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Pre-Rulemaking Measure Review (PRMR) Clinician Recommendation Group Meeting

Nicole Brennan | Battelle
Brenna Rabel | Battelle

January 16-17, 2024

Contract Number 75FCMC23C0010

Welcome and Review of Meeting Objectives

Nicole Brennan

Agenda

- Welcome & Roll Call
- Disclosures of Interest
- CMS Opening Remarks
- Overview of 2023 PRMR Process and Voting
- Voting Test
- Measure Review

Community Guidance

- Respect all voices
- Remain engaged and actively participate
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Introductions and Disclosures of Interest

Kate Buchanan

Introductions

Battelle Staff

- Nicole Brennan, DrPH, MPH – Executive Director
- Brenna Rabel, MPH – Technical Director
- Jeff Geppert, JD, EdM – Scientific Methods Lead
- Kate Buchanan, MPH – Deputy Task Lead
- Lydia Stewart-Artz, PhD – Measure Evaluation Lead
- Isaac Sakyi, MSGH – PRMR Team

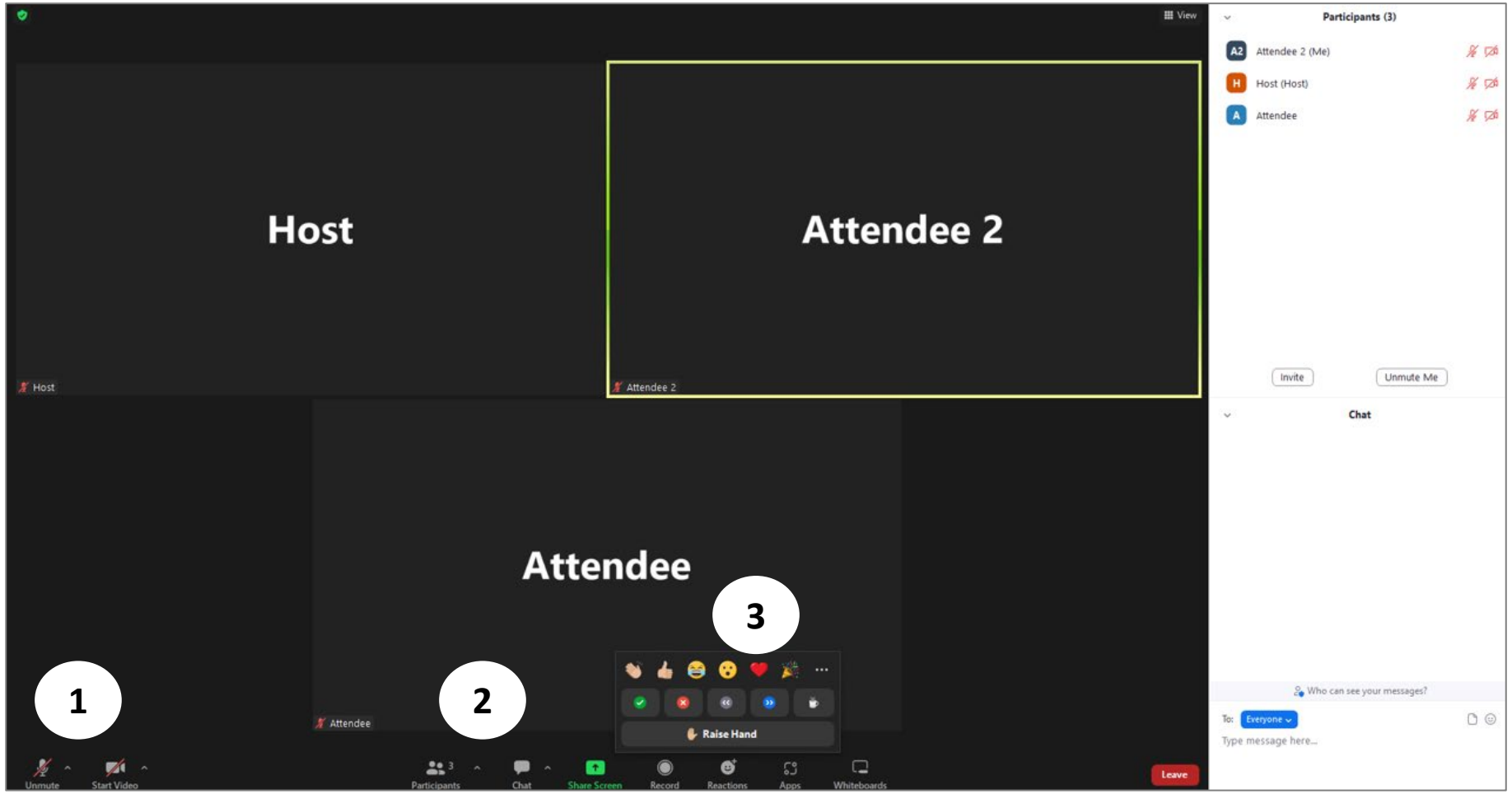
Centers for Medicare & Medicaid Services (CMS) Staff

- Dr. Michelle Schreiber, Director, Quality Measurement & Value Based Incentives Group (QMVIG), Center for Clinical Standards and Quality (CCSQ)
- Dr. Stephanie Clark, Medical Officer, CCSQ
- Dr. Dan Green, Medical Officer, CCSQ
- Dr. Ron Kline, Chief Medical Officer, QMVIG, CSSQ
- Dr. Marsha Smith, Medical Officer, CCSQ
- Dr. Tiffany Wiggins, Medical Officer, CCSQ

Housekeeping Reminders

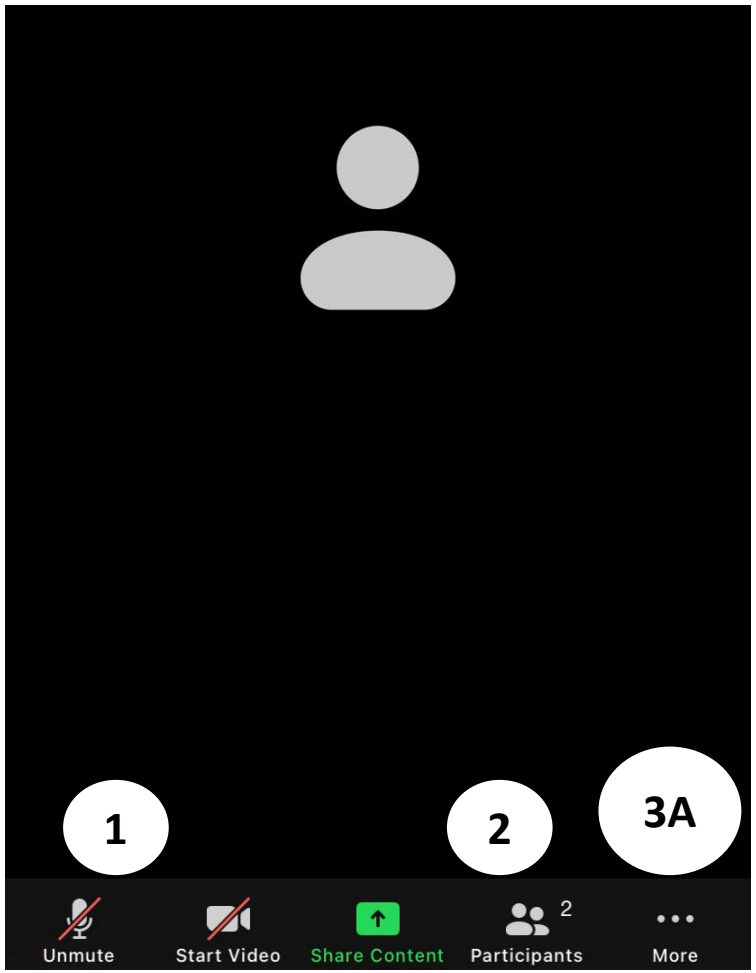
- Housekeeping reminders:
  - Review webinar settings for attendees.
  - Please state your first and last name if you are a call-in user.
  - We encourage you to keep your video on throughout the event.
  - Feel free to use the chat feature to communicate with Battelle staff.
- If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

Using the Zoom Platform



1. Click the lower part of your screen to mute/unmute, start, or pause video
2. Click on the participant or chat button to access the full participant list or the chat box
3. To raise your hand, select the raised hand function under the reactions tab

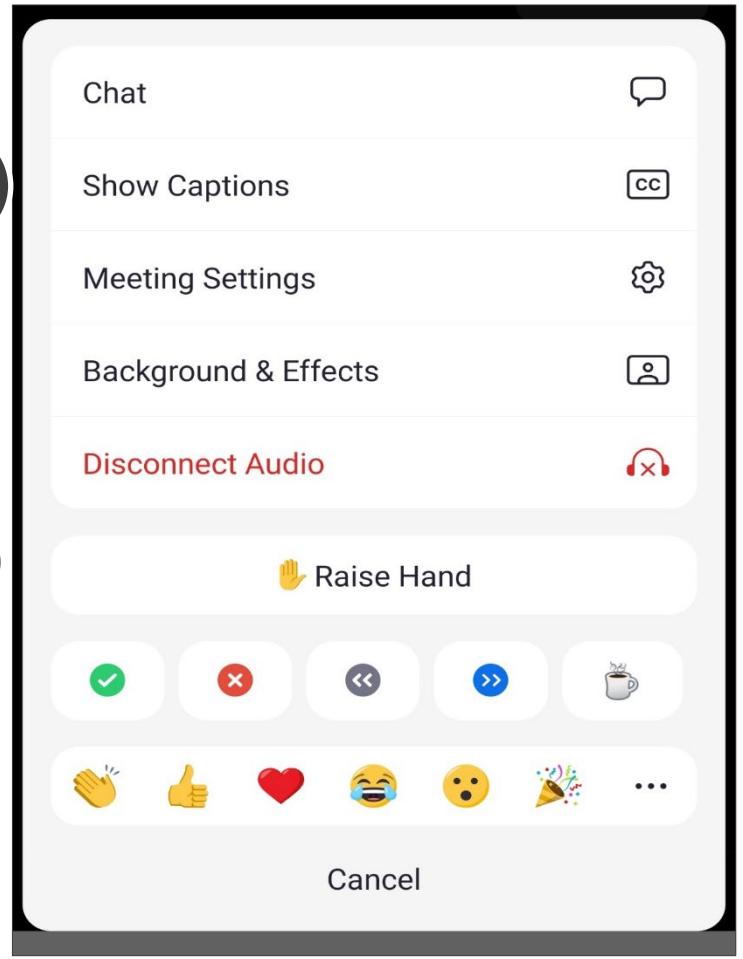
Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start or pause video.

2. Click on the participant button to view the full participant list.

3. Click on “more” button to (3A) view the chat box, (3B) show closed captions, or to (3C) raise your hand. To raise your hand, select the raised hand function under the reactions tab.



Conflict of Interest (COI) and Disclosure of Interest (DOI)

- Each PRMR Committee Member is required to complete
  - Initial personal/organizational Disclosure of Interest (DOI) form during the nomination process.
  - "Measure-specific DOI" form for each measure, or batch of measures, assigned to the committee.

Measure-Specific COI Guidance

A member has directly and substantially contributed to the development of a measure or measures being considered for selection or removal.

- The member or their spouse, domestic partner, or child could receive a direct financial benefit from a measure being recommended for selection or removal.
- In the last 5 years, the member has received an indirect financial benefit, i.e., not related to the measure under review, of $10,000 or more from a measure developer whose measure is under review, or an indirect financial benefit of $10,000 or more, in the aggregate, from an organization or individual which may benefit from a measure being considered for the selection or removal process.
- Member is currently employed by the measure developer and the developer has created the measure(s) under review, has created measure(s) in the topical area under review, or has created measure(s) that compete with measure(s) created by another developer and are under review.
- Member participated in the development, review, or served as a technical expert panel member for a measure under review.

Roll Call & Disclosures of Interest

Co-chairs: Reginald Barnes & Lisa Hines

- Lucas Beffa
- Michelle Dardis
- Jean Drummond
- Robert Fields
- Shani Francis
- Jennifer Gasperini
- Shawn Griffin
- Brandon Hawkins
- Wendy Holness
- Teresa Lubowski
- Chisa Nosamiefan
- Valarie Oji
- Amir Qaseem
- Robert Rauner
- Megan Reyna
- Koryn Rubin
- Jill Shuemaker
- Deidre Wheat

PRMR Co-Chair Introductions

Brenna Rabel

CMS Opening Remarks

Michelle Schreiber

PRMR Process and Evaluation Criteria

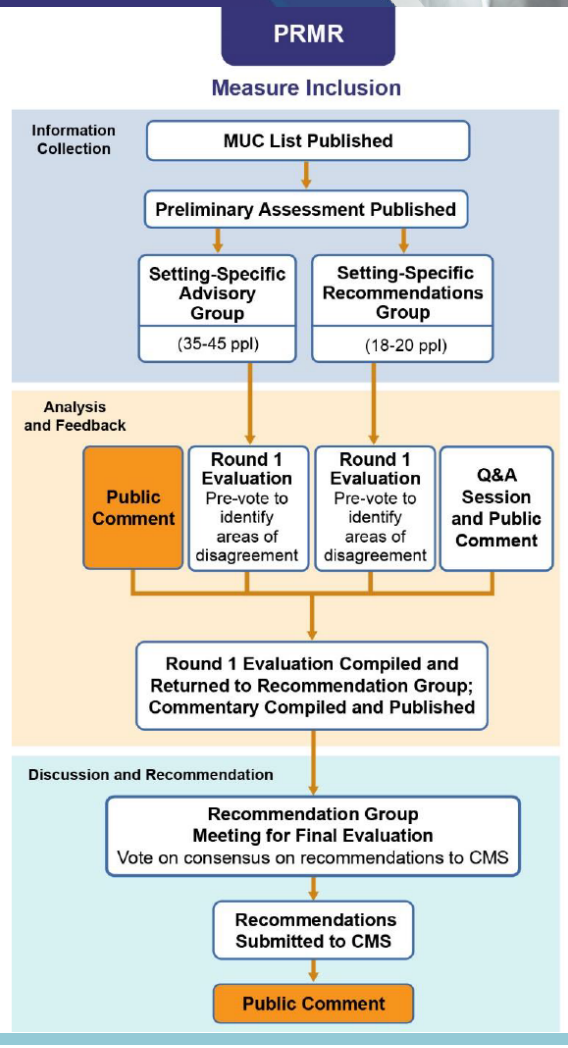
Kate Buchanan

PRMR Process

The PRMR process builds consensus regarding Measures Under Consideration (MUC) list measures as to whether they are appropriate for consideration for CMS quality reporting programs and value-based programs.

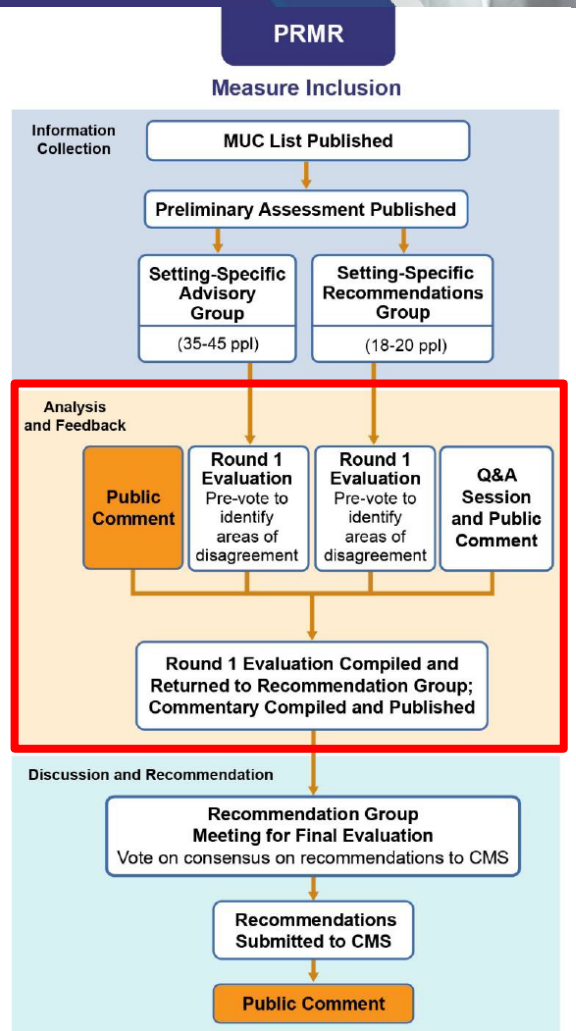
Three major phases:

1. Information collection
2. Analysis and feedback
3. Discussion and recommendation



PRMR Process: Analysis and Feedback

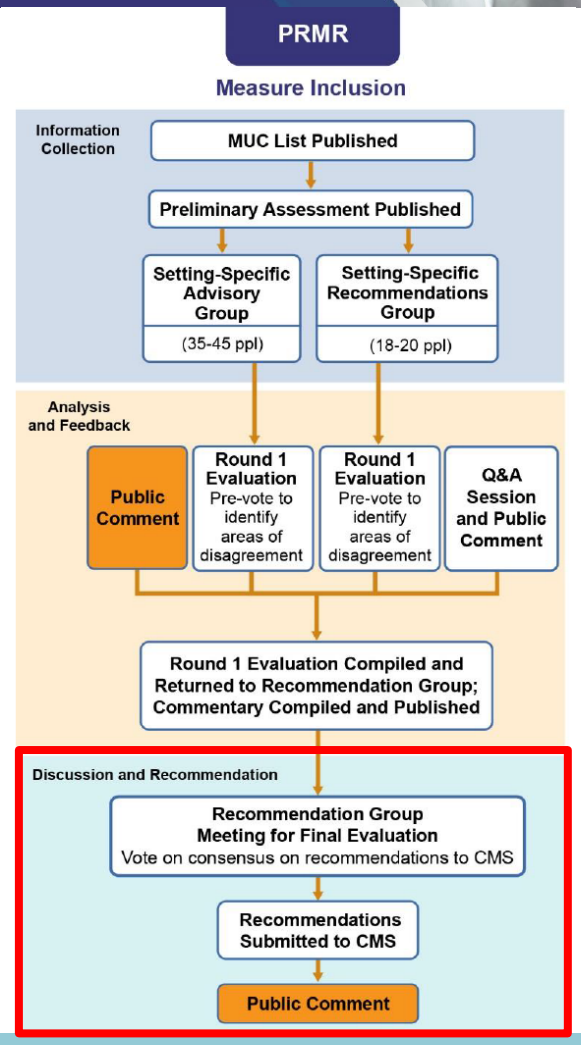
- **Round One Evaluation**
  - Advisory group and recommendation group members review preliminary assessments (PAs). They submit initial ratings on the measures with explanations. On average we received:
    - 31 responses per Hospital measure.
    - 20 responses per Clinician measure.
    - 34 responses per PAC/LTC measure.
- **Public Comment and Listening Sessions**
  - Battelle held a 21-day call for public comment between Dec. 1 – Dec. 22.
    - 495 written public comments from 147 organizations and 49 patients
  - PQM hosted three public listening sessions in December, one per setting:
    - 458 attendees
    - 70 people provided comments



PRMR Process: Discussion and Recommendation

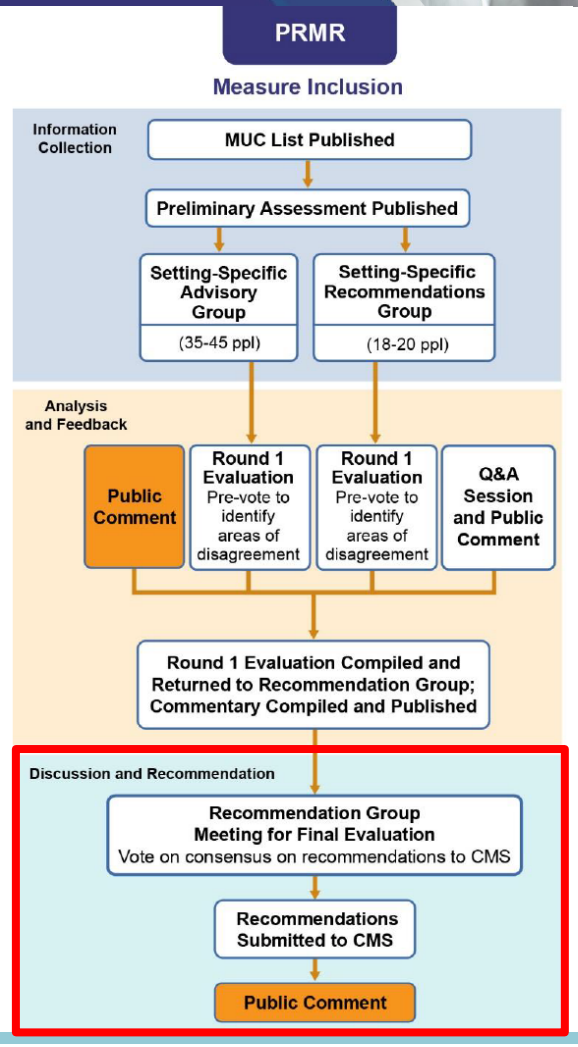
Today's Meeting: Recommendation Group Meeting for Final Evaluation

- In January, the recommendation groups meet to discuss issues/concerns raised during the public comment period and feedback from the advisory groups.
- The meeting agenda prioritizes areas of non-consensus identified in the analysis and feedback phase.
- The recommendation group meetings for final evaluation involves:
  - An efficient iterative voting process to ensure a meaningful approach for making final recommendations.
  - Trained facilitators and committee-selected lead discussants.
- Recommendations from the meeting are submitted to CMS.



PRMR Process: Discussion and Recommendation (cont.)

- Final recommendations from the recommendation group will be published February 1 on the PQM website.
- There will be a 15-day second public comment period.
- The intent of this opportunity is to provide additional feedback on MUC and the final recommendations to CMS.



Recommendation Group Meeting Structure

Committee members review measure information & discuss preliminary ratings.

Guided by Facilitator & Co-Chair Led Consensus-Building

Discuss potential "benefits" and "harms" for inclusion of the measure

Importance • Scientific Acceptability • Feasibility • Usability • Alternative Measures • Appropriateness of Scale • Time to Value Realization

Additional Perspectives from Public Comment

Recommend, Recommend with Conditions, or Do Not Include

End of Session: Committee consensus (≥75%) on whether measure should be considered for the Designated Program.

Establishing Consensus

Recommend (A)	Recommend with Conditions (B)	Do Not Recommend (C)	Consensus Voting Status
75% or More			Recommend (A)
	75% or More		Recommend with Conditions (B)
		75% or More	Do Not Recommend (C)
75% or More			Recommend with Conditions (B)
		Between 25%-75%	No Consensus

PRMR Evaluation Criteria

Criteria/Assertions	Evidence is complete and adequate	Evidence is either incomplete or inadequate but there is a plausible path forward	Evidence is either incomplete or inadequate and there is no plausible path forward
Meaningfulness: Importance, feasibility, scientific acceptability, and usability & criteria met for measure considering the use across programs and populations			
Appropriateness of scale – Patients/recipients of care: measure is implemented on patients/ recipients of care appropriate to the purpose of the program			
Appropriateness of scale – Entities: measure is implemented on entities appropriate to the purpose of the program			
Time to value realization: measure has plan for near- and long-term positive impacts on the targeted program- population as measure matures			
Overall	**Recommend**	**Recommend with conditions**	**Do not recommend**

- **Meaningfulness**: Has it been demonstrated that this measure meets criteria associated with importance, scientific acceptability, feasibility, usability, and use for the target population and entities of the program under consideration?
- **Appropriateness of scale**: Is the measure balanced and scaled to meet program-target population specific goals? Examine how potential benefits and harms of the measure are distributed across subpopulations.
- **Time to value realization**: To what extent does current evidence suggest a clear pathway from measurement to performance improvement?

Establishing Consensus

Consensus requires a minimum of 75% agreement among voting members.

Facilitators address areas of disagreement and the views of those in the voting minority to encourage meaningful, inclusive discussions to establish more convincing consensus decisions.

The voting quorum is at least 80% of active committee members (recommendation group), who have not been recused.

Quorum Requirements

- **Discussion quorum:** The discussion quorum requires the attendance of at least 60% of the recommendation group members at roll call at the beginning of the meeting.
- **Voting quorum:** The voting quorum requires at least 80% of active recommendation group members, who have not been recused.
  - In the case of the voting quorum not being met, we will collect the votes for those present and follow up with absent participants until a voting quorum is reached.

It is extremely important to the process to have voting quorum and we kindly request you stay for votes.

Online Voting

Online voting via Voteer (backup: Veevox)

Link provided via email to voting members

Vote at time indicated by facilitator for each measure

If you need voting assistance, please email Isaac Sakyi at sakyi@battelle.org

Break

Meeting resumes at 11:00 am ET

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Clinician Committee Measure Review

Part C and D Star Ratings Measures Under Review – Safety Measures

MUC2023-137 Initial Opioid Prescribing for Long Duration (IOP-LD)

- **Measure Steward:** Pharmacy Quality Alliance (PQA)
- **Brief Description of Measure:**
  - The IOP-LD measure analyzes the percentage of Medicare Part D beneficiaries, 18 years or older, with at least one initial opioid prescription for more than 7 cumulative days' supply.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	Medicare Part D: Medicare Advantage Prescription Drug Plans and Prescription Drug Plans	Endorsed	Health Plan

MUC2023-137 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Almost three-fourths of returned evaluations rated the evidence as complete and adequate on three assertions (meaningfulness, appropriateness of scale, time to value).
- Concerns:
  - Do the benefits of implementation outweigh the harms?
  - Is the measure equitable across populations?
  - Could the measure adversely affect hospitalists?

Public Comment

- Majority of public comments (6 of 7 written comments) did not support the measure.
- Support:
  - May protect many against long-term opioid use.
- Oppose:
  - Concerns about the scientific acceptability of the measure (validity, usability & feasibility).
  - Specifications around provider decision-making, too few exclusions, and a narrowly defined patient population.
  - Insufficient patient engagement in development.

MUC2023-137 Discussion Topics

- Several public comments pointed to concerns regarding lack of exclusions, are the measure exclusions sufficient and appropriate, given the target population?
  - As an organization dedicated to safety, Intermountain Health fully supports the need to minimize the opioid crisis in our patient populations. This process measure has good intentions and can benefit providers to be aware of their patient populations. However, the omittance of numerator exclusions is concerning, for without them, it is unclear how CMS plans to account for patients undergoing appropriate long-term opioid use…
- To what extent will this measure promote or limit equitable care?
- Do the benefits of the measure outweigh the potential harms of the measure?

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Voting

Please follow the link provided via email to committee members.

If you need voting assistance, please email Isaac Sakyi at sakyi@battelle.org

Part C and D Star Ratings Measures Under Review – Behavioral Health Measures

MUC2023-179 Initiation and Engagement of Substance Use Disorder Treatment (IET)

- **Measure Steward:** National Committee for Quality Assurance (NCQA)
- **Brief Description of Measure:**
  - The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:
    - Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
    - Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	Medicare Advantage	Not Endorsed	Health Plan

MUC2023-179 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Approximately 60% of returned evaluations rated the evidence as complete and adequate on three assertions (meaningfulness, appropriateness of scale, time to value).
- Concerns:
  - Plans may not have enough eligible members to meaningfully report.
  - Availability of treatment may vary geographically.

Public Comment

- Received 6 written comments, 4 opposed the measure.
- Support:
  - Addresses current measurement gaps.
- Oppose:
  - Recommend more testing on current version with telehealth included.
  - Several comments concerned around data availability and interoperability.
  - Treatment options may be dependent on the availability of services within a community or region.

MUC2023-179 Discussion Topics

- Do the benefits of this measure outweigh the potential harms?
  - The National Association of ACOs (NAACOS) agrees with the intent of this measure but asks that PRMR consider the potential for unintended consequences that may result from its use. We are concerned that there is a real risk that this measure will not truly represent the quality of care provided.
- How will performance on this measure be impacted by differences in treatment options/availability based on geography?
  - How will this measure apply to rural health settings?
- Given the above, is this measure more or less likely to promote equitable care among patients?

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Voting

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Part C and D Star Ratings Measures Under Review – Person-Centered Care Measures

MUC2023-212 Level I Denials Upheld Rate Measure

- **Measure Steward:** Federation of American Hospitals (FAH)
- **Brief Description of Measure:**
  - This rating shows how often a Medicare Advantage Organization review found their original determination decision to deny coverage to be reasonable. Percent of Level 1 appeals where a plan's determination decision was "upheld" by the plan out of all the reconsiderations made by a plan (upheld, overturned, and partially overturned determinations). This is calculated as: ([Determinations Upheld] / ([Determinations Upheld] + [Determinations Overturned] + [Determinations Partially Overturned]))* 100.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	Medicare Advantage	Not Endorsed	Health Plan

MUC2023-212 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- A majority of returned evaluations rated the evidence as complete and adequate on three assertions (meaningfulness, appropriateness of scale, time to value).
- Concerns:
  - Could favor smaller contracts/those with fewer complex patients; not within plan's control.
  - Duplicative of measure already in the MA Star Ratings program.
  - Has not gone through endorsement.

Public Comment

- Received 11 written comments, 8 supported, 1 support with conditions, 2 opposed.
- Support:
  - Could improve quality of care by reducing unnecessary delays in care related to coverage denials.
  - Will increase transparency around denials, decrease beneficiary frustration and provider burden.
- Oppose:
  - The measure is duplicative of an existing measure that evaluates level 2 appeals decisions.
  - Measure does not capture correct denials that are overturned after receiving new information.

MUC2023-212 Discussion Topics

- Many comments expressed this measure would not add burden and would increase transparency, what are the benefits to the patients of this level of transparency?
- To what extent does this measure fill a gap, despite the similar measure currently in MA Star Ratings?
  - Currently, there are 2 Part C appeals measures in the Star Ratings program. One measure focuses on how fast an MA plan sends information on a denial that has been appealed for an independent review and the other measure focuses on how often an independent reviewer found the health plan's decision to deny coverage to be reasonable. This proposed measure seems to duplicate this second Part C appeals measure that is already part of the MA Star Ratings program.
- To what extent is performance on this measure impacted by factors outside the entity's control?

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Voting

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Lunch Break

Meeting resumes at 1:15 pm ET

Medicare Shared Savings Program (Shared Savings Program) – Equity Measures

MUC2023-199 Connection to Community Service Provider

- **Measure Steward:** OCHIN
- **Brief Description of Measure:**
  - Percent of patients 18 years of age or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after discharge.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	All Payer	Not Endorsed	Facility

MUC2023-199 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings, which implies there are areas of non-consensus among members.
- Concerns:
  - The burden and feasibility of data collection.
  - Scientific acceptability of the measure.
  - Efficacy might vary based on the availability of community resources.
  - Unclear if connecting people to community service providers improves outcomes.
  - Could be out of the control of the hospital/ACO.

Public Comment

- Received 9 written comments (2 support, 2 support with conditions, 5 oppose)
- Support:
  - Measure intent and strong evidence base.
  - Validated for use in the Accountable Health Communities demonstration model and in the Comprehensive Primary Care Plus model.
- Oppose:
  - Concern about the evidence provided for the five social needs model and 60-day window.
  - Providers who serve patients with unmet social needs may be penalized
  - Should align with HL7 and USCDI standards.

MUC2023-199 Discussion Topics

- To what extent will feasibility challenges likely impact the successful implementation of this measure?
  - These measures are NECESSARY BUT INSUFFICIENT…Healthcare providers and their teams can spend all day connecting patients to resources, but in reality, it just connects them to waiting lines, where a response may or may not arrive within days, weeks, months, or even years.

- Community resource availability varies across geographic settings. How do patterns of resource availability across rural/urban areas impact the expected efficacy of the measure?
  - The National Hispanic Medical Association strongly supports the adoption of these two proposed measures. While there may be weaknesses identified by other stakeholders and there is critical nuance in social risk screening and care to consider, these measures advance crucial health equity efforts in quality measurement...

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Voting

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If you need voting assistance, please email Isaac Sakyi at sakyi@battelle.org

MUC2023-210 Resolution of At Least 1 Health-Related Social Need

- **Measure Steward:** OCHIN
- **Brief Description of Measure:**
  - Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety; and report that at least 1 of their HRSNs was resolved within 12 months after discharge.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	All Payer	Not Endorsed	Facility

MUC2023-210 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- More than three-fourths of the returned evaluations rated the assertions as “evidence is either incomplete or inadequate, but gaps are addressable” or “evidence is incomplete or inadequate and gaps are not addressable.”
- Concerns:
  - The burden and feasibility of data collection.
  - Scientific acceptability of the measure.
  - Unclear if connecting people to community service providers improves outcomes.
  - Could be out of the control of the hospital/accountable care organization (ACO).

Public Comment

- Received 10 written comments (3 support, 2 support with conditions, 5 oppose).
- Support:
  - Measure intent and importance.
  - Validated for use in the Accountable Health Communities demonstration model and in the Comprehensive Primary Care Plus model.
- Oppose:
  - Concern about the evidence provided for the five social needs model and 12-month timeframe.
  - Providers who serve patients with unmet social needs may be penalized.
  - Should go through CBE endorsement.

MUC2023-210 Discussion Topics

- To what extent are the measure outcomes within the control of the measured entity?
  - We hope CMS can provide insight into how it intends to coordinate the use of these measures across various quality reporting programs. If CMS were to adopt the measure into both the IQR and the MSSP, we are concerned that it may increase patient burden as patients would be asked to answer the same HRSN-related questions multiple times during the same year, and providing results that may not be consistent over time.

- What impacts will geography (urban/rural) and patient mix (in terms of prevalence of unmet social needs among patients) have on performance across facilities?

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Merit-based Incentive Payment System (MIPS) Quality Measures Under Review – Wellness and Prevention Measures

MUC2023-164 Adult COVID-19 Vaccination Status

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - Percentage of patients aged 18 years and older seen for a visit during the performance period that are up to date on their COVID-19 vaccinations as defined by CDC guidelines on current vaccination.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	All Payer	Not Endorsed	Clinician: Individual and Group

MUC2023-164 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings indicating varied committee support and likely areas of non-consensus.
- Concerns:
  - There are equity risks for the provider and facility.
  - Needs further development/testing.
  - Needs exclusion for patient refusal.

Public Comment

- Commenters divided on support (4 rated as support/support with conditions and other 4 opposed).
- Support:
  - Support for intent of measure, “vital” to the health and wellbeing of the community.
  - May encourage health plans and providers to promote uptake of COVID vaccination.
- Oppose:
  - Vaccine hesitancy, political divides, and regional variation are factors outside provider control.

MUC2023-164 Discussion Topics

- Given that there is no exclusion for patient refusal, is this measure more likely to negatively impact clinicians who practice in areas where vaccine hesitancy is more prevalent? Is that an acceptable risk, given the perceived benefits?
  - In 2022, we had concerns with this measure as it was specified for inclusion in the MIPS program since it did not include denominator exceptions for medical reasons for patients not being up-to-date on their vaccinations. However, now that the measure contains this exception, the AHA supports its inclusion in the program.
  - The American Medical Association (AMA) continues to have concerns with this measure and strongly encourages CMS to clarify its numerator… how to determine up-to-date

- What are the potential negative consequences of including an exclusion for patient refusals? Would that impact the validity of the measure?

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MUC2023-211 Melanoma: Tracking and Evaluation of Recurrence

- **Measure Steward:** American Academy of Dermatology (AAD)
- **Brief Description of Measure:**
  - Percentage of patients who had an excisional surgery for melanoma or melanoma in situ with initial American Joint Committee on Cancer (AJCC) staging of 0, I, or II, in the past 5 years in which the operating provider examines and/or diagnoses the patient for recurrence of melanoma.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	All Payer	Not Endorsed	Clinician: Individual and Group

MUC2023-211 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Burdensome to track and report.
  - Reliability testing meeting thresholds.
  - How performance measures will track with socioeconomic status.
  - Registry use already/similar measure in MIPS.
  - Can lead to increased rates of screening.

Public Comment

- Received 1 written public comment which was in support (no additional detail provided).

MUC2023-211 Discussion Topics

- How burdensome is this measure to report compared to other screening/tracking measures?
- What factors limited the reliability results for this measure?
- How does this measure perform across different patient populations?

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Voting

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Break

Meeting resumes at 3:15 pm ET

MIPS Quality Measures Under Review – Chronic Conditions Measures

MUC2023-141 Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy

- **Measure Steward:** Society for Immunotherapy of Cancer (SITC)
- **Brief Description of Measure:**
  - Percentage of patients aged 18 years and older, with a diagnosis of metastatic non-small cell lung cancer or squamous cell carcinoma of head and neck on first-line immune checkpoint inhibitor (ICI) therapy, who had a positive PD-L1 biomarker expression test result prior to giving ICI therapy.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	Medicare Fee-for-Service (FFS)	Not Endorsed	Clinician: Individual Only

MUC2023-141 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Burdensome to track and report.
  - Reliability testing meeting thresholds.
  - How performance measures will track with socioeconomic status.
  - Registry use already/similar measure in MIPS.
  - Can lead to increased rates of screening.

Public Comment

- Received 2 public comments: 1 in support and 1 support with conditions.
- Support:
  - Measure intent, specification and evidence-base and the alignment with National Comprehensive Cancer Network Oncology Guidelines.
- Concern:
  - Concerns about performance against an evolving standard, and that positive test results can vary based on clones and platforms used as well as interobserver reproducibility.

MUC2023-141 Discussion Topics

- The majority of the returned evaluations thought that evidence for the meaningfulness assertion was incomplete but there was a path forward. What does that path forward look like?

- A member of the public referred to this measure as being based on "an evolving standard." How strong is the evidence supporting this measure?
  - The CAP believes that the appropriateness of measuring performance against an evolving and inexact standard should be reconsidered. One possible consideration could be to respecify the current measure to indicate that simply considering PD-L1 testing regardless of specific testing platform utilized…
- Is this measure applicable to rural/low volume facilities?

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MUC2023-161 Appropriate Germline Testing for Ovarian Cancer Patients

- **Measure Steward:** American Society of Clinical Oncology (ASCO)
- **Brief Description of Measure:**
  - Percentage of patients, aged 18 and older, diagnosed with epithelial ovarian, fallopian tube, or primary peritoneal cancer who undergo germline testing within 6 months of diagnosis.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	• Medicare FSS • All Payer	Not Endorsed	Clinician: Individual and Group

MUC2023-161 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Burdensome to track and report.
  - Reliability testing meeting thresholds.
  - How performance measures will track with socioeconomic status.
  - Registry use already/similar measure in MIPS.
  - Can lead to increased rates of screening.

Public Comment

- Received 3 public comments, 2 in support and 1 support with conditions
- Support:
  - Intent of measure and evidence-base.
  - Potential for this measure to reduce patient suffering and healthcare costs while promoting effective treatments.
- Concern:
  - Concern for the lack of CBE endorsement for this measure.

MUC2023-161 Discussion Topics

- The majority of the returned evaluations thought that evidence for the meaningfulness assertion was incomplete but there was a path forward. What is that path?

- Do the benefits of this measure outweigh the potential burdens?
  - Lack of germline testing in ovarian cancer may lead to ineffective treatments, unnecessary patient suffering and increased healthcare costs. Additionally, germline testing can serve as an important tool in the early diagnosis of ovarian cancer for a patient's relatives, leading to improved outcomes.
- How will performance on this measure look across different socioeconomic groups?

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Voting

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If you need voting assistance, please email Isaac Sakyi at sakyi@battelle.org

MIPS Quality Measures Under Review – Person-Centered Care Measures Incentive Payment System

MUC2023-162 Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer

- **Measure Steward:** Purchaser Business Group on Health (PBGH)
- **Brief Description of Measure:**
  - The patient-reported outcome performance measure (PRO-PM) will assess pain interference following chemotherapy administered with curative intent to adult patients with breast cancer.

Measure Type	Target Population	Endorsement Status	Level of Analysis
PRO-PM or Patient Experience of Care	• Medicare FFS • Medicare Advantage • Medicaid • All Payer • All adult cancer patients not restricted by payer type	Not Endorsed	Clinician: Individual and Group

MUC2023-162 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings which indicated areas of non-consensus among the committee.
- Concerns:
  - Burdensome to track and report.
  - The efficacy of reporting the measure 3 months after treatment.

Public Comment

- Received 11 public comments: 9 in support and 2 support with conditions.
- Support:
  - Patient-reported outcome measures are well-suited for assessing cancer care.
  - May help patients to assume a more active role in their care and improve patient-provider communication/data-driven care management plans.
- Concern:
  - May not be applicable to oncology practices that have integrated other validated instruments into their practice.
  - Should be submitted to a CBE

MUC2023-162 Discussion Topics

- Do the benefits of this measure outweigh the potential burdens?
  - ASCO is supportive of PRO-PMs as they provide a patient-centered approach to assessing healthcare quality, incorporating direct input from patients on their symptoms, well-being, and treatment outcomes. By focusing on patient-reported outcomes within performance measures, PRO-PMs promote personalized care, continuous improvement, and informed decision-making, ultimately enhancing the overall quality and effectiveness of healthcare services.

- Is the measure feasible from a data collection perspective?

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Voting

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MUC2023-190 Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer

- **Measure Steward:** PBGH
- **Brief Description of Measure:**
  - The PRO-PM will assess fatigue following chemotherapy administered with curative intent to adult patients with breast cancer.

Measure Type	Target Population	Endorsement Status	Level of Analysis
PRO-PM or Patient Experience of Care	• Medicare FFS • Medicare Advantage • Medicaid • All Payer • All adult cancer patients not restricted by payer type	Endorsed	Clinician: Individual and Group

MUC2023-190 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings which indicates areas of non-consensus among the evaluations returned.
- Concerns:
  - Burdensome to track and report.
  - Reliability testing meeting thresholds.
  - Using race/ethnicity as a risk adjuster may lead to unequal care.

Public Comment

- Received 13 public comments: 11 support, 1 support with conditions, 1 oppose.
- Support:
  - Robust support for the use of patient-reported outcome measures (PROMs) for cancer care.
  - Measure may improve patient-provider communication and data-driven care management plans, which in turn can lead to improved patient experience and health equity.
- Oppose:
  - May not be applicable to oncology practices that have integrated other validated instruments into their practice.

MUC2023-190 Discussion Topics

- Do the benefits of this measure outweigh the potential burdens?
  - This patient reported outcome performance measure fills a gap in the existing measurement set for cancer care, directly supports performance improvement in the delivery of cancer care and supports accountability and value-based payment. The Leapfrog Group strongly supports the inclusion of this measure on the MUC list.

- Is the measure feasible from a data collection perspective?

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Voting

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Close of Day 1

- Thank you for your hard work today!
- We will reconvene at 10:00am ET tomorrow to finish review.
- It is very important that we maintain quorum throughout the meeting.

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Pre-Rulemaking Measure Review (PRMR) Clinician Recommendation Group Meeting: Day 2

Nicole Brennan | Battelle
Brenna Rabel | Battelle

January 17, 2024

Contract Number 75FCMC23C0010

Welcome and Roll Call

Nicole Brennan & Kate Buchanan

Recap of Day 1

Kate Buchanan

Online Voting

Online voting via Voteer (backup: Veevox)

Link provided via email to voting members

Vote at time indicated by facilitator for each measure

If you need voting assistance, please email Isaac Sakyi at sakyi@battelle.org

MIPS Cost Measures Under Review – Affordability and Efficiency Measures

MUC2023-201 Cataract Removal with Intraocular Lens (IOL) Implantation

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Cataract Removal with Intraocular Lens (IOL) Implantation episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients who undergo a procedure for cataract removal with IOL implantation. This procedural measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during each cataract removal episode from 60 days prior to the clinical event that opens, or "triggers," the episode through 90 days after the trigger.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare FFS	Not Endorsed	Clinician: Individual and Group

MUC2023-201 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Majority of returned evaluations rated the assertions as “evidence is complete and adequate.”
- Concerns:
  - Measure should have appropriate clinical and social risk adjustment, exclusions, and attribution methodology.
  - Rural setting is a risk factor for endophthalmitis. Access to early care can be challenging in rural areas.

Public Comment

- Received 6 written comments: 2 support with conditions and 4 oppose.
- Support:
  - The exclusion of complex cataract surgery, exclusion of Part D drug costs, inclusion of Part B drug costs, and removal of certain diagnoses from the exclusions.
- Oppose:
  - Recommend CBE endorsement.
  - Inconsistencies in service attribution.
  - Recommend improvements in scoring and performance feedback.
  - The procedure has a low reimbursement rate, the measure may disincentivize providers offering it.

MUC2023-201 Discussion Topics

- Given concern raised via public comment, is this measure likely to disincentivize providers from offering this procedure? If so, is that a positive or negative outcome for this population/program?

- Will this measure disproportionately impact rural communities, or high risk populations?
  - Additionally, we recommend that CMS risk adjust for social determinants of health ICD-10 codes that can make it more difficult for patients to access and/or comply with treatment… <American Academy of Ophthalmology>

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Voting

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MUC2023-205 Inpatient (IP) Percutaneous Coronary Intervention (PCI)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Inpatient (IP) Percutaneous Coronary Intervention (PCI) episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients who present with a cardiac event and emergently receive PCI as treatment. This acute inpatient medical condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee for Service (FFS)	Not Endorsed	Clinician: Individual and Group

MUC2023-205 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Majority of returned evaluations rated the assertions as “evidence is complete and adequate.”
- Concerns:
  - Measure should have appropriate clinical and social risk adjustment, exclusions, and attribution methodology.
  - Concerns around scientific acceptability of the measure.
  - Rural areas might be at a disadvantage because they do not have access to “wrap around” services to help prevent readmissions.

Public Comment

- Received 2 written comments: 1 in support and 1 in opposition.
- Support:
  - Intent of measure and recognition of measure target importance to patient care and cost containment.
- Oppose:
  - Should have an appropriate risk adjustment model, exclusions, and attribution methodology.
  - Concerns about the measure’s scientific acceptability.

MUC2023-205 Discussion Topics

- The need for an appropriate risk adjustment model, attribution methodology, and exclusions was raised during Round 1 Evaluations and public comment. What is missing from the measure as currently specified, and how does that impact this committee's recommendation?
  - AHIP appreciates the value of measurement in reducing healthcare costs. However, the measures must have appropriate clinical and social risk adjustment, exclusions, and attribution methodology Measures should be reviewed and CBE-endorsed.

- Can this measure be implemented equitably across care settings? Are rural facilities at a disadvantage, as highlighted in the Round 1 evaluations?

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Voting

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Break

Meeting resumes at 11:35 am ET

MIPS Cost Measures Under Review – Affordability and Efficiency Measures

MUC2023-203 Chronic Kidney Disease

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Chronic Kidney Disease (CKD) 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 stage 4 or 5 chronic kidney disease. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Chronic Kidney Disease episode.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee for Service	Not Endorsed	Clinician: Individual and Group

MUC2023-203 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings which implies there are areas of non-consensus among the committee.
- Concerns:
  - Lack of evidence submitted shows how clinicians will improve CKD care and slow progression to ESRD through implementation of cost measures.
  - Low reliability testing.
  - Patients in rural areas may lack access to specialists which could lead to hospitalizations/readmissions.

Public Comment

- 6 written public comments: 2 support with conditions and 4 opposing.
- Support:
  - Agreed with the decision to exclude SGLT2 inhibitor costs to avoid disincentivizing its use when appropriate.
  - Value of measurement in reducing health care costs.
- Oppose:
  - Nephrologists serving small or rural practices or serving disadvantaged populations could implement the necessary clinical redesign.
  - Concerns about measure's scientific acceptability.

MUC2023-203 Discussion Topics

- Is the evidence presented to support scientific acceptability (validity, reliability) sufficient for demonstrating that this measure is suitable for use in CMS programs?

- How will the implementation of this CKD cost measure impact the quality of care delivered to CKD patients?

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Voting

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MUC2023-204 End-Stage Renal Disease

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The End-Stage Renal Disease (ESRD) 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 ESRD. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during an ESRD episode.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee for Service	Not Endorsed	Clinician: Individual and Group

MUC2023-204 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings which implies there are areas of non-consensus among members.
- Concerns:
  - Decreasing costs may not lead to the goals and priorities of improving patient outcomes.
  - Low reliability testing.

Public Comment

- Received 6 written comments: 3 support with conditions and 3 oppose.
- Support:
  - Intent of measure and recognition of measure target importance to patient care and cost containment.
- Oppose:
  - Should have an appropriate risk adjustment model, exclusions, and attribution methodology.
  - Potential unintended consequence is that providers will select lower-risk patients or will not provide appropriate care due to cost concerns.

MUC2023-204 Discussion Topics

- What unintended consequences might arise from the implementation of this measure? E.g., one public commenter raised concerns about a bias toward lower-risk patients.

- To what extent does decreasing costs for ESRD compete with the program's broader goals to improve patient outcomes?

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MUC2023-206 Kidney Transplant Management

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Kidney Transplant Management 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 related to kidney transplant, beginning 90-days post-transplant. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Kidney Transplant Management episode.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee for Service	Not Endorsed	Clinician: Individual and Group

MUC2023-206 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution of assertion ratings which implies there are areas of non-consensus among the committee.
- Concerns:
  - Decreasing costs may not lead to the goals and priorities of improving patient outcomes.
  - Low reliability testing.
  - Might be useful to stratify by different categories such as rural/urban, race/ethnicity to better understand equity.

Public Comment

- Received 5 written comments: 3 support with conditions and 2 oppose.
- Support:
  - Intent of measure and recognition of measure target importance to patient care and cost containment.
- Oppose:
  - Concerns about the scientific acceptability of the measure.
  - Potential unintended consequence is that providers will select lower-risk patients or will not provide appropriate care due to cost concerns.

MUC2023-206 Discussion Topics

- Are there unintended consequences which might emerge if a kidney transplant cost measure were to be implemented?

- How will the implementation of this CKD cost measure impact the quality of care delivered to CKD patients?
  - Part D costs for insulin and other diabetes medications should be excluded, in order to not disincentivize their use. There is also concern regarding the inclusion of immunosuppressants within this measure. This might save costs in the short-term but have adverse effects on long-term graft survival if transplant nephrologists are pushed towards cheaper immunosuppressant regimens.

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Lunch Break

Meeting resumes at 1:45 pm ET

MIPS Cost Measures Under Review – Affordability and Efficiency Measures

MUC2023-207 Prostate Cancer

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Prostate Cancer 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 prostate cancer. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Prostate Cancer episode.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resources Use	Medicare Fee-for-Service	Not Endorsed	Clinician: Individual and Group

MUC2023-207 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Majority of returned evaluations rated the assertions as “evidence is complete and adequate.”
- Remaining ratings split evenly between “evidence is either incomplete or inadequate, but gaps are addressable” and “evidence is incomplete or inadequate and gaps are not addressable.”
- Concerns:
  - Measure should have appropriate clinical and social risk adjustment, exclusions, and attribution methodology.
  - Many committee members were concerned about the evidence the developer provided.

Public Comment

- Received 4 written comments: 2 support with conditions, 2 oppose.
- Support:
  - Intent of measure and recognition of measure target importance to patient care and cost containment.
- Oppose:
  - Information about clinical stage (metastatic vs. non-metastatic disease) is not available in claims, and the risk adjustment model cannot control for the higher expected cost of providing appropriate care for patients with metastatic disease.
  - Black men experience higher incidence, higher mortality, and later diagnosis with prostate cancer. Delays in care can lead to worse outcomes and higher cost, and providers may be disincentivized to take on these patients.

MUC2023-207 Discussion Topics

- Given concerns raised in public comment about disproportionate incidence and mortality due to prostate cancer among Black men, what health equity concerns should be considered specific to this measure?

- Does this measure align with the program's broader goals to improve patient outcomes?

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Voting

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MUC2023-208 Respiratory Infection Hospitalization

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Respiratory Infection Hospitalization episode-based cost measure evaluates a clinician's or clinician group's risk-adjusted cost to Medicare for patients who receive inpatient treatment for a respiratory infection. This acute inpatient medical condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during each episode from the clinical event that opens, or "triggers," the episode through 30 days after the trigger.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee-for-Service	Not Endorsed	Clinician: Individual and Group

MUC2023-208 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- The majority of returned evaluations rated the assertions as “evidence is complete and adequate.”
- Remaining ratings split evenly between “evidence is either incomplete or inadequate, but gaps are addressable” and “evidence is incomplete or inadequate and gaps are not addressable.”
- Concerns:
  - Concerns of this being used at the provider level and which clinician would be responsible.
  - Measure’s scientific acceptability.
  - Use of antibiotic stewardship programs and biomarkers (i.e. procalcitonin levels) may not decrease cost for this patient population.

Public Comment

- Received 4 written comments: 2 support with conditions, 2 oppose.
- Support:
  - Support for intent of the measure.
- Oppose:
  - The complexity and variation in respiratory infections is a challenge for interpretating the meaning of this cost measure.
  - Evidence on the effectiveness of procalcitonin is mixed.

MUC2023-208 Discussion Topics

- Does this measure fill a gap within the targeted program?
- Do the benefits of this measure outweigh perceived burden?

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MUC2023-209 Rheumatoid Arthritis

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Rheumatoid Arthritis 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 rheumatoid arthritis. This chronic condition measure includes the cost of services that are clinically related to the attributed clinician's role in managing care during a Rheumatoid Arthritis episode.

Measure Type	Target Population	Endorsement Status	Level of Analysis
Cost/Resource Use	Medicare Fee for Service	Not Endorsed	Clinician: Individual and Group

MUC2023-209 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Half of the returned evaluations members rated the assertions as “evidence is complete and adequate.”
- Remaining ratings split evenly between “evidence is either incomplete or inadequate, but gaps are addressable” and “evidence is incomplete or inadequate and gaps are not addressable.”
- Concerns:
  - Cost analysis may not improve patient outcome
  - May negatively impact patients who are in the lower spectrum in socioeconomic determinants.
  - Measure should seek CBE endorsement.
  - Insufficient risk adjustment.

Public Comment

- 6 written comments: 2 support with conditions and 4 oppose.
- Support:
  - Intent of the measure.
- Oppose:
  - CMS payment and coverage policies restrict the medications that rheumatologists can prescribe.
  - Concerns if the measure will improve care.

MUC2023-209 Discussion Topics

- Do the benefits of this measure outweigh potential burdens?
- Does this measure fill an important gap in the program?
- Are there any potential unintended consequences of measure implementation?
  - Rheumatologists are keenly aware of the impact medication costs have on RA episodes. However, due to CMS' coverage and payment policies associated with Part B ("physician-administered") and Part D ("self-administered") medications, including those governing Part D Prescription Drug Plans, rheumatologists may not be able to prescribe what they believe is the most clinically and cost-effective therapy.

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Next Steps

- Following this meeting, Battelle will summarize recommendation group discussion and votes.
- Battelle will submit these recommendations to CMS by February 1 and post to the PQM website.
- There will be an additional 15-day public comment period after:
  - Feb. 1 – Feb. 16
  - The goal of the public comment period is not to change the recommendation but is an additional opportunity for the public to provide information for CMS consideration.

Thank you!

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