Measure Set Review — 2023 Recommendation Group Education Meeting Summary

The Battelle staff convened the Measure Set Review (MSR) Recommendation Group for an educational web meeting on September 12, 2023, to provide an overview of the End-Stage Renal Disease Quality Incentive Program (ESRD QIP), discuss the 2023 MSR process and evaluation criteria, and review next steps and the process timeline.

Welcome and Introduction

Diptee Ojha, BDS, PhD, Pre-Rulemaking Measure Review (PRMR) and MSR Task Lead, welcomed everyone to the MSR Education Meeting. Dr. Ojha introduced Stephanie Clark, MD, MPH, MSHP, Medical Officer in the Division of Quality Management (DQM), Quality Measurement and Value-Based Incentives Group (QMVIG), Center for Clinical Standards and Quality (CCSQ) at the Centers for Medicare & Medicaid Services (CMS) for CMS Opening Remarks and to present the overview of the ESRD QIP.

CMS Opening Remarks and Overview of ESRD QIP

Dr. Clark welcomed the MSR Recommendation Group and expressed CMS's excitement to begin the new process with the group. She thanked them for their expertise, time, commitment, and feedback in the creation of meaningful streamlined measure sets that reflect high quality care for patients. In addition to noting the value of formal recommendations, Dr. Clark encouraged discussion about the measures as an important component of this process.

The ESRD is described in section 1881(h) of the Social Security Act, as added by Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The intent of the ESRD QIP is to promote patient health by providing a financial incentive for dialysis facilities to deliver high-quality patient care. The program must include measures specific to the conditions treated with oral-only drugs, and measures are required to be outcome-based to the extent feasible. MIPPA requires the Health and Human Services (HHS) Secretary to create an ESRD program that will select measures that: address the following topics to various extents, namely anemia, dialysis adequacy, patient satisfaction, iron management, bone mineral metabolism, and vascular access; establish performance standards; specify the performance period; develop a methodology for calculation of Total Performance Score (TPS); and apply an appropriate payment percentage reduction, with publicly reported results. ESRD QIP is a "pay for performance" or "value-based purchasing" (VBP) program.

Dr. Clark then reviewed ESRD QIP measure set and priorities. The two types of measures in the ESRD QIP are clinical measures, on which facilities are scored based on whether they meet specified performance standards, and reporting measures, on which facilities are scored based on whether they meet specific reporting requirements. The domains within the ESRD QIP are used to calculate the TPS. The domains, TPS weight, and their associated measures are as follows:

- Clinical Care Measure Domain (35%)
  - Kt/V Dialysis Adequacy (Comprehensive)
  - Standardized Transfusion Ratio (STrR)
  - Vascular Access Type: Standardized Fistula Rate (SFR)
  - Vascular Access Type: Long-term Catheter Rate

- Care Coordination Measure Domain (30%)
  - Standardized Readmission Ratio (SRR)
  - Standardized Hospitalization Ratio (SHR)
  - Percentage of Prevalent Patients Waitlisted (PPPW)
- Safety Measure Domain (10%)
  - NHSN Bloodstream Infection in Hemodialysis Patients
- Patient and Family Engagement Measure Domain (15%)
  - In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey
- Reporting Measure Domain (10%)
  - Hypercalcemia
  - Ultrafiltration Rate
  - NHSN Dialysis Event
  - COVID-19 Healthcare Personnel (HCP) Vaccination
  - Medication Reconciliation
  - Clinical Depression Screening and Follow-up.

The two additional ESRD programs that are related to but separate from the ESRD QIP are the Dialysis Facility Care Compare (DFCC) and the Dialysis Facility Star Ratings Program. The DFCC is a public reporting program that allows patients and providers to view and compare quality data about dialysis facilities. The Dialysis Facility Star Ratings Program uses a subset of the DFCC measures to create a rating that can be used to compare facilities.

Overview of the Partnership for Quality Measurement (PQM)

Dr. Ojha provided a recap of the Partnership for Quality Measurement (PQM). PQM includes all interested parties engaged in the measurement space. Battelle is a consensus-based entity (CBE) funded through the CMS National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract to oversee the endorsement and maintenance (E&M) of clinical quality measures as well as the engagement of interested parties in the CMS pre-rulemaking process. The PQM vision is that the quality measure endorsement and review processes should be reliable, transparent, attainable, equitable, and most of all, meaningful.

Dr. Ojha provided an overview of the PRMR and MSR processes. The PRMR process solicits input from interested parties to recommend whether measures on the Measures Under Consideration (MUC) List are reasonable and necessary. The MSR process allows interested parties to consider the purpose of each program's measures and weigh the impact of these measures against the burden of their implementation. Dr. Ojha noted several enhancements in the new process introduced under the current contract: more rigor, increased engagement, and transparency to the processes. The cross-cutting committee setting approach promotes efficiency and alignment, reduces burden, and increases transparency. Each committee includes an advisory group and a recommendation group.

For the 2023 MSR process, Battelle will focus on a specific CMS Medicare quality program rather than a priority area from the Cascade of Meaningful Measures (Cascade) as described in the PRMR and MSR Guidebook.

MSR Process and Evaluation

Kate Buchanan, PRMR and MSR Deputy Task Lead, reviewed the MSR process.

The MSR process builds consensus around measure removals to optimize the CMS measure portfolio in the quality reporting and value-based programs. The four major steps of the MSR process are:

1. Identify cycle focus
2. Information collection and synthesis
3. Recommendation Group feedback
4. Discussion and recommendations

Dr. Ojha then reviewed the MSR assertions, which are based on the evidence supporting the impact of the measure and how redundancies are addressed. The three main assertions are impact, entity data streams, and patient journey.

MSR preliminary assessment evaluation criteria are:

- **Importance**. Importance is measured by evidence that shows a causal link between measure targets and health outcomes, with the measure performance gap considered. There are two CMS removal factors, used as justifications for measure removal:
  1. Measure performance among the majority of ESRD facilities is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
  2. Performance or improvement on a measure does not result in better outcomes or the intended patient outcomes.

- **Scientific acceptability**. Scientific acceptability is measured by reliability and validity. The CMS removal factor for this criterion is if a measure no longer aligns with current clinical guidelines or practice.

- **Feasibility**. Feasibility is measured by whether the people, tools, tasks, and technologies necessary to implement this measure are reasonable for the chosen care settings. There are two CMS removal factors:
  1. It is not feasible to implement the measure specifications.
  2. The costs associated with a measure outweigh the benefit of its continued use in the program.

- **Usability**. Usability is measured by minimized unintended consequences and whether the measure is implemented across the patient journey as intended. The CMS removal factor is if collection or public reporting of a measure leads to negative or unintended consequences.

- **Alternative measures**. From the ESRD QIP program level, alternative measures are considered when measures remain appropriate for inclusion when compared with alternative measures. CMS removal factors are as follows:
  1. If a more broadly applicable measure for the topic or a measure that is more proximal in time to desired patient outcomes for the topic becomes available.
  2. If there is an alternative measure that is more strongly associated with desired patient outcomes for the topic available.

The task of the MSR Recommendation Group is to assess whether the assertions about potential pros and cons for retaining a measure for review under the program under consideration are supported by evidence, and whether the assessment of the related pros and

cons warrant the recommendation for retention or removal. MSR Recommendation Group members rate each criterion as one of the following three options: evidence is complete and adequate, or evidence is either incomplete or inadequate but there is a plausible path forward, or evidence is either incomplete or inadequate and there is no plausible path forward. An overall recommendation is then provided to either retain the measure or remove the measure from the designated CMS quality program.

Meeting Process

The all day in-person MSR Recommendation Group Measure Review meeting is scheduled for October 17, 2023. Virtual attendance is available for group members if they are unable to attend in person. Members of the public can attend virtually. During the meeting, the MSR Recommendation Group will discuss the measures, followed by an opportunity for public comment, and then voting.

The voting procedure is based on consensus, which is a simple majority greater than 50%. The process includes maintaining quorum for both discussion and voting. The discussion quorum requires the attendance of at least 60% of the Recommendation Group members at roll call at the beginning of the meeting. The voting quorum requires at least 80% of active Recommendation Group members, who have not been recused.

Following the MSR Recommendation Group review, there will be a recommendation report that includes MSR Recommendation Group recommendations and rationale, and MSR Recommendation Group and interested parties' concerns or areas of dissent. This report will be posted on the PQM website.

Next Steps and Key Timeline

The MSR draft report public comment period is now open, from September 11 – September 26, 2023, on the PQM website.

The MSR Review Meeting is scheduled for October 17, 2023, in Baltimore, Maryland, the registration link is https://PQM-MSR-Meeting.eventbrite.com.

Battelle will schedule a tentative, virtual back-up review meeting if the MSR Recommendation Group is unable to discuss all measures on October 17.

Questions and Discussion

Brenna Rabel, PQM Technical Director, thanked the MSR Recommendation Group for their willingness to serve, and for the time and effort given to this important work. MSR Recommendation Group members are encouraged to contact PQM and CMS via the PQMSupport@battelle.org email.

MSR Criteria and Process

A member asked if there would be separate criteria for each program. Battelle noted that the same core assertions will be used throughout the evaluation process: impact, entity data streams, and patient journey. Although the 2023 cycle focuses on one program, moving forward the review will be based on a Cascade domain.

A member asked if Battelle would seek input on formal or informal processes, particularly if Endorsement & Maintenance (E&M) committees would have the opportunity to provide input on MSR. Battelle stated that while there will not be a formal process to gather input, public comment from E&M committee members is welcome.

A member asked if the MSR recommendations will be incorporated into final rules. CMS replied that MSR recommendations will be considered but it will remain up to the individual CMS programs whether those decisions are put into effect for rulemaking.

One commenter asked for the definition of “a plausible path forward” which is used in the review criteria. Battelle explained that MSR Recommendation Group members are asked to specify if they feel like the evidence is complete and adequate, or if the evidence is not complete and not adequate. If the latter, the next decision would be to ask whether the evidence can be made complete or adequate. Or is there no path forward? Are there different methods or new evidence that could be generated to support the assertion being made? This is intentionally subjective. Everyone has their own perspective, and people need to be able to articulate their concerns. A large community is making this assessment. Plausibility has time, cost, and resource implications, but the decision should not be solely based on that.

MSR Membership and Communications

Battelle clarified that all MSR Recommendation Group members also serve on a PRMR committee. MSR Recommendation Group members are drawn from the three PRMR committees. This ensures continuity between the processes. If a PRMR committee member was appointed to the MSR Recommendation Group, they should have received a welcome email. A draft roster was released for public comment. If someone is unsure of their committee status, they should reach out to PQMSupport@battelle.org.

There were a couple of questions regarding term limits. MSR appointments are made on an annual basis, whereas PRMR committee member terms are three years. Since 2023 is the first cycle, PRMR terms are being randomized into one-, two-, and three-year appointments to allow for annual updates. PRMR committees are still being finalized based on public comment, but members should know their term length prior to the October meetings.

PQM communications to members are being sent primarily via email. There will be more updates available on the PQM website once the calendar is updated and rosters are finalized.

A member asked if Battelle or CMS has sent notifications to other HHS agencies about the PRMR process. Battelle replied that each committee has a federal agency spot, and CMS said that communications will be distributed to these federal partners at other HS agencies in the coming weeks.

PRMR/MSR Guidebook

A member asked if the PRMR/MSR Guidebook reflects any changes from the public comment period. Battelle explained that changes were made based on feedback from public comments. There were many changes incorporated, but there were two main changes. Firstly, co-chairs were added to the committee structures, to fulfill the need for that facilitation piece. Roles and responsibilities for co-chairs were also defined. The second change is that a second public comment period was added to the PRMR process. This was highly requested by commenters. The need was recognized for a second opportunity for feedback once the MSR committee had made their recommendations.

October 16-17 meetings

To clarify the purpose of each day's events, Battelle explained that October 16 is an in-person training for people who sit on the PRMR and MSR committees. This training is closed to the public and will be focused on getting committee members ready to serve. October 17 is the MSR review meeting, which is open to the public. MSR Recommendation Group members should plan to attend both days.

A member asked how feedback will be submitted and if any work needs to be done in advance of the meeting. Battelle noted that a template will be sent out to provide feedback on each measure. It will include a table listing how E&M criteria were applied against CMS removal factors. The template will guide Recommendation Group members through reviewing the preliminary assessment. Once the evidence is reviewed in the draft report, reviewers should note the pros and cons against each of these criteria on a copy of the template. The completed template will need to be emailed back to Battelle by September 26. This will allow Battelle to compile meeting materials that will be distributed a week ahead of the MSR meeting. The compiled feedback will be distributed so reviewers can peruse input from other committee members. The feedback will be used to guide discussion on October 17.

Meeting registration is through Eventbrite. MSR committee members should choose "yes" to the question regarding their involvement in MSR to be registered for both days. Battelle is covering travel costs for patient representatives. There is a scholarship program for other attendees based on need. Please contact PQMSupport@battelle.org for information. Both meetings are in-person this year since it is the first year of the new process. The format may change to virtual-only going forward, but those decisions are to be determined.

Stakeholder Engagement

Several members asked about engaging interested parties beyond committee members. Battelle explained that the PQM is a partnership of members made up of interested parties. Members who sit on the committees form the foundation of PQM. However, PQM members are also engaged via listservs and through our partners IHI and Rainmakers. Members receive e-blasts and newsletters to create awareness, so that when the MSR process begins, we can engage with those channels to get feedback.

Regarding methods of engaging the needed perspectives, from specialty providers or patients for example, part of the reason MSR appointments are annual is to focus on creating a group that best fits the expertise needed to review the measures within each MSR cycle. Representation was at the forefront when the decisions for MSR appointments were made. With the roster-based approach, a certain number of ESRD patients, those who have experienced kidney care, and clinician perspectives were targeted. Representation is significant and is a cornerstone of the committee composition.

Conclusion

Ms. Rabel and Dr. Ojha thanked committee members for their time and comments, pointed out important resources on the PQM website, and adjourned.