr. Kahn and Ms. Roberts noted working out future processes. Mr. Kahn noted the "yes" and "no" in the polling, but the gap must be filled. Ms. Roberts indicated the need for information as part of the decision making process, such as similar measures. Committee members also discussed some process items and noted discussing gaps in more detail as well as degrees of priority for measure removal.

Public Comment on (IPFQR) Tobacco and Alcohol Measures

No public or NQF member comments were provided for these measures.

Polling Results

- **CMIT 1677:** Yes–18, No–1, 94 percent in favor of removal
- **CMIT 2588:** Yes–14, No–5, 74 percent in favor of removal

- **CMIT 2589:** Yes–7, No–11, 41 percent in favor of removal
- **CMIT 2590:** Yes–8, No–9, 47 percent in favor of removal
- **CMIT 2591:** Yes–14, No–5, 74 percent in favor of removal
- **CMIT 2592:** Yes–15, No–4, 79 percent in favor of removal
- **CMIT 5555:** Yes–10, No–10, 50 percent in favor of removal

Ambulatory Surgical Center Quality Reporting (ASCQR) Program Measures

CMIT 1049: Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery

The Cataracts: Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery measure is focused on the percentage of patients ages 18 years and older who had cataract surgery and improvement in visual function achieved within 90 days following the cataract surgery (based on completing a preoperative and postoperative visual function survey).

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the status of NQF endorsement being removed, the measure being designed for physician use and not tested for the current level of measurement and setting, measure performance being uniformly high, and the presence of a similar measure.

General Committee comments focused on the lack of uptake of the measure due to voluntary reporting nature or reporting burden, not much data being reported from ASCs, cataract surgery being the primary surgery performed at these facilities, a similar measure with a specific visual function target being available, and the measure being recommended for mandatory reporting.

A Lead Discussant noted that of the data available on the Care Compare website, only 46 ASCs nationally provide data on this measure. Another Lead Discussant agreed and indicated that the lack of uptake is concerning because if the providers do not value the measure, then the outcomes will not be as good for patients and families. Another Lead Discussant mentioned a high performance from providers who are selecting to report.

A Committee member asked for clarification regarding the design for physician use and the measure not being tested for the current level of measurement and setting. CMS responded and emphasized the change in pending rulemaking from voluntary to mandatory reporting. CMS noted that the reporting history has been low; however, the small, dedicated group of facilities that strongly believe in this measure continue to report. The measure is a valuable, functional measure survey for the patient and shows how well patients are doing once they leave the facility.

Another Committee member strongly recommended this measure for mandatory reporting. The Committee member noted that there are very few measures on ASC performance, and few look at outcomes other than mortality. Another Committee member noted this is not a great outcome measure because the success of the cataract surgery is based on visual function or impairment, not how poor the cataracts or visual acuity is prior to surgery. After making the measure mandatory, the Committee member suggested improving the data reporting. CMS was also asked about the length of the survey because as a mandatory measure, there would be a greater spread. CMS answered that the original survey consisted of 32 questions, but others have less to reach the same outcome measure, thus making it easier to administer.

CMIT 1061: Appropriate Follow-Up Interval for Normal Colonoscopy in Average-Risk Patients

The *Appropriate Follow-Up Interval for Normal Colonoscopy in Average-Risk Patients* measure focuses on the percentage of patients ages 50 to 75 years receiving a screening colonoscopy without a biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for a repeat colonoscopy documented in their colonoscopy report.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the measure being designed for physician use and not being tested for this level of measurement and setting, a need for more robust measures for ASCs, and the unintended consequences of increased frequency of screening with provider outreach reminders issued at five years.

General Committee comments focused on outcomes and safety aspects instead of the procedural aspect of follow-up and the frequency of screening being more than the recommended 10 years for normal screening.

CMS reiterated that this measure was designed to decrease increased frequency and wants providers to screen/report every 10 years. There was further discussion between Committee members and CMS regarding the outreach reminders at five years. CMS indicated this was not listed in the specification details.

CMIT 2936: Normothermia Outcome

The *Normothermia Outcome* measure focuses on the percentage of patients having surgical procedures under general or neuraxial anesthesia of 60 minutes or more in duration who are normothermic within 15 minutes of arrival in the post-anesthesia care unit (PACU).

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included the NQF endorsement status being removed, chart abstraction burden, measure compliance aligning with standard of care, this measure being a part of Surgical Care Improvement Program (SCIP) measures that were retired in 2015 due to high performance, and the MIPS average performance rate for this measure being 98.0 percent.

General Committee comments focused on the lack of measures in this area, possible top out, the initiative to move to digital measures addressing some of the reporting burden, and the measure having serious safety implications.

CMS indicated the migration towards electronic measures and reported statistics for the measure, indicating there is room for improvement. The average performance rate was high, and the mean is currently at 86 percent; it is tested at the facility level for ASCs. CMS noted the measure is an ASC quality collaborative measurement. It was developed and tested but has yet to undergo the endorsement process due to the effort involved.

A Committee member noted there are not enough measures in this area to be comfortable with removing this one, while another member noted that the measure has some serious safety implications. CMS reported five measures in total in this program. No comments or complaints have been received on chart abstraction burden. CMS indicated the decrease in Medicare inpatient-only procedure reimbursements will lead to more measures in the area for those ASCs and that this is an important area to build.

A Committee member asked for comments on the burdensome aspect of the measure. Another Committee member noted the burden is due to the number of patients being seen at once. A Committee member asked whether there were other measures in development that would do more to create better outcomes and reduce burden. CMS indicated yes, and there are always measures in the pipeline. CMS agreed that more measures are needed for ASCs along with hospital procedural measures that will move into this space. CMS also agreed that this area is popular for future development, emphasized that public comment was sought for measure development for ASCs, and asked individuals to submit their written comments for review.

Public Comment on ASCQR Measures

A public comment advocated for measures in this area because not many outcome measures are present. The public comment noted that it is easy for nurses to capture this information on the PACU notes because patients are in the room for one to two hours in the ASC.

Polling Results

- **CMIT 1049:** Yes–6, No–14, 28 percent in favor of removal
- **CMIT 1061:** Yes–3, No–17, 15 percent in favor of removal
- **CMIT 2936:** Yes–1, No–20, 5 percent in favor of removal

Hospital Readmissions Reduction Program (HRRP) Measures

CMIT 78: Heart Failure (HF) 30-Day Readmission Rate

The *Heart Failure (HF) 30-Day Readmission Rate* measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of HF. *Readmission* is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions do not count as readmissions. CMS annually reports the measure for patients who are 65 years of age and older and are Medicare FFS beneficiaries hospitalized in nonfederal hospitals or Veterans Health Administration (VHA) hospitals.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included whether the measure should be combined in a properly risk-adjusted overall readmission measure that is not disease-specific.

General Committee comments focused on reservations about condition-specific measures due to the possibility of a high number of measures that could be brought forward for reporting; concerns about the risk adjustment model; and how a 30-day time frame could disproportionately have an impact on rural hospitals, with a suggestion for a nonspecific 30-day readmission measure to be utilized for specific areas and evaluated by condition through data queries that would reduce reporting burden.

The Lead Discussants noted that hospitals receive a report of readmissions data in advance of this information becoming publicly available. The report includes patient cohorts, readmissions dates, and diagnosis codes, which can be queried for similar information.

CMS provided additional clarification that the HRRP includes six condition-specific readmission measures, while the Hospital IQR Program does include one hospital-wide measure for readmissions.

CMS noted that some prior literature on the HF readmission rate included concerns about unintended consequences and issues regarding risk adjustment addressed by some of the Lead Discussants. At that time, CMS conducted an internal audit but was unable to substantiate that claim. CMS also asked Committee members to consider what value patients might find in condition-specific measures rather than in seeing results for an all-cause readmissions measure.

Other Committee member comments were reflective of ideas expressed by the Lead Discussants, with some support for the measure, agreement on issues presented by the program structure, and support for the idea of an all-cause readmission rate that could be queried for specific conditions in the HRRP or the Hospital IQR Program. CMS and measure stewards for the existing all-cause readmissions measure in the Hospital IQR Program noted that the measure was composed of five cohorts and that patient-level data are provided to hospitals privately.

In response to concerns about the measure's reliability, CMS clarified that a trend for improvement has developed, and the question remains whether the trend is flattening. CMS also noted that the HRRP has begun to stratify by dual eligibility, which has affected performance for some hospitals. Committee members appreciated this information and noted that this level of transparency is advantageous to understand shifts in data trends.

CMS reminded Committee members that each measure within the HRRP carries its own penalty, and removing a measure removes the penalty that the measure contributes to. Changes to measures will result in significant changes to hospitals' performance in addition to changes in the program itself. Broadly, Committee members recognized the need to include holistic considerations of each program during MSR processes and expressed a desire to have more information about the federal programs under discussion.

Committee members finally noted that readmissions rates for behavioral health were a gap in the program but clarified that readmissions for both mental and behavioral health were extremely complicated, involving numerous types of facilities and conditions that necessitate cyclical admissions. Committee members felt that generalizations should not be made, specifically the assumption that identical measures would be appropriate for psychiatric care.

CMIT 80: Acute Myocardial Infarction (AMI) 30-Day Readmission Rate

The *Acute Myocardial Infarction (AMI) 30-Day Readmission Rate* measure estimates a hospital-level, 30-day RSRR for patients discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions does not count as readmissions. CMS annually reports the measure for patients who are 65 years of age and older and are Medicare FFS beneficiaries hospitalized in nonfederal hospitals.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings included whether the measure should be combined in a properly risk-adjusted overall readmission measure that is not disease-specific, the results are more likely to be influenced by outside factors than in a shorter interval, and the question of the accuracy of risk adjustment.

General Committee comments provided were similar to those provided for CMIT 78 in that there are reservations about condition-specific measures due to the possibility of a high number of measures that

could be brought forward for reporting as well as concerns about the risk adjustment model and a 30-day time frame that could disproportionately have an impact on rural hospitals, with a suggestion for a nonspecific 30-day readmission measure to be utilized for specific areas and evaluated by condition through data queries and would reduce reporting burden.

Both Lead Discussants and Committee members emphasized that any decisions should be data based and questioned whether enough data had been provided to make decisions at this time. CMS noted that additional information could be provided, and measure stewards supplied some initial performance data through the chat. Committee members closed the discussion by considering the need for risk adjustment with particular attention to comorbidities and the coronavirus disease 2019 (COVID-19) pandemic.

CMIT 899: Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) 30-Day Readmission Rate

The *Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) 30-Day Readmission Rate* measure estimated a hospital-level, 30-day RSRR following elective primary THA and/or TKA. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions does not count as readmissions. CMS annually reports the measure for patients who are 65 years of age and older and are Medicare FFS beneficiaries hospitalized in nonfederal hospitals.

The Criteria/Rationale for removal included that the measure should be combined in a properly risk-adjusted overall readmission measure that is not disease-specific, and the patient population for elective procedures is shifting to the outpatient setting.

The Committee provided similar comments to those for CMIT 78 and CMIT 80 in that there are reservations about condition-specific measures due to the possibility of a high number of measures that could be brought forward for reporting as well as concerns about the risk adjustment model and a 30-day time frame that could disproportionately have an impact on rural hospitals. The Committee discussed a suggestion for a nonspecific 30-day readmission measure to be utilized for specific areas and evaluated by condition through data queries that would reduce reporting burden. Committee members noted procedures are shifting more to outpatient settings for populations with few morbidities and limited risk; however, complications result in patients being admitted to inpatient facilities, which may complicate the picture provided by data. The Committee noted it is not possible to compare inpatient and outpatient quality reporting upon initial procedure when a procedure necessitates a follow-up in an inpatient setting. There were also questions about the possibility of confounding factors that include comorbidities.

Committee Comments on HRRP Measures

Ms. Roberts raised concerns about having insufficient information for the decisions and opened the floor to additional Committee member thoughts. There was some agreement and additional concerns raised that if condition- or disease-specific readmission measures were removed in favor of all-cause readmissions measures, both consumers and hospitals would be at a disadvantage. Consumers may not be able to determine performance in areas relevant to their concerns, and hospitals quality improvement efforts could be hindered by aggregated data that hide poor performance in specific conditions. Follow-up comments from Committee members reiterated the challenges of the program's structure and penalties and questioned the consequences for removing or maintaining measures that may or may not be topped out.

Public Comment on HRRP Measures

There was one public comment offered, which encouraged the MAP to think more about how topping out on measures is defined. The comment noted that while developers had been sharing performance data demonstrating variability of these measures in the meeting chat, further conversation should be had about what the right amount of variability is. Even if the ideal state were achieved, the comment pointed out that variability may still exist, and therefore, more robust data are needed to understand outliers.

No other public comments were offered.

Polling Results

- **CMIT 78:** Yes–4, No–15, 21 percent in favor of removal
- **CMIT 80:** Yes–4, No–15, 21 percent in favor of removal
- **CMIT 899:** Yes–5, No–11, 31 percent in favor of removal

Hospital Value-Based Purchasing (VBP) Program and Hospital Inpatient Quality Reporting (IQR) Program Mortality Measures

CMIT 89: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization

The *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization* measure estimates a hospital 30-day risk-standardized mortality rate (RSMR). Mortality is defined as death for any cause within 30 days after the date of admission of the index admission for patients 18 years of age and older discharged from the hospital with a principal diagnosis of HF. CMS annually reports the measure for patients who are 65 years of age or older and are either enrolled in FFS Medicare and hospitalized in nonfederal hospitals or are hospitalized in VA facilities.

The Criteria/Rationale for removal prior to the MSR meetings included that the measure should be combined in a properly risk-adjusted overall mortality measure that is not disease-specific, the measure requires significant financial resources, and the risk of penalizing under-resourced hospitals.

The Committee's discussion included concerns that the measure and penalties may create perverse incentives against admittance of patients towards end of life and reiterated a suggestion issued during discussions of the HRRP measures that perhaps an all-cause measure would be preferable to condition-specific measures for mortality. CMS informed Committee members that a hybrid, hospital-wide mortality measure was recently finalized and would be publicly reported in the coming years.

CMIT 86: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization

The *Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization* measure estimates a hospital-level, 30-day risk RSMR for patients discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). Mortality is defined as death from any cause within 30 days after the index admission date. CMS annually reports the measure for patients who are 65 years of age and older and are Medicare FFS beneficiaries hospitalized in nonfederal hospitals.

The Criteria/Rationale for measure removal included that the measure should be combined in a properly risk-adjusted overall mortality measure that is not disease-specific, patient populations requiring more

care could be penalized, and targeting mortality rates would require significant resources to make minimal impact.

The Committee's discussion included preference for a general mortality measure. Further discussion included concerns for patients with complex comorbidities and the burden that a condition-specific, claims-based measure may impose. One of the Lead Discussants felt that the measure was valid and supported its continuation within the program.

Committee members noted that burden was not an initial criterion for MSR and considered its relevance for inclusion in future years. CMS reiterated that condition-specific measures are important to patients seeking information, as well as for quality improvement on low-performance areas, and suggested that other adjustments to future criteria should include the impact and importance to patients. Committee members additionally discussed the benefits and intents of CMIT 89 and CMIT 86 as reflecting gaps in end-of-life care and acute management of care, respectively.

CMIT 1357: CMS Death Rate Among Surgical Inpatients With Serious Treatable Complications

The *CMS Death Rate Among Surgical Inpatients With Serious Treatable Complications* measure measures in-hospital deaths per 1,000 surgical discharges among patients ages 18 through 89 years or obstetric patients with serious treatable complications (e.g., shock/cardiac arrest, sepsis, pneumonia, deep vein thrombosis/pulmonary embolism, or gastrointestinal hemorrhage/acute ulcer). The measure includes metrics for the number of discharges for each type of complication and excludes cases transferred to an acute care facility. A risk-adjusted rate is available. The risk-adjusted rate of Patient Safety Indicator (PSI) 04 relies on stratum-specific risk models. The stratum-specific risk models are combined to calculate an overall risk-adjusted rate.

The Criteria/Rationale for measure removal included NQF endorsement being removed and the measure being duplicative of other measures in the program.

Committee members discussed duplicity with existing electronic clinical quality measures (eCQMs) and additionally reiterated concerns for burden that could result from a high number of condition-specific mortality measures.

Committee members asked for clarification on whether this measure had been considered for removal in rulemaking and why its NQF endorsement status had been removed. CMS representatives stated that the measure had been proposed for removal but was continued after review of public comments. Developers of the measure noted that endorsement was removed when the measure steward was unable to continue supporting the measure through the endorsement process and withdrew as steward.

Committee members noted that the Hospital IQR Program includes a high number of measures and continues to receive additions, in contrast to programs previously discussed such as ASCQR, and cautioned again about the level of burden created as a result.

CMIT 902: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke

The *Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Acute Ischemic Stroke* measure estimates a hospital-level RSMR for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke. Mortality is defined as death from any cause within 30 days of the index admission date for patients discharged from the hospital with a principal diagnosis of acute ischemic stroke.

The Criteria/Rationale for measure removal included not being NQF endorsed, and the measure should be combined in a properly risk-adjusted overall mortality measure that is not disease-specific.

The Committee's discussion also reiterated prior comments regarding endorsement status and a preference for a properly risk-adjusted overall mortality measure that would not be disease-specific.

Committee members and CMS representatives discussed competing measures that would allow for more granular data evaluation and improved risk adjustment if implemented as replacements. Currently, alternatives do not have NQF endorsement and are not implemented. However, some Committee members questioned whether a forthcoming composite measure was sufficient reason to remove a current measure if no actual performance concerns were raised. CMS clarified that the measure still results in variation, and as part of the Hospital IQR Program, no penalties are associated with performance.

Committee Comments on VBP and Hospital IQR Mortality Measures

One additional comment from a Committee member re-emphasized the importance of CMIT 1357 to consumers.

Public Comment on VBP and Hospital IQR Mortality Measures

No public comments were made on these measures.

Polling Results

- **CMIT 89:** Yes–9, No–8, 53 percent in favor of removal
- **CMIT 86:** Yes–6, No–11, 35 percent in favor of removal
- **CMIT 1357:** Yes–3, No–16, 16 percent in favor of removal
- **CMIT 902:** Yes–8, No–11, 42 percent in favor of removal

Hospital Inpatient Quality Reporting (IQR) Program Measures

CMIT 1017: Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)

The *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)* focuses on adults 18 years of age and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, the measure contains several elements, including measurement of lactate; obtaining blood cultures; administering broad spectrum antibiotics, fluid resuscitation, and vasopressor administration; reassessment of volume status and tissue perfusion; and repeat lactate measurement. As reflected in the data elements and their definitions, these elements should be performed in the early management of severe sepsis and septic shock.

The Criteria/Rationale for measure removal included the measure not being evidence based and very difficult to collect, the measure excluding clinical judgement, and the potential for it to lead to unintended consequences or harm by treating patients who appear to be infected but are not.

The Committee's discussion included a referenced editorial written about the removal of the measure by the Infectious Diseases Society of America (IDSA) and other professional associations. The rationale of the article was this measure would be the driver for the overuse of antibiotics, and an accompanying

editorial criticized IDSA's response. A Lead Discussant also noted the existence of other articles about the claims-based denominator. The discussant noted that the prediction of who has serious sepsis or septic shock is deficient, and the reliability of the denominator is poor. This discussant indicated the existence of data on good guidelines on how to manage sepsis and septic shock; however, no one has truly looked at the outcomes. It was noted that severe sepsis and septic shock are serious, high-mortality events. The discussant noted it is unclear whether this measure is accomplishing that goal; nonetheless, the purpose of this program is public reporting. CMS measure maintenance responded to the comment regarding the denominator's reliability. The denominator is not defined solely by coding; coding casts the initial net, but patients who meet the criteria are defined.

Another Lead Discussant noted so much about sepsis, particularly that it should be treated early. This discussant questioned the outcomes of this measure and whether better outcomes are in the bundle. Mr. Kahn noted that there are hospital individuals on the line and questioned whether this is a collection issue. Mr. Kahn also indicated that there is rapid development in technology.

CMS thanked the Committee members for their comments. CMS indicated that concerns have been raised with burden since this is a chart-based measure. CMS considers all input to evaluate measures within programs. Additionally, CMS reviews measures, and this one was re-endorsed with NQF this year. CMS indicated that there is overwhelming evidence behind the measure, and robust public dialogue occurred during the review. CMS referenced and encouraged the reading of a recently published journal article that indicated compliance with the measure produced a 5.7 percent mortality reduction for Medicare beneficiaries. Per the 1.7 million sepsis cases a year, this result equals 15,000 lives saved. CMS is aware of the concerns of overuse, and discussion has occurred regarding the creation of a balancing metric to evaluate. CMS noted that based on the evidence, the measure stands on its own. Committee members agreed with the statements about the evidence and robust public discussion.

CMIT 5756: Exclusive Breast Milk Feeding (eCQM)

The *Exclusive Breast Milk Feeding (eCQM)* measure is reported as an overall rate, which includes all newborns who were exclusively fed breast milk during their entire hospitalization. Of note, this measure was finalized for removal from the program in FY 2022, beginning with the FY 2026 payment determination.

The Criteria/Rationale identified for measure removal ahead of the MSR meetings were duplicative of another measure and intent of measure.

The Committee's comments expressed surprise that the measure was slated for removal. A Lead Discussant noted that the measure's duplicity is unknown; no other comments were made regarding duplicity during the meeting. Another Lead Discussant indicated the data on breastfeeding are overwhelming and noted this measure has maintained endorsement with NQF. Another Lead Discussant noted the importance of this measure and that mothers needed support.

CMS indicated low reporting by hospitals, which contributed largely to the decision. CMS also heard of some instances in which mothers were feeling undue pressure.

Committee Comments on Hospital IQR Measures

Ms. Elliott noted that CMIT 5756 was recently finalized for removal from the program in FY 2022. Committee members shared final comments on CMIT 1017, noting the need for earlier identification and diagnosis of sepsis and the impact of the measure on this identification.

Public Comment on Hospital IQR Measures

Comments were offered on CMIT 1017 by representatives for a sepsis advocacy organization to shine light on the important role of the measure in decreasing time to diagnose sepsis due to its focus on screening and reporting. The comments stated that one in three inpatient deaths will result from sepsis and that mortality can increase as much as 8 percent for every hour that treatment is delayed. Commenters shared personal anecdotes of how sepsis had personally affected their lives and families and emphasized that measures and protocols requiring close monitoring for sepsis, such as CMIT 1017, can be lifesaving for patients. Commenters acknowledged that the measure was imperfect and could be improved but nonetheless encouraged Committee members to support its continuation as a critical opportunity to prevent mortality. Measure stewards confirmed that risk stratification has allowed for almost a 20 percent mortality reduction through early screening for sepsis.

No further public comments were offered. Representatives from CMS added final comments on CMIT 5756 to emphasize that although the measure had been finalized for removal, CMS has ongoing work in maternal health and continues to consider this a priority area.

Polling Results

- **CMIT 1017:** Yes–1, No–15, 6 percent in favor of removal
- **CMIT 5756:** Yes–8, No–7, 53 percent in favor of removal

Future Considerations for MSR

Committee members identified several opportunities for improvement of the MSR process within the areas of background information provided, measure review criteria, voting, and representation:

- **Background Information**
  - More data are needed in advance of measure selection and review, including trends, performance data, gaps and variation across subpopulations, endorsement status and rationales, and any recent literature or initiatives discussing the measures.
  - More information should be provided on the context of the programs housing the measures, including other measures in the program, to identify gaps or possibilities for gaps pending measure removal.
  - Information on similar measures in the development or implementation pipeline could help Committee members understand the impact of removing or continuing measures.
- **Measure Review Criteria**
  - Criteria should be added to evaluate measures as part of the overall set of measures in a program and to explicitly address gaps.
  - Criteria should be added to determine whether a measure differentiates between excellence and adequacy of performance.
  - Criterion #8 (measure has negative unintended consequences) should be split to create criteria explicitly assessing how a measure diminishes inequities or promotes equity.
  - Criterion #8 could also be used to ask about positive unintended consequences.

    - NQF should look at how many criteria were used during discussions as part of considerations for future iterations.
- **Voting**
    - MSR voting should include gradations of support, possibly in a similar matrix to MAP Pre-Rulemaking voting.
    - Possible gradations may include support for removal that is contingent upon the availability of replacement measures, timing of removal (i.e., "okay to wait"), and continuation of the measure with recommended changes, among others.
    - Voting abstention should be allowed; however, Committee members debated its inclusion as a voting category versus a notification process.
- **Representation**
    - Committee members encouraged increased representation of consumer (e.g., patient, family, and caregiver or advocate) voices.
    - Committee members encouraged continued or increased representation of nurses and social workers.
    - Committee members strongly appreciated the voices of impacted patients and families during public comment and would appreciate the continuation or expansion of these voices.

Committee members encouraged future continuation of the use of Lead Discussants and the grouping of measures by both programs and topic areas. Additionally, Committee members emphasized the need to approach MSR processes holistically and to examine the role of measures within a program and how they fit with other measures within these programs. Committee members also identified MSR as an opportunity to step back from individual measure scrutiny to broadly look at the role of quality measurement and programs in achieving desired health outcomes. On a note of caution, some comments reminded Committee members that changes made to these programs or measures send a message to stakeholders across the care continuum about the MAP's priorities, and Committee members should proceed with care in the removal of measures.

During the discussions on increased representation of consumer voices both on MAP initiatives and as commenters, Committee members called for increased simplification of the technical information provided in advance of meetings as well as measure selection in order to allow for greater participation by consumers. Committee members suggested possible solutions, such as consumer-focused orientations, to increase understanding of quality measurement and provision of plain-language materials.

Structurally, Committee members suggested that in future MSR cycles, NQF should provide MAP members more time to select and review measures and that it may be useful to build out specific agenda time to discuss federal programs rather than solely individual measures. Future iterations of the MSR process may also need to be thoughtful about the number of measures reviewed each cycle to allow for bandwidth limitations by participants. Overall, Committee members were pleased with the MSR process and appreciated the conversations that occurred during the pilot MSR cycle.

Appendix A: MAP Roster and NQF Staff

2021-2022 Measure Applications Partnership (MAP) Coordinating Committee

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