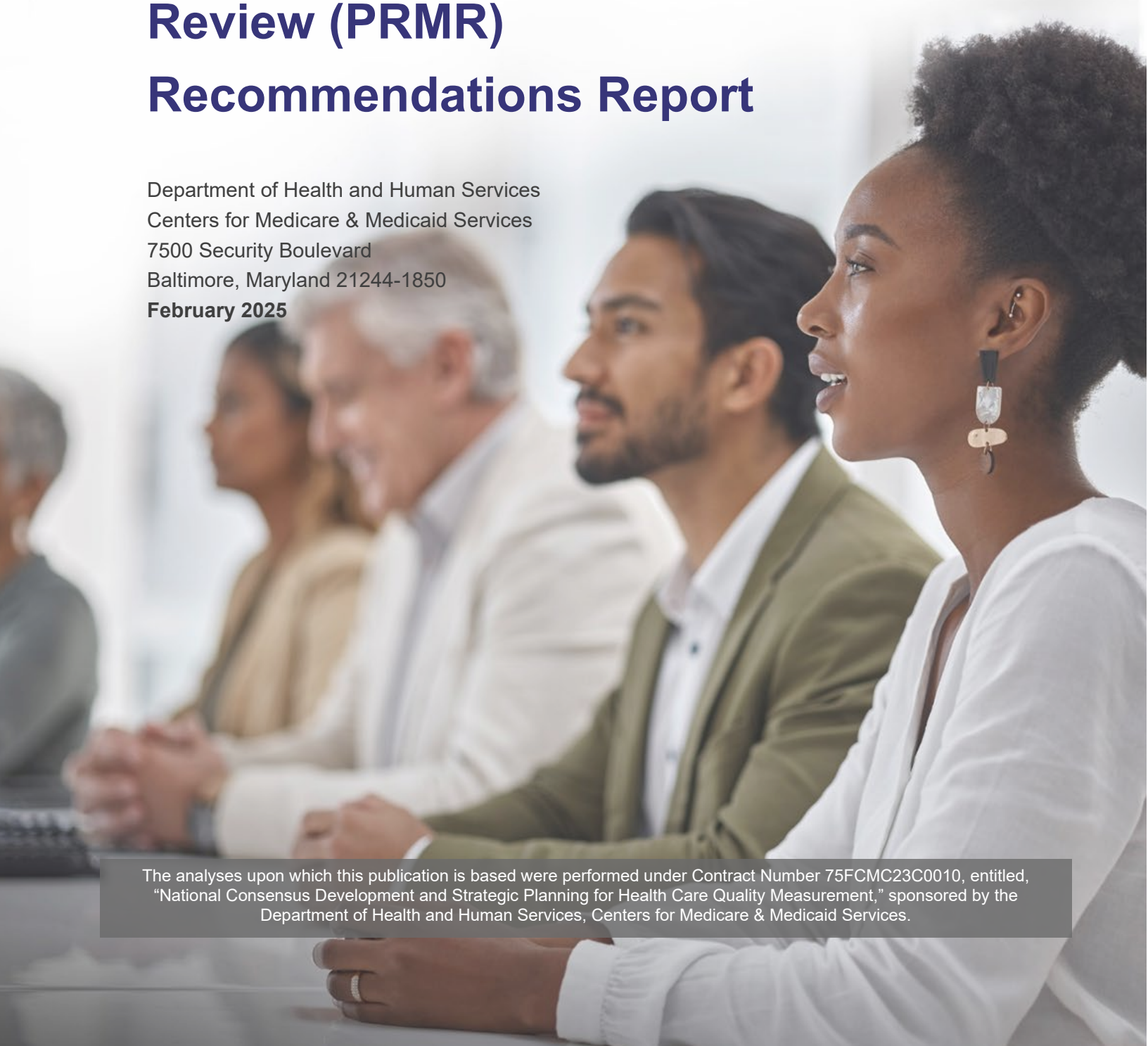
Partnership for Quality Measurement
Powered by Battelle

National Consensus Development and Strategic Planning for Health Care Quality Measurement

2024-2025 Pre-Rulemaking Measure Review (PRMR)

Recommendations Report

Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
February 2025



The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Table of Contents

List of Tables

Page

List of Figures

Page

Executive Summary

Battelle, as the Consensus-Based Entity (CBE) holding the national consensus development contract, managed the Pre-Rulemaking Measure Review (PRMR) process for the 2024–2025 cycle. We convened the Partnership for Quality Measurement (PQM) committee members to review measures submitted to the Centers for Medicare & Medicaid Services (CMS) as part of the pre-rulemaking process.

These committee members considered the critical question: Is the measure reasonable and necessary for use in the intended CMS value-based program(s)? Sponsored and overseen by CMS, the PRMR process provides recommendations to the Department of Health and Human Services (HHS) on selecting quality and efficiency measures under consideration (MUC) for use by HHS.

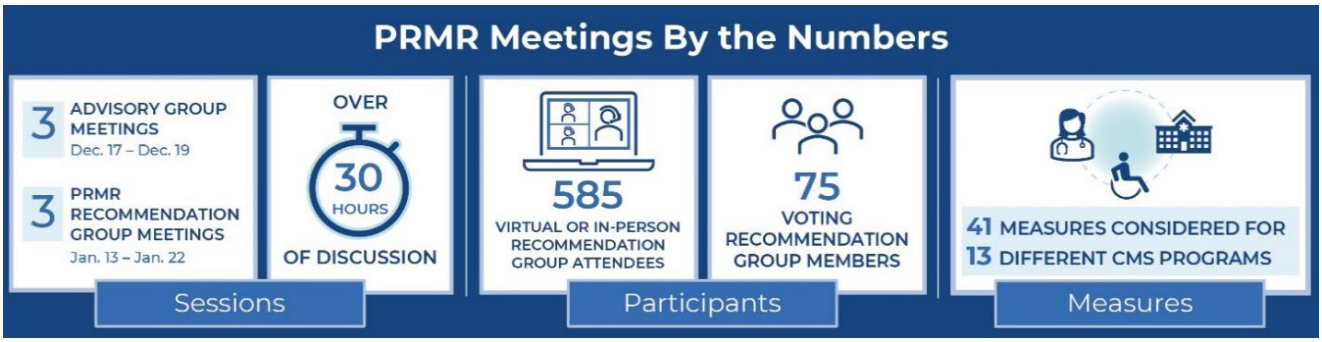


Figure 1. PRMR 2024 Meetings by the Numbers

Across three setting-specific committees, committee members reviewed 41 measures spanning 13 CMS programs. Of the 52 measure-to-program votes, 10 measures were recommended, 17 measures were recommended with conditions, 5 measures were not recommended, and the committee did not reach consensus on 20 measures.

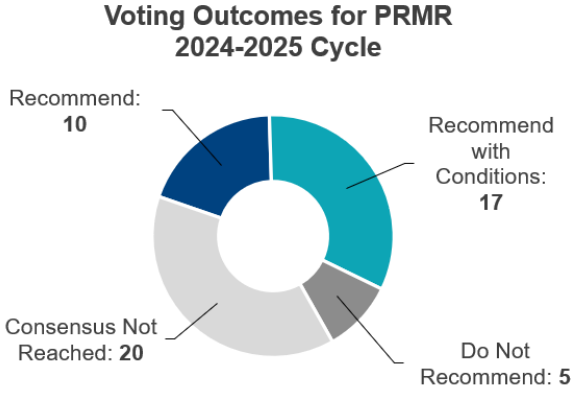


Figure 2. Voting Outcomes for PRMR 2024-2025 Cycle

This report summarizes the PRMR process, encompassing the following overarching steps:

Public Engagement: From November 25–December 30, 2024, Battelle held a call for public comment via the PQM website along with a series of setting-specific listening sessions held virtually over Zoom.

Preliminary Measure Assessment: Battelle staff conducted a preliminary assessment (PA) on PRMR evaluation criteria for each measure to inform and support committee members' reviews of the MUC List measures assigned to their committee.

Committee Evaluation: Advisory and Recommendation Group members reviewed the PAs and participated in Pre-meeting Initial Evaluations (PIEs) to assess initial strengths and areas of concern and generate a starting point for discussion during the Recommendation Group

meetings. Members of the Advisory Group for each committee met to discuss measure feedback.

Recommendation Group Discussion: In three meetings spanning five days, Battelle convened the Recommendation Group members of the Clinician, Hospital, and Post-Acute Care/Long-Term Care (PAC/LTC) committees together with CMS leadership and measure developers to evaluate the 41 measures under consideration for 13 CMS programs.

PRMR Votes and Outcomes: Table 1 outlines the final program specific votes of the Recommendation Groups for each CMS program. Section 2 of this report presents detailed discussions for each recommendation. Section 3 outlines common themes across the measure discussions as well as considerations for areas of further development and interest for CMS to explore based on the input of interested parties during this PRMR cycle.

Table 1. PRMR Recommendations for 2024 Measures Under Consideration[1,2]

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
PAC/LTC	MUC2024-054a	CAHPS® Home Health Care Survey Care of Patients	Home Health Quality Reporting Program	Recommend	22 (88%)	2 (8%)	1 (4%)	0
PAC/LTC	MUC2024-054b	CAHPS® Home Health Care Survey Communications Between Providers and Patients	Home Health Quality Reporting Program	Recommend	25 (100%)	0	0	0
PAC/LTC	MUC2024-054c	CAHPS® Home Health Care Survey Talk About Home Safety	Home Health Quality Reporting Program	Recommend	17 (68%)	4 (16%)	4 (16%)	0
PAC/LTC	MUC2024-054d	CAHPS® Home Health Care Survey Review Medicines	Home Health Quality Reporting Program	Recommend with Conditions	16 (67%)*	7 (29%)	1 (4%)	0
PAC/LTC	MUC2024-054e	CAHPS® Home Health Care Survey Talk About Medicine Side Effects	Home Health Quality Reporting Program	Recommend	19 (83%)	2 (9%)	2 (9%)	0

[1] Due to rounding, percentages may not always add up to 100%.
[2] Measures are presented in the order in which they were discussed during Recommendation Group meetings.

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-073	Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM)	Ambulatory Surgical Center Quality Reporting Program	Consensus Not Reached	5 (19%)	14 (52%)	8 (30%)	0
Hospital	MUC2024-060	In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure	End-Stage Renal Disease Quality Incentive Program	Recommend	24 (89%)	2 (7%)	1 (4%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-074	Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)	Hospital Outpatient Quality Reporting Program	Recommend with Conditions	16 (59%)	7 (26%)	4 (15%)	0
Hospital	MUC2024-074	Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)	Rural Emergency Hospital Quality Reporting Program	Consensus Not Reached	12 (48%)	4 (16%)	9 (36%)	0
Hospital	MUC2024-067	Proportion of Patients who Died from Cancer Admitted to the ICU in the Last 30 Days of Life	Hospital Inpatient Quality Reporting Program	Consensus Not Reached	3 (12%)	10 (38%)	13 (50%)	0
Hospital	MUC2024-068	Proportion of Patients who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life	Hospital Outpatient Quality Reporting Program	Consensus Not Reached	11 (42%)	6 (23%)	9 (35%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-078	Proportion of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days	Hospital Inpatient Quality Reporting Program	Consensus Not Reached	9 (35%)	7 (27%)	10 (38%)	0
Hospital	MUC2024-078	Proportion of Patients who Died from Cancer Admitted to Hospice for Less than 3 Days	Hospital Outpatient Quality Reporting Program	Consensus Not Reached	14 (54%)	4 (15%)	8 (31%)	0
Hospital	MUC2024-069	Addressing Social Needs Assessment & Intervention	Hospital Inpatient Quality Reporting Program	Consensus Not Reached	13 (48%)	6 (22%)	8 (30%)	0
Hospital	MUC2024-069	Addressing Social Needs Assessment & Intervention	Medicare Promoting Interoperability Program	Consensus Not Reached	13 (48%)	2 (7%)	12 (44%)	0
Hospital	MUC2024-069	Addressing Social Needs Assessment & Intervention	PCHQR	Consensus Not Reached	17 (63%)	2 (7%)	8 (30%)	0
Hospital	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Hospital-Acquired Condition Reduction Program	Consensus Not Reached	7 (26%)	6 (22%)	14 (52%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Hospital Inpatient Quality Reporting Program	Consensus Not Reached	6 (23%)	5 (19%)	15 (58%)	0
Hospital	MUC2024-085	Hospital Harm – Anticoagulant-Related Major Bleeding	Medicare Promoting Interoperability Program	Consensus Not Reached	5 (19%)	4 (15%)	18 (67%)	0
Hospital	MUC2024-027	Patient Safety Structural Measure	Hospital Inpatient Quality Reporting Program	Do Not Recommend	3 (12%)	1 (4%)	22 (85%)	0
Hospital	MUC2024-027	Patient Safety Structural Measure	Hospital Value-Based Purchasing Program	Do Not Recommend	4 (15%)	0 (0%)	23 (85%)	0
Hospital	MUC2024-027	Patient Safety Structural Measure	Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program	Do Not Recommend	2 (7%)	0 (0%)	25 (93%)	0
Hospital	MUC2024-075	Emergency Care Capacity and Quality (ECCQ)	Hospital Outpatient Quality Reporting Program	Consensus Not Reached	10 (37%)	10 (37%)	7 (26%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-095	Emergency Care Capacity and Quality (ECCQ)	Rural Emergency Hospital Quality Reporting Program	Consensus Not Reached	9 (35%)	6 (23%)	11 (42%)	0
Hospital	MUC2024-034	Influenza Vaccination Coverage Among Healthcare Personnel	Rural Emergency Hospital Quality Reporting Program	Recommend	26 (100%)	0 (0%)	0 (0%)	0
Hospital	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital-Acquired Condition Reduction Program	Recommend with Conditions	17 (63%)	8 (30%)	2 (7%)	0
Hospital	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital Inpatient Quality Reporting Program	Recommend with Conditions	18 (67%)	8 (30%)	1 (4%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-042	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital Value-Based Purchasing Program	Recommend with Conditions	17 (63%)	10 (37%)	0 (0%)	0
Hospital	MUC2024-043	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity	Hospital Inpatient Quality Reporting Program	Recommend with Conditions	18 (69%)	7 (27%)	1 (4%)	0
Hospital	MUC2024-043	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity	Hospital Value-Based Purchasing Program	Recommend with Conditions	19 (70%)	7 (26%)	1 (4%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-041	Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	Hospital Readmissions Reduction Program	Recommend with Conditions	19 (70%)	7 (26%)	1 (4%)	0
Hospital	MUC2024-046	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	Hospital Readmissions Reduction Program	Recommend with Conditions	19 (70%)	8 (30%)	0 (0%)	0
Hospital	MUC2024-030	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	Hospital Readmissions Reduction Program	Recommend with Conditions	18 (67%)	9 (33%)	0 (0%)	0
Hospital	MUC2024-032	Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization	Hospital Readmissions Reduction Program	Recommend with Conditions	17 (63%)	10 (37%)	0 (0%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Hospital	MUC2024-040	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	Hospital Readmissions Reduction Program	Recommend with Conditions	18 (67%)	9 (33%)	0 (0%)	0
Hospital	MUC2024-045	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization	Hospital Readmissions Reduction Program	Recommend with Conditions	17 (63%)	10 (37%)	0 (0%)	0
Clinician	MUC2024-052	Social Need Screening and Intervention	Part C Star Ratings Program	Consensus Not Reached	6 (26%)	2 (9%)	15 (65%)	0
Clinician	MUC2024-081	Adult Immunization Status (AIS-E)	Part C Star Ratings Program	Recommend	20 (87%)	1 (4%)	2 (9%)	0
Clinician	MUC2024-088	Depression Screening and Follow-Up for Adolescents and Adults	Part C Star Ratings Program	Consensus Not Reached	6 (26%)	10 (43%)	7 (30%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Clinician	MUC2024-026	Person-Centered Outcome Measures: Goal-Identification, Follow-Up, and Goal Achievement	Merit-based Incentive Payment System	Recommend with Conditions	13 (57%)	6 (26%)	4 (17%)	0
Clinician	MUC2024-082	Cancer Screening and Counseling Patient-Reported Outcome-Outcome-Based Measure (PRO-PM)	Merit-based Incentive Payment System	Consensus Not Reached	7 (30%)	1 (4%)	15 (65%)	0
Clinician	MUC2024-080	Patient Reported Falls and Plan of Care	Merit-based Incentive Payment System	Recommend	20 (87%)	3 (13%)	0 (0%)	0
Clinician	MUC2024-084	Quality of Life Outcome for Patients with Neurologic Conditions	Merit-based Incentive Payment System	Recommend	20 (91%)	2 (9%)	0 (0%)	0
Clinician	MUC2024-051	Prevalent Standardized Waitlist Ratio (PSWR)	Merit-based Incentive Payment System	Consensus Not Reached	13 (65%)	0 (0%)	7 (35%)	0
Clinician	MUC2024-072	Addressing Social Needs Assessment & Intervention	Merit-based Incentive Payment System	Consensus Not Reached	10 (48%)	2 (10%)	9 (43%)	0

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Clinician	MUC2024-025	Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care	Merit-based Incentive Payment System	Recommend with Conditions	16 (70%)	3 (13%)	4 (17%)	0
Clinician	MUC2024-028	Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes	Merit-based Incentive Payment System	Recommend	22 (100%)	0 (0%)	0 (0%)	1
Clinician	MUC2024-031	Hepatitis C Virus (HCV): Sustained Virological Response (SVR)	Merit-based Incentive Payment System	Recommend	23 (100%)	0 (0%)	0 (0%)	0
Clinician	MUC2024-079	Assessment of Autonomic Dysfunction and Follow-up	Merit-based Incentive Payment System	Recommend with Conditions	12 (55%)	7 (32%)	3 (14%)	0
Clinician	MUC2024-049	Breast Cancer Screening	Merit-based Incentive Payment System	Do Not Recommend	1 (5%)	2 (11%)	16 (84%)	2
Clinician	MUC2024-100	Non-Pressure Ulcers	Merit-based Incentive Payment System	Consensus Not Reached	4 (20%)	2 (10%)	14 (70%)	2

Committee	MUC ID	Measure Title	Program	Vote Outcome	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N(%)	Recusals
Clinician	MUC2024-101	Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)	Merit-based Incentive Payment System	Do Not Recommend	1 (5%)	1 (5%)	18 (90%)	0

1. Pre-Rulemaking Measure Review (PRMR) Overview

1.1 PRMR Overview

The goal of the PRMR process is to inform the selection of health care quality and efficiency measures for use in CMS Medicare quality programs. Per statute,[3] the Department of Health and Human Services (HHS) annually publishes a list of measures under consideration (MUC) for future federal rulemaking by December 1. The PRMR process provides consensus recommendations regarding the addition of measures being considered for CMS quality reporting and value-based programs. It focuses on evaluating a measure's appropriateness for a specific program, assessing whether the measure is meaningful, tailored to the program's unique needs, balanced, and scaled to meet program-specific goals. Additionally, the process examines if the measure demonstrates a clear vision of both near- and long-term program impacts.

The cornerstone of a transparent and meaningful consensus-based process is effective engagement of interested parties. This ensures that CMS has access to meaningful feedback on all measures proposed for inclusion in CMS quality programs. Battelle convenes and engages interested parties throughout the PRMR cycle. The interested parties include those who are impacted or affected by quality and efficiency measures. Interested parties come from a variety of places (Figure 3) and provide a balance of perspectives.

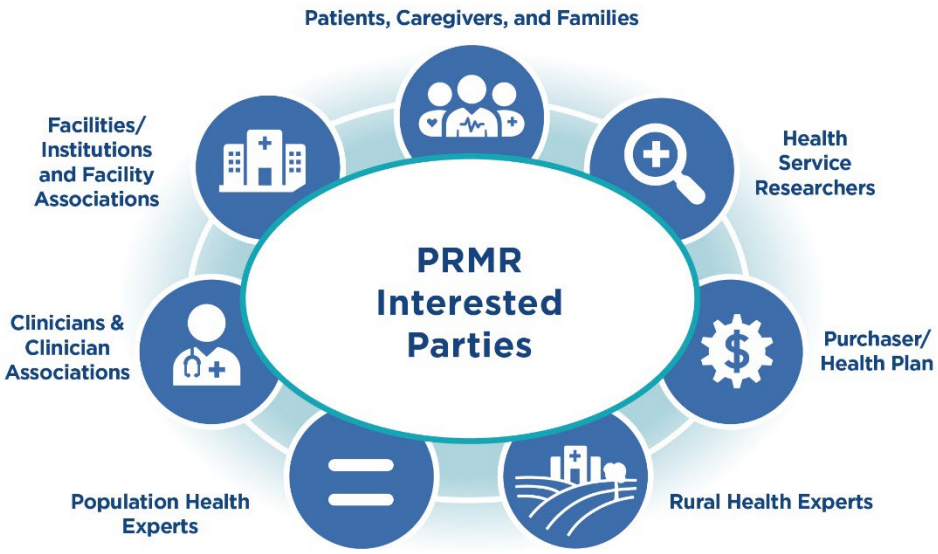


Figure 3. PRMR Interested Parties

[3] Section 3014 of the Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) created section 1890A of the Social Security Act (the Act), which required HHS to establish a federal pre-rulemaking process for the selection of quality and efficiency measures for use by HHS.

1.2 Committee Membership

Battelle staff conducted a public call for nominations and targeted outreach to solicit nominees for PRMR committees (Figure 4). Battelle prioritized individuals who 1) had previously participated in similar panels/committees or had demonstrated knowledge of these processes, 2) fit into more than one roster category, and 3) possessed lived experience interacting with the health care system.

Figure 4. PRMR Committees

To ensure all perspectives are represented, these committees included individuals from traditionally underrepresented groups such as patients/recipients of care and caregivers, people who belong to racial/ethnic minority groups, and rural health providers as well as experts in population health. At the start of the PRMR review process, all committee members attested to a measure disclosure of interest (DOI) form and were recused from discussing and voting on measures potentially affected by a conflict of interest (COI). Full committee rosters and biographies are posted on the PQM website.

Each committee includes two groups of reviewers—a Delphi group (hereafter referred to as an Advisory Group) and a nominal group (hereafter referred to as a Recommendation Group)—consistent with the principles of the Novel Hybrid Delphi and Nominal Group (NHDNG) Technique.[4] This technique relies on balancing broad representation with committee and subcommittee discussion to support better policy outcomes. The purpose of this technique is to significantly increase the number of interested parties participating in the consensus-building process and to ensure that one voice does not dominate the committee's advice and recommendations. Advisory Group input guides the Recommendation Groups' final consensus recommendations to CMS. Both groups work in tandem to provide meaningful impact on measures at different points of the PRMR process. This process is outlined in detail in the PRMR & MSR Guidebook.

1.3 Public Engagement

Each PRMR cycle begins with the publication of the MUC List. The PRMR process engages a diverse group of interested parties across the health care and quality measurement landscape

[4] Davies S., Romano P.S., Schmidt E.M., Schultz E., Geppert J.J., McDonald K.M. Assessment of a novel hybrid Delphi and nominal groups technique to evaluate quality indicators. Health Services Research. 2011 Dec; 46 (6pt1): 2005-18. https://doi.org/10.1111/j.1475-6773.2011.01297.x

to provide perspectives on these measures (Figure 5). Interested parties provide feedback received on the measure through written and spoken public comment opportunities. Battelle held a written public comment period from November 25–December 30, 2024. Battelle also hosted a series of setting-specific listening sessions where members of the public provided spoken feedback on measures under consideration.

Battelle received a total of 239 written comments and 51 spoken comments from 234 professional organizations/societies and 56 patients or patient organizations. A compiled list of public comments is available on the PQM website. Alongside feedback from the Advisory and Recommendation Groups, insights from public comments helped identify areas of non-consensus to focus on during the Recommendation Group meetings. This approach ensured that the voices of many interested parties were adequately represented in the Pre-Rulemaking process. Battelle held a final public comment period on the recommendations from this PRMR cycle from February 3-17, 2025 and received 5 public comments. These comments will not change the final committee recommendations but will serve as an additional source of information for CMS.

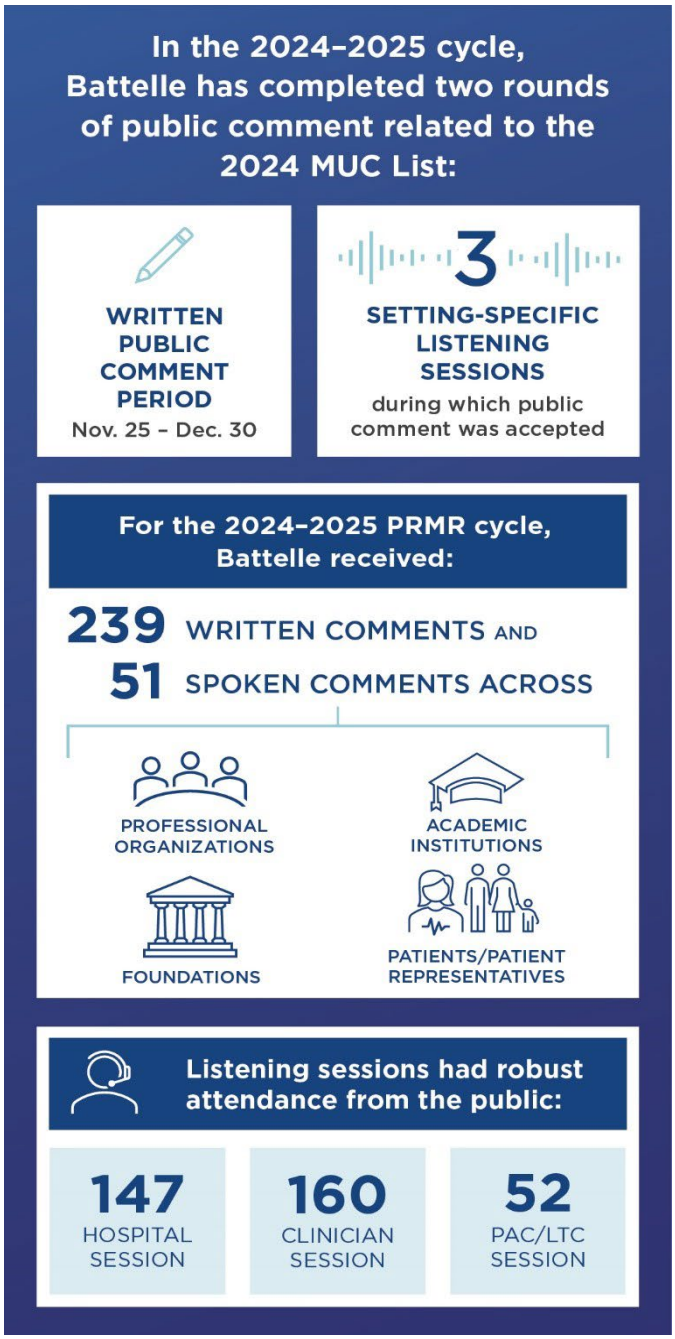


Figure 5. PRMR Public Engagement

1.4 PRMR Preliminary Assessments & MUC List Materials

To inform and guide committee members in reviewing the MUC List, Battelle staff conducted a preliminary assessment (PA) each measure. These PAs aimed to provide committee members with a comprehensive and standardized baseline evaluation of the measures under consideration. The PAs served as a tool to support members as they examined and discussed the suitability of measures for the proposed CMS program, both before and during the Recommendation Group meetings.

To develop the PAs, a team of experienced measure evaluators reviewed submission documentation in the MUC Entry/Review Information Tool (CMS MERIT) system including information provided in the submission form as well as any supplemental materials attached, which may include Measure Information Forms, peer-reviewed literature, clinical practice guidelines, validity and reliability testing methods and results, and electronic clinical quality measure (eCQM) feasibility testing information, as needed. The measure evaluators compared

this information against evaluation criteria as outlined in the PRMR Guidebook with an emphasis on measure importance, conformance, feasibility, reliability, validity, and usability (i.e., meaningfulness), as well as the measure's appropriateness of scale, and time-to-value realization for the selected CMS program.

Battelle created summaries each measure's performance on these evaluation criteria and discussed specific considerations for use of the measure within the CMS program. Each criteria could be rated as "Met", "Not Met but Addressable", or "Not Met." All summaries were sent to relevant CMS staff and measure developers for review and revisions were made based on collaboration with key informants before being made publicly available. Measures that had received prior CBE endorsement were considered "met" for meaningfulness criteria with added discussion on merits and concerns as well as questions for committees to consider when evaluating. PRMR committee members and the general public had access to these PAs through the Battelle website after the MUC list was published.

While reviewing the PAs, the committee also had full access to materials submitted by measure developers in CMS MERIT. CMS made these materials available to the public by posting them on the Measures Management System website.

1.5 PRMR Pre-meeting Initial Evaluation

Advisory and Recommendation Group members contributed written feedback on measures assigned to their committee through their pre-meeting initial evaluation (PIE) Forms. Battelle provided committee members with links to measure-specific Microsoft Forms that included eight questions with a mix of free text and categorical responses. These questions focused on the three domains of Meaningfulness, Appropriateness of Scale, and Time to Value Realization as outlined in the PRMR Guidebook. The goals of these PIE Forms were to assess initial strengths and areas of concern for each measure and generate a starting point for discussion during the Recommendation Group meetings.

Battelle staff compiled and synthesized the information collected from the public comment process, listening sessions, and PIE Forms to aid in the Advisory and Recommendation Group meetings. These materials helped identify areas of non-consensus for focus during the meetings.

1.6 Advisory Group Meetings

Battelle convened members of the Advisory Group in three setting-specific meetings from January 6–8, 2025. The Recommendation Group co-chairs facilitated these meetings, during which members of the Advisory Group shared feedback on the measures under consideration based on their examination of the measure submission materials, PAs, and their personal and professional experiences. The meetings created a forum for Advisory Group members to discuss the measures under consideration and prepared the co-chairs to provide a representative overview to the Recommendation Group during voting discussions. Meeting summaries for the Advisory Group meetings are posted on the PQM website.

1.7 Recommendation Group Meetings

In three meetings spanning five days, Battelle convened the Recommendation Group members of the Clinician, Hospital, and Post-Acute Care/Long-Term Care (PAC/LTC) Committees together with CMS leadership and measure developers to evaluate the 41 measures under consideration for 13 CMS programs. The Clinician Committee and PAC/LTC Committee

convened virtually while the Hospital Committee convened for a hybrid meeting with most attendees joining in-person from Baltimore, Maryland. Meeting summaries with detailed discussion notes and recordings are available on the PQM website.

Battelle collected Disclosures of Interest (DOIs) during roll call at the start of each meeting. Following opening remarks, Battelle facilitators outlined the procedures for discussing and voting on measures. The discussion quorum required at least 60% of the Recommendation Group members in attendance during roll call. The voting quorum required the presence of at least 80% of active Recommendation Group members who were not recused from the vote due to a COI. During the five meeting days, some members stepped away temporarily, so Battelle collected voting counts for each measure to ensure quorum was retained. A consensus vote required greater than or equal to 75% of voting members in agreement. Battelle directed committee members to provide conditions for any vote cast “recommend with conditions” even if duplicative of others’ stated conditions, but some members chose not to and there are several instances where the number of conditions do not correlate with the number of votes. The committee did not vote on conditions provided.

At the beginning of each measure discussion, Battelle introduced the measure, and CMS gave an overview of the measure and rationale for inclusion in one or more CMS programs. Battelle then provided a summary of the public comments and PIE Form responses, asked the Recommendation Group co-chairs to give an overview of Advisory Group feedback, and then opened the measure discussion.

During voting, committee members had the option to select “recommend”, “recommend with conditions” or “do not recommend” for each program-specific vote on measure inclusion. The intent of casting a "recommend with conditions" vote was to allow for committee members to provide actionable steps that they feel must happen before the measure is implemented within the program. Committee members were asked to submit specific conditions in the Zoom chat when casting a vote to "recommend with conditions"; however, this guidance was not consistently followed. There are several measures that had "recommend with conditions" votes cast but no submitted conditions. Additionally, conditions submitted may offer considerations or requests that may not be feasible or appropriate for CMS to achieve before measure implementation. We recommend that CMS consider submitted conditions when determining next steps for measure implementation and exploring future measure concepts.

2. Pre-Rulemaking Measure Review (PRMR) Recommendations

2.1 Post-Acute Care/Long-Term Care (PAC/LTC) Committee Measures

2.1.1 MUC2024-054a CAHPS® Home Health Care Survey Care of Patients [Centers for Medicare & Medicaid Services (CMS)/Agency for Healthcare Research and Quality (AHRQ)]

Description: Care of Patients is a multi-item measure derived from the updated CAHPS® Home Health Care Survey, also referred as “HHCAHPS.” This is a standardized survey instrument and data collection methodology for measuring home health patients’ perspectives on their home health care in Medicare-certified home health care agencies.

Program: Home Health Quality Reporting Program

Measure Review Final Vote: Recommend

Vote Count: Recommend, 22 (88%); Recommend with Conditions, 2 (8%); Do not Recommend, 1 (4%); No Recusals

Summary of Public Comment: This measure received seven public comments. One comment expressed support, highlighting the potential for the streamlined survey to better capture responses from underrepresented groups, particularly those with low literacy levels. However, six comments raised concerns around the importance of accurately attributing responses to the appropriate staffing type such as distinguishing between skilled rehabilitation therapists and personal care aides. Additionally, comments expressed concern about the accuracy of data collected from patients or caregivers, given the 2-month recall period, and how accessible the survey accessibility may be for those with lower literacy skills.

Discussion Themes	Recommendation Group Member Discussion
Capturing Negative Feedback	• The committee stressed the need to capture negative feedback from patients about their home health care experiences. CMS assured the committee that the survey questions are designed to allow a range of responses, including negative ones, to capture dissatisfaction or negative experiences.
Appropriateness of Reference Period	• The committee raised concerns about the 2-month reference period for patient responses, questioning patients' ability to accurately recall experiences over this time. CMS explained the rationale for the 2-month period as a benchmark for evaluating recent care, noting that similar surveys use extended reference periods, such as the Health Plan Survey's 6-month period.

Conditions[5]: The committee suggested CMS consider stratification by enrollment size for low-volume providers and geography for rural service areas.

2.1.2 MUC2024-054b CAHPS® Home Health Care Survey Communications Between Providers and Patients [CMS/AHRQ]

Description: Communications Between Providers and Patients is a multi-item measure derived from the updated CAHPS® Home Health Care Survey, also referred as “HHCAHPS.” This is a standardized survey instrument and data collection methodology for measuring home health patients’ perspectives on their home health care in Medicare-certified home health care agencies.

Program: Home Health Quality Reporting Program

Measure Review Final Vote: Recommend

Vote Count: Recommend, 25 (100%); Recommend with Conditions, 0 (0%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: This measure received six public comments. One comment supported the measure, stating the streamlined survey would more effectively capture feedback from underrepresented groups than the current survey. Five comments raised concerns,

[5] Although some conditions in the report are framed as consideration for future measure development, we are including them as conditions in this report to accurately reflect that the comment was submitted by a committee member in support of a "recommendation with conditions" vote.

including around the accuracy of data collected from patients or caregivers, given the 2-month recall period. Commenters expressed concerns around survey accessibility, the mode of survey administration for those with low literacy skills, and the absence of questions about other aspects of care such as timeliness and social needs.

Discussion Themes	Recommendation Group Member Discussion
Staff Timeliness and Caregiver Coordination	• Committee members highlighted the importance of measuring timely arrivals for staff, particularly to support family caregivers who need to adjust their schedules.
Meaningful Patient Engagement	• The committee placed emphasis on the importance of not just listening to patients but ensuring they are truly heard and understood, identifying this as a critical yet nuanced aspect of care.
Unmeasured Aspects of Care	• The committee expressed the need to consider unmeasured aspects of care such as cultural competence, mental health support, caregiver involvement, and coordination of care, suggesting these areas should be measured in the future to enhance overall care quality.

Conditions: None provided.

2.1.3 MUC2024-054c CAHPS® Home Health Care Survey Talk About Home Safety [CMS/AHRQ]

Description: Talk About Home Safety is a single-item measure derived from the updated CAHPS® Home Health Care Survey, also referred as "HHCAHPS." This is a standardized survey instrument and data collection methodology for measuring home health patients' perspectives on their home health care in Medicare-certified home health care agencies.

Program: Home Health Quality Reporting Program

Measure Review Final Vote: Recommend with Conditions

Vote Count: Recommend, 17 (68%); Recommend with Conditions, 4 (16%); Do Not Recommend, 4 (16%); No recusals

Summary of Public Comment: This measure received six public comments. One comment supported the measure, stating the streamlined survey would more effectively capture feedback from underrepresented groups than the current survey. Five comments raised concerns, including that the survey item only addresses safety at the beginning of home health care with the agency rather than the duration of care; how accurate that data collected from patients or caregivers may be, given the 2-month recall period; how accessible the survey may be; the mode of survey administration to populations with low literacy skills; and the absence of questions about other aspects of care such as timeliness and social needs.

Discussion Themes	Recommendation Group Member Discussion
Patient Safety	• Committee members agreed that the measure focus on conversations about home safety is important, but encouraged further action to ensure patient safety is fully addressed. • One committee member expressed concern that many patients do not have access to home safety equipment like walkers and grab bars, and therefore must rely on borrowed or shared safety equipment unsuitable to address their needs.
Variation in Quality	• One committee member shared their recent experiences with home health agencies to explain how different agency protocols for addressing home safety can be.

Conditions: The committee recommended CMS pair the measure with a safety assessment item to ensure comprehensive evaluation. They also suggested CMS implement a follow-up mechanism to ensure that patients fully understand the conversation about safety and use the collected data to identify and address patients' needs for safe equipment, potentially influencing policy changes.

2.1.4 MUC2024-054d CAHPS® Home Health Care Survey Review Medicines [CMS/AHRQ]

Description: Review Medicines is a single-item measure derived from the updated CAHPS® Home Health Care Survey, also referred as "HHCAHPS." This is a standardized survey instrument and data collection methodology for measuring home health patients' perspectives on their home health care in Medicare-certified home health care agencies.

Program: Home Health Quality Reporting Program

Measure Review Final Vote: Recommend with Conditions

Vote Count: Recommend, 16 (67%); Recommend with Conditions, 7 (29%); Do Not Recommend, 1 (4%); No recusals

Summary of Public Comment: This measure received six public comments. The comments mirrored those provided for MUC2024-054c. One comment supported streamlining the HHCAHPS survey while five comments raised concerns about the use of the 2-month recall period, survey accessibility, the mode of survey administration for populations with low literacy skills, and the absence of questions about other aspects of care such as timeliness and social needs.

Discussion Themes	Recommendation Group Member Discussion
Medication Management	• Committee members agreed this measure is a good step toward measuring effective medication management, but it is insufficient to ensure this counseling is taking place.

Discussion Themes	Recommendation Group Member Discussion
Suggested Revisions	• The committee's suggestions to improve the measure included adding information about the quality of the conversations, including discussion about indications for medications, avoiding the term "over-the-counter medications," and continued. measure development to drive improvements in the quality and consistency of medication reconciliation conversations.

Conditions: The committee recommended that the measure include guidance to help survey administrators prompt patients on over-the-counter medications they may take, including supplements and other non-prescription medication such as vitamins and home remedies. They said that the measure should include indications for medications, review should be ongoing, and that the process should account for cultural sensitivities and language barriers.

2.1.5 MUC2024-054e CAHPS® Home Health Care Survey Talk About Medicine Side Effects [CMS/AHRQ]

Description: Talk About Medicine Side Effects is a single-item measure derived from the updated CAHPS® Home Health Care Survey, also referred as "HHCAHPS." This is a standardized survey instrument and data collection methodology for measuring home health patients' perspectives on their home health care in Medicare-certified home health care agencies.

Program: Home Health Quality Reporting Program

Measure Review Final Vote: Recommend

Vote Count: Recommend, 19 (83%); Recommend with Conditions, 2 (9%); Do Not Recommend, 2 (9%); No recusals

Summary of Public Comment: This measure received six public comments. The comments mirrored those provided for MUC2024-054c and MUC2024-054d. One comment supported the measure, stating the streamlined survey would more effectively capture feedback from underrepresented groups than the current survey. Five comments expressed concerns, including that the survey item only addresses safety at the beginning of care, concerns about patients' ability to use the 2-month recall period, survey accessibility, the mode of survey administration to populations with low literacy skills, and the absence of questions about other aspects of care such as timeliness and social needs.

Discussion Themes	Recommendation Group Member Discussion
Patient Education	• Committee members discussed the importance of ensuring patients understand why they are taking their medications, including how different medications can interact with one another.
Unintended Consequences	• One committee member expressed concern that a potential unintended consequence of discussing side effects is that patients may stop taking their medications.

Conditions: The committee recommended that CMS consider development of a composite measure on medication topics for more actionable insights in the future.

2.2 Hospital Committee Measures

2.2.1 MUC2024-073 Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) [CMS]

Description: The Information Transfer PRO-PM collects information from patients aged 18 years or older who had a procedure or surgery at an Ambulatory Surgical Center (ASC). Using a nine-item survey, the measure collects the average score patients rated the ASC''s ability to clearly communicate personalized discharge instructions. Patients are asked to answer a brief web-based survey, comprised of three domains: applicability; medications; and daily activities. Patients would receive the survey within 2-7 days post-procedure. Individual scores would be calculated using a top-box approach, which accounts for the percentage of the total number of items respondents selected the most favorable responses ("Yes" or "Very Clear") out of the total number of items respondents deemed applicable to their procedure/surgery.

Program: Ambulatory Surgical Center Quality Reporting Program (ASCQR)

Measure Review Final Vote: Consensus Not Reached

Vote Count: Recommend, 5 (19%); Recommend with Conditions, 14 (52%); Do Not Recommend, 8 (30%); No Recusals

Summary of Public Comment: The measure received eight public comments, with five in support and three expressing concerns. The supportive comments highlighted the importance of delivering personalized and clear discharge instructions to ensure patient compliance and prevent unnecessary hospital readmissions. Commenters also expressed strong support for using patient-reported data to enhance patient-centered care, improve satisfaction, reduce costs, and lead to better outcomes. Public comments also raised issues about the survey burden on patients potentially impacting response rates, the timeline of survey administration overlapping with other patient experience surveys, and the evaluation of patients' ability to comprehend the information rather than the quality of information provided. The public comments also raised concerns about the evidence supporting the implementation of this measure in the ambulatory surgical center (ASC) setting, given a lack of testing in ASC settings.

Discussion Themes	Recommendation Group Member Discussion
Testing Across Settings	• The committee expressed concern that the measure was not tested in ASC settings. CMS acknowledged challenges in getting ASCs to participate in testing.
Survey Fatigue and Overlap	• The committee expressed concern about survey fatigue and overlap with the Outpatient and Ambulatory Surgery (OAS) CAHPS survey. • A committee member inquired if CMS considered harmonizing this survey with the current CAHPS survey. The developer noted harmonization was considered but found unfeasible due to differing questions and specifications.

Discussion Themes	Recommendation Group Member Discussion
Reporting Requirements and Scoring	• Committee members asked whether reporting would be required or voluntary, with CMS indicating that measures like this typically begin with voluntary reporting and may become mandatory. In response to an inquiry about the scoring of low response rates, CMS confirmed that a minimum number of responses is required for scoring.
Importance of Patient Feedback	• Despite concerns, the committee emphasized the importance of obtaining patient feedback, especially in small or rural facilities.

Conditions: The committee suggested that CMS continue to harmonize this measure with the CAHPS and other measures relying on patient-reported data. The committee also suggested developing guidance to exclude patients who have recently taken another patient experience survey to reduce redundancy and burden for patients. Committee members also recommended additional testing in ASCs before the measure is fully implemented within the program.

2.2.2 MUC2024-060 In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey - Quality of Dialysis Center Care and Operations (QDCCO) measure [CMS/AHRQ]

Description: The ICH CAHPS Survey is designed to measure the experiences of people receiving in-center hemodialysis care from Medicare-certified dialysis centers. The survey is designed to meet the following three broad goals:

- Produce comparable data from the patient's perspective that will allow objective and meaningful comparisons between dialysis centers on domains that are important to consumers.
- Create incentives for dialysis centers to improve their quality of care.
- Enhance public accountability in health care by increasing the transparency of the quality of care provided in return for public investment.

Specifically, the survey measures patients' experiences on topics that are important from the perspective of patients and help them make more informed choices when selecting a dialysis center as well as helping dialysis centers improve the quality of dialysis care for their patients. The QDCCO measure asks questions related to the quality of care and operations at the dialysis center. RTI International worked closely with CMS to develop a shortened ICH CAHPS Survey; this included reducing the number of items in the QDCCO measure.

Program: End-Stage Renal Disease Quality Incentive Program (ESRD QIP)

Measure Review Final Vote: Recommend

Vote Count: Recommend, 24 (89%); Recommend with Conditions, 2 (7%); Do Not Recommend, 1 (4%); No Recusals

Summary of Public Comment: The measure received four public comments, three in support and one expressing concern. Supportive comments highlighted the survey's availability in multiple languages and its alignment with CMS's National Quality Strategy, which encourages patient engagement. The comment that expressed concern focused on wanting to see this version of the measure submitted for endorsement. Overall, public commenters viewed the measure as a valuable tool for assessing patient experiences related to their dialysis treatment,

with a call for further exploration into its effectiveness in driving significant improvements in health care quality.

Discussion Themes	Recommendation Group Member Discussion
Patient-Centered Survey Design	• Committee members emphasized the importance of centering the survey around patient needs and reducing burden for respondents.
Inclusion of Home Dialysis and CMMI Models	• Committee members inquired about home dialysis being included in the survey population given the success of Center for Medicare & Medicaid Innovation (CMMI) models in reducing the number of dialysis patients or promoting home dialysis and encouraged inclusion of in-home care.
Stratification by Race and Ethnicity	• A committee member suggested that CMS stratify the results by race and ethnicity. CMS confirmed that data for stratification by race and ethnicity is available, noting that stratified reports have been provided with previous CAHPS surveys. However, CMS also mentioned that in other CAHPS settings, data were combined over time to create a reliable estimate.
Survey Response Rates and Outreach	• The committee supported the reduction in the number of survey questions but inquired whether additional outreach could be conducted to enhance response rates among hard-to-reach populations. In response, CMS noted they have developed posters and online resources to promote the survey, acknowledged varying response rates by race and ethnicity, and indicated that survey vendors are continually working to determine the most effective mode of data collection for different patient populations.

Conditions: The committee suggested a continued assessment by the developer on ways to obtain data from removed questions such as nephrologist performance with other measures and additional testing on hard-to-reach populations.

2.2.3 MUC2024-074 Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE) [American Society of Hematology (ASH)]

Description: Median time (in minutes) from ED arrival to initial administration of pain medication for all patients, regardless of age, with a principal encounter diagnosis of SCD with VOE.

Program 1: Hospital Outpatient Quality Reporting Program (OQR)

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 16 (59%); Recommend with Conditions, 7(26%); Do Not Recommend, 4 (15%); No Recusals

Program 2: Rural Emergency Hospital Quality Reporting Program (REHQR)

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 12 (48%); Recommend with Conditions, 4 (16%); Do Not Recommend, 9 (36%); No Recusals

Summary of Public Comment: The measure received 29 public comments. Twenty-five supported the measure, highlighting its role in improving the quality and equity of care, promoting accountability, and streamlining care processes in emergency departments. Commenters shared that the measure would lead to better patient outcomes and enhanced patient trust in the health care system. The few comments expressing concern called for a more holistic approach that includes rapid triage and thorough patient assessment to avoid compromising care quality.

Discussion Themes	Recommendation Group Member Discussion
Stratification	• One committee member noted that in addition to stratifying by medication route, the measure should also be stratified by facility rurality. The developer agreed with the comment about rural stratification, but also noted the measure is designed to work in all facilities unless the hospital falls below the number of cases needed for reporting.
Unintended Consequences	• Several members expressed concerns for penalizing providers for not providing medication quickly enough, suggesting that this measure may reduce quality of care and flexibility in provider discretion.
Rural and Low Volume Facilities	• A committee member offering a rural perspective explained that administering medication within a set time frame may not be feasible due to staffing, hospital policy, and workflow concerns. • Committee members expressed concerns about penalizing providers for slower distribution of medication, which may include opioids, especially in rural facilities impacted by the opioid epidemic. • One committee member added that while the measure is important, with a minimum reporting number of 20 cases, small and rural hospitals may not qualify.

Conditions: The committee suggested that CMS provide case minimum exclusions, stratify by case volume or rural status, establish a threshold appropriate for rural or low volume facilities, adopt annual reporting to improve actionability of measure, explore ways to include a patient's care plan, consider optional 2-year reporting of this measure before full implementation and explore ways this or other future measures could incentivize rather than penalize time to pain medication administration.

2.2.4 MUC2024-067 Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life [American Society of Clinical Oncology (ASCO)]

Description: Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life.

Program: Hospital Inpatient Quality Reporting Program (IQR)

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 3 (12%); Recommend with Conditions, 10 (38%); Do Not Recommend, 13 (50%); No Recusals

Summary of Public Comment: The measure received five public comments. Two comments indicated support for the measure, as it helps increase patients' comfort and respects their wishes while ensuring they are receiving appropriate palliative and hospice care. Public comments expressing concerns highlighted the measure's inability to account for patient preference, attribution concerns, questions about the measure's ability to distinguish between necessary and unnecessary services, and the reporting burden for rural hospitals.

Discussion Themes	Recommendation Group Member Discussion
Variation in ICU Admission	• One committee member cited variation in ICU admission criteria among hospitals as a potential issue as admission to ICU for similar patients may vary across measured entities due to policy differences. • Another committee member agreed and added that smaller hospitals serving populations with different socioeconomic and demographic characteristics might face unique challenges that affect ICU admission rates such as fewer ICU beds and patients with a higher burden of comorbidities.
Risk Adjustment and Stratification	• Multiple committee members noted their concern around the lack of risk adjustment or stratification for severity of cancer diagnosis and prognosis.
Attribution	• A committee member asked about last-minute transfers and attribution to more than one hospital. • The committee had a robust back and forth with the developer to clarify measure attribution during the 6-month look back period. The developer explained that the measure is attributed to the institution that provided most of the care for patients included in the cohort during the 6-month lookback period. This is to ensure that only patients who have an established relationship with the health care institution are included in the numerator.
Patient Engagement and Shared Decision Making	• Many committee members stated that end-of-life conversations should occur earlier in care. • One committee member noted that these conversations are best had in the outpatient setting with the patient's primary oncologist. Another committee member agreed, adding that the measure should be applied to the ambulatory or outpatient setting rather than the hospital inpatient setting. • A committee member speaking from the patient perspective provided a personal story about their own experience with their mother and highlighted the importance of shared decision making for end of life.

Conditions: The committee recommended that the measure include the addition of data on the type of treatment received in the ICU, more clearly define attribution, add patient preference for treatment, stratify for ICU capabilities based on geographic variability and resource capability, and consideration of Medicare Advantage inclusion.

2.2.5 MUC2024-068 Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life [ASCO][6]

Description: Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life.

Program: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 11 (42%); Recommend with Conditions, 6 (23%); Do Not Recommend, 9 (35%); No Recusals

Summary of Public Comment: This measure received four public comments. Three comments indicated strong support for expanding cancer-specific measures to general hospital settings and praised this measure for aligning with patient safety and quality care goals. Additionally, comments expressed support for encouraging earlier palliative and hospice care for patients in order to significantly improve end-of-life care quality. However, one comment expressed concern, highlighting the need for clarification on the exclusion of health maintenance organization (HMO) patients and emphasizing the necessity for transparency regarding the measure scope and applicability.

Discussion Themes	Recommendation Group Member Discussion
Shared Decision Making	• Like the discussion for MUC2024-067, the committee agreed that patient preference should be accounted for in this measure. • One committee member advised the committee to consider both the potential harms and benefits of having broad pushback against very aggressive forms of cancer treatment during the end-of-life period, which echoed the theme of accounting for patient preference in the measure.
Measure Benefits	• One committee member thought this measure could inspire less-aggressive care, better use of advanced care planning and shared decision-making, and increased use of hospice and palliative care. • A committee member suggested evaluating associated increases in appropriate use of hospice and palliative care services and documentation of advance care planning and physician orders for life-sustaining treatment (POLST), which would reflect an improvement in end-of-life care.
Hospice and Palliative Care Availability	• The committee highlighted that limited access to hospice and palliative care in rural communities often forces patients to leave their homes for treatment. This underscores the importance of considering patient preference and convenience. Additionally, geographic disparities can result in patients from underserved areas receiving more aggressive end-of-life therapies.

[6] The developer indicated during Recommendation Group discussion that the name of this measure will be changed to “Proportion of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life,” as the phrase “systemic cancer-directed therapy” is more inclusive than “chemotherapy.”

Discussion Themes	Recommendation Group Member Discussion
Attribution	• The committee discussed decision-making and attribution for chemotherapy administration. A co-chair questioned whether an outpatient facility can choose not to administer chemotherapy if the oncologist is unavailable. CMS clarified that the hospital outpatient department controls chemotherapy administration. • Additionally, a member raised a question about attributing chemotherapy administered by an independent physician if the patient dies in an unaffiliated facility. The measure developer explained that such claims would not be included in the numerator.

Conditions: The committee recommended the addition of an ability to account for patient preference, distinction between curative vs. palliative chemotherapy within the specification, exclusion of other therapies that do not affect quality of life, provision of training and resources in implementation guides so that hospitals are best able to have difficult end-of-life conversations, and an attribution model that is limited to inpatient care/visits only.

2.2.6 MUC2024-078 Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days [ASCO]

Description: Proportion of patients who died from cancer admitted to hospice for less than 3 days.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 9 (35%); Recommend with Conditions, 7 (27%); Do Not Recommend, 10 (38%); No Recusals

Program 2: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 14 (54%); Recommend with Conditions, 4 (15%); Do Not Recommend, 8 (31%); No Recusals

Summary of Public Comment: This measure received five public comments, four in support and one expressing concern. There was support for expanding cancer-specific measures to general hospital settings and praised this measure for aligning with patient safety and quality care goals. Additionally, comments expressed support for encouraging earlier palliative and hospice care for patients in order to significantly improve end-of-life care quality. However, one comment expressed concern, highlighting the need for clarification on the exclusion of health maintenance organization (HMO) patients and highlighted the limited resources for in-depth end-of-life discussions that may prevent substantive improvements on this measure.

Discussion Themes	Recommendation Group Member Discussion
Rural and Low-Volume Settings	• A committee member noted that the denominator requires a minimum of 25 patients attributed to the hospital facility within the measurement period for the measure to be applied to that facility. This would address any concerns around penalizing rural hospitals.
Improving End-of-Life Planning	• Several committee members emphasized the importance of having end-of-life conversations earlier in the care journey to improve quality of care and capacity for shared decision making. • One member proposed developing paired measures to track the timing of these discussions. Another member concurred, suggesting that a measure focusing on earlier conversations could lead to overall improvement.

Conditions: Continuing the concerns around attribution voiced for measures 067 and 068, the committee again recommended that CMS address hospital attribution, specifically defining it based on inpatient visits only. For exclusion criteria, the committee suggested excluding hospitals or regions without access to hospice, adjusting for geographical service availability, and excluding programs without available services in the region. Lastly, they said that providers should initiate conversations with patients about preferences earlier.

2.2.7 MUC2024-069 Addressing Social Needs Assessment & Intervention [CMS]

Description: Percentages of inpatient encounters for patients of all ages reflecting whether patients were assessed in four domains of social need: food, housing, transportation, and utilities; and whether the patient received a qualifying follow-up action within the visit for any positive social needs. Qualifying follow-up actions were identified from Gravity Project: adjustment, assistance/assisting, coordination, counseling, education, evaluation of eligibility, provision, and referral.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 13 (48%); Recommend with Conditions, 6 (22%); Do Not Recommend, 8 (30%); No Recusals

Program 2: Medicare Promoting Interoperability Program (PI)

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 13 (48%); Recommend with Conditions, 2 (7%); Do Not Recommend, 12 (44%); No Recusals

Program 3: Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 17 (63%); Recommend with Conditions, 2 (7%); Do Not Recommend, 8 (30%); No Recusals

Summary of Public Comment: The measure received seven public comments. Two comments in support noted the measure's potential to improve health outcomes by addressing social

needs and reducing disparities. Supporters appreciated the switch to an eCQM for reporting and comprehensive approach. Five comments expressed concerns related to the lack of alignment with an existing social drivers of health (SDOH) screening measure, feasibility challenges related to electronic health record (EHR) data collection, lack of exclusions for instances where there are limited community support services and the question of whether reimbursement is possible for measured entities participating in SDOH screening and intervention.

Discussion Themes	Recommendation Group Member Discussion
Data Element Availability	• The committee expressed concern about the availability of data elements related to social needs in common EHRs, which could present a feasibility challenge. CMS noted that the Gravity Project's work has resulted in standardized codes for data elements required for the measure. While many facilities have all the fields required for reporting, the committee noted that some smaller EHRs may not yet have all fields required for this digital measure/eCQM.
Alignment & Harmonization	• The committee shared concern about potential overlap and burden associated with a hospital needing to report this measure under both the Hospital Inpatient Quality Reporting and Medicare Promoting Interoperability Programs. • A committee member voiced concerns about introducing this measure, given the newness of other social drivers of health (SDOH) measures in the programs. They stressed the importance of preserving the processes and infrastructure hospitals have already implemented to meet the requirements of other SDOH measures. Several members shared that they would prefer that CMS harmonize this measure with the existing one so that hospitals aren't being forced to try to meet requirements of two separate but related measures. • CMS confirmed that this measure is moving toward alignment with the NCQA measure, and while some infrastructure building is required for EHRs, the measure will help to capture data that can be used to determine national standards for collecting SDOH data.
Qualifying Follow-Up Actions	• The committee had robust discussion about the types of follow-up actions that would qualify under the current measure specification. CMS clarified that the measure has flexibility to include a range of actions from patient education to referral. • Based on the broad scope of the qualifying follow-up actions, the committee discussed whether all actions are equally meaningful from a patient perspective in addressing the social need. • One member voiced concern about potentially overburdening community services in areas of high need.
Feasibility Challenges for Lower Resource Facilities	• A committee member raised concerns about whether critical access hospitals have adequate staffing to conduct follow-up assessments on weekends, noting that hiring additional staff could lead to increased costs.

Discussion Themes	Recommendation Group Member Discussion
Availability of Community Resources	• While there was support for the intent of this measure, members voiced concern about potentially overburdening community services in areas of high need or asking providers to make referrals where services are not available.

Conditions: The committee suggested that this measure include accounting for rural facilities, critical access hospitals, and facilities with limited community resources, which may not have as many interventions available for referral. Committee members also suggested making the measure voluntary to give time for additional testing and for hospitals to meet technical requirements. One member encouraged CMS to re-introduce domestic violence as a domain to better align with prior measures.

2.2.8 MUC2024-085 Hospital Harm – Anticoagulant-Related Major Bleeding [CMS]

Description: The proportion of inpatient hospitalizations for patients ages 18 and older who were administered at least one anticoagulant medication within the first 24 hours of admission and had a subsequent bleeding event. Bleeding events must occur during the encounter.

Program 1: Hospital-Acquired Condition Reduction Program (HACRP)

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 7 (26%); Recommend with Conditions, 6 (22%); Do Not Recommend, 14 (52%); No Recusals

Program 2: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 6 (23%); Recommend with Conditions, 5 (19%); Do Not Recommend, 15 (58%); No Recusals

Program 3: Medicare Promoting Interoperability Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 5 (19%); Recommend with Conditions, 4 (15%); Do Not Recommend, 18 (67%); No Recusals

Summary of Public Comment: The measure received seven public comments. Three comments expressed support and appreciation that the measure is an eCQM and has the potential to prevent common and preventable bleeding events. Four comments expressed concerns about discouraging the appropriate use of anticoagulants and that the measure may not effectively mitigate hospital harm.

Discussion Themes	Recommendation Group Member Discussion
Unintended Consequences	• A committee member observed that, from a clinical perspective, there is significantly more harm to patients who do not receive an anticoagulant when it is clinically indicated compared to the inappropriate use of anticoagulants. They expressed concern that the measure might discourage the use of these medications. • Several members expressed concerns about unintended consequences and the need for clinicians to balance the risk of thrombosis with the risk of bleeding.
Measure Specification	• One member raised concerns about Criterion B, which involves an absolute decrease in hemoglobin levels of 2 g/dL within a 48-hour period, excluding the first 24 hours after arrival. They noted that a drop in hemoglobin could be due to various factors unrelated to anticoagulant use. The developer confirmed that the technical expert panel (TEP) provided feedback to consider a hemoglobin drop greater than two points, and further research is being conducted to determine if adjustments are necessary. • Committee members asked if severe sepsis is considered an exclusion and if those on thrombolytics were included in the denominator. The developer confirmed sepsis is not an exclusion.

Conditions: The committee suggested that the measure include reevaluating Criterion B, an absolute decrease in hemoglobin results of 2 g/dL within a 48-hour period excluding the first 24 hours of arrival. Committee members noted there are a range of reasons for a 2 g/dL drop in hemoglobin that are unrelated to anticoagulants. Other conditions included removing thrombolytics from the denominator and making reporting voluntary for the first 2 years.

2.2.9 MUC2024-027 Patient Safety Structural Measure [CMS]

Description: The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety. The Patient Safety Structural Measure comprises five domains, each containing multiple statements that aim to capture the most salient structural and cultural elements of patient safety. This measure is designed to identify hospitals that practice a systems-based approach to safety, as demonstrated by leaders who prioritize and champion safety; a diverse group of patients and families meaningfully engaged as partners in safety; and practices indicating a culture of safety and continuous learning and improvement.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Do Not Recommend

Vote Count: Recommend, 3 (12%); Recommend with Conditions, 1 (4%); Do Not Recommend, 22 (85%); No recusals

Program 2: Hospital Value-Based Purchasing Program (VBP)

Committee Final Vote: Do Not Recommend

Vote Count: Vote Count: Recommend, 4 (15%); Recommend with Conditions, 0 (0%); Do Not Recommend, 23 (85%); No recusals

Program 3: Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Committee Final Vote: Do Not Recommend

Vote Count: Vote Count: Recommend, 2 (7%); Recommend with Conditions, 0 (0%); Do Not Recommend, 25 (93%); No recusals

Summary of Public Comment: The measure received 12 public comments. Four comments were received in support of the measure, with encouragement of measure use to establish patient safety as a key organizational goal for hospitals. This measure was viewed as a way to hold organizations more accountable for the care provided. Eight comments were received expressing concerns, including the belief that structural measures are not appropriate for value-based purchasing programs, possible redundancy with existing policies, and a lack of clarity in the attestation language. Additionally, commenters cautioned that this measure focuses on patient safety-focused documentation rather than patient outcomes and questioned whether variation in state laws may present legal or liability challenges for measure use.

Discussion Themes	Recommendation Group Member Discussion
Intent of Structure Measure	• There was general agreement that disruption to the medication supply chain is a patient safety issue, but committee members also felt that the appropriate role of a structure measure is to address foundational issues rather than take up specific safety problems.
Locus of Control	• Many committee members raised the concern that the medication supply chain is not within the direct control of most hospitals, and that related systemic issues, such as industry monopolies, were best dealt with through policy.
Measure Changes	• Committee members voiced support for the measure without the addition of the medication supply chain component and indicated that the prior version of the measure had already provided actionable information. • The committee requested more information on the rationale for why supply chain items were included in this measure version and received guidance from CMS that the changes stem from shortages of multiple medications, including pain medications, which can put patients at risk.
Legality	• One committee member highlighted that hospitals already use policies and procedures to address medication shortages and argued that the attestation focused on participation in a patient safety organization (PSO) may not be consistent with federal law.
Measure Scoring	• One committee member raised the issue of measure scoring on a scale of 0 to 5 and expressed concern that there would not be sufficient variation in the scale for a hospital to show improvement.

Condition: The committee recommended to “change language to not be duplicative with the mentioned supply chain measure and align with intent (broader scope).”

2.2.10 MUC2024-075 Emergency Care Capacity and Quality (ECCQ) [CMS]

Description: This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access:

1. The patient waited longer than 1 hour to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or

2. The patient left the ED without being evaluated by a physician/advanced practice nurse/physician's assistant, or

3. The patient boarded (time from Decision to Admit [order] to ED departure for admitted patients) in the ED for longer than 4 hours, or

4. The patient had an ED length of stay (LOS) (time from ED arrival to ED physical departure as defined by the ED depart timestamp) of longer than 8 hours.

Program: Hospital Outpatient Quality Reporting Program

Measure Review Final Vote: Consensus Not Reached

Vote Count: Recommend, 10 (37%); Recommend with Conditions, 10 (37%); Do Not Recommend, 7 (26%); No recusals

Summary of Public Comment: The measure received 10 public comments, five in support and five expressing concerns. Supporters, including patient advocates, emphasized the necessity of the measure to establish standards that address long wait times in emergency departments, particularly for patients with rare and chronic conditions. They highlighted its critical role in tackling the crisis of emergency department overcrowding. Comments expressing concern conveyed worry about the measure components overlapping with existing measures, which could be redundant. They also felt the measure was too encompassing and burdensome, especially for facilities with limited resources. Additionally, there were concerns that the 4-hour threshold for boarding might not be suitable for patients who need more urgent care.

Discussion Themes	Recommendation Group Member Discussion
Support for Insights	• Members indicated support for the measure's ability to provide insight into ED capacity and wait time issues impacting perceptions of care.
Future Program Inclusion	• A committee member expressed concern that the measure could be added to CMS Star Ratings and influence payment before demonstrating appropriate performance and undergoing sufficient measure testing.
Measure Name	• Members indicated that the measure's name should be revised to better reflect unplanned healthcare needs. One member suggested renaming the measure to "unplanned care capacity" to better reflect unplanned health care needs.

Discussion Themes	Recommendation Group Member Discussion
Locus of Control	• Members discussed the complexity of upstream and downstream variables, specifically factors outside of the hospital's control (e.g., case mix and the availability of post-acute and behavioral care in the community). • They emphasized the need to focus on transfer quality rather than just ED capacity.
Stratification	• Members discussed additional stratification by type of care received (e.g., maternity).
Importance to Patients	• A member of the committee representing the patient perspective emphasized the importance of this measure topic to patients and encouraged more work to be conducted on this topic.

Conditions: The committee recommended revisions to the measure title, stratifying by factors such as care type (i.e., maternity, behavioral health etc.), geographic location (urban vs. rural), and hospital or trauma level designation to account for contextual variability. One committee member submitted a condition that encouraged the developer to revise the specifications by separating measure components 1 and 2 from 3 and 4, with a suggestion to explore additional measures for components 3 and 4 to reduce complexity. Another committee member requested that CMS exclude the measure from CMS Star Ratings to prioritize data collection.

2.2.11 MUC2024-095 Emergency Care Capacity and Quality (ECCQ) [CMS]

Description: This measure captures the proportion of Emergency Department (ED) visits where patients (all ages, all payers) experienced any one of four quality gaps in access:

1. The patient waited longer than 1 hour to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination, or

2. The patient left the ED without being evaluated by a physician/advanced practice nurse/physician's assistant, or

3. The patient, if transferred (time from Decision to Transfer to ED departure), boarded for longer than 4 hours, or

4. The patient had an ED length of stay (LOS) (time from ED arrival to ED physical departure as defined by the ED depart timestamp) of longer than 8 hours.

Program: Rural Emergency Hospital Quality Reporting Program

Measure Review Final Vote: Consensus Not Reached

Vote Count: Recommend, 9 (35%); Recommend with Conditions, 6 (23%); Do Not Recommend, 11 (42%); No recusals

Summary of Public Comment: The measure received seven public comments, with four expressing support and three raising concerns. Supporters, including patient advocates, emphasized the necessity of the measure to establish standards that address long wait times in emergency departments, particularly for patients with rare and chronic conditions. They highlighted its critical role in tackling the crisis of emergency department overcrowding.

Additionally, a commenter provided a recommendation for voluntary reporting initially, allowing hospitals, especially in rural areas, time to develop and test the eCQM.

Comments raised concerns about the 4-hour threshold from decision time to admit or transfer, which may not be suitable for all patients or feasible in rural settings. Reporting could be challenging for Rural Emergency Hospitals due to potential IT resource limitations and the use of separate EHRs for emergency departments. Commenters deemed more testing of the measure in rural settings necessary. Furthermore, they suggested that using median times rather than fixed timeframes to define delays might be more appropriate for this measure.

Discussion Themes	Recommendation Group Member Discussion
Additional Testing	• Members indicated that more feasibility testing is needed and recommended evaluation with expanded rural emergency hospitals specific to components 3 and 4.
Phased Implementation	• Members discussed the phased implementation, involving two years of voluntary reporting.
Stratification	• The committee indicated that additional stratification by geography/region could be beneficial.
Importance to Patients	• A member of the committee representing the patient perspective emphasized the importance of this measure topic to patients and encouraged more work to be conducted on this topic.

Conditions: The committee suggested renaming the measure for clarity; conducting further testing to expand its applicability to REH hospitals, particularly concerning elements 3 and 4; considering additional stratification; and implementing a phased approach with two years of voluntary reporting.

2.2.12 MUC2024-034 Influenza Vaccination Coverage Among Healthcare Personnel [CMS/Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)]

Description: Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

Program: Rural Emergency Hospital Quality Reporting Program

Measure Review Final Vote: Recommend

Vote Count: Recommend, 26 (100%); Recommend with Conditions, 0 (0%); Do Not Recommend, 0 (0%); No recusals

Summary of Public Comment: The measure received two public comments that were supportive of the measure due to the potential to reduce flu spread and decrease morbidity and mortality related to flu infections in Rural Emergency Hospitals. This measure was seen as having high feasibility as hospitals are well-equipped to capture vaccination information among healthcare personnel.

Discussion Themes	Recommendation Group Member Discussion
Current Use in CMS Programs	• The committee supported the measure, citing current program use that provides protection for the workforce and patients, especially vulnerable populations such as infants less than six months old and patients who respond poorly to vaccinations.

Conditions: None provided.

2.2.13 MUC2024-042 Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) [CMS]

Description: The measure estimates a hospital-level risk-standardized complication rate (RSCR) associated with elective primary THA and/or TKA procedure. The outcome (complication) is defined as any one of the specified complications occurring from the date of index admission to up to 90 days post-date of the index admission (the admission included in the measure cohort). Complications are counted in the measure only if they occur during the index hospital admission or during a readmission. The complication outcome is a dichotomous (yes/no) outcome. If a patient experiences one or more of these complications in the applicable time period, the complication outcome for that patient is counted in the measure as a "yes."

Program 1: Hospital Value-Based Purchasing Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 17 (63%); Recommend with Conditions, 10 (37%); Do Not Recommend, 0 (0%); No Recusals

Program 2: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 18 (67%); Recommend with Conditions, 8 (30%); Do Not Recommend, 1 (4%); No Recusals

Program 3: Hospital-Acquired Condition Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 17 (63%); Recommend with Conditions, 8 (30%); Do Not Recommend, 2 (7%); No Recusals

Summary of Public Comment: The measure received 10 public comments. Three comments supporting the measure noted the focus on safety and the inclusion of Medicare Advantage (MA) data for improving comprehensiveness of the measure for better policy-making and patient care improvement. Seven comments expressing concerns cited the importance of ensuring MA data accuracy and comparability and the unclear implications of including MA beneficiaries on measure scores or thresholds. Additionally, concern was expressed for the measure's reliability and ability to drive improvements. Commenters also raised concern that reimbursement rates may not reflect specialists' experience or procedure frequency, potentially impacting care quality. Finally, commenters noted the increasing number of elective procedures in ambulatory care settings and considered the impact of that care trend on this measure's applicability and effectiveness within the program.

Discussion Themes	Recommendation Group Member Discussion
Support for Adding Medicare Advantage Data	• A committee member from a hospital perspective supported including MA data in the measure to enhance statistical reliability by assessing a larger population. • A committee member representing a rural perspective noted that although enrollment in MA plans in rural areas has traditionally been lower than in urban areas, they are now observing up to "50% rural penetration." This suggests that including MA beneficiaries would enhance the measure's relevance to rural areas.
Potential Impacts of Adding MA Data	• The committee encouraged CMS to consider how differences in patient populations between MA and fee-for-service, which are not currently reflected in risk models, might affect performance scores. • The committee discussed the possibility that adding new MA beneficiaries to the measure calculation could shift benchmarks, and CMS acknowledged this as a potential outcome pending further analysis.
Outpatient and Ambulatory Care	• A committee member highlighted the increasing trend of shifting surgical procedures to ambulatory care settings and discussed the implications for patients remaining in inpatient facilities. There was concern that these patients might have worse health status, greater medical complexity, or higher risk for complications compared to those in ambulatory surgical centers. CMS acknowledged this concern and outlined plans for similar measures in ambulatory surgical center-related programs.
Stratified Reporting & Transparency	• Committee members encouraged CMS to explore stratified reporting either publicly or through confidential reporting back to facilities so that any differences due to patient characteristics across MA and fee-for-service plans could be assessed and acted on in a timely manner to promote effective performance.

Conditions: The committee recommended that the measure include stratified reporting, providing hospitals with feedback on outcome variations between Medicare Advantage (MA) and Medicare Shared Savings Program (MSSP) populations, and breaking down performance data by payer. CMS should re-evaluate risk models as the measure matures to identify any adjustments needed for variation at the patient level across plans. Additionally, CMS should consider if the reporting period is sufficient to avoid time lags that may hinder data usefulness and measure improvement.

2.2.14 MUC2024-043 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity [CMS]

Description: The measure estimates the hospital-level, risk-standardized mortality rate (RSMR) for patients discharged from the hospital with a principal discharge diagnosis of acute ischemic stroke. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death, for stroke patients. The measure includes the National Institutes of Health (NIH) Stroke Scale as an assessment of stroke

severity upon admission in the risk-adjustment model. This measure uses Medicare fee-for-service (FFS) and Medicare Advantage (MA) administrative claims for the cohort derivation, outcome, and risk adjustment.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 18 (69%); Recommend with Conditions, 7 (27%); Do Not Recommend, 1 (4%); No Recusals

Program 2: Hospital Value-Based Purchasing Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 19 (70%); Recommend with Conditions, 7 (26%); Do Not Recommend, 1 (4%); No Recusals

Summary of Public Comment: The measure received five public comments, and two comments supported the inclusion of MA data for improving applicability and relevance, while concerns from three comments focused on accuracy, comparability, reliability and timeliness of data, and use of a predicted-to-expected ratio for the score. Clarification on the rationale for the scope of the measure and inclusion criteria were also requested.

Discussion Themes	Recommendation Group Member Discussion
Measure Focus	• One committee member voiced a general concern regarding mortality-focused measures, noting that these measures may capture variation due to a hospital and patient population's culture around palliative care rather than the quality of care provided. This committee member cautioned that conditions such as stroke could be considered natural causes of death and may not reflect worse quality of care but perhaps a different culture related to end of life.
Considerations for Low Patient Volume	• The committee discussed ways to mitigate concerns about reporting for facilities with low patient volumes including expanding reporting periods or using analytic techniques to compensate for low volume.
Endorsement	• The committee reviewed reasons for the lack of measure endorsement and emphasized the importance of endorsement in communicating that a measure has scientific rigor.
Risk Adjustment	• One committee member voiced support for adding core clinical data elements to the risk-adjustment model to determine impact on performance as the measure matures.

Conditions: The committee recommended that the measure undergo CBE endorsement, reconsider the measure structure to reduce the time lag to allow for timely information and useful data, and add risk stratification for pre-existing do-not-resuscitate orders.

2.2.15 MUC2024-041 Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) [CMS]

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. The following table will include discussion for this measure group, with specific considerations for individual measure called out as themes.

Description: The measure estimates a hospital-level risk-standardized readmission rate (RSRR) following elective primary THA and/or TKA in Medicare Fee-For-Service (FFS) and/or Medicare Advantage (MA) beneficiaries who are 65 years and older. The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome.

Program: Hospital Readmissions Reduction Program (HRRP)

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 19 (70%); Recommend with Conditions, 7 (26%); Do Not Recommend, 1 (4%); No Recusals

Summary of Public Comment: The measure received six public comments, with one in support and five expressing concerns. The supportive comment highlighted that including MA data enhances reporting and improves policy and care. This inclusion provides a comprehensive view of Medicare beneficiaries, aiding in better policy-making and continuous improvement in patient care.

However, the comments raised several concerns. Commenters noted that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. Commenters expressed apprehension that including MA beneficiaries might impact hospital performance metrics, calling for additional analysis and transparency in program implementation. Additionally, one comment suggested that the measure's reliability indicates it may not effectively distinguish hospital performance or drive improvements. Commenters shared that evaluating 30-day readmission rates poses challenges such as potentially unfairly penalizing hospitals, particularly smaller ones with low patient volumes. Lastly, the reporting methodology was seen as payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Discussion Themes	Recommendation Group Member Discussion
Measure Testing & National Benchmarks	• The committee initiated the discussion on this measure group by examining existing performance gaps and variations in performance data. They asked CMS for clarification on any testing conducted within Medicare Advantage (MA) populations to assess the potential impacts of the proposed addition. • CMS and the developer offered context regarding previous testing and how national benchmarks are represented in the data. • Several committee members encouraged re-assessment of national benchmarks after inclusion of MA data to ensure benchmarks remain appropriate.
Outpatient and Ambulatory Care	• A committee member revisited the shift of procedures like Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA), which are the focus of measure MUC2024-041, to ambulatory care settings. The committee discussed how this trend might affect the types of patients who remain in inpatient care and are captured by these measures
Primary Care and Care Coordination	• The committee discussed the role of primary care in preventing readmissions. They considered the potential benefits of utilizing primary care and care coordination resources to address readmissions in addition to hospital focused interventions, noting that this area is worth exploring in future measure development.
Unavoidable Readmissions	• The committee discussed situations for which readmissions would be the necessary action to maintain high-quality care, such as for communities with limited care settings to address complications other than an inpatient option.
Scientific Acceptability	• One member expressed concern for the narrow spread of measure scores and lower reliability for MC2024-030 and MUC2024-032 compared to other measures in this group. The committee discussed the variation in reliability and clustering of performance scores, with recognition that each measure may have varying room for improvement before it is “topped out.”
Measure Specific: MUC2024-030 Acute Myocardial Infarction	• For the Acute Myocardial Infarction (AMI) measure (MUC2024-030), the committee considered the reporting window for the measure in relation to what is known about risk for readmissions related to AMI. The committee considered whether the addition of MA data may impact reporting period concerns due to an influx of more reporting data that may enable shorter reporting periods.

Conditions: The risk-standardized readmission rate measures were discussed as a group during the Hospital Recommendation Group meeting, with committee members providing recommendations that spanned across measures. The committee recommended that CMS revise these measures to include care provided in ambulatory settings, a shorter inclusion window of 7 to 14 days, stratification of the measure by MA vs. fee-for-service, and additional testing to evaluate whether the measure is topped out for all subgroups reporting.

2.2.16 MUC2024-046 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery [CMS]

Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital after a qualifying isolated coronary artery bypass graft (CABG) surgery. Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are Medicare fee-for-service (FFS) beneficiaries and/or Medicare Advantage (MA) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 19 (70%); Recommend with Conditions, 8 (30%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received six public comments, with one in support and five expressing concerns. The supportive comment highlighted that including MA data enhances reporting and improves policy and care. This inclusion provides a comprehensive view of Medicare beneficiaries, aiding in better policy-making and continuous improvement in patient care.

However, the comments raised several concerns. Commenters noted that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. Commenters expressed apprehension that including MA beneficiaries might impact hospital performance metrics, calling for additional analysis and transparency in program implementation. Additionally, one comment suggested that the measure's reliability indicates it may not effectively distinguish hospital performance or drive improvements. Commenters shared that evaluating 30-day readmission rates poses challenges such as potentially unfairly penalizing hospitals, particularly smaller ones with low patient volumes. Lastly, the reporting methodology was seen as payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. See MUC2024-041 for analysis of the Recommendation Group discussion and conditions.

Conditions: See MUC2024-041.

2.2.17 MUC2024-030 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients ages 65 and older discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS annually reports the measure for patients who are 65 years or older and

enrolled in fee-for-service (FFS) Medicare and/or Medicare Advantage (MA) and are hospitalized in non-federal short-term acute care hospitals.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 18 (67%); Recommend with Conditions, 9 (33%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received six public comments, with one in support and five expressing concerns. The supportive comment highlighted that including MA data enhances reporting and improves policy and care. This inclusion provides a comprehensive view of Medicare beneficiaries, aiding in better policy-making and continuous improvement in patient care.

However, the comments raised several concerns. Commenters noted that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. Commenters expressed apprehension that including MA beneficiaries might impact hospital performance metrics, calling for additional analysis and transparency in program implementation. Additionally, one comment suggested that the measure's reliability indicates it may not effectively distinguish hospital performance or drive improvements. Commenters shared that evaluating 30-day readmission rates poses challenges such as potentially unfairly penalizing hospitals, particularly smaller ones with low patient volumes. Lastly, the reporting methodology was seen as payment-oriented, with a two-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. See MUC2024-041 for analysis of the Recommendation Group discussion and conditions.

Conditions: See MUC2024-041.

2.2.18 MUC2024-032 Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization [CMS]

Description: This measure estimates a hospital-level, 30-day risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal discharge diagnosis of heart failure (HF). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The Centers for Medicare & Medicaid Services (CMS) annually reports this measure for patients who are 65 years or older and are either Medicare fee-for-service (FFS) and/or Medicare Advantage (MA) beneficiaries hospitalized in non-federal short-term acute care hospitals and critical access hospitals.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 17 (63%); Recommend with Conditions, 10 (37%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received four public comments, with one in support and three expressing concerns. The supportive comment highlighted that including MA data could enhance quality measurement across Medicare groups, thereby improving policy-making and patient care.

However, comments also highlighted several concerns. Commenters pointed out that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. They expressed concern that including MA beneficiaries might impact hospital performance metrics, calling for additional analysis and transparency in program implementation. Commenters stated that the measure's low reliability suggests it may not effectively distinguish hospital performance, making it ineffective in driving improvements. Additionally, they were concerned that challenges in evaluating 30-day readmission rates could unfairly penalize hospitals, especially smaller ones with low patient volumes. Lastly, commenters saw the reporting methodology as payment oriented, with a 2-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. See MUC2024-041 for analysis of the Recommendation Group discussion and conditions.

Conditions: See MUC2024-041.

2.2.19 MUC2024-040 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients age 65 and over discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. The outcome (readmission) is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. CMS annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and/or Medicare Advantage (MA) and hospitalized in non-federal short term acute care hospitals.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 18 (67%); Recommend with Conditions, 9 (33%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received five public comments, with one expressing support and four raising concerns. The supportive comment emphasized that including MA data could enhance quality measurement across Medicare groups, thereby improving policy-making and patient care.

However, the comments also highlighted several concerns. Commenters pointed out that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. The comments expressed concern that including MA beneficiaries might impact hospital performance metrics,

calling for additional analysis and transparency in program implementation. Commenters stated that the measure's low reliability suggests it may not effectively distinguish hospital performance, making it ineffective in driving improvements. Additionally, they were concerned that challenges in evaluating 30-day readmission rates could unfairly penalize hospitals, especially smaller ones with low patient volumes. Lastly, commenters saw the reporting methodology as payment oriented, with a 2-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. See MUC2024-041 for analysis of the Recommendation Group discussion and conditions.

Conditions: See MUC2024-041.

2.2.20 MUC2024-045 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization [CMS]

Description: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients age 65 and older discharged from the hospital with either a principal discharge diagnosis of pneumonia (including aspiration pneumonia) or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). Readmission is defined as an unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and/or Medicare Advantage (MA) and hospitalized in short term non-federal acute care hospitals.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 17 (63%); Recommend with Conditions, 10 (37%); Do Not Recommend, 0 (0%); No Recusals

Public Comment Summary: The measure received five public comments, with one in support and four expressing concerns. The supportive comment highlighted that including Medicare MA data enhances data reporting and improves policy and care by providing a comprehensive view of Medicare beneficiaries. This inclusion aids in better policy-making and continuous improvement in patient care.

However, comments also highlighted several concerns. Commenters pointed out that the unclear and insufficiently understood implications of adding MA beneficiaries requires further analysis to ensure accuracy and comparability with fee-for-service data. They expressed concern that including MA beneficiaries might impact hospital performance metrics, calling for additional analysis and transparency in program implementation. Commenters stated that the measure's low reliability suggests it may not effectively distinguish hospital performance, making it ineffective in driving improvements. Additionally, they were concerned that challenges in evaluating 30-day readmission rates could unfairly penalize hospitals, especially smaller ones with low patient volumes. Lastly, commenters saw the reporting methodology as payment oriented, with a 2-year data lag potentially misrepresenting current outcomes and affecting risk adjustment.

Measure Group Discussion: This measure was discussed as a group with other RSRR measures including MUC2024-046, MUC2024-030, MUC2024-032, MUC2024-040, and MUC2024-045. See MUC2024-041 for analysis of the Recommendation Group discussion and conditions.

Conditions: See MUC2024-041.

2.3 Clinician Committee Measures

2.3.1 MUC2024-052 Social Need Screening and Intervention [National Committee for Quality Assurance (NCQA)]

Description: The percentage of persons who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention within 30 days if the screening was positive.

Program: Part C Star Ratings

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 6 (26%); Recommend with Conditions, 2 (9%); Do Not Recommend, 15 (65%); No recusals

Summary of Public Comment: The measure received 15 public comments, with nine in support and six expressing concerns. Commenters said the measure was important, addressing social determinants of health and enhancing health equity. Commenters saw the measure as an important step in aligning federal programs, integrating health care with community and social services, and enhancing health equity and transparency around community-level social needs. Commenters expressed concerns about the potential overlap with other social determinants of health measures and added burden for providers, as well as the potential for human bias and privacy issues during measure implementation.

Discussion Themes	Recommendation Group Member Discussion
Endorsement & Measure Testing	• Several committee members strongly encouraged developers and CMS to pursue CBE endorsement prior to program implementation and provide more robust measure testing at the level of proposed use.
Qualifying Interventions	• The committee sought clarification on what types of screening tools and interventions are included in this measure specification. The developer provided guidance on the types of interventions that would be qualifying actions under this measure, including assessment, assistance, coordination, counseling, education, evaluation of eligibility, provision, and referral, which align with Gravity Project definitions and terminology. • Committee members expressed concern for the feasibility of implementing the measure in communities where resources are not readily available. There was also a call for exceptions for providers outside the geographic footprint of available resources.

Discussion Themes	Recommendation Group Member Discussion
Measure Scope and Complexity	• The committee raised concerns about the complexity of the measure, as it involves multiple components and drivers, making it challenging for any one clinician or clinician group to manage.
Alignment and Harmonization	• The committee questioned the alignment of specifications across other social needs focused measures and how to handle cases where patients have multiple social needs. The developer and CMS shared that they are working on improving alignment across measures of similar topic areas, to reduce burden.
Risk Adjustment	• The committee expressed concerns for the lack of risk adjustment and shared doubts about the ability of this measure to match screening to appropriate and meaningful interventions, given the wide variety of qualifying follow-up actions.

Conditions: None provided.

2.3.2 MUC2024-081 Adult Immunization Status (AIS-E) [National Committee for Quality Assurance (NCQA)]

Description: The percentage of Medicare Advantage plan members 19 years of age or older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster and pneumococcal.

Program: Part C Star Ratings

Committee Final Vote: Recommend

Vote Count: Recommend, 20 (87%); Recommend with Conditions, 1 (4%); Do Not Recommend, 2 (9%); No recusals

Summary of Public Comment: The measure received four public comments, with one in support and three expressing concerns. One commenter highlighted the importance of vaccinations for population health, noting that vaccination rates have fallen. The commenter indicated that the measure is flexible, allowing adjustments for updated vaccine guidelines, and contributes to alignment with the Universal Foundation and other payment programs. Commenters expressed concerns about the exclusion of the COVID-19 vaccine, differences in accuracy of clinical data versus survey data, and accessibility issues with the state immunization registry that may increase burden in finding immunization records. Commenters were also concerned about attribution of this measure to clinicians when immunization decision-making has influences outside of a clinician's control.

Discussion Themes	Recommendation Group Member Discussion
Exclusions	• The committee initiated the discussion on this measure by seeking clarification on whether there is an exclusion for patient vaccine refusal. The developer clarified that such an exclusion is not included in the current specification.

Discussion Themes	Recommendation Group Member Discussion
Feasibility Concerns	• A committee member expressed that while the measure was meaningful and aligned with clinical best practices, concerns remained about its feasibility due to data accuracy issues and referenced error rates found in the Immunization Integration Project, due to a lack of standardization in EHR documentation. • The committee considered how variation in vaccine registry data and ability to share with health plans across states may impact use of this measure within the program.

Conditions: None provided.

2.3.3 MUC2024-088 Depression Screening and Follow-Up for Adolescents and Adults (DSF) [National Committee for Quality Assurance (NCQA)]

Description: The percentage of Medicare Advantage plan members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days.

Program: Part C Star Ratings

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 6 (26%); Recommend with Conditions, 10 (43%); Do Not Recommend, 7 (30%); No recusals

Summary of Public Comment: The measure received eight public comments, with four in support and four expressing concerns. Commenters expressed appreciation for the holistic approach to depression treatment and the 30-day follow-up period, which was seen as beneficial compared to shorter timeframes. Commenters expressed concerns about the vagueness of what constitutes a follow-up, potentially leading to fragmented care or duplication of services, particularly in facilities with limited resources or rural settings. Commenters were also concerned with the potential for increased administrative burden, as well as the negative impact of feasibility and data availability on the measure's implementation.

Discussion Themes	Recommendation Group Member Discussion
Importance	• Several committee members expressed support for the measure concept and focus on depression screening and paired follow up for adolescent and adult populations.
Alignment & Harmonization	• The committee requested clarification on how this measure differs from the current depression screening measures in MIPS. The developer explained that a key distinction is the specification at the health plan level and the focus on examining follow-up actions when positive screenings occur. • The committee expressed interest in improved alignment across measures assessing depression to reduce complexity of reporting and avoid feasibility concerns related to programming appropriate data elements with EHR vendors.

Discussion Themes	Recommendation Group Member Discussion
Reporting	• Several committee members voiced concerns about the potential for "masking" follow-up rates if screening and follow up are not reported separately. They urged CMS to ensure these metrics are reported independently to clearly distinguish how screening and follow up are conducted. The developer clarified that there is a plan to report screening and follow-up rates separately to address this concern.
Timeframe	• A committee member working with adolescents questioned the appropriateness of the 30-day window for follow up, emphasizing the importance of rapid follow up in addressing suicidal ideation.

Conditions: The committee suggested that the measure be aligned with what is currently in use with MIPS, consider replacing the MIPS measure with this one, and report the screening and follow-up rates separately.

2.3.4 MUC2024-026 Person-Centered Outcome Measures: Goal-Identification, Follow-Up, and Goal Achievement [NCQA]

Description: The percentage of individuals 18 years of age and older with a complex care need who identified and documented person-centered goal and action plan, followed up with the identified goal, and achieved the identified goal.

Three rates are reported:

- Goal Identification: percentage of individuals aged 18 or above with complex care need who had a person-centered outcome goal identified resulting in completion of goal attainment scaling (GAS) or patient-reported outcome measure (PROM) and development of an action plan.
- Follow-up: percentage of individuals aged 18 or above with complex care need who received follow-up on their person-centered outcome goal within two weeks to six months of when the person-centered outcome goal and goal attainment scaling (GAS) or person-centered outcome measure (PROM) were identified.
- Achievement: percentage of individuals aged 18 or above with complex care need who achieved their person-centered outcome goal within two weeks to six months of when the person-centered outcome goal and goal attainment scaling (GAS) or person-centered outcome measure (PROM) were identified.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 13 (57%); Recommend with Conditions, 6 (26%); Do Not Recommend, 4 (17%); No Recusals

Summary of Public Comment: The measure received six public comments, with four in support and two expressing concerns. Commenters expressed support for the measure's focus on aligning care with patient goals to enhance client engagement, reduce unwanted care, and empower patients in decision-making. Commenters also noted that the measure aligns with CMS's health equity goal to address the needs of geriatric patients. Commenters indicated that

measures such as this one are useful in other fields (e.g., occupational therapy) to develop care plans and encouraged expanding the measure to payment programs. Commenters expressed concerns around the lack of clarity and the definitions for what a goal is and what complex care needs are, noting that this could lead to inconsistencies in implementation. Commenters also suggested the standardized tool used in the measure may not reflect individual patient priorities or cultural values. They also noted the burden associated with collecting data for three denominators.

Discussion Themes	Recommendation Group Member Discussion
Stratification	• The committee requested clarification from the developer about the recommendation in the measure submission to stratify by group type. They discussed reasons for variation in goal identification and follow up among primary care, behavioral health, and long-term services and supports for patient populations. They supported stratified reporting by group type or care setting.
Goal Attainment	• One member commented that engaging patients and counseling them to set realistic goals, as well as providing techniques that might help them achieve the goals, is universally desired in healthcare.
Considerations for Low Resource Settings	• The committee discussed concerns that goal attainment and follow up may be more difficult in resource-constrained settings. The committee encouraged the developer to further consider how to address this limitation within measure specification or risk adjustment.

Conditions: The committee recommended that the measure go through CBE endorsement, stratification by group type, and undergo further assessment of reporting burden.

2.3.5 MUC2024-082 Cancer Screening and Counseling Patient-Reported Outcome-Based Measure (PRO-PM) [CMS]

Description: A PRO-PM to assess the quality of clinician counseling for patients eligible for select cancer screenings. The PRO-PM focuses on incentivizing high-quality counseling services to reduce disparities in screenings for four cancer types: 1) breast, 2) cervical, 3) colorectal, and 4) lung cancer. The PRO-PM requires use of a novel PRO survey instrument to collect the outcome data from patients while minimizing the burden of data collection on providers and patients and optimizing response rates. The PRO survey instrument includes questions focused on the quality of clinician counseling for cancer screening and its impact on decisions to screen for cancer.

Program: Merit-based Incentive Payment System

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 7 (30%); Recommend with Conditions, 1 (4%); Do Not Recommend, 15 (65%); No Recusals

Summary of Public Comment: The measure received four public comments, with one in support and three expressing concerns. One commenter expressed their support for PRO-PMs in general as a way of improving patient experiences within the health care system. Commenters questioned how clinician and “high-quality counseling” are defined in the measure

specification. Commenters were also concerned about the workflows for holding those conversations, feasibility challenges such as how one determines if a visit is long enough to satisfy the measure, and the measure not accounting for patient refusals. Comments inquired about the age range for the measure not aligning with current guidelines for certain cancer screenings.

Discussion Themes	Recommendation Group Member Discussion
Measure Testing	• The committee dedicated a significant portion of the discussion to the survey instrument; several members inquired about the testing procedures and whether the instrument had undergone validation. They expressed concerns regarding the lack of empiric validity testing performed on the instrument.
Specification and Measure Complexity	• A member observed that the tool requires refinement, as combining all patient populations and screening types may not yield the desired outcomes for clinicians and CMS. Another member concurred, expressing concern about the complexity of including four different cancer types, as each cancer screening type necessitates distinct approaches. • The committee indicated that the broad scope of the current specification may limit the measure's usefulness in improving clinical care. .

Conditions: None provided.

2.3.6 MUC2024-080 Patient Reported Falls and Plan of Care [American Academy of Neurology (AAN)]

Description: Percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend

Vote Count: Recommend, 20 (87%); Recommend with Conditions, 3 (13%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received four public comments. Two indicated support for the measure and recognized the measure's importance and alignment with clinical literature on falls in the patient population over 65 years of age. Two public comments highlighted concerns around unclear measure specifications and burdensome narrative documentation. The commenters also noted the desire for the measure to be tested at the group level and added that the measure may not be appropriate for those with severe frailty or advanced dementia.

Discussion Themes	Recommendation Group Member Discussion
Measure Concept	• The committee expressed concern that this measure focuses on secondary prevention of falls rather than primary prevention. One member of the committee expressed support for a revised or alternative measure instead addressing primary prevention of falls for at-risk patients.
Plan of Care	• After requesting clarification on the types of appropriate referral services that qualify under the plan of care specification, the committee considered the appropriateness of these services across different patient populations. • A member provided their caregiver perspective on the measure and qualifying plan of care actions. This member supported referral for activities such as gait training therapy and encouraged clinicians to consider all the recommended referral services to create the best possible outcome for the patient.

Conditions: None provided.

2.3.7 MUC2024-084 Quality of Life Outcome for Patients with Neurologic Conditions [AAN]

Description: Percentage of patients whose quality of life assessment results are maintained or improved during the measurement period.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend

Vote Count: Recommend, 20 (91%); Recommend with Conditions, 2 (9%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received five public comments, three of which were supportive and two that expressed concerns. Supporters viewed the measure as a tool that facilitates quality-of-life discussions with patients with neurological conditions and appreciated its promotion of early referrals to palliative care. Other comments expressed a potential need for risk adjustment based on comorbidities and the duration of neurological disease. Commenters also questioned the sufficiency of testing for reliability and validity, implementation issues around response rates, and whether patients' treatment choices might lead to decreased quality of life.

Discussion Themes	Recommendation Group Member Discussion
Exclusions	• The committee raised concerns about excluding patients who did not complete the second survey. They suggested implementing more objective exclusion criteria, such as cases where a patient was transferred to another facility.

Discussion Themes	Recommendation Group Member Discussion
Feasibility Challenges	• The committee addressed the feasibility of implementing the measure, raising questions about who would be responsible for integrating it into existing EHR systems due to the additional knowledge of the Patient-Reported Outcomes Measurement Information System (PROMIS) required. • Although the tool is free, there may be costs related to its implementation, especially if using the app or requiring translations. The feasibility was deemed comparable to other measures, with potential cost savings if PROMIS is used in other contexts. • A committee member noted that from a business perspective, the measure is feasible, particularly considering potential negative payment adjustments for non-compliance.
Locus of Control	• Several members highlighted concerns that quality of life assessments might reflect negatively on providers due to the natural decline in neurological diseases, which are beyond their control.

Conditions: The committee recommended that the developer modify the specifications so that lack of follow-up survey is not a denominator exclusion.

2.3.8 MUC2024-051 Prevalent Standardized Waitlist Ratio (PSWR) [CMS]

Description: The PSWR measure tracks the number of prevalent dialysis patients in a practitioner (inclusive of physicians and advanced practice providers) group who are under the age of 75 and were listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant. For each practitioner group, the PSWR is calculated to compare the observed number of waitlist events in a practitioner group to its expected number of waitlist events. The PSWR uses the expected waitlist events calculated from a Cox model, adjusted for patient age, incident and prevalent comorbidities, previous waitlisting and transplant, dual eligibility, ADI, and transplant center characteristics.

Program: Merit-based Incentive Payment System

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 13 (65%); Recommend with Conditions, 0 (0%); Do Not Recommend, 7 (35%); No Recusals

Summary of Public Comment: The measure received two public comments that acknowledged the importance of improving transplantation rates and noted concerns that the measure might penalize physicians for factors beyond their control, such as changes in patient insurance and varying eligibility criteria across transplant centers, which could undermine the measure's validity and fairness. Commenters also raised concerns about the measure's reliability, particularly for smaller providers, and the need for measures that align incentives across the care continuum to more accurately reflect nephrologists' roles in the transplantation process.

Discussion Themes	Recommendation Group Member Discussion
Endorsement	• The committee reviewed the endorsement history of the measure and discussed the validity concerns that led to a lack of endorsement during the submission cycle. • The committee reviewed the validity testing in the measure submission and discussed limitations.
Exclusions	• The committee expressed concern about insufficient exclusions, such as for patients opting out of waitlisting.
Attribution	• While the developer and CMS outlined ways in which individual nephrologists can impact transplant decisions through care coordination, communication with transplant centers, and focusing on optimizing patient health so they are excellent candidates for transplant, many committee members voiced concern that this measure unfairly attributes responsibility for transplant decisions to nephrologists despite multiple patient and transplant facility level factors that influence that decision. • The developer did outline ways in which this concern may be addressed through adjustments for transplant center characteristics, such as waitlist mortality and organ availability, to account for variations in patient acceptance criteria.

Conditions: None provided.

2.3.9 MUC2024-072 Addressing Social Needs Assessment & Intervention [CMS]

Description: Percentages of patients with a qualifying evaluation and management outpatient visit during the performance period of all ages reflecting whether patients were assessed in four domains of social need: food, housing, transportation, and utilities, and whether the patient received a qualifying follow-up action within the visit for any positive social needs. Qualifying follow-up actions were identified from Gravity Project: adjustment, assistance/assisting, coordination, counseling, education, evaluation of eligibility, provision, and referral.

Program: Merit-based Incentive Payment System

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 10 (48%); Recommend with Conditions, 2 (10%); Do Not Recommend, 9 (43%); No Recusals

Summary of Public Comment: This measure received seven public comments, four of which shared support and three that expressed concern. Supporters praised the measure's comprehensive approach to addressing social determinants of health, such as economic stability, food and housing insecurity, transportation, and utilities. They noted its alignment with National Quality Strategy goals and role in advancing health equity. Supporters also appreciated its inclusion across multiple quality reporting programs, viewing this as a positive step toward integrating social needs assessment into broader health care quality improvement efforts. Concerns included potential survey fatigue for patients if both health plans and clinicians screen for social needs, the capacity of community-based organizations to handle increased referrals, and the need for new payment models. There were also concerns about varying measure scoring and implementation across settings and a call for further testing. Suggestions included

expanding the measure to include occupational therapy services and adjusting scoring to support improvement by excluding patients who decline screening or follow-up.

Discussion Themes	Recommendation Group Member Discussion
Availability of Social Support Services	• Committee members expressed concerns about the variability of social support services across different regions, highlighting the difficulty of making referrals when community services are unavailable or overburdened with existing clients. • One member emphasized the potential for penalizing clinicians for follow-up actions that require systemic support in areas where the lack of these supports is outside the clinician's control. • Despite these challenges, they supported the measure for its potential to provide valuable data that can help health systems identify and address service gaps. • The committee recognized that data from this measure could also support the business case for health systems to offer these services internally, creating a net positive social impact.
Feasibility Challenges	• The committee expressed significant concern about the measure's complexity and broad scope of social needs included in the specifications, particularly regarding EHR implementation. They noted the need for further testing across diverse settings to ensure its feasibility and effectiveness. • One member stated that the measure needs to better facilitate quality improvement, be feasible to implement, and produce reliable and valid results.
Importance	• While acknowledging its imperfections, several committee members suggested that the measure moves in the right direction by promoting a more comprehensive framework to address social determinants within clinical settings.

Conditions: The committee suggested that this measure should "require denominator exclusion for patients who refuse screening, additional testing with non-hospital based data, and implementation or testing with additional EHRs."

2.3.10 MUC2024-025 Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care [Brigham and Women's Hospital]

Description: The DOVE eCQM assesses the rate of delayed diagnosis of VTE in adults aged 18 years and older in the primary care setting. Delayed diagnosis is defined as diagnosis of a lower limb VTE that occurs >24 hours following the index primary care visit where symptoms for the VTE were first present (within 30 days). The target population for this measure is all patients, 18 years and older, across all payers.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 16 (70%); Recommend with Conditions, 3 (13%); Do Not Recommend, 4 (17%); No Recusals

Summary of Public Comment: The measure received eight public comments, four in support and four expressing concerns. Supporters praised the measure for enhancing diagnostic safety and potentially lowering health care costs by improving diagnostic performance and reducing complications from delayed treatment. Others expressed concerns about the practicality of the measure in primary care settings, particularly regarding access to diagnostic tools and the time required for prior authorization for imaging studies. Commenters expressed worries about the measure's focus on primary care not accounting for other patient entry points into the health care system and the potential for penalizing physicians, as performance is tied to payment in the MIPS program.

Discussion Themes	Recommendation Group Member Discussion
Measure Specification	• The committee had a robust discussion about the threshold for identifying VTE-related symptoms during the index primary care visit and received clarification on use of ICD-10 codes, CPT code scanning, and Rx Norm code use.
Unintended Consequences	• A committee member asked if overuse of imaging might be a potential unintended consequence associated with this measure. The developer noted they did not conduct testing in this area, but the measure will help to conduct root cause analysis. The developer also noted that currently underutilized means such as D-dimer testing may provide a cost-effective alternative to imaging in some cases and that the team is developing clinical decision support tools to help determine when that might be a suitable alternative. • Another committee member expressed the desire to strike a balance between potential for imaging overuse and the diagnosis and treatment of a potentially fatal condition.
Stratification	• Another committee member offered support for the measure, but also emphasized the need to stratify the data by demographics. The developer noted they are currently conducting a study to investigate disparities. For this measure, there were no significant differences by race, ethnicity, sex, insurance, and age. The developer confirmed they will continue to explore this data.
Natural Language Processing (NLP) & EHRs	• A committee member asked if facilities must use Natural Language Processing (NLP) to define symptoms. The developer noted the measure is an eCQM, and includes a value set for symptoms. If the facility's EHR has those symptoms in structured fields, they will not need the NLP, but if not, the facility can use NLP to define symptoms. A free license is available for the NLP program. The developer confirmed the NLP model has been tested and successful in different health systems. • A committee member emphasized the importance of ensuring testing is done in facilities with smaller EHRs as well.
Scientific Acceptability	• The committee discussed measure testing, and some members expressed concerns about low reliability.

Discussion Themes	Recommendation Group Member Discussion
Voluntary Reporting	• A member noted that typically accountable care organizations (ACOs) are made up of smaller independent practices and does not feel the measure is ready to be mandatory and confirmed the voluntary nature of selecting measures for reporting in MIPS.

Conditions: The committee requested that CMS address implementation burdens for facilities with "less sophisticated EHRs."

2.3.11 MUC2024-028 Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes [American Medical Association]

Description: Percentage of adult patients with risk factors for type 2 diabetes who are due for glycemic screening for whom the screening process was initiated during the measurement period.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend

Vote Count: Recommend, 22 (100%); Recommend with Conditions, 0 (0%); Do Not Recommend, 0 (0%); 1 Recusal

Summary of Public Comment: The measure received 32 public comments, with 30 expressing support and two raising concerns. Supporters noted the measure enhances the early detection and prevention of diabetes, aligns with national guidelines and recommendations, is feasible because the data elements are commonly captured in electronic health systems, and offers a cost-effective strategy for reducing long-term burden. The public comment concerns included the suggestion to remove the two office visits criteria and to ensure disproportionately affected populations, including racial and ethnic minorities, are reached.

Discussion Themes	Recommendation Group Member Discussion
Alignment with Guidelines	• Committee members discussed BMI and age ranges within the measure specification and the measure developer noted alignment with the U.S. Preventive Services Task Force (USPSTF) clinical recommendations for screening and expressed support for this alignment.
Measure Development	• Several committee members commended the developer on developing a meaningful and evidence-based measure in alignment with guidelines. Measure testing approaches were commended for their appropriateness and scientific rigor. • The committee expressed support and appreciation for the measure's feasibility testing three EHR systems to align with the Health Information and Management Systems Society (HIMSS) recommendations.

Conditions: None provided.

2.3.12 MUC2024-031 Hepatitis C Virus (HCV): Sustained Virological Response (SVR) [American Gastroenterological Association]

Description: Percentage of patients aged greater than or equal to 18 years with active hepatitis C (HCV) with negative/undetectable HCV ribonucleic acid (RNA) at least 20 weeks to 12 months after positive/detectable HCV RNA test result.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend

Vote Count: Recommend, 23 (100%); Recommend with Conditions, 0 (0%); Do Not Recommend, 0 (0%); No Recusals

Summary of Public Comment: The measure received two public comments that indicated concerns around patients' abilities to access services and adhere to treatment, not excluding patients with concomitant infections from the denominator, and the potential for health care providers to favor patents more likely to return for post-SVR testing.

Discussion Themes	Recommendation Group Member Discussion
Importance	• There was robust support for this measure, with one member noting that the steps required for measure implementation align with standard quality of care. • This measure was commended for being important to patients and was seen to have benefits to patient quality of care.

Conditions: None provided.

2.3.13 MUC2024-079 Assessment of Autonomic Dysfunction and Follow-Up [AAN]

Description: Percentage of patients with a diagnosis of Parkinson's disease (or caregivers as appropriate) who were assessed for symptoms of autonomic dysfunction in the past 12 months, and if autonomic dysfunction was identified, patient had appropriate follow-up.

Program: Merit-based Incentive Payment System

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (55%); Recommend with Conditions, 7 (32%); Do Not Recommend, 3 (14%); No Recusals

Summary of Public Comments: The measure received two public comments; both expressed support for the measure. Commenters emphasized the importance of identifying and addressing autonomic dysfunction to prevent serious injuries caused by falls and fainting. They also highlighted the incorporation of occupational therapy as a benefit of the measure. Additionally, the comments called for more measures within MIPS to support those providing care to patients with neurologic disorders.

Discussion Themes	Recommendation Group Member Discussion
Follow-up	• One committee member questioned the types of qualifying follow up to screening, such as referral, and emphasized that merely providing follow up without ensuring its effectiveness might not adequately address the issue. They highlighted the importance of matching appropriate care to patients' needs. • The committee called for expanding the qualifying referrals to include allied health professionals, ensuring a broader range of support for patients.
Feasibility Challenges Due to AAN Registry Closure	• The committee also discussed the measure's feasibility, particularly since the AAN is no longer maintaining their Axon registry. This change impacts data access and complicates the integration of electronic and manual data extraction methods. The committee expressed concerns about how this might affect the measure's implementation and data collection. CMS noted that while Axon is not a current QCDR, QCDRs and Qualified Registries can support any MIPS quality measure, and they determine how best to collect the data.
Alignment with Clinical Guidelines	• One member questioned the measure's alignment with current clinical guidelines and the committee emphasized the need to keep the measure up to date with current guidelines, as outdated guidelines could undermine its effectiveness.
Benchmarks	• The committee raised questions about the MIPS benchmark and its representativeness. CMS clarified that a process measure is considered "topped out" at a 95% median performance rate, but this may not reflect the general population of clinicians who could report the measure.

Conditions: The committee recommended that the developer review current clinical guidelines to ensure alignment with the latest recommendations and clinical evidence as well as expand referral options in specifications.

2.3.14 MUC2024-049 Breast Cancer Screening [Acumen, LLC]

Description: The Breast Cancer Screening episode-based cost measure evaluates a clinician's or clinician group's average risk-adjusted cost to Medicare for providing care to females 40 years of age or older, who received a screening mammogram during an episode of care. The measure score is the clinician's or clinician group's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician or clinician group. This measure includes costs for certain services (calculated from claims submitted under Medicare Parts A and B) that are clinically related to the attributed clinician's or clinician group's role in managing care during each episode. Each episode starts from the screening mammogram that opens, or "triggers," the episode and continues through 12 months after the trigger or the next screening mammogram. This measure would assess the costs of certain assigned services clinically related to breast cancer screening, including basic and advanced diagnostic services and cancer treatment services.

Program: Merit-based Incentive Payment System

Committee Final Vote: Do Not Recommend.

Vote Count: Recommend, 1 (5%); Recommend with Conditions, 2 (11%); Do Not Recommend, 16 (84%); 2 Recusals

Summary of Public Comments: This measure received three public comments, one in support and two expressing concerns. Supporters noted that the measure incentivizes cost-effective imaging practices and discourages unnecessary follow-ups. However, concerns included the potential penalization of primary care physicians for increasing screenings, the lack of transparency and interoperability across care settings, and inadequate risk-adjustment methodologies that fail to consider patients' social and economic contexts. Additionally, commenters warned that lower costs do not necessarily equate to better-quality care and could lead to poor patient outcomes. They recommended a slow, phased implementation of cost measures, pending proper testing, to address these issues.

Discussion Themes	Recommendation Group Member Discussion
Attribution	• An often-cited concern was the attribution methodology, with committee members worried that costs might be incorrectly assigned to clinicians who do not have decision-making authority, such as mid-level providers. • This concern was particularly relevant for an example given in oncology, where complex care decisions are often made by attending physicians rather than those who might be attributed costs under the current measure. • The developer clarified that the measure is primarily attributed to radiologists who bill for screening mammograms, aiming to ensure accurate attribution. They explained that the measure is designed to incentivize early cancer detection by focusing on the costs associated with screening and early diagnostics, while excluding unrelated treatment costs unless late cancer detection occurs. • Several committee members encouraged the developer to use testing data to explore attribution concerns. This was emphasized as an important component of testing for cost measures in general.
Measure Concept	• The committee also questioned the measure's focus, noting that it seemed to extend beyond screening to include diagnostic and treatment services. This expansion could complicate the measure's purpose, as it blurs the line between screening and subsequent care processes. • Members expressed confusion over the measure's intent, as it appeared to encompass a wide range of services, from basic diagnostics to advanced treatments, which could lead to unintended penalties for clinicians if not clearly defined and managed.

Discussion Themes	Recommendation Group Member Discussion
Pairing Cost with Quality Measures	• Another critical point raised was the need for the measure to be paired with quality measures. The committee emphasized that without accompanying quality metrics, there is a risk of the measure driving a "race to the bottom," where cost-cutting could occur at the expense of care quality. This concern underscores the importance of ensuring that cost measures do not inadvertently compromise patient outcomes by focusing solely on financial metrics. • CMS noted efforts to align cost measures with quality measures within MIPS Value Pathways (MVPs) to ensure comprehensive value assessment.
Benchmarking	• Additionally, the committee highlighted the importance of clear and meaningful benchmarking. They noted that the current cost distribution across deciles might not accurately reflect true performance differences, given the narrow range of cost variation. • This issue raises questions about the measure's ability to effectively distinguish between high and low performers, potentially undermining its utility as a tool for improvement.
Reporting Frequency	• There was also a call for more frequent feedback reports to clinicians, suggesting that annual reports are insufficient for timely performance improvement. The committee advocated for quarterly feedback to provide clinicians with more actionable insights, enabling them to make necessary adjustments in a timely manner.

Conditions: The committee advocated for quarterly feedback to provide clinicians with more actionable insights, enabling them to make necessary adjustments in a timely manner, which was viewed as a consideration for cost measures in general.

2.3.15 MUC2024-100 Non-Pressure Ulcers [CMS]

Description: The Non-Pressure Ulcers episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted and specialty-adjusted cost to Medicare for patients who receive medical care to manage and treat non-pressure ulcers. This chronic condition measure includes Medicare Parts A, B, and D costs for services that are clinically related to managing and treating non-pressure ulcers.

Program: Merit-based Incentive Payment System

Committee Final Vote: Consensus Not Reached.

Vote Count: Recommend, 4 (20%); Recommend with Conditions, 2 (10%); Do Not Recommend, 14 (70%); 2 recusals

Summary of Public Comment: Among the 14 public comments received, a majority were from individuals who had participated in the expert workgroup development of the measure. Several comments raised concerns about the measure's potential to hold clinicians accountable for the work of others due to group-level attribution. Commenters also questioned the appropriateness of subgrouping ulcer types and the use of certain diagnosis codes. These commenters noted a lack of transparency during the measure's development and the need for additional testing.

Commenters expressed concern that patients with extremely low costs were excluded from the measure. Additionally, while wound care is multidisciplinary, several commenters saw the measure as overly focused on podiatrists, raising further attribution concerns. Lastly, commenters criticized the assumption that lower costs equate to higher quality, which they argued is not necessarily true.

Discussion Themes	Recommendation Group Member Discussion
Measure Readiness	• Committee members expressed concerns about the measure, highlighting the numerous public comments from the expert workgroup that suggested dissatisfaction with the measure's readiness. • One member stressed the importance of understanding how CMS and the developer intend to address these concerns, particularly regarding the measure's validity and attribution accuracy. • Another member shared these concerns, questioning whether the developer had implemented any changes since December, when the technical expert panel identified significant issues with the measure. The developer shared that TEP concerns were addressed during development.
Actionability of Reporting	• A clinician member stressed the importance of providing clinicians with actionable feedback to improve patient care, rather than just reporting scores. • Several committee members agreed with the importance of receiving accurate, meaningful feedback from measures so that they could improve the quality of care delivered.
Benchmarking	• One member requested to see cost distribution results using the new benchmarking methodology, stressing the importance of providing meaningful feedback for clinicians to improve actionability.
Attribution	• Several committee members representing clinician and systems perspectives shared concerns about this measure related to appropriate attribution and voiced support for appropriate attribution as a focus of testing.
Pairing Cost and Quality Measures	• A committee member reiterated the importance of pairing cost and quality measures to promote meaningful improvement on this clinical area and provide a more comprehensive view of care performance.

Conditions: The committee recommended that future cost measures to be paired with quality measures and have reporting mechanisms that provide meaningful, actionable, and scaled feedback to clinicians to ensure their ability to improve the quality of care for patients.

2.3.16 MUC2024-101 Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) [CMS]

Description: The Parkinson's Syndromes, MS, and ALS episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted and specialty-adjusted cost to Medicare for patients who receive medical care to manage and treat Parkinson's and related conditions, MS, or ALS. This chronic condition measure includes the Medicare Parts A, B, and D costs for

services that are clinically related to managing and treating Parkinson's Syndromes, MS, or ALS episode.

Program: Merit-based Incentive Payment System

Committee Final Vote: Do Not Recommend

Vote Count: Recommend, 1 (5%); Recommend with Conditions, 1 (5%); Do Not Recommend, 18 (90%); No recusals

Summary of Public Comment: The measure received five public comments, one in support of measure inclusion and four expressing concerns. One commenter expressed general support for the measure intent and suggested including occupational therapists in the attribution list. Commenters expressed concern about the complexity of the measure's cost improvement methodology and the relationship between lower cost and higher quality of care. Commenters also reported concerns about the attribution methodology, reliability, and the potential to disincentivize treating higher-cost patients. Commenters also questioned grouping ALS with conditions that have more variable outcomes, such as MS.

Discussion Themes	Recommendation Group Member Discussion
Measure Focus	• A committee member inquired about the measure's focus on Parkinson's, MS, and ALS, asking why these specific chronic conditions, known for high costs and advanced therapeutic interventions, were chosen for a cost measure. The developer clarified conditions are high-cost and involve many beneficiaries, providing opportunities for cost-effective care. • Several committee members expressed support for focusing on these conditions separately across multiple measures.
Endorsement	• A committee member expressed broad concerns about the lack of endorsement for cost measures and the absence of accompanying quality measures. They stressed the importance of understanding cost measures and their implications on clinician payments. • A CMS representative acknowledged the feedback and mentioned ongoing considerations for informational reporting and endorsement processes.

Conditions: Committee recommendations included separating the three conditions and reporting separately as well as coupling this cost measure with an appropriate quality measure.

3. Common Themes and Future Considerations

During the series of PRMR meetings, Recommendation Group members expressed several recurring themes for where they would like to see measures or measure sets be revised and improved moving forward. The most common conditions submitted for measures included stratification, conducting additional measure testing, undergoing CBE endorsement, revising inclusion criteria to address measure-specific concerns, and addressing reporting burden through alignment across programs or additional feasibility considerations.

In addition to these common conditions, committees provided robust discussion on topics of high priority to interested parties, including the importance of pairing cost and quality measures to improve actionability for clinicians, ensuring that measures allow flexibility for patient choice and shared decision-making, and emphasizing the benefits of continuous measure review and transparency after implementation so that risk adjustment models can be updated appropriately.

Figure 6 shows the synthesis of topics that members would like to see measure developers and CMS dedicate resources to addressing in future CMS programs during pre-rulemaking.

Figure 6. Areas for Future Consideration

Increase Stratified Reporting to Promote Meaningful Interpretation

The most common condition provided by PRMR committees were requests for stratification. Committees requested stratification by factors at the measured entity level—referred to as peer group stratification—such as geographic region, rural vs. urban status, care type or hospital trauma level, and case volume. The intent of these types of stratification is to improve the interpretability of the performance scores and ensure that measured entities that may experience greater challenges related to measure implementation and performance are evaluated appropriately.

Rural & Low-Volume Settings

One example of this theme was the request for geographic, rural vs. urban, or low case volume stratification of measures that rely on referral or coordination with community resources such as the social needs focused measures (MUC2024-052, 59 & 72) measures or Proportion of

Patients Who Died from Cancer Admitted to Hospice for Less Than 3 Days (MUC2024-78). Committees noted that providers in areas where community resources for referral and intervention are limited or geographically distanced may experience greater challenges in implementing measures that rely on some level of community resource availability.

Patient & Plan Subgroups

The committee also requested stratification for existing risk-adjusted complication, mortality, and readmission measures that have been revised to include the Medicare Advantage (MA) population. Several experts on the hospital committee noted that the variation in patient demographics across MA and fee-for-service programs may represent meaningful differences in factors that influence health outcomes and are not reflected in current risk models for these measures.

Measure-Specific Factors

The committees requested stratification for specific measures to enhance the interpretability and actionability of performance scores. They recommended stratifying the Person-Centered Outcome Measures: Goal-Identification, Follow-Up, and Goal Achievement (MUC2024-026); and Emergency Care Capacity and Quality (MUC2024-075 & 95) measures by factors such as the type of care sought (e.g., behavioral health, maternity care). This stratification aims to help measured entities identify performance gaps across a range of services. Similarly, they recommended stratifying the Cancer Screening and Counseling Patient-Reported Outcome-Based (MUC2024-82) measure by cancer type to improve the ability of the measured entity to pinpoint areas for improvement in screening and counseling services for cancer patients.

In the future, the committees encouraged measure developers and CMS to look beyond patient-level risk-adjustment models and focus on identifying subgroups within measured entities that may show performance variations. By effectively utilizing stratified measure performance scores, these subgroups can be pinpointed, allowing for targeted improvements in specific areas.

Encourage Consensus-Based Entity (CBE) Endorsement

During the measure discussions, the committee frequently expressed uncertainty about measure performance and scientific acceptability based on the information submitted to MERIT at the start of the PRMR cycle. Several committees emphasized the critical importance of obtaining CBE endorsement to ensure scientific rigor. They highlighted that endorsement committees, with their specialized expertise in measurement science, are better equipped to evaluate complex concerns such as reliability and validity. These committees possess the necessary knowledge and experience to scrutinize the measures thoroughly, ensuring that they meet the highest standards of scientific accuracy and effectiveness.

Although CBE endorsement is not currently required for a measure to be considered for a CMS program, several members strongly recommended that CMS place greater emphasis on its importance. By doing so, CMS can foster more effective programmatic discussions, ensuring that all interested parties have confidence in the measures being considered. Emphasizing CBE endorsement for developers wishing to submit to the MUC List would not only enhance the credibility of the measures but also facilitate more informed and productive discussions, ultimately leading to better decision-making and improved outcomes for the programs involved.

Promote Representative and Rigorous Measure Testing

Members of the clinician and hospital committees had robust discussions about the quality and appropriateness of measure testing for MUC list measures. Common concerns related to testing included small sample sizes, low reliability scores, a lack of empirical validity or reliability testing, testing within populations not representative of the program population, and limited feasibility testing. These discussions often resulted in recommendations for measures to receive CBE endorsement prior to being accepted onto the MUC List to assure scientific acceptability. While CBE endorsement will improve the likelihood that measures coming to PRMR committees for consideration have acceptable validity and reliability, there is still a need for measure testing with CMS programs in mind. For example, the committees noted feasibility challenges related to implementation of eCQMs, with concerns voiced about data element availability and workflows across EHRs commonly used in clinical practice across a range of price points, not just a selection of EHRs used at large academic health systems, for example.

Members of the committee also encouraged greater transparency in the measure development process and were eager to learn the rationale for development decisions during Q&A with developers. Examples of this interest in understanding development decisions included inquiring about the rationale for the addition of the medication supply domain to the Patient Safety Structural Measure (MUC2024-027) and learning how TEP feedback was incorporated during development of the Non-Pressure Ulcer measure (MUC2024-100). Measure developers looking to improve their development processes should look to the measure submission for Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes (MUC2024-028) which was lauded by committee members for its measure development and testing approaches.

Members of the clinician committee encouraged measure developers to leverage measure testing data to further assess whether cost measures provide appropriate attribution. Members expressed concern that cost measures do not adequately represent the scope of care and decision-making pathways within an episode of care and may inappropriately attribute health outcomes or resource use to clinicians that do not hold a majority share of the responsibility for that outcome or resource use. Several committee members representing clinician organizations expressed strong support to incorporate attribution review into measure testing as part of routine cost measure development to understand which provider types and specialists are being captured by the measure. While this type of measure testing is not commonly performed, discussions highlighted the benefits such testing could have on obtaining clinician support for measures and reducing unintended consequences to providers. In the future, developers may wish to pull a subset of testing data and map attribution decisions to demonstrate that measures provide accurate reflection of real-world clinical practice.

Pair Cost and Quality to Assess Value

During discussion of cost measures, a committee member representing clinician perspectives called for CMS to explore pairing cost measures with relevant quality measures to better empower clinicians to achieve meaningful improvement. This recommendation stemmed from concern that clinicians may not always have cost data readily available to inform decision making and that without matching quality measures, gaps in care may persist or worsen as clinicians reduce cost at the expense of quality. An example provided of this pairing was offered during discussion of Breast Cancer Screening (MUC2024-049), with a clinician member suggesting pairing this measure with appropriate quality metrics targeting breast cancer screening. The clinician member of the committee explained how a paired quality measure would enable clinicians to see where appropriate care was being provided and guide

clinical decision making. While MIPS MVPs provide the opportunity to bundle measures, the availability of complementary cost and quality measures differ depending on the clinical specialty and condition of focus. This theme continued into discussion of MUC2024-100 and 101, with committee members noting the high cost of care for Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) (MUC2024-100) and encouraging a paired quality measure to guide improvements.

Improve Actionability

Committee members made recommendations to improve the actionability of measure performance data. From stratification to more frequent reporting and pairing cost with quality measures, there was robust discussion of the ways in which CMS can improve the ability of measured entities to make necessary changes to improve the quality of care delivered.

Across committees, members from clinical practice or health systems backgrounds expressed enthusiasm and support for improvements in quality of care but stressed that such improvement is only possible if measured entities are provided with meaningful, accurate, and timely data on their performance. They encouraged CMS to provide feedback that will enable entities to identify and target opportunities for improvement. In discussion of MUC2024-049, the committee encouraged quarterly reporting or sharing of feedback to improve clinicians' ability to improve the quality of care delivered. In encouraging CMS to analyze the impacts of adding MA data during implementation, committee members expressed interest in partnering with CMS to identify aspects of measures that need revision, such as updating risk adjustment models or exclusion criteria to reduce unintended consequences. This willingness for collaboration underscores an interest in quality measure reporting that is dynamic, transparent, and bidirectional to better empower measured entities to deliver high quality care efficiently.

Account for Shared Decision-Making

Conversations around the end-of-life focused measures such as Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (MUC2024-067) demonstrated a need for measures that are reflective of shared decision making. During discussion of these measures, committee members emphasized the importance of ensuring flexibility for patient choice and following of individual care plans. These discussions suggest that patient empowerment through quality measurement requires actions beyond engaging patients in reporting through PROMs which can lead to survey fatigue. When possible, measures should account for shared decision making in specification through use of exclusions, adjustment, or other means of ensuring that providers are encouraged to engage in shared decision making without fear of penalization.

Promote Harmonization and Alignment

Several of the measures discussed during this PRMR cycle had similar measures currently in use in other CMS programs. Examples of this include the Depression Screening and Follow-Up for Adolescents and Adults (MUC2024-088) and the social needs focused measures (MUC20204-052, 069 & 072). Committee members shared concerns about potential lack of harmonization of these measures, encouraging standardization of specifications for similar measures to reduce burden in data collection and reporting. As outlined on the CMS Measures Management System Hub, when two measures address a similar measure topic within the same population, developers are encouraged to standardize specification and risk-

adjustment methods unless there is a compelling reason for deviation, backed by evidence. When slight variation in measure components or risk models exists between two measures on similar topics, it can introduce added complexity and feasibility challenges for measured entities. One committee member explained how variation in measures focused on depression screening could require changes to EHR configurations to ensure all needed data elements are captured.

Similarly, alignment ensures that similar standardized measures are used across government efforts such as CMS programs. The committee emphasized the need for alignment across programs during the hospital recommendation group discussion of social needs-focused measures and PAC/LTC discussions of CAHPS measures. The committee discussed differences in domains for measures on this topic and the potential for added burden in reporting if hospitals participate in multiple programs. For CAHPS measures, committee members expressed concern that some patients might be asked to complete similar surveys or answer nearly identical questions to fulfill patient reporting requirements for multiple programs. CMS representatives participating in these discussions echoed the importance of harmonization and alignment and shared steps being taken to ensure meaningful measure implementation.

Explore Impacts of Health Services Trends on Quality Measures

During the hospital recommendation group meeting, a committee member asked attendees to consider how recent shifts in care such as Total Hip Arthroplasty (THA) from traditional hospital inpatient settings to outpatient and ambulatory surgical centers (ASC) may impact quality measurement. This question sparked a robust discussion about how trends such as a move to ASCs or other outpatient settings may result in a clinically relevant difference in the patient populations seen at inpatient settings. The committee considered if patients opting for ASC services might have less medical complexity than those who remained with inpatient services. Differences in patient characteristics could impact measure performance if shifts occur in the types of patients captured within relevant reporting programs. The committee considered how revisions to risk adjustment models could address this and encouraged further analysis of any variation in patient mix as well as development of similar measures for ASC and hospital outpatient quality reporting programs.

Consider Phased Implementation

During the measure discussions, committee members often voiced hesitancy about implementing measures within programs. To mitigate their concerns, they suggested conditions like "voluntary reporting for two years" or “phased implementation” (MUC2024-075 & 85) to facilitate a more cautious and gradual adoption process. Committee members expressed concern that measures may go into value-based payment programs without prior pay-for-reporting program use to provide evidence of benefit. These discussions demonstrated that, while there is support for the use of these measures within their selected programs, interested parties wish to balance the gathering of information that comes from these measures with the impact of formal measure reporting. Several committee members expressed that while they recognize the benefit of the measure and the data provided, they did not want to be penalized for performance on a measure that may need additional measure testing or revision to provide the best fit within the context of the CMS program and population. To address these concerns, CMS may wish to explore ways to expand methods like the Part C and D Star Ratings display page where measures have a softer launch into programs.

4. Pre-Rulemaking Measure Review Next Steps

Detailed summaries of each of the PRMR meetings are available at the PQM website. Moving forward, CMS will consider the Recommendation Group votes, discussion points, conditions, and recommendation rationales in future rulemaking for the measures and programs reviewed during the 2024-2025 PRMR cycle.


Partnership for
Quality Measurement
Powered by Battelle