DEPARTMENT OF HEALTH AND HUMAN SERVICES

[CMS–3432–N]

Secretarial Review and Publication of the 2022 Annual Report to Congress and the Secretary Submitted by the Consensus-Based Entity Regarding Performance Measurement

AGENCY: Office of the Secretary of Health and Human Services, HHS.

ACTION: Notice.

SUMMARY: This notice acknowledges the Secretary of the Department of Health and Human Services' (the Secretary's) receipt and review of the 2022 National Quality Forum Annual Report to Congress and the Secretary submitted by the consensus-based entity under a contract with the Secretary as mandated by the Social Security Act. The Secretary has reviewed and is publishing the report in the **Federal Register** together with the Secretary's comments on the report not later than 6 months after receiving the report in accordance with section 1890(b)(5)(B) of the Act. This notice fulfills the statutory requirements.

FOR FURTHER INFORMATION CONTACT: Carrie Sena, (410) 786–8003.

SUPPLEMENTARY INFORMATION:

I. Background

The United States Department of Health and Human Services (HHS) has long recognized that a high functioning health care system that provides higher quality care requires accurate, valid, and reliable measurement of quality and efficiency. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275) added section 1890 of the Social Security Act (the Act), which requires the Secretary of HHS (the Secretary) to contract with a consensus-based entity (CBE) to perform multiple duties to help improve performance measurement. Section 3014 of the Patient Protection and Affordable Care Act (the Affordable Care Act) (Pub. L. 111–148) expanded the duties of the CBE to help in the identification of gaps in available measures and to improve the selection of measures used in health care programs. The Secretary extends his appreciation to the CBE in their partnership for the fulfillment of these statutory requirements.

In January 2009, a competitive contract was awarded by HHS to the National Quality Forum (NQF) to fulfill requirements of section 1890 of the Act. A second, multi-year contract was awarded again to NQF after an open competition in 2012. A third, multi-year contract was awarded again to NQF after an open competition in 2017. Section 1890(b) of the Act requires the following:

Priority Setting Process: Formulation of a National Strategy and Priorities for Health Care Performance Measurement: The CBE must synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In doing so, the CBE must give priority to measures that: (1) address the health care provided to patients with prevalent, high-cost chronic diseases; (2) have the greatest potential for improving quality, efficiency, and patient-centered health care; and (3) may be implemented rapidly due to existing evidence, standards of care, or other reasons. Additionally, the CBE must take into account measures that: (1) may assist consumers and patients in making informed health care decisions; (2) address health disparities across groups and areas; and (3) address the continuum of care furnished by multiple providers or practitioners across multiple settings.

Endorsement of Measures: The CBE must provide for the endorsement of standardized health care performance measures. This process must consider whether measures are evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, responsive to variations in patient characteristics such as health status, language capabilities, race or ethnicity, and income level and are consistent across types of health care providers, including hospitals and physicians.

Maintenance of CBE Endorsed Measures: The CBE is required to establish and implement a process to ensure that endorsed measures are updated (or retired if obsolete) as new evidence is developed.

Convening Multi-Stakeholder Groups: The CBE must convene multi-stakeholder groups to provide input on: (1) the selection of certain categories of quality and efficiency measures, from among such measures that have been endorsed by the entity and from among such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and in the delivery of health care services for consideration under the national strategy. The CBE may also provide input to the Secretary on measures that could be considered for removal. The CBE provides input on measures for use in certain specific Medicare programs, for use in programs that report performance information to the public, and for use in health care programs that are not included under the Act. The multi-stakeholder groups provide input on quality and efficiency measures for various federal health care quality reporting and quality improvement programs including those that address certain Medicare services provided through hospices, ambulatory surgical centers, hospital inpatient and outpatient facilities, physician offices, cancer hospitals, end stage renal disease (ESRD) facilities, inpatient rehabilitation facilities, long-term care hospitals, psychiatric hospitals, and home health care programs.

Transmission of Multi-Stakeholder Input: Not later than February 1 of each year, the CBE must transmit to the Secretary the input of multi-stakeholder groups.

Annual Report to Congress and the Secretary: Not later than March 1 of each year, the CBE is required to submit to the Congress and the Secretary an annual report. The report is to describe:

- The implementation of quality and efficiency measurement initiatives and the coordination of such initiatives with quality and efficiency initiatives implemented by other payers;
- Recommendations on an integrated national strategy and priorities for health care performance measurement;
- Performance of the CBE's duties required under its contract with the Secretary;
- Gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act (National Quality Strategy), and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps;
- Areas in which evidence is insufficient to support endorsement of quality and efficiency measures in priority areas identified by the Secretary under the National Quality Strategy, and where targeted research may address such gaps; and
- The convening of multi-stakeholder groups to provide input on: (1) the selection of quality and efficiency measures from among such measures that have been endorsed by the CBE and such measures that have not been considered for endorsement by the CBE but are used or proposed to be used by

the Secretary for the collection or reporting of quality and efficiency measures; and (2) national priorities for improvement in population health and the delivery of health care services for consideration under the National Quality Strategy.

Section 50206(c)(1) of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) amended section 1890(b)(5)(A) of the Act to require the CBE's annual report to the Congress to include the following: (1) an itemization of financial information for the previous fiscal year ending September 30th, including annual revenues of the entity, annual expenses of the entity, and a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity; and (2) any updates or modifications to internal policies and procedures of the entity as they relate to the duties of the CBE including specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity, and information on external stakeholder participation in the duties of the entity.

The statutory requirements for the CBE to annually report to the Congress and the Secretary also specify that the Secretary must review and publish the CBE's annual report in the **Federal Register**, together with any comments of the Secretary on the report, not later than 6 months after receiving it.

This **Federal Register** notice complies with the statutory requirement for Secretarial review and publication of the CBE's annual report. NQF submitted a report on its 2022 activities to the Congress and the Secretary on March 1, 2023. The Secretary's Comments on this report are presented in section II. of this notice, and the 2022 Annual Report to the Congress and the Secretary is provided, as submitted to HHS, in the addendum to this **Federal Register** notice in section III.

II. Secretarial Comments on the National Quality Forum 2022 Activities: Report to Congress and the Secretary of the Department of Health and Human Services

Across the country, many communities are facing immense challenges that have been exacerbated by public health emergencies including the opioid crisis, disasters related to climate change, and the COVID–19 pandemic. Throughout these recent crises and to prudently prepare for imminent threats the Department of Health and Human Services (HHS) must continue to focus on advancing equity and inclusion, strengthening public trust, and building meaningful engagement and learning across the health care system. By embedding the cross-cutting principles [1] of equity, public trust, and collaboration into its diverse programs and initiatives, HHS is working to improve the health and well-being of individuals and families.

HHS values the work of the consensus-based entity for performance measurement and our mutual commitment to promote a resilient, high value, and safe health care system for all Americans. In 2022, HHS supported the work conducted by the CBE to identify health care quality measurement priorities and to provide consensus-based recommendations about measures to use for assessing and improving quality. As the CBE in 2022, the NQF continued to use rigorous standards to review measures for quality measure endorsement and maintain highly reliable and scientifically sound measures across priority health care topic areas. As required by section 1890(b) of the Act, the NQF Measure Applications Partnership (MAP) provided input on measures under consideration for quality reporting and value-based purchasing programs across various settings including ambulatory, acute care, post-acute care and long-term care. Specifically, the MAP considered measures related to health equity, COVID–19, person-centered care, rural health, and care coordination. The MAP also deliberated over measures for potential removal from HHS programs. The MAP supported HHS and national priorities to keep measures that are of the highest-value, aligned across programs, prioritizing patient-reported outcome measures, digital measures, and those that reflect consideration of social determinants of health.

In 2022, the CBE also convened the Core Quality Measures Collaborative (CQMC), a public-private partnership with the Centers for Medicare and Medicaid Services (CMS) and America's Health Insurance Plans (AHIP), to maximize alignment of quality measures among public and private payers. The CBE established a Health Equity Workgroup that identified disparity-sensitive measures within the CQMC core sets and proposed approaches for future considerations to prioritize measures that address social determinants of health. In alignment with HHS priorities to advance data interoperability and digital measure use, the CQMC Digital Measurement Workgroup continued, in 2022, to identify ways to address barriers to using digital quality measures and supporting efforts to align data standards for measurement.

To support the CMS National Quality Strategy [2] and critical health care priorities, the CBE worked with quality measurement experts, clinicians, health plans, hospitals, accrediting and certifying entities, consumer organizations and others to improve areas of behavioral health, rural health, health care communication and coordination, and patient-centered care. In 2022, the CBE developed measurement frameworks detailing guidance, recommendations, and identifying measurement gaps for Opioid-Related Outcomes Among Individuals With Co-occurring Behavioral Health Conditions; Leveraging Quality Measures to Improve Rural Health; and Leveraging Electronic Health Record-Sourced Measures to Improve Care Communication and Coordination. Additional CBE projects included provided guidance for Best Practices for Developing and Testing Risk Adjustment Models; Building a Roadmap From Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures; and establishing a Patient and Caregiver Engagement Advisory Group.

In many ways, the CBE activities detailed in its 2022 Report to Congress enhanced quality measurement strategies that support HHS and national progress towards safe, accessible, value-based, and equitable care for individuals and communities. As our world and the demands on our health care system continue to evolve, HHS recognizes the increasing importance of varied experiences and perspectives, of consensus-based recommendations, and of evidence-based foundations that inform policies and strategies to improve the health care system. HHS looks forward to the continuity of activities with a new CBE, Battelle, who has extensive expertise and experience in collaborating with and engaging various health care partners to advance quality performance measurement.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements.

[1] HHS Strategic Cross-Cutting Principles, available at *https://www.hhs.gov/about/strategic-plan/2022-2026/overview/index.html.*

[2] CMS National Quality Strategy available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.*

Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

IV. Addendum

In this Addendum, we are publishing the *NQF Report on 2022 Activities to Congress and the Secretary of the Department of Health and Human Services,* as submitted to HHS.

Dated: September 12, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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NATIONAL QUALITY FORUM
Driving measurable health improvements together

NQF 2022 Activities: Report to Congress and the Secretary of the Department of Health and Human Services

Final Report

March 1, 2023

This report was funded by the U.S. Department of Health and Human Services under contract number HHSM-500-2017-00060I Task Order HHSM-500-T0002.

Contents

I. Executive Summary

Introduction

The National Quality Forum (NQF) is a not-for-profit, nonpartisan, membership-based organization. NQF brings together highly diverse experts with unique healthcare quality and safety perspectives to develop consensus-based standards and recommendations to eliminate avoidable healthcare harms and advance optimal patient health outcomes, equity, and affordability. Since 2009, NQF has served as the nation's statutorily recognized consensus-based entity (CBE), fostering multistakeholder collaboration to oversee the nation's portfolio of healthcare quality measures. NQF's work to endorse best-in-class measures, bring multistakeholder input to federal programs, and identify measure gaps and measurement strategies improves the health and well-being of all individuals. NQF Committees are established as volunteer, multistakeholder groups that develop consensus standards and recommendations and are responsible for tasks such as evaluating measures and providing strategic recommendations and technical guidance. A variety of value-based programs in both the public and private sectors use NQF's work and provide important levers to drive better health outcomes that are both affordable and equitable.

This Annual Report to Congress and the Secretary of the Department of Health and Human Services (HHS) summarizes NQF's work under contract with HHS between January 1 and December 31, 2022. As required by statute, this report, mandated by section 1890(b)(5)(A) of the Social Security Act (SSA), addresses the following items:

- Recommendations on national strategies and priorities
- Implementation of quality and efficiency measurement initiatives
- Stakeholder recommendations on the priority-setting process
- Identified gaps in endorsed quality and efficiency measures
- Targeted research areas not supported by the endorsement of quality and efficiency measures
- Coordination with measurement initiatives led by other payers
- Other activities performed under contract with HHS
- Financial information for fiscal year (FY) 2022
- Updates to CBE policies and procedures in 2022

The body of this report describes NQF's work funded by the Centers for Medicare & Medicaid Services (CMS) on each of the items referenced above. This Executive Summary presents a brief synthesis.

Summary of 2022 Activities

In 2022, NQF worked with CMS to continue to identify quality measurement priorities and advance consensus on methods and measures for assessing and improving quality. NQF achieves these aims through three ongoing programs and targeted projects. In 2022, as the CBE, NQF continued to run core programs (as described below) through structured, transparent, and consensus-based processes that

convene diverse volunteer stakeholders and multiple committees to review and comment on the endorsement, use, and alignment of quality measures:

- **Endorsement and Maintenance:** Through its Endorsement & Maintenance (E&M) process, NQF convened stakeholders to set rigorous standards for quality measures as well as to endorse and maintain scientifically sound and feasible healthcare quality measures across 14 clinical and cross-cutting topic areas. In 2022, NQF reviewed a total of 54 measures across a wide variety of topics reflecting some of the CMS National Quality Strategy focus areas, including health equity, COVID-19 vaccination coverage, rural health, and patient experience of care. NQF endorsed 47 measures and approved two for trial use. [Section IV: Implementation of Quality and Efficiency Measurement Initiatives (Performance Measurement)]
- **Measure Applications Partnership:** The Measure Applications Partnership (MAP) provides multistakeholder input on ambulatory, acute, and post-acute care/long-term care measures proposed for use in specific CMS public-reporting and value-based payment programs. NQF also formally launched a new MAP process to annually review measures for potential removal from these CMS programs. During its most recent deliberations, the MAP considered the need for, validity of, and burden of proposed and actively used measures across a wide scope of topics, including health equity, COVID-19, person-centered care, rural health, and care coordination. The MAP also provided input on 29 measures CMS suggested for use in its programs and considered 22 measures for removal. [Section V: Stakeholder Recommendations on the Priority-Setting Process]
- **Core Quality Measures Collaborative:** This public-private partnership, convened in partnership with CMS and America's Health Insurance Plans (AHIP), continued to align the measures that payers use to assess ambulatory clinicians, maintaining 10 common core sets of measures for use in value-based payment programs and addressing barriers to implementation of the core measure sets. In 2022, the Core Quality Measures Collaborative (CQMC) conducted four main activities: maintenance of its 10 core measure sets; launching an effort to elevate and address health equity and health disparities; lowering the burden of using digital quality measures (dQMs) through advancing data interoperability and other mechanisms; and reducing reporting burden through increased alignment on aspects of measurement, such as collection, transmission, standardization, aggregation, and dissemination of measure data. These efforts reflect a recognition that aligning multiple aspects of measurement can better support implementing CQMC core sets. For example, to speed implementation of digital measures, the CQMC is identifying specific data elements as priorities for interoperability in Fast Healthcare Interoperability Resources (FHIR) to inform the Office of the National Coordinator for Health Information Technology's (ONC) alignment of data standards for measurement. [Section VIII: Coordination With Measurement Initiatives Led by Other Payers]

To address persistent gaps in equity, NQF enhanced activities in all three core programs mentioned above to advance stakeholder consensus on the use of quality measures that support progress on equity. For example, NQF seated a Health Equity Workgroup to identify which measures in the CQMC's existing aligned core sets of measures can best be used to measure, track, and reduce disparities and

reviewed additional measures of health equity that the collaborative could consider for later addition to its existing sets of measures.

In addition to the three core programs, NQF worked with CMS to target priority gap areas in which there may not yet be sufficient research or measures. For these projects, NQF developed measurement "frameworks" that organize the most important topics to measure about a critical priority area and describe how measurement should take place (e.g., entities involved in measurement, who is held responsible for measurement, relevant care settings, cadence of measurement, and relevant population). NQF's measurement framework projects (described further below) align with and advance the priorities identified in the CMS National Quality Strategy and Meaningful Measures 2.0:

- The **CMS National Quality Strategy**, introduced in 2022, is a "long-term initiative that aims to promote the highest quality outcomes and safest care for all individuals."[2] It supports progress toward a person-centered approach to healthcare across the life span of an individual, builds on lessons learned from the COVID-19 pandemic, and reflects increased demand from stakeholders for data to inform healthcare decisions. The CMS National Quality Strategy sets eight specific goals: (1) embedding quality in the care journey, (2) advancing health equity, (3) promoting patient safety, (4) fostering patient engagement, (5) strengthening resiliency, (6) embracing digital measurement, (7) adopting innovative technology, and (8) increasing measurement alignment for better care coordination.[2]
- **CMS Meaningful Measures 2.0** is consistent with the CMS National Quality Strategy but more specifically guides quality measurement priorities to have a maximal impact with minimum burden. It sets forth a measurement strategy of using the highest-value measures, aligning measures across programs, prioritizing patient-reported measures that augment the patient's voice and other outcome measures, transitioning to fully digital measures, and advancing measures that reflect consideration of social determinants of health (SDOH).[3]

NQF's 2022 measurement framework projects include work to identify and address measurement strategies, including identifying gaps, critical to the health of the nation. Reports from each of these projects provide specific recommendations, guidance, and/or strategies:

- **Opioid-Related Outcomes Among Individuals With Co-occurring Behavioral Health Conditions:** Detailed guiding principles and use case exemplars on how to implement a recommended quality measurement framework for measuring, evaluating, and addressing overdose and mortality for individuals with substance use disorder/opioid use disorder (SUD/OUD) and co-occurring behavioral health conditions.
- **Leveraging Quality Measures to Improve Rural Health:** An updated set of the best-available measures for measurement and quality improvement programs in rural areas, including measures that address rural-relevant topics, such as behavioral health, infectious disease, access to care, and equity, and are resistant to low case-volume challenges.
- **Leveraging Electronic Health Record-Sourced Measures to Improve Care Communication and Coordination:** An overview of multistakeholder recommendations on how to use EHR data to

facilitate more effective care communication and coordination and advance the measurement of these functions to better support high quality healthcare.

In addition, NQF worked with stakeholders to advance consensus and strategies for measurement science to support the development and use of high-priority patient-centered measures, such as clinical outcome and patient-reported outcome measures. In 2022, CMS supported NQF projects to create the following:

- **Best Practices for Developing and Testing Risk Adjustment Models:** Stakeholder-informed detailed guidance that advances consensus on best practices for the use of social risk factors (e.g., race, ethnicity, and income) and functional risk factors (e.g., frailty) in risk-adjusted outcome measures to make certain such measures are fair and advance equity.
- **Building a Roadmap From Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures:** A comprehensive roadmap providing guidance and links to resources to support the development and implementation of patient-reported outcome performance measures (PRO-PMs).
- **Patient and Caregiver Engagement Advisory Group:** Approaches to expand patient and caregivers' input into the work of the CBE.

Measurement Gaps Identified Through NQF Activities

NQF identifies gaps in measurement areas through several mechanisms. Standing Committees, focused on reviewing and endorsing measures as part of NQF's E&M process, also discuss measurement gaps in their topical area of focus. They identified gaps focused on behavioral health, cost measurement, palliative care, and perinatal care. Likewise, the MAP identified gaps relating largely to long-term and post-acute care settings, stating a need for more patient experience measures and PRO-PMs, as well as measures of mental health. MAP members also noted that the COVID-19 pandemic has exposed a lack of infection control measures in many long-term care facilities. In addition, the CQMC, as part of maintaining its 10 clinician-focused aligned measure sets, identified gaps for each of the sets. Overarching gaps included outcome measures (e.g., PRO-PMs), cross-cutting measures (e.g., patient safety, patient and family engagement, care coordination, and population health), health equity and disparities-sensitive measures, digital quality measures, and telehealth-relevant measures. Lastly, several additional NQF projects, including the work on opioids, rural health, and equity noted above, identified measure gaps. The Opioid-Related Outcomes Among Individuals With Co-occurring Behavioral Health Conditions project highlighted gaps in behavioral health measures, including all-payer measures addressing behavioral health, measures addressing harm reduction strategies, and measures on person-centered and evidence-based SUD care. The Leveraging Quality Measures to Improve Rural Health project also emphasized specific topic areas lacking measures on care quality, such as care for intentional and unintentional injuries, serious illness and end-of-life care, and telehealth care. Overarching comments from these projects noted the need for measures on access to care and care coordination, as well as the need to develop risk-adjusted and stratified versions of measures that do not unintentionally penalize providers that serve high-risk populations.

Conclusion

In summary, as the recognized CBE, NQF achieves the administration and evolution of three major ongoing consensus-based processes—E&M, the MAP, and the CQMC—and targeted activities. NQF's work is both informed by and guides the identification and alignment of national priorities. Figure 1 illustrates how NQF's 2022 activities advance the 2022 CMS National Quality Strategy Goals.

This alignment of priorities facilitates progress across the measurement community and is helping advance the measurement methods and measures we most need to improve quality. For example, measures newly endorsed in 2022 focused on improving patient safety and moving to fully digital measurement to lower measurement burden, such as NQF #0471e *ePC-02 Cesarean Birth*, which is a fully digital version of a currently endorsed cesarean birth measure that looks at nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Other new measures sought to improve patient-centered care via patient-reported outcomes (PROs), such as a PRO-PM measuring improvement in function after elective hip and knee replacements, NQF #3639 *Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty*. Still, others aimed to improve value, such as NQF #3626 *Lumber Spine Fusion for Degenerative Disease, 1-3 Levels*, an episode-based cost measure that evaluates a clinician's risk-adjusted cost to Medicare for patients who undergo surgery for lumbar spine fusion. The availability of feasible endorsed measures in high-priority areas is critical to advance optimal patient health outcomes, equity, and affordability.

Figure 1. Crosswalk Between NQF's 2022 Activities and the CMS National Quality Strategy Goals

The deliverables produced under contract with HHS in 2022 are referenced throughout this report. Appendix I lists these deliverables and indicates their alignment with the CMS National Quality Strategy and Meaningful Measures 2.0 goals. For more information on the contents of this report as required in statutory language, please reference Appendix J.

II. Introduction

NQF, a not-for-profit, nonpartisan, membership-based organization, brings together highly diverse experts with unique healthcare quality and safety perspectives to develop consensus-based standards and recommendations to eliminate avoidable healthcare harms and advance optimal patient health outcomes, equity, and affordability. Since 2009, NQF has served as the nation's statutorily recognized CBE, fostering multistakeholder collaboration to oversee the nation's portfolio of healthcare quality measures. NQF's work to endorse best-in-class measures, bring multistakeholder input to federal programs, and identify measure gaps and measurement strategies improves the health and well-being of all individuals. NQF Committees are established as volunteer, multistakeholder groups that develop consensus standards and recommendations and are responsible for tasks such as evaluating measures, providing strategic recommendations, and offering technical guidance. A variety of value-based programs in both the public and private sectors use NQF's work and provide important levers to drive better health outcomes that are both affordable and equitable.

In 2022, NQF collaborated with CMS to continue to identify quality measurement priorities and advance consensus on methods and measures for assessing and improving quality. NQF achieved these aims through three ongoing core programs and targeted projects. The core programs are:

- **Endorsement and Maintenance**: Through its E&M process, NQF convened stakeholders to set rigorous standards for quality measures as well as to endorse and maintain scientifically sound and feasible healthcare quality measures across 14 clinical and cross-cutting topic areas. *[Section IV: Implementation of Quality and Efficiency Measurement Initiatives (Performance Measurement)]*
- **Measure Applications Partnership:** The MAP provided multistakeholder input on which ambulatory, acute, and post-acute care/long-term care measures to incorporate into some of CMS' public-reporting and value-based payment programs. *[Section V: Stakeholder Recommendations on the Priority-Setting Process]*
- **Core Quality Measures Collaborative**: This public-private partnership, convened in partnership with CMS and AHIP, continued to align the measures that payers use to assess ambulatory clinicians, maintaining common core sets of measures for use in value-based payment programs and providing input on activities to advance the implementation of the core measure sets. *[Section VIII: Coordination With Measurement Initiatives Led by Other Payers]*

NQF's 2022 work also included targeted projects to advance measurement science and identify measurement strategies and gaps critical to the health of the nation. Specifically, NQF provided guidance related to use of social and functional risk factors in risk-adjusted outcome measures, development and implementation of PRO-PMs, and expansion of patient and caregivers' input into the work of the CBE. In addition, NQF reports provided specific recommendations, guidance, and/or strategies on implementing a recommended quality measurement framework for measuring, evaluating, and addressing overdose and mortality for individuals with SUD/OUD and co-occurring behavioral health conditions, using an updated set of the best-available measures for measurement and quality

improvement programs in rural areas, and using EHR data to facilitate providing and measuring more effective care communication and coordination.

This Annual Report to Congress and the Secretary of HHS summarizes NQF's work under contract with HHS between January 1 and December 31, 2022. As required by statute, this report, mandated by section 1890(b)(5)(A) of the SSA, addresses the following items:

- Section III: Recommendations on National Strategies and Priorities
- Section IV: Implementation of Quality and Efficiency Measurement Initiatives
- Section V: Stakeholder Recommendations on the Priority-Setting Process
- Section VI: Identified Gaps in Endorsed Quality and Efficiency Measures
- Section VII: Targeted Research Areas Not Supported by the Endorsement of Quality and Efficiency Measures
- Section VIII: Coordination With Measurement Initiatives Led by Other Payers
- Section IX: Other Activities Performed Under Contract With HHS
- Section X: Financial Information for Fiscal Year 2022
- Section XI: Updates to CBE Policies and Procedures in 2022

This report describes NQF's CMS-funded work in sections aligned with the list above.

III. Recommendations on National Strategies and Priorities

Section 1890(b)(1) of the Social Security Act (the Act) mandates that the consensus-based entity (entity) shall "synthesize evidence and convene key stakeholders to make recommendations . . . on an integrated national strategy and priorities for healthcare performance measurement in all applicable settings.[1] In making such recommendations, the entity shall ensure that priority is given to measures: (i) that address the healthcare provided to patients with prevalent, high-cost chronic diseases; (ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of healthcare; and (iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons."[1] In addition, the entity is to "take into account measures that: (i) may assist consumers and patients in making informed healthcare decisions; (ii) address health disparities across groups and areas; and (iii) address the continuum of care a patient receives, including services furnished by multiple healthcare providers or practitioners and across multiple settings."[1] The CBE is required to describe this activity in this report pursuant to section 1890(b)(5)(A)(i)(II) of the Act.[1]

Overview of National Strategies and Priorities

One responsibility of the CBE is to make recommendations on national strategies and priorities for healthcare measurement. In accordance with the statutory language, NQF's work is both informed by and guides the identification and alignment of national priorities. Furthermore, NQF's 2022 projects align with and advance the priorities identified in the CMS National Quality Strategy and Meaningful Measures 2.0:

- The **CMS National Quality Strategy**, introduced in 2022, is a "long-term initiative that aims to promote the highest quality outcomes and safest care for all individuals."[1] It supports progress toward a person-centered approach to healthcare across the life span of an individual, builds on lessons learned from the COVID-19 pandemic, and reflects increased demand from stakeholders for data to inform healthcare decisions. The CMS National Quality Strategy sets eight specific goals: (1) embedding quality in the care journey, (2) advancing health equity, (3) promoting patient safety, (4) fostering patient engagement, (5) strengthening resiliency, (6) embracing digital measurement, (7) adopting innovative technology, and (8) increasing measurement alignment for better care coordination.[2]
- **CMS Meaningful Measures 2.0** is consistent with the CMS National Quality Strategy but more specifically guides quality measurement priorities to have a maximal impact with minimum burden. It sets forth a measurement strategy of using the highest value measures, aligning measures across programs, prioritizing patient-reported measures that augment the patient's voice and other outcome measures, transitioning to fully digital measures, and advancing measures that reflect consideration of social determinants of health (SDOH).[3]

This alignment of priorities facilitates progress across the measurement community and is helping advance the measurement methods and measures we most need to improve quality. In 2022, NQF worked with CMS to continue to identify quality measurement priorities and gap areas through the three core multistakeholder convenings as described above [Section II: Introduction]:

- E&M [Section IV: Implementation of Quality and Efficiency Measurement Initiatives (Performance Measurement)]
- MAP [Section V: Stakeholder Recommendations on the Priority-Setting Process]
- CQMC [Section VIII: Coordination With Measurement Initiatives Led by Other Payers]

Consistent with section 1890(b)(1), NQF addressed persistent gaps in equity by enhancing activities in all three core programs mentioned above as well as additional projects described throughout this report. This work advanced stakeholder consensus on and the use of quality measures that support progress on equity. For example, NQF seated a Health Equity Workgroup to identify which measures in the CQMC's existing core sets of measures can best be used to measure, track, and reduce disparities and reviewed additional measures of health equity that the collaborative could consider for later addition to its existing sets of measures. More information is in Section VIII: Coordination With Measurement Initiatives Led by Other Payers.

In addition, NQF furthered work on behavioral health by reconvening a multistakeholder committee on co-occurring opioid use disorder and behavioral health to create guiding principles and a use case to inform implementation of prior NQF recommendations. NQF also updated a proposed list of measures for measuring quality in underserved rural populations. These two specific projects are described below.

Priority Initiative: Opioid and Behavioral Health

Overdose deaths in the United States (U.S.) reached a historic high in 2021, with 107,270 reported fatalities. This fourth and newest wave of the opioid crisis[5,6] has been driven by polysubstance use

involving synthetic and semi-synthetic opioids (SSSOs) and the co-use of opioids and psychostimulants. Adding to the complexity of this wave is the increased overlap between individuals with SUDs and co-occurring behavioral health conditions. Furthermore, COVID-19 has increased risks for this population: Research has shown that individuals with a recent diagnosis of SUD, specifically OUD and tobacco use disorder, were at higher risk for worse outcomes from COVID-19.[28]

The co-occurrence of OUD with other behavioral health conditions remains a national priority as the crisis continues to escalate. Measurement is urgently needed to guide improvement. To address this gap, NQF convened the Opioid and Behavioral Health Committee from 2020 to 2022. The multistakeholder Committee's charge was overseeing the development of an approach to measuring performance on this topic (i.e., a measurement framework) to help payers and providers combat the fourth wave of the opioid crisis. The resulting framework identified the three most important domains to measure:

- Equitable access
- Clinical interventions
- Integrated and comprehensive care for concurrent behavioral health conditions

While the development of this framework does provide guidance on how to use measurement to support better care, NQF and CMS recognized that it is also critical to prepare the field for implementation, given the significant impact from OUD, SUD, and behavioral health on public health. In response, NQF reconvened the Opioid and Behavioral Health Committee in 2022 to continue building on this framework through the development of a use case that showcases examples of the measurement framework in action.

The 2022 updates to the Opioid and Behavioral Health Final Report focus on application and implementation. To provide additional guidance on how to use the measurement framework, the Committee identified five guiding principles for driving measurement and reducing overdose and mortality: promoting health equity, reducing stigma, emphasizing shared decision making, encouraging innovation, and intentionality in measure development. The Committee also created a use case to demonstrate how to apply the framework. The use case provides the following: (1) a detailed overview of critical stakeholders most affected by existing gaps in care or who could help address measurement areas identified in the report, (2) overarching barriers and challenges to measuring SUD and co-occurring behavioral health conditions (e.g., stigma, limited resources, payment, data inconsistency, and a rapidly evolving measurement) along with corresponding solutions, and (3) three case exemplars that show specific barriers and solutions to each of the domains of the measurement framework. In these case exemplars, the strategies include relevant existing measures or measure concepts, prevalent barriers in SUDs/OUD and behavioral healthcare pathways, performance gaps that can be addressed, and diversification of settings to showcase variation in performance.

The measurement framework provides the foundational steps to begin measuring, evaluating, and addressing overdose and mortality for individuals with SUD/OUD and co-occurring behavioral health conditions. In addition to alignment with the President's priority to address the opioid and addiction

epidemic,[10] the Committee's efforts also align with the health equity goals in the 2022 CMS National Quality Strategy.[9] During its discussion in 2022, the Committee identified health equity as a foundational guiding principle. Furthermore, the Committee incorporated health equity via the Equitable Access framework domain, which recognizes and identifies equity-related measures, barriers to care, and social risk factors and their impact on vulnerable populations who are at higher risk for SUDs/OUD and co-occurring behavioral health conditions.[12,13] Furthermore, the Committee's work focuses on fostering better engagement and coordination of care and ensuring quality in a patient's care journey. This report successfully establishes foundational tools that stakeholders can use to help mitigate the national opioid crisis and its effects from the COVID-19 pandemic.

Priority Initiative: Leveraging Quality Measures to Improve Rural Health

Nearly 1 in 5 Americans live in rural areas,[10] with rural patients experiencing factors such as geographic isolation and transportation issues, higher rates of comorbid conditions (e.g., smoking and high blood pressure) as compared to their non-rural counterparts, and limited access to healthcare supports.[11] Addressing challenges to high quality rural care is a national priority for achieving optimal health outcomes. This measurement gap area is further complicated by issues such as low case-volume[12] (i.e., when providers do not have enough patients to achieve reliable and valid measurement results).

In response to measurement challenges in rural populations, NQF continued to support the MAP Rural Health Advisory Group's role in the MAP and expanded its work to address additional rural measure priorities. In addition to its continued review of all measures considered for use or removal from selected CMS programs (see Section V: Stakeholder Recommendations on the Priority-Setting Process), the Rural Health Advisory Group also undertook a major effort to update a list of key rural measures—the best-available measures that focus on topics relevant to rural areas and are resistant to low case-volume challenges.

The updated key measures list is summarized in the 2022 Key Rural Measures Final Report. The Advisory Group did not elect to remove any measures from the existing key measures list due to the importance of the topics addressed and the lack of alternative measures. The Advisory Group did, however, add 17 new measures (for a total of 37 rural measures), with a heavy focus on measures of behavioral and mental health, substance use, infectious disease, access to care, equity, and SDOH.

Advisory Group members also discussed existing gaps and emerging needs for performance measurement in rural health. While the updated key measures list addresses several prioritized topic areas, such as substance use, the Advisory Group noted that measurement gaps remain where existing measures did not adequately address intentional or unintentional injury; infectious diseases, such as COVID-19 and HIV; cost measures; cancer screening; and telehealth-relevant measures. Future iterations may include community-level measures to reflect SDOH and population health. The updated list offers providers and administrators a more comprehensive set of quality measures for conditions relevant to rural populations that may be feasible to implement in their facilities. The updated list can also promote alignment and inform the development of new measures. The group also underscored the rapidly evolving nature of healthcare in rural communities and emphasized the importance of regular updates

to the list of key rural measures and recommended summarizing best practices for implementing and monitoring measures in rural areas in the future.

IV. Implementation of Quality and Efficiency Measurement Initiatives (Performance Measurement)

Section 1890(b)(2) of the Social Security Act requires that "The entity shall provide for the endorsement of standardized healthcare performance measures. The endorsement process under the preceding sentence shall consider whether a measure—(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and (B) is consistent across types of healthcare providers, including hospitals and physicians."

Section 1890(b)(3) of the Social Security Act also requires that "The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed."

The CBE is required to describe these duties in this report pursuant to section 1890(b)(5)(A)(i)(I) of the Act.

NQF uses a structured, transparent, multistakeholder process to review and endorse quality measures submitted to NQF for endorsement that fully aligns with statutory requirements. NQF convenes diverse experts and stakeholders to review new and existing measures against NQF's rigorous, consensus-based measure evaluation criteria. The process supports the endorsement of measures that stakeholders agree reflect current evidence, are reliable and valid, are useful for accountability and quality improvement, and are feasible. The process takes into consideration measure importance, including how well measures support progress on national quality aims, and as noted above, considers measure alignment across programs.

In addition to maintaining a portfolio of NQF-endorsed measures, NQF also conducts additional projects that support improvements in measurement science and provide useful guidance to those who develop and implement measures. Below is an overview of the current NQF measure portfolio, as well as updates on ongoing cross-cutting projects.

NQF Measure Portfolio

Overview of the Endorsement and Maintenance Process

Through its E&M process, NQF convenes diverse stakeholders to set rigorous standards for quality measures as well as to endorse and maintain measures through inclusive, structured processes. High quality, standardized measures help stakeholders assess and address healthcare performance by highlighting whether the care provided is optimal and appropriate; identifying where to focus efforts to improve care; and allowing for comparisons across clinicians, hospitals, health plans, and other providers. Payers may use measures for a variety of reporting and accountability purposes.

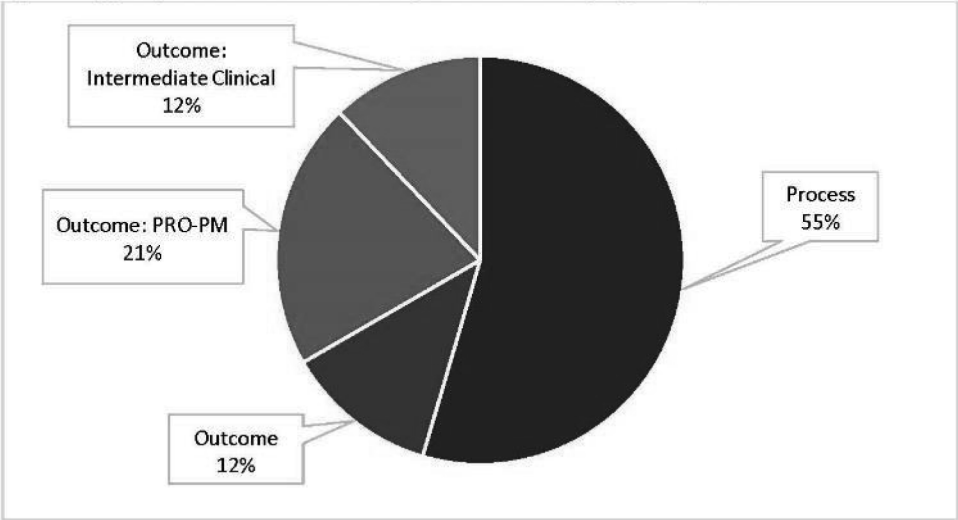
NQF's E&M process comprises six main components, including a request for candidate measures; a call for nominations to seat review committees; Standing Committee review of candidate measures; a public commenting period; an endorsement decision made by a governing body (the Consensus Standards Approval Committee [CSAC]); and an appeals period. Through this process NQF generates and maintains a portfolio of endorsed measures that meet NQF's rigorous evaluation criteria, ensuring they are up to date, reflective of the current evidence, reliable and valid, useful for accountability and quality improvement, and feasible. To keep the endorsed measure portfolio current and up to date, the E&M process also includes maintenance activities (i.e., a Committee review of previously endorsed measures to determine whether a measure should keep or lose endorsement.)

NQF's current endorsed measure portfolio represents 14 clinical and cross-cutting topic areas. From 2021 to 2022, NQF reviewed a total of 54 measures across a wide variety of topics reflecting some of the CMS National Quality Strategy focus areas, including health equity, COVID-19 vaccination coverage, rural health, and patient experience of care.

Table 1. Number of New and Maintenance Measures Reviewed During E&M Fall 2021/Spring 2022 Cycle (N=54)

Measure Cycle	Number of New Measures	Number of Maintenance Measures
Fall 2021	10	2
Spring 2022	18	24

Figure 2. Types of Measures Reviewed During E&M Fall 2021/Spring 2022 Cycles



Measure Endorsement and Maintenance Accomplishments

The results of the endorsement process during the spring and fall cycles follow below. Results are presented by portfolio: All-Cause Admissions and Readmissions, Behavioral Health and Substance Use, Cancer, Cardiovascular, Cost and Efficiency, Geriatrics and Palliative Care, Neurology, Patient Experience and Function, Patient Safety, Perinatal and Women's Health, Prevention and Population Health, Primary Care and Chronic Illness, Renal, and Surgery.

All-Cause Admissions and Readmissions

Unplanned hospital readmissions are associated with poor health outcomes and are a leading healthcare concern in the U.S. due to the implications for the quality of care provided to hospitalized patients as well as the healthcare costs associated with readmission.[13,14] Avoidable admissions and readmissions affect patients' daily lives and contribute to unnecessary healthcare spending.[15] In 2018, the U.S. had a total of 3.8 million adult hospital readmissions within 30 days among all payers, of which Medicare accounted for 60.3 percent (2.3 million readmissions) and Medicaid accounted for 19.0 percent (721,300 readmissions).[16] Furthermore, the average readmission rate for the U.S. is 14 percent, with an average readmission cost of $15,200, accounting for more than $17 billion in Medicare expenditures annually.[13,16] Preventable hospital readmissions are often attributed to structural and process issues, such as gaps in care coordination, rather than disease-specific factors.[17-19] This has prompted important study and discussion to meet quality goals while protecting access to necessary and appropriate care. The measures reviewed and endorsed by the Standing Committee for this portfolio align with the CMS National Quality Strategy goals of embedding quality into the care journey, increasing alignment, and promoting safety. The measures also align with Meaningful Measures 2.0's focus on aligning quality measures with quality improvement activities and improving patient safety.

The All-Cause Admissions and Readmissions portfolio currently includes 37 endorsed measures, including all-cause and condition-specific admissions and readmissions measures addressing numerous settings (e.g., hospital, hospital outpatient, ambulatory surgical centers [ASCs], skilled nursing facility [SNFs], home health, and accountable care organizations [ACOs]). Table 2 reports recent activity for the All-Cause Admissions and Readmissions portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 2. 2022 Updates to the All-Cause Admissions and Readmissions Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	The All-Cause Admissions and Readmissions Standing Committee evaluated two maintenance measures focused on unplanned readmissions among patients who enter an SNF from an acute care hospital and hospitalizations among long-term residents of SNFs. The Standing Committee recommended two measures for endorsement. The CSAC upheld the Standing Committee's recommendation and endorsed both measures.
Fall 2022 Cycle	Two measures were submitted for review.

Behavioral Health and Substance Use

Behavioral health disorders, including mental illness and SUD, affect millions of Americans, their families, and their communities. One in five U.S. adults, and 1 in 6 children, experience mental illness each year. In 2020, 17 million adults experienced co-occurring mental illness and SUD.[20,21] While these data demonstrate the prevalence of behavioral health disorders in the U.S., many Americans are not pursuing treatment for these conditions. Quality measurement and quality improvement tools remain important aspects of assessing and improving the treatment of behavioral health disorders. The measures reviewed by the Standing Committee for this portfolio align with the CMS National Quality Strategy goals of embedding quality into the care journey, advancing equity, and fostering patient engagement. The measures also align with the Meaningful Measures 2.0 goal of promoting health equity.

The Behavioral Health and Substance Use portfolio currently includes 34 endorsed measures, including measures for alcohol and drug use, care coordination, depression, medication use, the experience of care, tobacco use, and physical health. Table 3 reports recent activity for the Behavioral Health and Substance Use portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 3. 2022 Updates to the Behavioral Health and Substance Use Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	The Behavioral Health and Substance Use Standing Committee evaluated seven maintenance measures addressing depression screening, response, and remission; follow-up care for medication management; and continuity of care for withdrawal management. The Standing Committee recommended four measures for endorsement but did not recommend the three remaining measures. The CSAC upheld the Standing Committee's recommendations and endorsed the four recommended measures.
Fall 2022 Cycle	No measures were submitted for review.

Cancer

Cancer remains a significant burden to patients and the U.S. healthcare system. According to the National Cancer Institute (NCI), an estimated 15.7 million people live with cancer in the U.S.[22] In 2022 alone, an estimated 1.9 million new cancer cases were diagnosed in the U.S., and more than 600,000 people died of cancer.[24] Furthermore, a recent study estimates that the costs of cancer care could reach $222 billion in 2025.[23] Given these data points, cancer continues to be recognized as a national priority for quality improvement by HHS, CMS, and other healthcare stakeholders, including commercial payers and medical professional societies. These organizations are actively engaged in strategies to address quality of care issues in cancer, including the development and use of quality measures.[24-26] The measures in this portfolio align with CMS National Quality Strategy priorities by embedding quality into the care journey, advancing health equity, and fostering engagement between individuals and their care teams. These measures also align with Meaningful Measures 2.0 in their focus on promoting equity and closing gaps in care.

The Cancer portfolio currently includes 18 endorsed measures, including measures for hematologic cancers (e.g., lymphomas, leukemias, and myelomas), breast cancer, colon cancer, prostate cancer, and other cancer measures. Table 4 reports recent activity for the Cancer portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 4. 2022 Updates to the Cancer Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	No measures were submitted for review.
Fall 2022 Cycle	No measures were submitted for review.

Cardiovascular

Cardiovascular disease (CVD) is the foremost cause of death in the U.S., leading to approximately 1 in 4 deaths per year and significantly impacting most ethnic and racial groups.[27,28] In addition, heart disease is the highest direct health expenditure in the U.S. From 2016 to 2017, heart disease accounted for 13 percent of healthcare expenditures and was responsible for approximately $363 billion of accrued cost annually to the U.S. healthcare system (direct costs [i.e., cost of physicians and other professionals, hospital services, prescribed medications, and home healthcare] and indirect costs [i.e., lost productivity]).[27] The ongoing COVID-19 pandemic has heightened existing health inequities related to CVD and adds importance and urgency to the measures in this portfolio. This work aligns with the CMS National Quality Strategy's focus on embedding quality in the care journey, advancing health equity, promoting safety, and fostering engagement between individuals and their care teams. These measures similarly align with Meaningful Measures 2.0 in their efforts to promote health equity.

The Cardiovascular portfolio currently includes 39 endorsed measures, including primary prevention and screening, coronary artery disease (CAD), ischemic vascular disease (IVD), acute myocardial infarction (AMI), cardiac catheterization, percutaneous catheterization intervention (PCI), heart failure (HF), rhythm disorders, implantable cardioverter-defibrillators (ICDs), cardiac imaging, cardiac rehabilitation, and high blood pressure. Table 5 reports recent activity for the Cardiovascular portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 5. 2022 Updates to the Cardiovascular Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	No measures were submitted for review.
Fall 2022 Cycle	Four measures were submitted for review.

Cost and Efficiency

U.S. healthcare spending was estimated to have reached $4.3 trillion per year and is projected to have grown by 4.2 percent in 2021.[29] Total spending is projected to increase to $6.8 trillion per year by 2030.[29] Currently, U.S. healthcare costs are growing 1.1 percent faster than the annual gross domestic product (GDP), and it is estimated that U.S. healthcare spending will account for almost 20 percent of the GDP by 2028.[29] Medicare is expected to experience the fastest spending growth due to having the

highest projected enrollment growth (7.6 percent per year over 2019–2028).[30] U.S. hospital spending and physician and clinical service spending rates were also expected to increase in 2022 (6.9 percent for hospital spending and 6.2 percent for physician and clinical service spending).[29] Compared to other high-income countries, the U.S. has worse health outcomes and mortality rates while having the highest costs.[31] Resource use must be examined to improve efficiencies and value in the healthcare delivery system. The measures overseen by the Cost and Efficiency Standing Committee support the CMS National Quality Strategy goal of improving alignment and the Meaningful Measures 2.0 goal of streamlining and aligning quality measurement.

The Cost and Efficiency portfolio currently includes 13 endorsed measures, including both condition-specific and non–condition-specific measures, cost and resource measures, and broader efficiency measures. Table 6 reports recent activity for the Cost and Efficiency portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 6. 2022 Updates to the Cost and Efficiency Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	The Cost and Efficiency Standing Committee evaluated three newly submitted measures focused on Medicare spending per beneficiary. These measures examined elective primary hip arthroplasty, nonemergency coronary artery bypass graft (CABG), and lumbar spine fusion for degenerative disease. All three measures were recommended for NQF endorsement. The CSAC upheld the Standing Committee's recommendation and endorsed all three measures.
Fall 2022 Cycle	No measures were submitted for review.

Geriatrics and Palliative Care

Palliative care focuses on improving the quality of life for people living with a serious illness by easing pain and discomfort and relieving the stress and symptoms associated with a severe medical illness.[32,33] It aims to improve the quality of life for the patient and those who care for the patient. Palliative care is beneficial to patients and their families, as it provides mental and physical comfort while allowing the continuation of curative measures and prolonging survival.[34,35] The need for palliative care is highlighted by the increasing population of individuals ages 65 and older in the U.S. In 2019, more than 1 in every 7 Americans were over the age of 65, which totaled approximately 54.1 million older American adults (i.e., 16 percent of the total U.S. population).[36] Additionally, the provision of palliative care lowers healthcare expenditures, thereby increasing cost savings with an average of $3,237 per hospital stay per patient.[37-39] The measures stewarded by this Standing Committee are aligned with the CMS National Quality Strategy goals of embedding quality in the care journey, fostering patient engagement, and promoting safety and alignment, as well as the Meaningful Measures 2.0 goals of increasing caregiver engagement in measure development and aligning quality measures with quality improvement activities.

The Geriatrics and Palliative Care portfolio currently includes 35 endorsed measures, including measures related to physical, spiritual, religious, ethical, and legal aspects of palliative/end-of-life (EOL) care; general care of the patient nearing the EOL; and measures relating to geriatrics. Table 7 reports recent

activity for the Geriatrics and Palliative Care portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 7. 2022 Updates to the Geriatrics and Palliative Care Portfolio

Cycle	Measures Reviewed
Fall 2021 **Cycle**	The Geriatrics and Palliative Care Standing Committee evaluated three newly submitted measures. One measure focused on hospice visits in the last days of life, and the other two measures were PRO-PMs focusing on ambulatory care palliative patients' experience of feeling heard and understood, as well as receiving desired help for pain. The Standing Committee recommended all three measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed all three measures.
Spring 2022 **Cycle**	The Geriatrics and Palliative Care Standing Committee evaluated four maintenance measures undergoing maintenance review. Measures reviewed during this cycle focused on timely enrollment in palliative and hospice services, reduction of aggressive EOL interventions, and documentation of patient treatment preferences. The Standing Committee recommended three measures for endorsement. For the fourth measure, the Standing Committee recommended the measure at the facility level but not at the clinician-group level. The CSAC upheld the Standing Committee's recommendation and endorsed all four measures according to the recommendations.
Fall 2022 Cycle	Seven measures were submitted for review.

Neurology

Neurological conditions affect the brain, spinal cord, and nerves found throughout the body. The Global Burden of Disease study found that stroke, Alzheimer's and other dementias, and migraine headaches are the three most burdensome neurological conditions in the U.S. Additionally, the study found that due to an increasingly aging population, many neurological disorders are rising in prevalence, incidence, and mortality, impacting absolute numbers of disability-adjusted life years (DALYs).[32] Measuring the quality of care is a fundamental step toward improving healthcare outcomes, and quality measures are increasingly used in value-based purchasing (VBP) applications and maintenance of certification requirements. The measures overseen by the Neurology Standing Committee align with the CMS National Quality Strategy's focus on embedding quality into the care journey and advancing health equity as well as the Meaningful Measures 2.0 goal of leveraging quality measures to promote health equity and close gaps in care.

The Neurology portfolio currently includes 14 endorsed measures, including measures for stroke, subarachnoid and intracerebral hemorrhage, dementia, and carotid stenosis. Table 8 reports recent activity for the Neurology portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 8. 2022 Updates to the Neurology Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	No measures were submitted for review.

Cycle	Measures Reviewed
Fall 2022 Cycle	No measures were submitted for review.

Patient Experience and Function

Patient experience and function (PEF) is an important measure topic area that encompasses patient functional status, satisfaction, the experience of care, and issues related to care coordination. While it is a desirable outcome unto itself, positive patient experience of care has also been shown to be associated with improved clinical outcomes.[40,41] The U.S. healthcare delivery system has increasingly embraced the idea of ensuring each person, family, and caregiver is engaged within a care partnership, which is critical to achieving better patient outcomes.[42] Care coordination measures spanning the continuum of care are important for the success of promoting quality care delivery, better patient experiences, and more meaningful outcomes.[43-45] Well-coordinated care includes effective shared communication and decision making among all patients and providers across the care spectrum and supports accountable structures and processes in place for the integration of comprehensive plans of care across providers and settings.[46-48] The measures in the PEF portfolio align with the CMS National Quality Strategy goals of fostering engagement between individuals and their care teams, advancing health equity, and embedding quality into the care journey. PEF measures also align with the Meaningful Measures 2.0 goals due to their focus on promoting health equity, expanding and prioritizing caregiver engagement during the measure development process, and increasing the number of PRO-PMs.

The PEF portfolio currently includes 42 endorsed measures, including measures on functional status change and assessment, shared decision making, care coordination, patient experience, and long-term services and support measures. Table 9 reports recent activity for the PEF portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 9. 2022 Updates to the Patient Experience and Function Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	No measures were submitted for review.
Fall 2022 Cycle	Five measures were submitted for review.

Patient Safety

While widespread efforts have been made over the past 20 years to reduce preventable harm across healthcare arenas, mistakes continue to happen, with more than 200,000 patients annually suffering from hospital errors, injuries, accidents, and infections.[49] Patient safety and high quality care remain a top priority for the U.S.[50] Patient safety is not only about providing safe and efficient care but also about promoting a culture of safety across the continuum of healthcare settings. An environment that fosters equitable psychological safety in reporting errors, implementing solutions, and adopting system improvements is vital to harm reduction.[51] All healthcare team members and systems significantly impact the delivery of care and the culture of the environment in which care is delivered. The work of the Patient Safety Standing Committee directly connects with the CMS National Quality Strategy goals of embedding quality into the care journey, advancing health equity, promoting safety, and embracing the

digital age through interoperable and shared data. Patient Safety measures also align with the Meaningful Measures 2.0 goal of promoting health equity to close gaps in care and streamlining quality measurement to align with quality improvement activities.[49]

The Patient Safety portfolio currently includes 51 endorsed measures, including measures on medication safety, healthcare-associated infections, perioperative safety, falls, mortality, venous thromboembolism, pressure ulcers, workforce safety, and radiation safety. Table 10 reports recent activity for the Patient Safety portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 10. 2022 Updates to the Patient Safety Portfolio

Cycle	Measures Reviewed
Fall 2021 **Cycle**	The Patient Safety Standing Committee evaluated four newly submitted measures and one maintenance measure. Measures reviewed during this cycle focused on unintended weight loss, COVID-19 vaccination coverage, and radiation exposure from computed tomography (CT) scans. The Standing Committee recommended all five measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed all five measures.
Spring 2022 **Cycle**	The Patient Safety Standing Committee evaluated three newly submitted measures and three maintenance measures. The measure topics reviewed include the inappropriate diagnosis of illness in hospitalized medical patients, pediatric CT radiation dosing, measuring the nursing work environment, and reducing blood culture contamination rates. The Standing Committee recommended all six measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed all six measures.
Fall 2022 Cycle	Five measures were submitted for review.

Perinatal and Women's Health

Women in the U.S. face a variety of health and wellness concerns during pregnancy and childbirth. Despite spending nearly 1 in every 5 dollars on healthcare expenditures, which is more than twice that of other high-income countries (i.e., Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom), the U.S. continues to have the highest maternal morbidity and mortality rates among these countries.[52] A 2020 report published by the Commonwealth Fund found that while most maternal deaths are preventable, the U.S. rates for maternal deaths have continued to increase rather than decrease since 2000. Data also show significant disparities for marginalized women (including those with demographic, economic, and other social risk factors) in maternal and infant morbidity and mortality, health screenings and prevention, and the treatment of preventable conditions. In 2020, the U.S. maternal mortality rate was 28.3 deaths per 100,000 live births, increasing to 55.3 deaths per 100,000 live births for non-Hispanic Black populations.[53] Maternal health disparities vary across the country based on ethnicity, socioeconomic status, and access to quality healthcare. Lack of access to high quality care decreases the opportunity for the identification of risk factors and mitigation of conditions that lead to poor outcomes. Appropriate care and management of pregnancy and childbirth are essential to the health and wellness of women and their families across the nation. The measures overseen by the Perinatal and Women's Health Standing Committee align with the CMS National Quality Strategy and Meaningful Measures 2.0 goals of

promoting health equity and closing gaps in care. These measures also align with the CMS National Quality Strategy goal of promoting safety.

The Perinatal and Women's Health portfolio currently includes 13 endorsed measures, including measures for life-threatening maternal or newborn complications, cesarean delivery, and contraception. Table 11 reports recent activity for the portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 11. 2022 Updates to the Perinatal and Women's Health Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	The Perinatal and Women's Health Standing Committee evaluated four newly submitted measures addressing reproductive health for both pregnant and nonpregnant women. These measures focus on severe obstetric complications, cesarean birth, and the self-identified need for contraceptive care. The Standing Committee recommended one measure for endorsement and two measures for trial use. The Standing Committee did not recommend one measure for endorsement; however, the measure developer submitted an appeal to the CSAC, with which the CSAC agreed. Therefore, the endorsement determination is not yet final. The Standing Committee will re-evaluate this measure in 2023.
Fall 2022 Cycle	No measures were submitted for review.

Prevention and Population Health

Prevention and population health services play a key role in the mitigation of disease and the improvement of the nation's health. Prevention and population health services are often characterized by routine disease screening practices and various risk assessment methods, as well as early disease detection and treatment. The results of these activities support the achievement of positive health outcomes within an identified population. A study revealed that primary clinical preventive services have an estimated net savings of $7 billion on personal health expenditures.[54] Population health activities also target the reduction of health inequities and disparities across populations; however, nearly 50 percent of health outcomes are affected by SDOH, which include housing, food and nutrition, transportation, social and economic mobility, education, and environmental conditions.[55] The prevention-based population health approach remains a relevant practice across all domains of disease control and provides a commonly shared roadmap for clinical health professionals to optimally engage their patients. The Prevention and Population Health Standing Committee oversees measures that directly align with the CMS National Quality Strategy and Meaningful Measures 2.0 goals of promoting health equity and closing gaps in care.

The Prevention and Population Health portfolio currently includes 21 endorsed measures, including measures for dental care, cancer screenings, immunizations, and well-child visits. Table 12 reports recent activity for the Prevention and Population Health portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 12. 2022 Updates to the Prevention and Population Health Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.
Spring 2022 Cycle	The Prevention and Population Health Standing Committee evaluated two newly submitted measures and four maintenance measures. Measures reviewed during this cycle focused on topical fluoride for cavity prevention and influenza vaccination. The Standing Committee recommended all six measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed all six measures.
Fall 2022 Cycle	Three measures were submitted for review.

Primary Care and Chronic Illness

Primary care is a multidimensional framework that serves as the primary medical resource for patients to access equitable and affordable quality healthcare. Primary care encompasses health maintenance and promotion, disease prevention, counseling, patient education, and diagnosing and treating acute and chronic illnesses. Chronic diseases, broadly defined as conditions lasting a year or more and requiring continuous medical attention, are the leading causes of illness, disability, and death in the U.S.[56] Chronic diseases, such as cancer, heart disease, and diabetes, account for most of the nation's $4.1 trillion healthcare expenditures.[57] Healthcare costs are expected to grow at an average rate of 5.4 percent between 2019 and 2028, reaching $6.2 trillion by 2028.[30] The measures in the Primary Care and Chronic Illness portfolio align with the CMS National Quality Strategy goals of embedding quality into the care journey, advancing health equity, and fostering patient engagement. They also align with the Meaningful Measures 2.0 goal of promoting health equity and closing gaps in care.

The Primary Care and Chronic Illness portfolio currently includes 61 endorsed measures related to primary care and management of chronic disease, including nonsurgical procedures for eyes, ears, nose, and throat conditions; diabetes care; osteoporosis; HIV; rheumatoid arthritis; gout; back pain; asthma; chronic obstructive pulmonary disease (COPD); and acute bronchitis. Table 13 reports recent activity for the Primary Care and Chronic Illness portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 13. 2022 Updates to the Primary Care and Chronic Illness Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	The Primary Care and Chronic Illness Standing Committee evaluated two newly submitted measures and one measure undergoing maintenance review. These measures focused on monitoring patients' days at home and out of the hospital, biomarker genetic testing of surgical pathology reports in some cancers, and behavioral health assessments in children. The Standing Committee recommended two measures for endorsement but did not recommend the remaining measure for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed the two recommended measures.

Cycle	Measures Reviewed
Spring 2022 Cycle	The Primary Care and Chronic Illness Standing Committee evaluated one newly submitted measure and three measures undergoing maintenance review. Measures reviewed during this cycle focused on several clinical areas, including asthma care, specifically emergency department (ED) visits for children post-discharge; Transcranial Doppler (TCD) ultrasonography screening among children with sickle cell anemia (SCA); diabetes care; and lung cancer operative-associated morbidity and mortality. The Standing Committee recommended all four measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed the four recommended measures.
Fall 2022 Cycle	No measures were submitted for review.

Renal

Chronic kidney disease (CKD) has emerged as one of the most prominent causes of morbidity and mortality in the 21st century.[58] Worldwide, kidney disease has increased in prevalence from 2000 to 2019 and rose from the 13th leading cause of death to the 10th.[59] In 2020, it was the 10th leading cause of death in the U.S.[60] It is also estimated that 37 million adults in the U.S. have CKD.[61] If CKD is not treated, it can progress to end-stage renal disease (ESRD), which is treated via dialysis or a kidney transplant. The Centers for Disease Control and Prevention (CDC) estimate that 360 new people per day begin dialysis treatment.[61] The selection of treatment and the education accompanying the treatment are critical factors for the overall cost and quality of patient outcomes. Treating kidney disease has also led to increased Medicare expenditures. In 2019, treating those with CKD cost $87.2 billion, and treating those with ESRD cost $37.3 billion.[61] The measures overseen by the Renal Standing Committee align with the CMS National Quality Strategy goals of advancing health equity, improving patient safety, and embedding quality in the care journey. The measures also align with Meaningful Measures 2.0 goals of promoting health equity and streamlining quality measurement to align with quality improvement activities.

The Renal portfolio currently includes 17 endorsed measures, including measures for hemodialysis, standardized mortality and transfusion ratios, phosphorus concentration, hypercalcemia, pediatric hemodialysis, angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, optimal ESRD treatment cycle starts, and bloodstream infections in hemodialysis patients. Table 14 reports recent activity for the Renal portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 14. 2022 Updates to the Renal Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	No measures were submitted for review.

Cycle	Measures Reviewed
Spring 2022 Cycle	The Renal Standing Committee reviewed five newly submitted measures and one maintenance measure. These measures focused on the rate of fistula use, the ratio of switches from in-center to home dialysis, the timely start of renal replacement therapy, and timely access to kidney or kidney-pancreas transplants. The Standing Committee recommended two of the six measures for endorsement. The CSAC upheld the Standing Committee's recommendations and endorsed the two recommended measures.
Fall 2022 Cycle	Three measures were submitted for review.

Surgery

Patients undergo surgery to repair an injury, relieve symptoms, restore function, remove diseased organs, and replace diseased body parts. Many surgeries are planned, though several types occur under emergency conditions, such as trauma, burns, and fracture. For example, in the U.S., more than 1 million total knee and total hip procedures occur annually, a number that is expected to rise with the aging population.[62] By 2030, it is estimated that roughly 2 million arthroplasties will be performed annually, with an accrued cost of nearly $50 billion each year.[62] The measures reviewed and endorsed by the Surgery Standing Committee align with the CMS National Quality Strategy and Meaningful Measures 2.0 goals of promoting health equity. These Surgery measures also align with the CMS National Quality Strategy goals of promoting patient safety and fostering engagement between individuals and their care teams.

The Surgery portfolio currently includes 57 endorsed measures, including measures on perioperative safety; general surgery; and specialty surgeries, including cardiac, cardiothoracic, colorectal, ocular, orthopedic, urogynecology, and vascular surgery. Table 15 reports recent activity for the Surgery portfolio during the fall 2021, spring 2022, and fall 2022 measure cycles.

Table 15. 2022 Updates to the Surgery Portfolio

Cycle	Measures Reviewed
Fall 2021 Cycle	The Surgery Standing Committee evaluated one newly submitted measure: a PRO-PM focused on providing information to patients and clinicians about clinician and clinician group-level, risk-standardized PROs, such as pain and functional status, following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). The Standing Committee recommended the measure for endorsement. The CSAC upheld the Standing Committee's recommendation and endorsed the measure.
Spring 2022 Cycle	No measures were submitted for review.
Fall 2022 Cycle	No measures were submitted for review.

Cross-Cutting Initiatives to Improve the Measurement Process

With funding from CMS, NQF implemented several projects that advance consensus on measurement science and policy. The measurement activities described in these cross-cutting projects span care settings and providers and deliver practical insights for a wide variety of patients, providers, and payers.

This year's cross-cutting work advanced progress on high-priority measures through projects that refined guidance and established strategies (i.e., strategies that: (1) addressed social risk factors in risk adjustment, (2) addressed barriers to the development of digital PRO-PMs, and (3) furthered patient and caregiver engagement in NQF's review of measures for endorsement).

Cross-Cutting Initiative: Best Practices for Developing and Testing Risk Adjustment Models

Risk adjustment is a statistical method that can be applied to certain types of healthcare quality measures to account for different characteristics that put some patients at greater risk of worse health outcomes. Using risk adjustment to account for differences in clinical factors, such as severity of illness or other health conditions, is widely accepted and widely implemented in quality measurement to ensure fair comparisons across providers. However, adjusting for social factors, like income or education, and functional risk factors, such as the ability to perform activities of daily living, is not yet standard practice and merits careful consideration.

There is broad agreement that quality measurement must support efforts to improve health equity and that measures should not be biased. Yet, the root causes of inequities that affect health outcomes are multiple and often interrelated, and the question of whether and how to use risk adjustment to account for social and functional risk is a matter of significant debate. Both proponents and critics of adjusting for social risk factors point to concerns about possible unintended consequences. Those who favor adjustment note that failure to account for social risk factors in performance metrics can result in lower scores for providers that care for populations with high social risk and might, therefore, cause them to avoid caring for these populations. On the other hand, opponents argue that adjusting measures obscures true disparities in care and fails to promote further investment in achieving health equity.

In 2022, NQF completed and released Technical Guidance for developing risk adjustment models to facilitate unbiased healthcare quality measurement and to advance health equity. The Technical Guidance addresses a longstanding need for standardization and transparency by providing a step-by-step process for developing and testing risk models that consider social and functional risk. As the shift to value-based payment programs closely linking payment to quality has taken hold, it has highlighted the importance of understanding and accounting for the impact social factors have on healthcare quality assessments.

The Guidance is the result of a two-year effort. In the first year, NQF conducted an environmental scan, convened a Technical Expert Panel (TEP), and solicited public input to produce the initial draft guidance. During this second year, the draft guidance was vetted through a series of focus groups that included representatives from patient groups, clinicians, public and private health system administrators, risk adjustment methodologists, and NQF-convened measure evaluation Committees. With keen attention to divergent perspectives, NQF placed particular emphasis on gathering feedback from stakeholders with contrasting viewpoints to the Guidance and from historically, medically underserved communities.

Based on the input from stakeholders and the TEP, the final Technical Guidance identifies several key areas of consensus and defines seven risk adjustment best practices. Among other practices, it recommends that measure developers prepare a conceptual model that illustrates the potential

pathways between the social and/or functional risk factors, patient clinical risk factors, and the measured outcome. It establishes a minimum set of social and functional risk factors to consider within the overall risk adjustment strategy. It reflects the consensus that race is qualitatively different from other social risk factors and should be considered for adjustment on a case-by-case basis. And it articulates guidance for stratification analyses, as this can be a critical tool for reporting on differences in measure results between patient subgroups.

The specific design of risk adjustment models is left up to developers. The statistical approaches identified within the Guidance are not intended to be overly prescriptive as to limit the use of novel methods or to add significant burden to measure developers. The Guidance is intended to facilitate greater consistency in the development and evaluation of risk adjustment models by guiding developers through a step-by-step process to get there.

Cross-Cutting Initiative: Building a Roadmap From Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures

PRO-PMs are unique quality measures that are specifically designed to elevate patients' voices in quality assessment. PRO-PMs are measures that assess quality using patient responses to patient-reported outcome measure (PROM) survey instruments. PRO-PMs therefore reflect quality as uniquely informed by patients' direct self-report of their outcomes.[63] Healthcare stakeholders, including professional societies across multiple disciplines, healthcare information technology (IT) providers, and federal agencies, recognize PRO-PMs as an important opportunity in quality measurement. CMS has repeatedly expressed its support for digital PRO-PMs, including through Meaningful Measures 2.0 (which explicitly identifies the importance of "prioritizing outcome and patient-reported measures") and the CMS National Quality Strategy goals of fostering engagement with patients and embracing the digital age. At present, PRO-PMs compose less than seven percent of all NQF-endorsed quality measures, and only one PRO-PM was included on the CMS list of Merit-Based Incentive Payment System (MIPS) quality measures for 2022.[64,65]

Challenges continue to hamper the broad adoption of these measures. PROMs, the tools on which PRO-PMs are based, have not become standard in clinical practice, and their implementation requires data gathering and clinical workflow changes. Patients lack awareness about the benefits of PROMs and PRO-PMs, such as the ability to compare outcomes across different clinicians, hospitals, and health plans, and may not prioritize responding to PROMs. PRO-PMs are also complex measures, and measure developers lack thorough yet accessible technical guidance to develop high quality performance measures based on patient-reported data.[66,63] Digital measurement is uniquely challenging for PRO-PMs, in part due to the reliance on data that patients digitally generate.

To further the development and use of PRO-PMs, in 2022 CMS and NQF continued the Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures project to continue addressing the need for straightforward guidance to help developers navigate the unique challenges of developing digital PRO-PMs. To update guidance helpful for developers with different levels of experience and at different stages in their careers, NQF worked with a 22-member Technical Expert Panel (TEP) representing the combined experience and perspectives of

measure developers, health IT professionals, clinicians, researchers, payers, patients, and others. This initiative produced the updated Building a Roadmap From Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures technical guidance report that serves as a catalyst for building a more robust database of digital PRO-PMs, which will ultimately elevate patient voices and prioritize outcomes that matter to patients.

Cross-Cutting Initiative: Patient and Caregiver Engagement

Including patient advisors' perspectives (i.e., those who provide the primary perspective of patients, caregivers, and patient advocates) throughout the measure development and endorsement process is essential for quality measurement. In 2022, NQF convened the PACE Advisory Group, composed of 14 patient advisors, on a quarterly basis. The Advisory Group provided guidance on how to best prepare patient advisors to effectively participate in NQF's Standing Committees. The PACE Advisory Group helped brainstorm opportunities to increase participation of patient advisors in the E&M process, reviewed E&M pre-evaluation survey questions for readability and understandability, and provided feedback on a pilot mentorship program to pair new patient advisors with more experienced patient advisors. NQF also continued to offer an honorarium to mitigate the financial barriers that could hinder the participation of patient advisors in Standing Committees. Engaging patients and caregivers aligns with the CMS National Quality Strategy by fostering engagement, promoting equity, and ensuring quality in the care journey. This effort also aligns with the Meaningful Measures 2.0 goals of empowering consumers and closing gaps in care.

V. Stakeholder Recommendations on the Priority-Setting Process

Section 1890(b)(7)(A)(i) of the Social Security Act (the Act) requires that "The entity shall convene multistakeholder groups to provide input on (i) the selection of certain quality and efficiency measures from among: (I) such measures that have been endorsed by the entity; and (II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality and efficiency measures; and (ii) national priorities (as identified under section 280j of this title) for improvement in population health and in delivery of healthcare services for consideration under the national strategy established under section 280j of this title." The CBE is required to describe these duties in this report pursuant to section 1890(b)(5)(A)(i)(VI) of the Act.

Under section 1890A(a) of the Act, the HHS Secretary "shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality and efficiency measures described in the consensus-based entity section 1395aaa(b)7(B) of this title:

(1) Input - Pursuant to section 1395aaa(b)7 of this title, the entity with a contract under section 1395aaa (currently NQF) shall convene multistakeholder groups to provide input to the Secretary on the selection of quality and efficiency measures for use in certain federal programs described in subparagraph (B) of such paragraph.

(2) Public Availability of Measures Considered for Selection - Not later than December 1 of each year (beginning with 2011), the Secretary shall make available to the public a list of quality and efficiency measures described in section 1395aaa(b)7(B) of this title that the Secretary is considering for selection.

(3) Transmission of Multi-Stakeholder Input - Pursuant to section 1395aaa(b)8 of this title, not later than February 1 of each year (beginning with 2012), the consensus-based entity shall transmit to the Secretary the input of the multistakeholder groups described in paragraph (1).

(4) Consideration of Multi-Stakeholder Input - The Secretary shall take into consideration the input from the multistakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1395aaa(b)."

Overview of the Measure Applications Partnership

The MAP is a multistakeholder set of committees convened by NQF that brings together consumers and patients, purchasers, health plans, clinicians and providers, community and state agencies, and suppliers to advise CMS on measures proposed for use in specific CMS public-reporting and value-based payment programs. Since 2011, CMS has called on the MAP to convene multistakeholder groups that review and provide recommendations to HHS on which measures to use in select public-reporting and performance-based payment programs (Appendix C). The MAP provides input to HHS so that the measures used in federal programs address national healthcare priorities, fill critical measurement gaps, and increase public-private payer alignment. The MAP's reviews and recommendations directly support the CMS National Quality Strategy and Meaningful Measures 2.0 goals to use the highest value and highest-impact measures in key quality domains, integrate quality into the care journey, use measures to drive outcome improvement, advance health equity, promote safety, support the digital age, incorporate patients' voices, and align measures across public and private entities. During its most recent deliberations, the MAP considered the need for validity and the burden of proposed and actively used measures across a wide scope of topics, including health equity, COVID-19, person-centered care, rural health, and care coordination.

The MAP operates under a three-part structure consisting of the following: (1) a Coordinating Committee, (2) three setting-specific Workgroups (i.e., Clinician, Hospital, and Post-Acute Care/Long-Term Care [PAC/LTC]), and (3) two Advisory Groups (i.e., Rural Health and Health Equity). The Coordinating Committee provides strategic direction and final approval of the measure

recommendations. The three Workgroups advise the Coordinating Committee on measures for specific care settings, care providers, and patient populations. The two Advisory Committees provide feedback to the Workgroups on cross-cutting issues. For example, the Rural Health Advisory Group provides input on access, cost, or quality issues encountered by rural residents, data collection and/or reporting challenges, and potential unintended consequences for rural providers when reviewing proposed measures. The Health Equity Advisory Group provides feedback on relevant SDOH; methodological challenges related to data collection, stratification, and risk adjustment; and potential unintended consequences when reviewing proposed measures.

The MAP consists of two processes: the Measures Under Consideration (MUC) process and the Measure Set Review (MSR) process.

Measures Under Consideration (MUC) Process. The annual MUC process begins with a public call for measures, after which CMS selects candidate measures that HHS is considering adopting, through the federal rulemaking process, for use in Medicare reporting and value-based payment programs. This list of candidate measures is referred to as the measures under consideration (MUC) list. The MAP convenes to review the measures on the list and make recommendations about whether the proposed measures are appropriate for use in select federal healthcare quality programs. The recommendations are published in a notice of proposed rulemaking in the *Federal Register*. The Workgroups use the MAP-developed measure selection criteria (MSC) to assess how well each measure fits the needs of a specified program and make one of the following determinations for each candidate measure: support for rulemaking, conditional support for rulemaking, do not support for rulemaking with potential for mitigation, or do not support for rulemaking.

Measure Set Review (MSR) Process. The 2021 Consolidated Appropriations Act expanded the role of the CBE and allowed it the opportunity to "provide input to the Secretary on quality and efficiency measures that could be considered for removal"[1] from select public-reporting and performance-based payment programs. In 2022, NQF expanded the MAP's scope to include the MSR process. The Workgroups use the MAP-developed Measure Review Criteria (MRC) to identify measures that no longer meet program priorities and provide valuable information for public-reporting and payment systems. The MAP makes one of the following determinations for each nominated measure: support for retaining, conditional support for retaining, conditional support for removal, or support for removal.

Within this section of the report, NQF will reference and describe enhancements to the MAP process in 2022 and recommendations resulting from the 2021–2022 MUC and 2022 MSR cycles.

2022 Enhancements to the MAP Process: MSR Process Implementation for Workgroups and Advisory Groups

During the 2022 cycle, NQF expanded the MSR process based on feedback on the criteria and processes from the 2021 pilot. The pilot process only included a review of measures by the Coordinating Committee. In the 2022 cycle, NQF expanded the process to include measure reviews by the three setting-specific Workgroups and two Advisory Groups, added two public comment opportunities, and piloted a consent calendar process. To begin the MSR process, NQF and CMS worked together to select

federal programs for review conducted by the MAP. The Workgroups and Advisory Groups then responded to a survey nominating measures to discuss for removal from the selected programs, using the MRC to inform their decisions. NQF posted the measures with the most survey votes for public comment, then sent the measures to the MAP Workgroups and Advisory Groups for discussion. The measures were then sent to the Coordinating Committee, using a consent calendar to facilitate and focus the review. More specifically, the process placed measures with strong consensus (i.e., 80 percent or more of the Workgroup voting for the same decision category) on the consent calendar. The process calls for pulling measures from the consent calendar if no consensus was reached, a strong consensus was not reached, or the Committee members requested to pull the measures with a clear and compelling rationale. The Coordinating Committee discussed those measures that were pulled from the consent calendar.

2021–2022 MAP Measures Under Consideration Cycle Results

The MAP published the results of its 2021–2022 pre-rulemaking deliberations in February and March of 2022. The MAP made recommendations on 29 unique measures for 13 federal programs, including several cross-setting measures considered for multiple programs, resulting in 44 measure-program pairs. Measure alignment, health equity, risk adjustment, and PROs were common themes throughout the cycle, not only in member discussion but also in the public comments. Members also emphasized the important role of cross-setting digital and safety measures to prevent critical clinical safety events in the inpatient setting.

Rural Health Advisory Group Recommendations

The Rural Health Advisory Group reviews MUCs in order to highlight issues that may be particularly relevant to rural populations, such as access, cost, or quality issues encountered by rural residents, data collection and/or reporting challenges, and potential unintended consequences for rural providers. This input directly supports HHS' commitment to better understand and improve outcomes for patients in rural areas throughout the U.S.

As part of the MAP's annual pre-rulemaking process, the Rural Health Advisory Group: (1) provides input to the MAP Workgroups on any potential rural health issues related to MUCs; (2) identifies gaps in measurement that might specifically impact rural settings; and (3) provides recommendations regarding priority rural measurement challenges, including low case-volume and access to care.

Key themes from the Rural Health Advisory Group's discussion included the following:

1. Low case-volume could affect the reliability of measures that address specialty procedures and conditions instead of cross-cutting topics, such as medication safety, immunizations, obstetric care, and kidney health.
2. Risk adjustment is especially important to fairly interpret and compare performance for rural providers. Rural patients are more likely to have unique risk factors (e.g., they may be more likely to work physically demanding jobs, which can impact outcomes after hip or knee surgery) and rural practices tend to have limited resources in which rural providers cannot always affect the social needs of their patients.

3. Availability of services and access to specialty care can be a challenge for rural patients and providers. These issues can lead to loss-to-follow-up situations in their patient population, and data collection for rural providers can be especially difficult.
4. Reporting burden tends to have a higher impact on rural providers. Rural settings may have lower overall staffing numbers, thus placing greater reporting burden on the clinician. Rural providers who have been unable to update their infrastructure may score poorly or have incomplete data for measures that depend on EHR data.
5. The newly established Rural Emergency Hospitals program should focus on measures related to care coordination and communication (e.g., understanding transfers) and focus measurement on measures with low reporting burden.

Health Equity Advisory Group Recommendations

New to the 2021–2022 MAP cycle, NQF convened a Health Equity Advisory Group to provide input on MUCs to HHS with a lens to measurement issues affecting health disparities and the 1,000-plus U.S. critical access hospitals (CAHs). The Health Equity Advisory Group provides input on MUCs with the goal of reducing health differences closely linked with social, economic, or environmental disadvantages. This input aligns with the CMS National Quality Strategy and Meaningful Measures 2.0 goals to advance health equity and leverage quality measures to close gaps in care.

During the MAP's annual pre-rulemaking process, the Health Equity Advisory Group: (1) provides input to the MAP Workgroups on measurement issues affecting CAHs, (2) identifies health disparities affecting MUCs, measures under review, and disparity-related gaps in measurement, and (3) provides recommendations to reduce disparities that are linked to SDOH.

Key themes from the Health Equity Advisory Group's discussion included the following:

- Potential categories of stratification could include age, sex, race, ethnicity, English proficiency, gender identity, sexual orientation, visit type, insurance, disability, markers of economic disparities, rurality, setting type, etc.
- Measures should only be stratified where appropriate rather than stratifying measures by all categories. The group emphasized the need for guidance on standardized data collection and the stratification of measures.
- Equity should be considered throughout the measure development process (e.g., understanding access to procedures and treatments, focusing on conditions with known disparities, translating and validating PRO-PM tools, and testing measures with diverse patient populations).
- Improving health equity will be an iterative process, and organizations should monitor the use of equity measures for any unintended consequences, especially for measures tied to payment that could reduce funding for low-resource facilities.

Clinician Workgroup Recommendations

The MAP Clinician Workgroup provides recommendations for coordinating clinician performance measurement across federal programs, including feedback on the alignment of measures and data sources to reduce burden, promote program goals, and drive standardization. This Workgroup typically reviews measures and provides annual pre-rulemaking input for three programs: MIPS, the Medicare

Shared Savings Program (SSP), and the Medicare Part C and Part D Star Ratings. During the 2021–2022 MAP cycle, the MAP Clinician Workgroup reviewed 13 measures across MIPS and the Medicare Part C and D Star Ratings programs; the SSP did not have any measures under consideration during this cycle.

Recommendations for the Merit-Based Incentive Payment System

MIPS 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 in beneficiary outcomes, increased adoption of advanced alternative payment models (APMs) which use additional payments to incentivize high-quality care, 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, and 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.

The MAP Clinician Workgroup reviewed 10 measures for inclusion in MIPS. The measures and their final decision categories are as follows:

Table 16. MAP Clinician Workgroup Recommendations on Measures Under Consideration for MIPS

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-127**	Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
Conditional Support for Rulemaking	**MUC2021-058**	Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated With Immune Checkpoint Inhibitors
*	**MUC2021-090**	Kidney Health Evaluation
*	**MUC2021-105**	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma
*	**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)
*	**MUC2021-125**	Psoriasis – Improvement in Patient-Reported Itch Severity
*	**MUC2021-134**	Screen Positive Rate for Social Drivers of Health
*	**MUC2021-135**	Dermatitis – Improvement in Patient-Reported Itch Severity
*	**MUC2021-136**	Screening for Social Drivers of Health
Do Not Support for Rulemaking with Potential for Mitigation	**MUC2021-063**	Care Goal Achievement Following a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)

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Recommendations for Medicare Part C and Part D Star Ratings

The Medicare Part C and Part 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 ratings of health plans (Part C) are based on performance in five domains: staying healthy (i.e., screenings, tests, and vaccines), managing chronic (i.e., long-term) conditions, member experience with the health plan, member complaints and changes in the health plan's performance, and health plan customer service. The ratings of drug plans (Part D) are based on four domains: drug plan customer service, member complaints and changes in the drug plan's performance, member experience with the drug plan, and drug safety and accuracy of drug use.

The MAP Clinician Workgroup reviewed three measures for inclusion in the Medicare Part C and Part D Star Ratings Program. The measures and their final decision categories are as follows:

Table 17. MAP Clinician Workgroup Recommendations on Measures Under Consideration for Medicare Part C and D Star Ratings

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-053**	Concurrent Use of Opioids and Benzodiazepines (COB)
Conditional Support for Rulemaking	**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)

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Key Themes From the Clinician Workgroup Review

Key themes from the Clinician Workgroup's discussion included the following:

- The Workgroup noted that reporting on all-payer data in the Medicare SSP could have unintended consequences related to equity, as Federally Qualified Health Centers (FQHCs) or others who care for disproportionately disadvantaged populations with limited access to care could be inappropriately penalized in payment programs.
- The Workgroup expressed enthusiasm for equity-related measurement and noted that proposed SDOH measures would fit well within the SSP.
- The Workgroup's review of equity-related measures supports the CMS National Quality Strategy goal to advance health equity, as well as the Meaningful Measures 2.0 goal to promote health equity with quality measures.
- The Workgroup recognized that MUCs for the Medicare Part C and D Star Ratings Program focused on opioid use and polypharmacy in older adults. These measures support CMS' efforts to use measures for improved patient safety and equity in alignment with the CMS National Quality Strategy and Meaningful Measures 2.0 and reflect important national care gaps.

Hospital Workgroup Recommendations

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:

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

The following programs did not have any MUCs during the 2021–2022 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

Recommendations for the Hospital Inpatient Quality Reporting Program

The Hospital Inpatient Quality Reporting (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 Inpatient Prospective Payment System (IPPS) to report on process, structure, outcome, patient perspectives on care, efficiency, and cost of care measures. Hospitals that do not participate or that 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 providing consumers with information about hospital quality to make informed choices about care. The data are publicly reported on the CMS Care Compare website.

The MAP Hospital Workgroup reviewed 11 measures for inclusion in the Hospital IQR Program. The measures and their final decision categories are as follows:

Table 18. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the Hospital IQR Program

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-084**	Hospital Harm – Opioid-Related Adverse Events
*	**MUC2021-122**	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)

Determination	Measure No.	Measure Description
*	MUC2021-131	Medicare Spending per Beneficiary (MSPB) Hospital
Conditional Support for Rulemaking	MUC2021-098	National Healthcare Safety Network (NHSN) Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure
*	MUC2021-100	National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure
*	MUC2021-104	Hospital Harm – Severe Obstetric Complications eCQM
*	MUC2021-106	Hospital Commitment to Health Equity
*	MUC2021-118	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
*	MUC2021-120	Hospital-Level, Risk-Standardized Payment Associated With an Episode of Care for Primary Elective Total Hip and/or Knee Arthroplasty (THA/TKA)
*	MUC2021-134	Screen Positive Rate for Social Drivers of Health
*	MUC2021-136	Screening for Social Drivers of Health

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Recommendations for the Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

The Medicare Promoting Interoperability Program for Hospitals (originally established as the Medicare and Medicaid EHR Incentive Program) 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's name change in 2018 reflected the focus on interoperability and improving patient access to health information.

The MAP Hospital Workgroup reviewed four measures for inclusion in the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals. The measures and their final decision categories are as follows:

Table 19. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Determination	Measure No.	Measure Description
Support for Rulemaking	MUC2021-084	Hospital Harm – Opioid-Related Adverse Events
Conditional Support for Rulemaking	MUC2021-098	National Healthcare Safety Network (NHSN) Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure

Determination	Measure No.	Measure Description
*	**MUC2021-100**	National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure
*	**MUC2021-104**	Hospital Harm – Severe Obstetric Complications eCQM

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Recommendations for the Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing (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 FY to hospitals meeting performance standards established for a performance period of the program year. The amount equal to 2 percent of the 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.

The MAP Hospital Workgroup reviewed two measures for inclusion in the Hospital VBP Program. The measures and their final decision categories are as follows:

Table 20. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the Hospital VBP Program

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-131**	Medicare Spending per Beneficiary (MSPB)
Conditional Support for Rulemaking	**MUC2021-118**	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Recommendations for the 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 Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program for hospitals referred to as PPS-Exempt Cancer Hospitals or PCHs. Currently, 11 PCHs are excluded from payment under the IPPS. The PCHQR Program is a voluntary, quality-reporting program intended to encourage hospitals and clinicians to improve the quality of care, share information, and learn from each other's experiences and best practices. There are no payment implications for these hospitals, and data are published on the Provider Data Catalog (PDC) website.

The MAP Hospital Workgroup reviewed three measures for inclusion in the PCHQR Program. The measures and their final decision categories are as follows:

Table 21. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the PPS-Exempt Cancer Hospital Quality Reporting Program

Determination	Measure No.	Measure Description
Conditional Support for Rulemaking	MUC2021-091	Appropriate Treatment for Patients With Stage I (T1c) Through III HER2 Positive Breast Cancer
*	MUC2021-098	National Healthcare Safety Network (NHSN) Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure
*	MUC2021-100	National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

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Recommendations for the Hospital-Acquired Conditions Reduction Program

The Hospital-Acquired Conditions Reduction Program (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.

The MAP Hospital Workgroup reviewed two measures for inclusion in the HACRP. The measures and their final decision categories are as follows:

Table 22. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the HACRP

Determination	Measure No.	Measure Description
Conditional Support for Rulemaking	MUC2021-098	National Healthcare Safety Network (NHSN) Healthcare-Associated *Clostridioides difficile* Infection Outcome Measure
*	MUC2021-100	National Healthcare Safety Network (NHSN) Hospital-Onset Bacteremia & Fungemia Outcome Measure

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Recommendations for the End-Stage Renal Disease Quality Incentive Program

The End-Stage Renal Disease Quality Incentive Program (ESRD QIP) is a value-based payment 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 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 improving the quality of dialysis care and producing better outcomes for dialysis beneficiaries.

The MAP Hospital Workgroup reviewed one measure for inclusion in the ESRD QIP. The measure and the final decision category are as follows:

Table 23. MAP Hospital Workgroup Recommendations on Measures Under Consideration for the ESRD QIP

Determination	Measure No.	Measure Description
Do Not Support for Rulemaking	**MUC2021-101**	Standardized Readmission Ratio (SRR) for Dialysis Facilities

Key Themes From the Hospital Workgroup Review

Key themes from the Hospital Workgroup's discussion included the following:

- The Workgroup discussed, by statutory requirement, that any measure intended for the Hospital VBP Program must first be implemented for at least one year in the Hospital IQR Program.
- The Workgroup noted that older versions of some measures are currently implemented in federal programs. When these measures are replaced with updated versions in federal programs, it may be helpful for hospitals to receive communications to provide context on any associated performance changes.
- The Workgroup expressed support for increased equity-related measurement.
- The Workgroup's cross-program discussion (e.g., discussion of MUC2021-084, MUC2021-098, MUC2021-100, and MUC2021-104 for both the Hospital IQR Program and the Promoting Interoperability Program) further reinforced the CMS National Quality Strategy goal of increasing quality measurement alignment.

Post-Acute Care/Long-Term Care Workgroup Recommendations

The PAC/LTC Workgroup reviews measures for post-acute and long-term care programs. The PAC/LTC Workgroup makes recommendations for alignment while considering the broad range of patient needs across settings (e.g., different types and levels of care; multiple provider types; and varying payment structures, including differing requirements between Medicare and Medicaid).

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 Value-Based Purchasing (SNF VBP) Program
- 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)

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)

Recommendations for the Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility Value-Based Purchasing (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.

The MAP reviewed four MUCs for inclusion in the SNF VBP Program. The measures and their final decision categories are as follows:

Table 24. MAP PAC/LTC Workgroup Recommendations on Measures Under Consideration for SNF VBP

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-130**	Discharge to Community – Post Acute Care Measure for Skilled Nursing Facilities
*	**MUC2021-095**	CoreQ Short Stay Discharge Measure
Conditional Support for Rulemaking	**MUC2021-124**	Skilled Nursing Facility Healthcare–Associated Infections Requiring Hospitalization
*	**MUC2021-137**	Total Nursing Hours per Resident Day

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Recommendations for the Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility Quality Reporting Program (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 from 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 2 percentage points. SNF QRP data are publicly reported on the Care Compare website with the goal of increasing transparency so that patients, families, and caregivers can make informed choices.

The MAP reviewed two MUCs for inclusion in the SNF QRP. The measures and their final decision categories are as follows:

Table 25. MAP PAC/LTC Workgroup Recommendations on Measures Under Consideration for SNF QRP

Determination	Measure No.	Measure Description
Support for Rulemaking	**MUC2021-123**	Influenza Vaccination Coverage Among Healthcare Personnel
Conditional Support for Rulemaking	**MUC2021-098**	National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

Recommendations for the Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital Quality Reporting Program (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 Fee-for-Service (FFS) claims, the CDC's National Healthcare Safety Network (NHSN) data submissions, and the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) assessment data.

The MAP reviewed one MUC for inclusion in LTCH QRP. The measure and the final decision category are as follows:

Table 26. MAP PAC/LTC Workgroup Recommendations on Measures Under Consideration for LTCH QRP

Determination	Measure No.	Measure Description
Conditional Support for Rulemaking	**MUC2021-098**	National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

Recommendations for the Inpatient Rehabilitation Facility Quality Reporting Program

The Inpatient Rehabilitation Facility Quality Reporting Program (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 a 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.

The MAP reviewed one MUC for inclusion in IRF QRP. The measure and the final decision category are as follows:

Table 27. MAP PAC/LTC Workgroup Recommendations on Measures Under Consideration for IRF QRP

Determination	Measure No.	Measure Description
Conditional Support for Rulemaking	**MUC2021-098**	National Healthcare Safety Network (NHSN) Healthcare-associated *Clostridioides difficile* Infection Outcome Measure

Key Themes From the PAC/LTC Workgroup Review

Key themes from the PAC/LTC Workgroup's discussion included the following:

- The Workgroup discussed the topic of infection throughout the cycle, reviewing multiple measures related to healthcare-associated infections (i.e., MUC2021-098 and MUC2021-124).
- The Workgroup noted that the COVID-19 pandemic uncovered an under-preparedness and lack of resources related to infection control. Infection control resources have recently been provided for nursing homes, but these are time-limited. Aligning measures on infection control performance is a high priority in the future.
- The Workgroup agreed with the importance of health equity and equity-related measurement.
- The Workgroup's discussion and review of infection measures reinforce national quality priorities, given that promoting safety is a CMS National Quality Strategy goal.

2022 MAP Measure Set Review Cycle Results

During the 2022 MSR cycle, the MAP reviewed and made recommendations on 32 measures under review for six CMS quality reporting and value-based payment programs covering ambulatory, acute, and PAC/LTC settings. The MAP submitted recommendations to HHS on September 22, 2022. The MAP's recommendations for measures included in the MSR reflect national priorities to ease the burden associated with an increased number of performance measures and identify measures that no longer meet program priorities and provide valuable information for public-reporting and payment programs.

Rural Health Advisory Group Recommendations

The Rural Health Advisory Group provides input on all measures under review 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 provides a rural health perspective to the MAP Workgroups on the measures under review during the MSR, as well as identifying rural-relevant gaps in measurement and providing recommendations on priority rural health issues.

No common themes arose from the Rural Health Advisory Group's measure discussions this cycle.

Health Equity Advisory Group Recommendations

During the 2021–2022 MUC cycle, NQF launched the Health Equity Advisory Group to incorporate perspectives on health inequities and disparities into the measure review. This Advisory Group provides input on all measures under review, focusing on measurement issues related to health disparities and their potential impact on CAHs. The Health Equity Advisory Group also identifies health disparities and gaps in measurement, as well as provides recommendations to identify and reduce health differences linked with social, economic, or environmental disadvantages.

Key themes from the Health Equity Advisory Group's discussion included the following:

- Grouping measures by specific equity concerns (e.g., related to care delivery or limited community resources) could be a valuable approach for future measure evaluations.
- Measures are not consistently stratified, which makes it difficult to evaluate measures without a direct focus on equity. The Advisory Group noted that performance stratified by factors such as race and ethnicity are needed for a full review of disparities-sensitive measures.

- The Advisory Group suggested engaging academics and researchers to identify equity-related literature on measures and to develop a framework to better assess measures for equity sensitivity.
- The Advisory Group's discussion supports national quality priorities: Advancing health equity is a goal of the CMS National Quality Strategy, and promoting health equity is a facet of the CMS Meaningful Measures 2.0 initiative.

Clinician Workgroup Recommendations

The Clinician Workgroup provides recommendations related to clinician performance measurement in federal programs. The Clinician Workgroup provides feedback on the alignment of measures and data sources, with the goal of reducing burden, helping to identify characteristics of an ideal measure set to promote cross-cutting goals, and promoting standardization.

During the 2022 MSR cycle, the Clinician Workgroup reviewed 14 measures for two programs, the Medicare SSP and MIPS. No measures for the Medicare Part C and D Star Ratings Program were reviewed during the 2022 MSR cycle.

Recommendations for the Medicare Shared Savings Program

The Medicare SSP was established by section 3022 of the ACA to facilitate coordination and cooperation among healthcare providers to improve the quality of care for Medicare FFS beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. The goals for this value-based program include the promotion of accountability for a patient population, the coordination of items and services for the ACOs' patient population Medicare FFS beneficiaries, and the encouragement of investment in high quality and efficient services. Beginning with performance year 2021, ACOs are required to report their quality data to CMS via the APM Performance Pathway (APP). Their performance will be evaluated in the following four categories:

- Quality (50 percent)
- Cost (0 percent)
- Promoting interoperability (30 percent)
- Improvement activities (20 percent)

The MAP Clinician Workgroup reviewed seven measures for the 2022 MSR deliberations in the SSP. The measures and their final decision categories are as follows:

Table 28. MAP Clinician Workgroup Recommendations From Measure Set Review for the Medicare Shared Savings Program

Determination	Measure No.	Measure Description
Support for Retaining	**00515-C-MSSP**	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
*	**eCQM ID: CMS2v11**	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)
*	**06040-C-MSSP**	Hospital-Wide, 30-Day All-Cause Unplanned Readmission (HWR) Rate for MIPS-Eligible Clinician Groups

Determination	Measure No.	Measure Description
*	02517-C-MSSP	Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey
Conditional Support for Retaining	02816-C-MSSP	Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
*	01246-C-MSSP	Controlling High Blood Pressure
*	eCQM ID: CMS165v10	Controlling High Blood Pressure (eCQM)

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Recommendations for the Merit-Based Incentive Payment System

The MIPS Program was established by the MACRA to consolidate pre-existing Medicare incentive and quality-reporting programs for clinicians into a single program. The Quality Payment Program (QPP) goals for the MIPS Program include improving the quality of patient care and outcomes for Medicare FFS, rewarding clinicians for innovative patient care, and driving fundamental movement toward value in healthcare. The MIPS Program makes positive and negative payment adjustments for ECs (including clinical social workers and midwives) based on their performance in four categories:

- Quality (30 percent)
- Cost (30 percent)
- Promoting interoperability (25 percent)
- Improvement activities (15 percent)

The MAP Clinician Workgroup reviewed seven measures for the 2022 MSR deliberations in the MIPS Program. The measures and their final decision categories are as follows:

Table 29. MAP Clinician Workgroup Recommendations From Measure Set Review for MIPS

Determination	Measure No.	Measure Description
Support for Retaining	00641-C-MIPS	Functional Outcome Assessment
*	05826-E-MIPS	Closing the Referral Loop: Receipt of Specialist Report
Conditional Support for Retaining	02381-C-MIPS	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery
*	00254-C-MIPS	Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care
*	05796-E-MIPS	Diabetic Retinopathy: Communication With the Physician Managing Ongoing Diabetes Care
Conditional Support for Removal	01101-C-MIPS	Barrett's Esophagus

Determination	Measure No.	Measure Description
*	**05837-E-MIPS**	Children Who Have Dental Decay or Cavities

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Key Themes From the Clinician Workgroup Review

Key themes from the Clinician Workgroup's discussion included the following:

- During the MUC cycle, the Workgroup raised concerns with an all-payer approach to electronic clinical quality measures (eCQMs) within the SSP. Specific concerns were raised on behalf of facilities and clinicians with large populations of disadvantaged patients (e.g., Medicaid or uninsured patients) whose results could be skewed.
- This theme is in alignment with the CMS National Quality Strategy goal to increase quality measurement alignment to promote seamless and coordinated care.

Hospital Workgroup Recommendations

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.

During the 2022 MSR cycle, the Hospital Workgroup reviewed eight measures across three programs:

- Hospital OQR Program
- ASCQR Program
- PCHQR Program

The Hospital Workgroup did not review any measures for the following programs during the 2022 MSR:

- IPFQR Program
- HRRP
- Hospital IQR Program
- Medicare Promoting Interoperability Program for Hospitals
- Hospital VBP Program
- HACRP
- ESRD QIP

Recommendations for the Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting Program (Hospital OQR Program) was enacted by section 109 of the Tax Relief and Healthcare Act (TRHCA) of 2006. The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care measures. The goals of this pay-for-reporting and public-reporting program are to progress towards paying providers based on the quality rather than the quantity of care they give patients and to provide consumers information about hospital outpatient departments' (HOPD) quality so that they can make informed choices about their care. Data are publicly reported on the CMS Hospital Compare website.

The MAP Hospital Workgroup reviewed five measures for the 2022 MSR deliberations in the Hospital OQR Program. The measures and their final decision categories are as follows:

Table 30. MAP Hospital Workgroup Recommendations From Measure Set Review for the Hospital OQR Program

Determination	Measure No.	Measure Description
Support for Retaining	02930-C-HOQR	Hospital Visits After Hospital Outpatient Surgery
Conditional Support for Retaining	00140-C-HOQR	Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain
*	02599-C-HOQR	Abdomen Computed Tomography (CT)—Use of Contrast Material
*	00930-C-HOQR	Median Time From ED Arrival to ED Departure for Discharged ED Patients
*	00922-C-HOQR	Left Without Being Seen

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Recommendations for the Ambulatory Surgical Center Quality Reporting Program

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program was enacted by section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, and Title I of the Healthcare TRHCA of 2006. The statute provides the authority for requiring ASCs paid under the ASC fee schedule (ASCFS) to report on process, structure, outcomes, patient experience of care, efficiency, and costs of care measures. The goals of this quality payment and public-reporting program are to progress towards paying providers based on the quality rather than the quantity of care they give patients and to provide consumers information about ASC quality so that they can make informed choices about their care.

The MAP Hospital Workgroup reviewed two measures for the 2022 MSR deliberations in the ASCQR Program. The measures and their final decision categories are as follows:

Table 31. MAP Hospital Workgroup Recommendations From Measure Set Review for the ASCQR Program

Determination	Measure No.	Measure Description
Support for Retaining	02936-C-ASCQR	Normothermia Outcome
Conditional Support for Retaining	01049-C-ASCQR	Improvement in Patient's Visual Function Within 90 Days Following Cataract Surgery

Recommendations for the Prospective Payment System Exempt Cancer Hospital Quality Reporting Program

Section 3005 of the ACA added subsections to section 1866 of the SSA and established the PCHQR Program for hospitals referred to as PCHs. These hospitals (currently, 11 have been granted with this distinction by CMS) are excluded from payment under the IPPS. The PCHQR Program is a voluntary

quality-reporting program. There are no payment implications for these hospitals, and data are published on the 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.

The MAP Hospital Workgroup reviewed one measure for the 2022 MSR deliberations in the PCHQR Program. The measure and the final decision category are as follows:

Table 32. MAP Hospital Workgroup Recommendations From Measure Set Review for the PCHQR Program

Determination	Measure No.	Measure Description
Conditional Support for Retaining	05735-C-PCHQR	Proportion of Patients Who Died From Cancer Not Admitted to Hospice

Key Themes From the Hospital Workgroup Review

Key themes from the Hospital Workgroup's discussion included the following:

- The Workgroup members expressed a desire for additional measures that address imaging services and emergency department (ED) care.
- The Workgroup noted that because ASCs provide a wide range of services, it is difficult for outpatient quality reporting programs to capture the quality of these services. A potential approach may be focusing on patient volume in future measure development.
- The Workgroup noted an observed decline in patient safety since the start of the COVID-19 pandemic across the three hospital programs reviewed during the MSR. Patient safety measures should be prioritized and evaluated after re-evaluating performance gaps, and future discussion should balance broader program discussion with condition-specific discussion.
- These themes are in direct alignment with several of the 2022 CMS National Quality Strategy goals: embed quality into the care journey, promote patient safety, and increase quality measurement alignment to promote seamless and coordinated care.

Post-Acute/Long Term Care Workgroup Recommendations

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

In the 2022 MSR cycle, the PAC/LTC Workgroup reviewed 10 measures for the Home Health Quality Reporting Program (HH QRP). The Workgroup also reviewed the Hospice Quality Reporting Program (HQRP) as part of the 2022 MSR; however, no measures in this program were selected for discussion.

The PAC/LTC Workgroup did not review any measures for the following programs during the 2022 MSR:

- SNF QRP

- IRF QRP
- LTCH QRP
- SNF VBP Program

Recommendations for the Home Health Quality Reporting Program

The HH QRP was established by section 1895 of the SSA. The goals of this pay-for-reporting program include alignment with the mission of the National Academy of Medicine (NAM), which has defined quality as having the following properties or domains: effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness. For the 2022 MSR deliberations, the MAP reviewed 10 measures for the HH QRP.

The measures and their final decision categories are as follows:

Table 33. MAP PAC/LTC Workgroup Recommendations From Measure Set Review for HH QRP

Determination	Measure No.	Measure Description
Support for Retaining	02944-C-HHQR	Discharge to Community – Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
Conditional Support for Retaining	00185-C-HHQR	Improvement in Bathing
*	00187-C-HHQR	Improvement in Dyspnea
*	00189-C-HHQR	Improvement in Management of Oral Medications
*	00196-C-HHQR	Timely Initiation of Care
*	00212-C-HHQR	Influenza Immunization Received for Current Flu Season
*	01000-C-HHQR	Improvement in Bed Transferring
Conditional Support for Removal	03493-C-HHQR	Application of Percent of Residents Experiencing One or More Falls With Major Injury (Long Stay)
*	02943-C-HHQR	Total Estimated Medicare Spending per Beneficiary (MSPB) – Post Acute Care (PAC) HHQRP
*	05853-C-HHQR	Application of Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function

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Key Themes From the PAC/LTC Workgroup Review

Key themes from the PAC/LTC Workgroup's discussion included the following:

- The Workgroup expressed interest in better-aligned measures addressing patient function and symptoms (e.g., dyspnea). Members were also interested in measures related to systematic barriers to care and preventive care.
- The Workgroup suggested reviewing current measures for their relevance across all PAC/LTC settings, as well as identifying functional measures that are most strongly linked to outcomes.
- The Workgroup suggested that the goals of care for certain populations may be stabilization and risk mitigation rather than improvement.

- The Workgroup stated that SDOH should be used for risk adjustment where appropriate, and measures that capture disparities are priorities for future discussion.
- The Workgroup noted that using EHRs and interoperable systems will contribute to more consistent measurement; funding a tiered, mandated approach could help encourage the use of EHRs for home healthcare.
- The Workgroup's discussion reinforced priorities stated in the CMS National Quality Strategy, including embedding quality into the care journey, addressing health equity, embracing the digital age, and increasing alignment.

VI. Identified Gaps in Endorsed Quality and Efficiency Measures

Under section 1890(b)(5)(A)(i)(IV) of the Act, the entity is required to describe in the annual report "gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 280j of this title and where quality measures are unavailable or inadequate to identify or address such gaps."

As part of the NQF's work, NQF identifies gaps in measurement and available quality measures. These gap areas, noted throughout this document and summarized below, can inform future priorities and drive measure development and inclusion in reporting programs.

Gaps Identified in Endorsement Projects

As part of the endorsement process, NQF's Standing Committees reviewed their current measure portfolios and identified gap areas in which few or no measures exist. The Behavioral Health and Substance Use Standing Committee highlighted measurement of telehealth services as a gap since these are often not included in the development of outcome measures was noted as gaps in the area of behavioral health. For cost and efficiency measures, more measures are needed that link cost and quality. The Perinatal and Women's Health Standing Committee noted a need for specialized measures examining independent conditions of maternal morbidity in order to produce data that can be translated into quality improvement efforts. Measurement gaps were also noted in the area of palliative care concerning hospice care for pediatric patients, as well as the need to approach hospice measures holistically and include all care disciplines involved for a more thorough understanding of the care experience. These gap areas align with the CMS National Quality Strategy goals of embedding quality into the care journey, incentivizing innovation and technology, and increasing alignment. A list of the gap areas identified by the Standing Committees in 2022 is included in Appendix G.

Gaps Identified in the Measure Applications Partnership

In addition to making recommendations on MUC list measures, the MAP also provides feedback on measurement gaps within federal programs. In 2022, the MAP identified gaps in measures of infection control, mental health, and patient-reported outcomes. The MAP also noted the need for measures that reflect not only the patient perspective, but also that of the family and caregiver, stating that these perspectives must be integrated into measurement for individual needs to be met. Regarding mental health, the MAP recognized isolation, loneliness, and depression as program measure gaps. In the area

of infection control, the MAP noted an under-preparedness and a general lack of resources in both SNFs and LTCHs. A complete list of the identified gap areas, organized by program, is included in Appendix H.

Gaps Identified in the Core Quality Measures Collaborative

As part of the CQMC's core set maintenance process, the CQMC Workgroups identify measurement gaps in clinician-level measures appropriate for use in value-based payment programs. Across all 10 core sets, the Workgroups identified broad gap areas: outcome measures, including PRO-PMs; cross-cutting measures addressing topics such as patient safety, patient and family engagement, care coordination, and population health; health equity and disparities-sensitive measures that assess social needs and risks, quality of care, and the wider equity ecosystem; digital quality measures; and telehealth-relevant measures that account for telehealth visits and address access and quality of care provided via telehealth. For example, the Pediatrics Workgroup identified gap areas, including obesity and body mass index measures (outcomes); substance use screening measures appropriate for adolescents and follow-up visits after identifying behavioral health conditions (cross-cutting); disparities in access to care (equity); and well-care visits, including telehealth and virtual care. Some Workgroups also indicated a preference for clinician-level versions of existing measures that address priority conditions (e.g., a clinician-level version of the Pharmacy Quality Alliance's [PQA] plan-level *Adherence to Antiretrovirals* measure). The detailed gap areas identified by the CQMC Workgroups between 2021 and 2022 are available in the Analysis of Measurement Gap Areas and Measure Alignment Report online.

Gaps Identified in Additional Targeted Research

In addition to gaps identified as part of E&M, MAP, and the CQMC, the following measurement gap areas were identified through NQF's special projects related to opioids, rural health, and equity:

- **Opioid and Behavioral Health**: all-payer measures addressing opioid use, misuse, and behavioral health conditions; care coordination and collaboration with nonmedical professionals; harm reduction strategies; person-centeredness and recovery; linking individuals to evidence-based treatment for SUDs/OUD; recognition of high-risk populations; monitoring of unintended consequences, impact on quality, and outcomes; and mortality from polysubstance use
- **Leveraging Quality Measures to Improve Rural Health**: access to timely care; care coordination; intentional and unintentional injury; COVID-19 measures; HIV; serious illness, including hospice and palliative care; telehealth-relevant measures; equity and disparities measures; provider-level measures addressing topics such as cancer screening measures; and cost measures that do not unfairly penalize rural providers
- **The CQMC's Health Equity Workgroup**: community or population-level metrics to understand population health and the equity ecosystem; system-level measures to assess services that affect access and experience of care (e.g., availability of interpreters and translation services); care coordination, transitions, and equity considerations throughout the patient journey; geriatrics and hospice; and palliative care

VII. Targeted Research Areas Not Supported by the Endorsement of Quality and Efficiency Measures

Under section 1890(b)(5)(A)(v) of the Act, the entity is required to describe "areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 280j of this title and where targeted research may address such gaps."

NQF drives meaningful improvements in care through its work to tackle emerging issues and national priorities. Often, critical issues are measurement gap areas in need of guidance on measurement and improvement strategies. To address these needs, NQF develops measurement "frameworks" with multistakeholder input that organize the most important topics to measure about a critical priority area and describe how measurement should take place (e.g., entities involved in measurement, who is held responsible for measurement, relevant care settings, cadence of measurement, and relevant population). These frameworks also describe currently available measures and measure concepts and identify additional gap areas in which measures should be developed in the future.

In 2022, NQF completed targeted research and produced framework documents in five areas: opioid use, adjustment for social risk factors, rural health, digital PRO-PMs, and EHR-sourced measures for care coordination. Two of these initiatives, the Opioids and Behavioral Health project and the Leveraging Quality Measures to Improve Rural Health project, are described in more detail within the *Recommendations on National Strategies and Priorities* section of this report (pages 12 and 14). Two other framework projects, the Best Practices for Developing and Testing Risk Adjustment Models project and the Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures project, are described within the *Cross-Cutting Initiatives to Improve the Measurement Process* section of this report (pages 28 and 29). The goals and outcomes of the fifth project on EHR-sourced measures are described in more detail below.

Leveraging Electronic Health Record-Sourced Measures to Improve Care Communication and Care Coordination

In our healthcare system, patients interact with a wide range of clinicians and allied health professionals across different settings. Patient care in the U.S. has become increasingly fragmented as medical care has advanced and disparities in care have widened. Seamless care communication and care coordination across the care team and between settings are essential for ensuring patients receive high quality care. However, these functions are often limited by the intricacies of the healthcare system, which is poorly designed for the coordinated treatment needed to care for complex patients. Poor care communication and care coordination can negatively affect a patient's ability to achieve their goals and limits a care team's ability to adhere to care standards by either prescribing treatments that directly conflict with other treatments or are unnecessarily duplicative.[67] The Leveraging EHR-Sourced Measures to Improve Care Communication and Care Coordination project focused on addressing these problems in the healthcare system, aligning with the 2022 CMS National Quality Strategy goals of increasing quality

measurement alignment to promote seamless and coordinated care, embracing the digital age, and incentivizing innovation and technology adoption to drive care improvements.

From 2021 to 2022, NQF convened a multistakeholder Committee to identify best practices for leveraging EHR-sourced measures, namely recommendations for using EHRs to measure and improve care communication and care coordination across payers and settings. NQF collaborated with the Committee to develop two final Recommendations Reports designed for two different audiences: one report is high level for nontechnical stakeholders (i.e., Shortened Final Recommendations Report) and one is extensively detailed for technical stakeholders (i.e., Final Recommendations Report).

These reports emphasize that improving EHRs is crucial to enable patients, families, and caregivers to engage more deeply with their care to improve clinical outcomes and reduce healthcare disparities. EHR maturity (i.e., an EHR's ability to perform care communication and care coordination functions and leverage these functions for EHR-sourced measurement) is on a continuum and can vary within and across EHR systems. The report provides examples of important EHR functionalities at different maturities, as well as recommending incremental approaches to increase interoperability and use existing data standardization initiatives wherever possible. The report also summarizes important themes related to trust between clinicians, healthcare systems, and patients; the burden of data collection from both clinicians and patients; the cost of EHR utilization; and the role of incentives related to data collection and use.

The report puts forth five recommendations to support the evolution of EHR-based care communication, care coordination, and performance measurement to drive quality improvement and equitable health outcomes:

1. **Collect and share standardized data**: Stakeholders should focus on advancing interoperability and data standardization in their efforts to enhance EHR functionalities; EHRs should incorporate SDOH data elements, which can be used in measurement and can help identify health disparities.
2. **Optimize EHR usability for patients and caregivers**: For EHRs to be usable and intuitive for patients and caregivers, stakeholders should incorporate innovative solutions, such as the utilization of patient portals and other virtual communication.
3. **Optimize EHR usability for clinicians**: For EHRs to be usable and intuitive for clinicians, stakeholders should create solutions that improve clinical workflows and enhance evidence-based care.
4. **Develop novel EHR data elements to improve measurement**: New, standardized EHR data elements can help facilitate the measurement of care communication and care coordination.
5. **Leverage EHR data to fill measurement gaps**: Existing and novel EHR data elements can be leveraged in new measures to close priority measurement gaps (e.g., patient goals, SDOH measures, and follow-up measures with better specificity).

In addition to the previously listed CMS National Quality Strategy goals of increasing alignment, embracing the digital age, and incentivizing innovation and technology, the Leveraging EHR-Sourced Measures to Improve Care Communication and Care Coordination project also addresses the goal of

embedding quality into the care journey. The Committee's recommendations focus on coordinated care as a part of the overall care journey for a patient, recognizing that care coordination can facilitate optimal and affordable care and best outcomes for patients (e.g., avoiding duplicative testing, choosing treatment based on patient goals). In addition, the use of EHR-sourced measures to measure and improve care communication and care coordination minimizes the burden for providers because the data for these measures are less time-consuming to collect. Lastly, improving care communication and care coordination creates a significant opportunity to improve health outcomes by making care safer (e.g., reducing diagnostic errors) and more affordable by increasing the communication and coordination of patient care. The project also addresses goals of the CMS National Quality Strategy and Meaningful Measures 2.0 initiatives, including leveraging quality measures to promote health equity and close gaps in care, streamlining quality measurement, and improving efficiency by transitioning to digital measures. The Committee recommended improving EHR functionalities to better facilitate the collection of standardized electronic data (e.g., meaningful SDOH data) for digital quality measures and highlighted the importance of measurement to promote health equity and close gaps in care.

VIII. Coordination With Measurement Initiatives Led by Other Payers

Section 1890(b)(5)(A)(i)(I) of the Social Security Act (the Act) mandates that the Annual Report to Congress and the Secretary include a description of "the implementation of quality measurement initiatives under this chapter and the coordination of such initiatives with quality initiatives implemented by other payers."

Alignment of quality measures among public and private payers helps maximize the impact and efficiency of performance measurement and quality improvement. NQF continues to drive alignment through facilitating important dialogue and building consensus among private and public payers, particularly through the CQMC.

Core Quality Measures Collaborative – Private and Public Alignment

As the U.S. healthcare system shifts from a quantity-based FFS model to a value-based model, quality measures have become increasingly important in assessing the success of value-based payment programs and APMs. However, the increasing number and lack of alignment among measures used by different stakeholders have increased reporting burden and difficulty comparing performance results for providers, payers, consumers, and purchasers.[68,69] The CQMC was founded in 2015 to address these challenges and is currently supported by both CMS and AHIP and convened by NQF. This public-private partnership convenes approximately 80 member organizations, including providers, primary care and specialty societies, payers, consumers and purchasers, and regional quality collaboratives. To reduce measurement burden on clinicians measured by multiple payers, CQMC members review and align on high value, high-impact measures for use by public and private payers in VBPs and APMs, thus reducing measurement burden and improving health outcomes. The CQMC also creates guidance and recommendations on high-priority topics in quality measurement, identifies gap areas for measure development, and proposes solutions to implementation challenges.

In conducting its work, the CQMC leverages other areas of CMS-funded work to maximize alignment. For example, the CQMC Workgroups review relevant MAP rulemaking recommendations for clinician programs to inform maintenance and potential additions. The CQMC Workgroups also review information generated through the E&M review process for NQF-endorsed measures to help make certain the highest value measures are included in the core sets. In addition, the CQMC continues to advance elements in the CMS National Quality Strategy and Meaningful Measures 2.0, contributing to a better understanding of health disparities and gaps in care, empowerment of consumers through performance measures, promotion of digital measures, and increased quality measurement alignment to move towards more coordinated care and improved outcomes.

In 2022, NQF convened the CQMC to update and maintain its existing consensus-based core measure sets, ensuring their continued relevancy to the current measurement landscape. The CQMC Workgroups convened and shared recommended updates for eight of the 10 measure sets: Accountable Care Organization (ACO)/Patient-Centered Medical Home (PCMH)/Primary Care, Behavioral Health, Cardiology, Gastroenterology, HIV and Hepatitis C, Obstetrics and Gynecology (OB/GYN), Orthopedics, and Pediatrics. Notable Workgroup recommendations included the addition of a person-centered primary care measure in the ACO/PCMH/Primary Care core set, a pharmacotherapy measure for OUD in the Behavioral Health set, a maternal morbidity measure in the OB/GYN set, and behavioral health measures for children in the Pediatrics set. In addition to core set maintenance, the CQMC also continued to develop and update supporting materials and guidance, including yearly updates to the CQMC's measure selection principles, the Analysis of Measurement Gap Areas and Measure Alignment Report summarizing outstanding measurement gaps that should be prioritized by developers, and updates to the CQMC Implementation Guide summarizing barriers and solutions to the implementation of the core sets within value-based payment and APMs.

In early 2022, NQF also established the CQMC Health Equity Workgroup to elevate and align approaches to measuring health inequities and disparities through the CQMC core sets. The Workgroup included 34 representatives representing healthcare professionals, specialty societies, health plans, hospitals, nonprofits, state agencies, quality measurement organizations, and regional health collaboratives. The Workgroup developed and applied criteria for identifying disparities-sensitive measures already included in the CQMC core sets. These criteria categorized 137 of 150 measures in the CQMC core sets as potentially disparities-sensitive, illustrating that most measures likely demonstrate some level of disparity and that further prioritization is needed to determine the most important measures and appropriate stratification recommendations. The Health Equity Workgroup also identified 11 measures and measure concepts for future consideration into the core sets that align with the CQMC's measure selection principles and promote health equity (i.e., addressing topics including enablers of cultural responsiveness, access to care, social needs and risks, quality of care, and the broader equity ecosystem). The Health Equity Workgroup summarized its findings and recommendations through October 2022 in the CQMC Health Equity Final Report, which puts forth the proposed approach to prioritize disparities-sensitive measures within the CQMC core sets; identifies measures that directly address aspects of health equity, such as consideration of SDOH; and explores future opportunities to integrate health equity considerations into the CQMC core set maintenance process. In late 2022, the

Health Equity Workgroup launched a six-month effort to further refine the approach for identifying disparities-sensitive measures and to test the approach in the Pediatrics and Cardiology core sets. The Workgroup is also evaluating how health equity-focused measures should be considered in future core sets.

To address barriers to the uptake and full use of the aligned core sets, the CQMC also conducted focused work in two areas. First, the CQMC addressed barriers to the use of lower-burden dQMs, including the eCQMs currently in the core sets. In 2022, the CQMC's Digital Measurement Workgroup continued to further the collaborative's understanding of barriers to dQM use and opportunities to lower them. The CQMC Digital Measurement Report establishes common terminology and characterizes the digital measurement landscape, including a shared, near-term future state data flow that illustrates potential pathways for the exchange of interoperable data defined in FHIR resources and is applicable to both public- and private-sector stakeholders. The report also proposes future activities for the CQMC, such as identifying and accelerating the interoperability of key data elements needed for measurement. In late 2022, the Workgroup launched a six-month effort to develop a measure-driven approach to advance the use of interoperable data elements. CQMC members will identify high-impact measures for which identifying and specifying FHIR data elements should be prioritized. The CQMC's data priorities will directly inform the ONC's efforts to align data standards for measurement.

Second, to lower the burden of measure use, the CQMC examined ways that aspects of the measurement process (e.g., collection, transmission, standardization, aggregation, and dissemination practices) could be aligned to potentially lower measure implementation burden. The Measure Model Alignment Workgroup's findings, summarized in the Aligning Approaches to Measure Models Report, include options and examples of governance, structural, and operational models that may pose opportunities for increased alignment in the future.

IX. Other Activities Performed Under Contract With HHS

Common Formats for Patient Safety

In partnership with the Agency for Healthcare Research and Quality (AHRQ) and with support from CMS, NQF continues to address patient safety in alignment with the CMS National Quality Strategy goals to both improve patient safety and strengthen the resilience of healthcare systems through its work on Common Formats. AHRQ develops and maintains the Common Formats to facilitate and support standardized data collection for patient safety events. The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) provides for the development of reporting formats that use common language and definitions (i.e., Common Formats) to standardize the reporting of information for healthcare quality and patient safety improvement purposes both clinically and electronically. Common Formats is a set of standardized definitions and formats for providers to collect and exchange information for any patient safety event. They apply to all patient safety concerns, including incidents, near misses or close calls, and unsafe conditions.

In 2022, NQF continued to provide the public opportunities to comment on all elements of Common Formats modules using commenting tools developed and maintained by NQF to collect data for analysis. Specifically, NQF updated the Common Formats for Event Reporting – Diagnostic Safety Version 1.0

(CFER-DSV1.0) commenting tool. In addition, NQF reviewed public comments for six Common Formats for Event Reporting and Common Formats for Surveillance tools. During the commenting period, NQF did not receive any public comments across all Common Formats. NQF shared quarterly public commenting updates with AHRQ for review. Maintaining Common Formats advances CMS' 2022 priorities on patient safety and strengthening resilience in health systems in alignment with the CMS National Quality Strategy and Meaningful Measures 2.0 goals.

X. *Financial Information for FY 2022 (October 1, 2021 – September 30, 2022)*

Section 1890(b)(5)(A) (ii)(I)(II)(III) of the Social Security Act contains a requirement for the Consensus-Based Entity (CBE) to include in its annual report to Congress and the Secretary "An itemization of financial information for the fiscal year ending September 30 of the preceding year, including—

(I) Annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue); (II) Annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs); and

(III) A breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity. "

NQF's revenues for FY 2022 were $16,538,896, including federal funds authorized under section 1890(d) of the SSA, private-sector contributions, membership revenues, and investment revenue. NQF's expenses for FY 2022 were $21,351,595. These expenses include grants and benefits paid, salaries and other compensations, fundraising expenses, and overhead costs. A complete breakdown of the amount awarded per contract is available in Appendix A. NQF has made no updates or modifications to the disclosure of interest and conflict of interest policies. Rosters of Committees, Workgroups, and TEPs funded under the CBE contract are available in Appendix B.

XI. *Updates to CBE Policies and Procedures in 2022*

There were no updates made to the CBE policies or procedures in 2022.

XII. *Summary and Conclusion*

In 2022, NQF continued to deliver on its core work to identify quality measurement priorities and advance consensus on methods and measures for assessing and improving healthcare quality. NQF achieves these aims through three core programs (i.e., E&M, the MAP, and the CQMC) and targeted projects. This past year, NQF convened stakeholders to review a total of 54 measures for endorsement and maintenance across a variety of topics reflecting the CMS National Quality Strategy focus areas, including health equity, COVID-19 vaccination coverage, rural health, and patient experience of care. NQF endorsed 47 measures and approved two measures for trial use. The MAP reviewed measures for CMS' value-based payment and quality reporting programs, considering the need for, validity of, and burden of

proposed and actively used measures across a wide scope of topics, including health equity, COVID-19, person-centered care, rural health, and coordination measures. Further, NQF launched a process to review measures for potential removal from these CMS programs. The MAP provided input on 29 measures suggested for use in CMS programs and considered 22 measures for removal. The CQMC continued to align the measures that payers use to assess ambulatory clinicians, updating and maintaining CQMC measure sets. In addition, the CQMC Workgroups put forth recommendations and initiated actions to address barriers to uptake and use. The recommendations focused on three important opportunities for further alignment, including but not limited to, digital measurement, aligning measure models, and health equity.

In addition to the three core programs, NQF's work advanced consensus and strategies for measurement science to support the development and use of high-priority measures. Specifically, NQF released best practices for the use of social risk factors (e.g., race, ethnicity, and income) and functional risk factors (e.g., frailty) in risk-adjusted outcome measures; guidance to support the development and implementation of PRO-PMs; and approaches to expanding patient and caregivers' input into the work of the CBE. In 2022, NQF also worked with CMS to identify and address measurement strategies, including identifying gaps, critical to the health of the nation. These measurement framework initiatives produced the following: (1) guiding principles and use case exemplars on how to implement a recommended quality measurement framework for measuring, evaluating, and addressing overdose and mortality for individuals with SUD/OUD and co-occurring behavioral health conditions; (2) an updated set of the best-available measures for measurement and quality improvement programs in rural areas; and (3) recommendations on how to use EHR data for more effective care communication and coordination and measurement of these functions.

NQF identified gaps in measurement areas throughout its work in 2022. The E&M process led to identification of gaps related largely to long-term and post-acute care settings, demonstrating a need for more patient experience measures and PRO-PMs, as well as measures of mental health. MAP members also noted that the COVID-19 pandemic has exposed a lack of infection control measures in many long-term care facilities. In addition, the CQMC, as part of maintaining its 10 clinician-focused aligned measure sets, identified gap areas for each of the sets. Overarching gaps included outcome measures (e.g., PRO-PMs), cross-cutting measures (e.g., patient safety, patient and family engagement, care coordination, and population health), health equity and disparities-sensitive measures, digital quality measures, and telehealth-relevant measures. Lastly, several additional NQF projects, including the work on opioids, rural health, and equity described in this report, identified gaps as well as overarching themes, including the need for measures on access to care and care coordination, as well as the need to develop risk-adjusted and stratified versions of measures that do not unintentionally penalize providers that serve high-risk populations.

In summary, as the statutorily recognized CBE, NQF successfully executed three core ongoing consensus-based processes as well as targeted activities to advance and align high-impact valid quality measures. NQF's work was informed by and guided the identification and alignment of critical national priorities. For example, to address persistent gaps in equity, NQF enhanced activities in all three core programs mentioned above and throughout additional NQF projects to advance stakeholder consensus on and the

use of quality measures that support progress on equity. NQF's work also addressed key priority areas, such as SUD/OUD and co-occurring behavioral health conditions; measurement in rural areas, digital measurement, PRO-PMs, use of EHR data for measurement, and incorporating the patient voice. NQF has the unique ability to bring stakeholders together to advance consensus on quality measurement and improvement strategies by driving consensus. NQF's work in 2022 has facilitated progress across the measurement community and is advancing the measurement methods and measures we most need to strengthen patient and caregiver engagement, eliminate disparities, reduce burden, and improve quality for all.

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Appendix A: 2022 Activities Performed Under Contract With HHS and Financials

Table 1. Federally Funded Contracts Awarded in FY 2022 Under IDIQ Contract HHSM-500-2017-0060I

Contract Number	Task Order Name	Description	Period of Performance	Negotiated Contract Amount for FY 2022
75FCMC19F0007	Leveraging Quality Measurement to Improve Rural Health	Reconvene the MAP Rural Health Workgroup to review, update, and potentially expand a core set of rural-relevant measures originally created in 2017-2018 that represent the best-available measures to address topics relevant to rural patients and are resistant to low case-volume.	12/14/2021-8/15/2022 (Option Period 2)	$274,023
75FCMC20F0003	Building a Roadmap from Patient-Reported Outcome Measures to Patient-Reported Outcome Performance Measures	This project will create a roadmap for measure developers to utilize the attributes of high quality PROMs in developing digital PRO-PMs.	12/1/2021-11/30/2022 (Option Period 1)	$666,673
75FCMC21F0002	Measure Additional, Removal, and Prioritization for Expansion of the CQMC	Identify and align high value, high-impact, and evidence-based measures across public and private payers that promote better patient outcomes and provide useful information for improvement, decision making, and payment.	9/17/2022-3/26/2023	$348,018
HHSM500T0001	Endorsement & Maintenance	Endorsement and maintenance of endorsement of standardized healthcare performance measures	9/27/2022-3/26/2023 (Option Year 5)	$3,774,201

Contract Number	Task Order Name	Description	Period of Performance	Negotiated Contract Amount for FY 2022
HHSM500T0002	Annual Report to Congress and HHS	Report to Congress and the Secretary that highlights the implementation of quality and efficiency measurement initiatives under the SSA	9/27/2022-3/26/2023 (Option Year 5)	$144,341
HHSM500T0003	Measure Applications Partnership	Provide recommendations related to multistakeholder group input on the selection of quality and efficiency measures for payment and public-reported programs.	9/27/2022-3/26/2023 (Option Year 4)	$2,430,758
Total Award	*	*	*	**$7,638,014**

* Cell intentionally left empty

Table 2. NQF Financial Information for FY 2022 (unaudited)

Financial Statement 2022	Amount
Contributions and Grants	$17,284,623
Program Service Revenue	$7,600.00
Investment Income	$-771,096.00
Other Revenue	$17,769.00
TOTAL REVENUE	$16,538,896.00
Grants and Similar Amounts Paid	0.00
Benefits Paid to or for Members	0.00
Salaries, Other Compensation, Employee Benefits	$14,032,329.00
Other Expenses	$7,319266.00
TOTAL EXPENSES	$21,351,595.00

Appendix B: All NQF Multistakeholder Group Rosters

As a CBE, National Quality Forum (NQF) includes comprehensive representation from the healthcare sector across all its convened Committees, Workgroups, Task Forces, and Advisory Panels. In addition, NQF requires all multistakeholder representatives to undergo a disclosure of interest (DOI) process prior to being appointed. This allows for a fair, open, and transparent process. During this time, NQF did not identify any known conflicts of interest that would undermine the objectivity of the deliberations mentioned above.

Per the NQF Conflict of Interest Policy for Committees, all nominees are asked to complete a general DOI form for each Committee to which they have applied prior to being seated on the Committee. The DOI form for each nominee is reviewed holistically and in the context of the topic area in which the Committee will be reviewing measures, if applicable. This general DOI form must be completed annually through NQF's website in order to participate in a Committee. Specific to E&M Standing Committees, once nominees have been selected to serve on a Committee, a measure-specific DOI form is distributed near the beginning of each evaluation cycle. This measure-specific DOI form is used to determine whether any members will be required to recuse themselves from the discussion of one or more measures under review based on prior involvement or relationships to entities relevant to the topic area. Because Standing Committee members are asked to review various types of measures throughout their term of service, NQF asks members to complete the measure-specific DOI form for all measures being evaluated in each cycle, as well as any measures that are related to, or competing with, measures being evaluated to identify any potential conflicts or biases. Committee members who fail to return a completed measure-specific DOI form prior to the measure evaluation meetings will not be allowed to participate in the discussion or submit votes on the measures being evaluated.

In 2022, NQF collected DOI forms from 28 Committees. No conflicts that impacted their participation on Committees were disclosed.

In 2022, NQF convened 1,036 volunteers across 41 multistakeholder groups. Of these groups, it included the following:

Healthcare Sector	Percentage
Consumer	1%
Health Plan	20%
Health Professional	24%
Patient/Caregiver	9%
Provider	18%
Public Community Health Agency Council	5%
Purchaser	3%
Quality Measurement Research & Improvement	14%
Supplier	6%

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Appendix C: Federal Quality Reporting and Performance-Based Payment Programs Considered by MAP

Measures within the following programs, which now use or will use quality and efficiency measures, are reviewed by the MAP as part of the MUC pre-rulemaking and MSR processes. Programs shown in boldface had one or more measures reviewed during the 2021–2022 pre-rulemaking cycle. Programs indicated with an asterisk (*) had one or more measures reviewed during the 2022 MSR process.

- ASCQR*
- **ESRD QIP**
- HH QRP*
- Hospice Quality Reporting Program (HQRP)
- **HACRP**
- **Hospital IQR**
- Hospital OQR*
- HRRP
- **Hospital VBP**
- IPFQR
- **IRF QRP**
- **LTCH QRP**
- **Medicare Part C and D Star Ratings**
- **Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) and CAHs (Medicare Promoting Interoperability Program)**
- Medicare SSP*
- **MIPS***
- **PCHQRP***
- **SNF QRP**
- **SNF VBP**

Appendix D: MAP Structure, Members, Criteria for Service, and Rosters

The MAP operates through a two-tiered structure. Guided by the priorities and goals of the Department of Health and Human Services' (HHS) National Quality Strategy, the MAP Coordinating Committee provides direction and direct input to HHS. The MAP Workgroups and Advisory Groups counsel the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Each multistakeholder group includes individuals with content expertise and organizations particularly affected by the work.

MAP members are selected based on National Quality Forum (NQF) Board-adopted selection criteria through an annual nominations process and an open public commenting period. Balance among stakeholder groups is paramount. Due to the complexity of the MAP's tasks, individual subject-matter experts are included in the groups. Federal government ex officio members are nonvoting because federal officials cannot advise themselves. MAP members serve staggered three-year terms.

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AmeriHealth Caritas
Blue Cross Blue Shield Association
Covered California
The Joint Commission
The Leapfrog Group
National Committee for Quality Assurance
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Medtronic
Memphis Business Group on Health
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Appendix E: CQMC Measure Selection Principles

Background

The selection principles guide the development and revision of the CQMC core sets and serve as a reference when determining whether a measure should be included in a core set. The principles for core measure sets are intended to balance concepts valued across the membership and outline the CQMC's vision for a comprehensive core set. They aid members in determining whether a set is promoting the overarching values and goals of the Collaborative. The principles for measure selection describe the attributes a measure should possess for inclusion in the CQMC core sets so that the CQMC members can weigh the merits of an individual measure, in addition to whether it will contribute to a balanced core set that meets the CQMC's intention. Ideally, each core set should encompass all core measure set principles, and individual measures should reasonably align with all principles for measures. However, some principles are more aspirational in nature to encourage advancement in the field. Measures in a core set that no longer meet the selection principles should be considered for potential removal and discussed by the appropriate Workgroup.

Principles for the CQMC Core Measure Sets

1. Provide a holistic view of quality that assesses whether care is safe, effective, person-centered, timely, efficient, and equitable.
2. Provide meaningful and usable information to all the CQMC constituencies (i.e., consumers, providers, payers, purchasers, and regional collaboratives).
3. Include measures relevant to the medical condition of focus (i.e., "specialty-specific measures"), but also promote care that is coordinated across care settings and/or integrated across specialties.
4. Seek parsimony, alignment, and efficiency of measurement (i.e., minimum number of measures and the least burdensome measures).
5. Include an appropriate mix of measure types:
    a. Allow for structural and process measures as needed, particularly for emerging areas of measurement.
    b. Emphasize outcome measures.
    c. Exclude cost and resource use measures, as such aspects are encompassed in value-based care payment programs.
6. Highlight the value of consumer engagement in healthcare including through the incorporation of PRO-PMs.
7. Encourage the use of solely standardized digital measurement to harness new data sources and reduce reporting burden.
8. Encourage continuous improvement by seeking out novel measures that address identified clinical quality gaps.
9. Pursue measures that go beyond clinical care and are intended to address health equity and SDOH.

Principles for Measures Included in the CQMC Core Measure Sets

I. Align with the CQMC's values, goals, and measure set selection principles.
II. Support the advancement of health and healthcare improvement goals.

1. Prioritize measures addressing clinical areas with significant impacts on health.
2. Emphasize measure concepts that have a strong tie to outcomes.
3. Address areas in which change would be consequential (i.e., where there is variation in clinical care or an opportunity for overall improvement).

III. Are unlikely to promote unintended adverse consequences.

IV. Promote health equity by adopting measures that measure access to care, stratify clinical care measures to identify disparities, or measure progress toward addressing social needs.

V. Are scientifically sound (e.g., NQF-endorsed or otherwise proven to be evidence based, reliable, and valid in diverse populations).
1. Articulate the source of the evidence used to form the basis of the measure clearly.
2. Demonstrate high quality, sufficient quantity, and consistency of evidence that acting on the measure result will reduce variation and improve health outcomes.
3. Define the measure specifications clearly and transparently.
4. Are tested at the applicable level of care.

VI. Represent a meaningful balance between measurement burden and innovation.
1. Minimize data collection and reporting burden, while maintaining clinical credibility (i.e., measures that fit into existing workflows, are feasible, and do not duplicate efforts).
2. Are ambitious, yet providers being measured can meaningfully influence the results and are implemented at the intended level of attribution.
3. Are appropriately risk-adjusted and account for factors beyond the control of providers, as necessary.

VII. Encourage the use of digital quality measures, including eCQMs, to take advantage of the opportunities provided by digital data sources.

Appendix F: CQMC Workgroup Rosters

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American Medical Association (AMA)
American Occupational Therapy Association
America's Health Insurance Plans (AHIP)
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Blue Cross and Blue Shield of North Carolina (BCBSNC)
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Cardiology Workgroup

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Blue Cross Blue Shield Association
CareFirst Blue Cross Blue Shield
Centene
Centers for Medicare & Medicaid Services (CMS)
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Cross Cutting Workgroup

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American Gastroenterological Association (AGA)
American Occupational Therapy Association
America's Health Insurance Plans (AHIP)
AmeriHealth Caritas
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Centers for Medicare & Medicaid Services (CMS)
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America's Health Insurance Plans (AHIP)
AmeriHealth Caritas
Arkansas Blue Cross Blue Shield
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Centene
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Measure Model Alignment Workgroup

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AmeriHealth Caritas
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Centene
Centers 84or Medicare & Medicaid Services (CMS)
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Blue Cross Blue Shield Association
CareFirst Blue Cross Blue Shield
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Child Neurology Foundation (CNF)
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Civitas Network for Health
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Obesity Medicine Association
Texas Medical Association (TMA)
Vizient

Orthopedics Workgroup

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Blue Cross Blue Shield Association

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American College of Physicians (ACP)
American Medical Association (AMA)
American Occupational Therapy Association
American Specialty Health (ASH)
America's Health Insurance Plans (AHIP)
Blue Cross and Blue Shield of North Carolina (BCBSNC)
Blue Cross Blue Shield of Michigan
Bone Health and Osteoporosis Foundation
CareFirst Blue Cross Blue Shield
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Civitas Network for Health
Memorial Hermann Health System
Obesity Medicine Association
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Pediatrics Workgroup

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American College of Emergency Physicians (ACEP)
American College of Physicians (ACP)
American Heart Association
America's Health Insurance Plans (AHIP)
AmeriHealth Caritas
Blue Cross and Blue Shield of North Carolina (BCBSNC)
Blue Cross Blue Shield Association
Blue Cross Blue Shield of Michigan
CareFirst Blue Cross Blue Shield
Centers for Medicare & Medicaid Services (CMS)
Defense Health Agency (DHA)
Health Resources and Services Administration (HRSA)
Kentuckiana Health Collaborative
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The Leapfrog Group	American College of Lifestyle Medicine	Healthcare Transformation Task Force (HCTTF)
UnitedHealth Group	Children's Hospital Association (CHA)	Memorial Hermann Health System
	Civitas Network for Health	Texas Medical Association (TMA)
(NONVOTING)	Contexture	

Appendix G: Identified Gaps by NQF Measure Portfolio

In 2022, National Quality Forum (NQF) Standing Committees identified the following measure gaps—in which high value measures are too few or nonexistent to drive improvement—across topic areas for which measures were reviewed for endorsement.

All-Cause Admissions and Readmissions

No measure gaps were identified.

Behavioral Health and Substance Use

The Standing Committee highlighted that the significant increase in the use of telehealth behavioral health services since the COVID-19 pandemic should be accounted for in current and future measures. The Standing Committee also emphasized the need for more innovative Behavioral Health and Substance Use measures, noting that the Standing Committee rarely reviews new Behavioral Health and Substance Use measures, and most measures in the current portfolio are process measures that were initially developed over a decade ago.

Cancer

No measure gaps were identified.

Cardiovascular

No measure gaps were identified.

Cost and Efficiency

The Standing Committee emphasized the importance of creating measures that linked cost and quality, noting that while it is important to demonstrate improvements in costs, those reductions in cost should not result in reductions in quality. Specifically, the Standing Committee noted that measures should either measure both cost and quality or be able to demonstrate the relationship between performance on cost and related quality measures.

Geriatrics and Palliative Care

The Standing Committee noted that hospice measures should account for adult and pediatric patients either in the same measure or with separate related measures. The Standing Committee also stressed that all care disciplines that provide support during hospice care should be incorporated into measures in order to conduct a more holistic review of the patient and caregiver experience.

Neurology

No measure gaps were identified.

Patient Experience and Function

No measure gaps were identified.

Patient Safety

No measure gaps were identified.

Perinatal and Women's Health

The Standing Committee emphasized the need to create specialized or condition-specific measures instead of broad measures so that accountable entities can foster and improve data for quality and process improvement efforts.

Prevention and Population Health

No measure gaps were identified.

Primary Care and Chronic Illness

No measure gaps were identified.

Renal

No measure gaps were identified.

Surgery

No measure gaps were identified.

Appendix H: Medicare Measure Gaps Identified by MAP

MAP Clinician Workgroup

Within the Medicare SSP, the MAP noted a concern regarding the application of an all-payer approach to eCQMs and its impact on those facilities and clinicians with large populations of disadvantaged patients, particularly Medicaid or uninsured patients. The MAP further noted that it is problematic to adopt measures that are meant for individual clinicians for large groups, such as ACOs, because performance issues could arise.

MAP Hospital Workgroup

The MAP noted a limited number of measures on imaging and emergency departments, highlighting this as critical to outpatient care. The MAP further noted a lack of measures within outpatient quality reporting programs and commented on the need to better understand patient safety since the pandemic and the gaps that exist.

MAP Post-Acute Care/Long-Term Care Workgroup

The MAP suggested alignment across measures for the PAC/LTC programs related to function and symptoms, care initiation, and prevention. In addition, the MAP identified a broader issue regarding systematic barriers when accessing home health and access to care and measures to capture SDOH and health disparities as suggestions for future measures.

Further, the MAP noted a lack of FFS data and that quality should be measured in both the FFS and Medicare Advantage plans to evaluate the quality being delivered. It suggested interoperability as another gap within PAC/LTC programs, especially for the prevention of errors and to streamline information.

In addition, the MAP suggested caregivers' needs and training as a gap and noted the importance of mental health, such as depression and social isolation, and the need for psychiatric nurse practitioners across PAC settings.

The MAP noted a lack of PRO-PMs within SNF QRP, suggesting that the definition of quality is different for each individual, and unless that definition is integrated into measurement, individual needs will not be met. The MAP also suggested mental health, specifically isolation, loneliness, and depression, as potential program measure gaps. It noted the need for a focus on community re-integration, especially functional performance measures related to mobility.

The MAP noted that the COVID-19 pandemic has uncovered a huge under-preparedness and lack of resources related to infection control; therefore, aligned, ongoing measurement that reflects overall infection control performance for SNFs and LTCHs is needed.

Within SNF QRP, the MAP noted that pain management is a measurement gap that needs to be considered.

The MAP also noted the importance of a balance of structure, process, and outcome measures within SNF value-based payment, especially regarding patient experience. It suggested the need for information transfers and not just within the silos of care settings. In addition, the MAP specifically commented on medication reconciliation and its impact on care, such as decreasing hospital readmissions.

Appendix I: Crosswalk Between 2022 NQF Activities and CMS Meaningful Measures 2.0 Goals

Appendix J: Statutory Requirement of Annual Report Components

The Social Security Act (the Act)—specifically section 1890(b)(5)(A)— mandates that the entity report be sent to Congress and the Secretary of the Department of Health and Human Services (HHS) no later than March 1st of each year.

The report must include descriptions of the following:

- How the entity has implemented quality and efficiency measurement initiatives under the Act and coordinated these initiatives with those implemented by other payers
- The entity's recommendations with respect to an integrated national strategy and priorities for healthcare performance measurement in all applicable settings
- The entity's performance of the duties required under its contract with HHS (Appendix A)
- Gaps in endorsed quality and efficiency measures, including measures that are within priority areas identified by the Secretary under HHS' national strategy, and where quality and efficiency measures are unavailable or inadequate to identify or address such gaps
- Areas in which evidence is insufficient to support endorsement of measures in priority areas identified by the Secretary under the [National Quality Strategy], and where targeted research may address such gaps
- Matters related to convening multistakeholder groups to provide input on the following: (1) the selection of certain quality and efficiency measures and (2) national priorities for improvement in population health and in the delivery of healthcare services for consideration under the National Quality Strategy
- An itemization of financial information for the fiscal year ending September 30 of the preceding year, including the following: (1) annual revenues of the entity (including any government funding, private sector contributions, grants, membership revenues, and investment revenue); (2) annual expenses of the entity (including grants paid, benefits paid, salaries or other compensation, fundraising expenses, and overhead costs); and (3) a breakdown of the amount awarded per contracted task order and the specific projects funded in each task order assigned to the entity
- any updates or modifications of internal policies and procedures of the entity as they relate to the duties of the entity under this section, including the following: (1) specifically identifying any modifications to the disclosure of interests and conflicts of interests for committees, work groups, task forces, and advisory panels of the entity and (2) information on external stakeholder participation in the duties of the entity under this section (including complete rosters for all committees, workgroups, task forces, and advisory panels funded through government contracts, descriptions of relevant interests and any conflicts of interest for members of all committees, work groups, task forces, and advisory panels, and the total percentage by healthcare sector of all convened committees, workgroups, task forces, and advisory panels.

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