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

Nicole Brennan | Battelle
Brenna Rabel | Battelle

January 18-19, 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

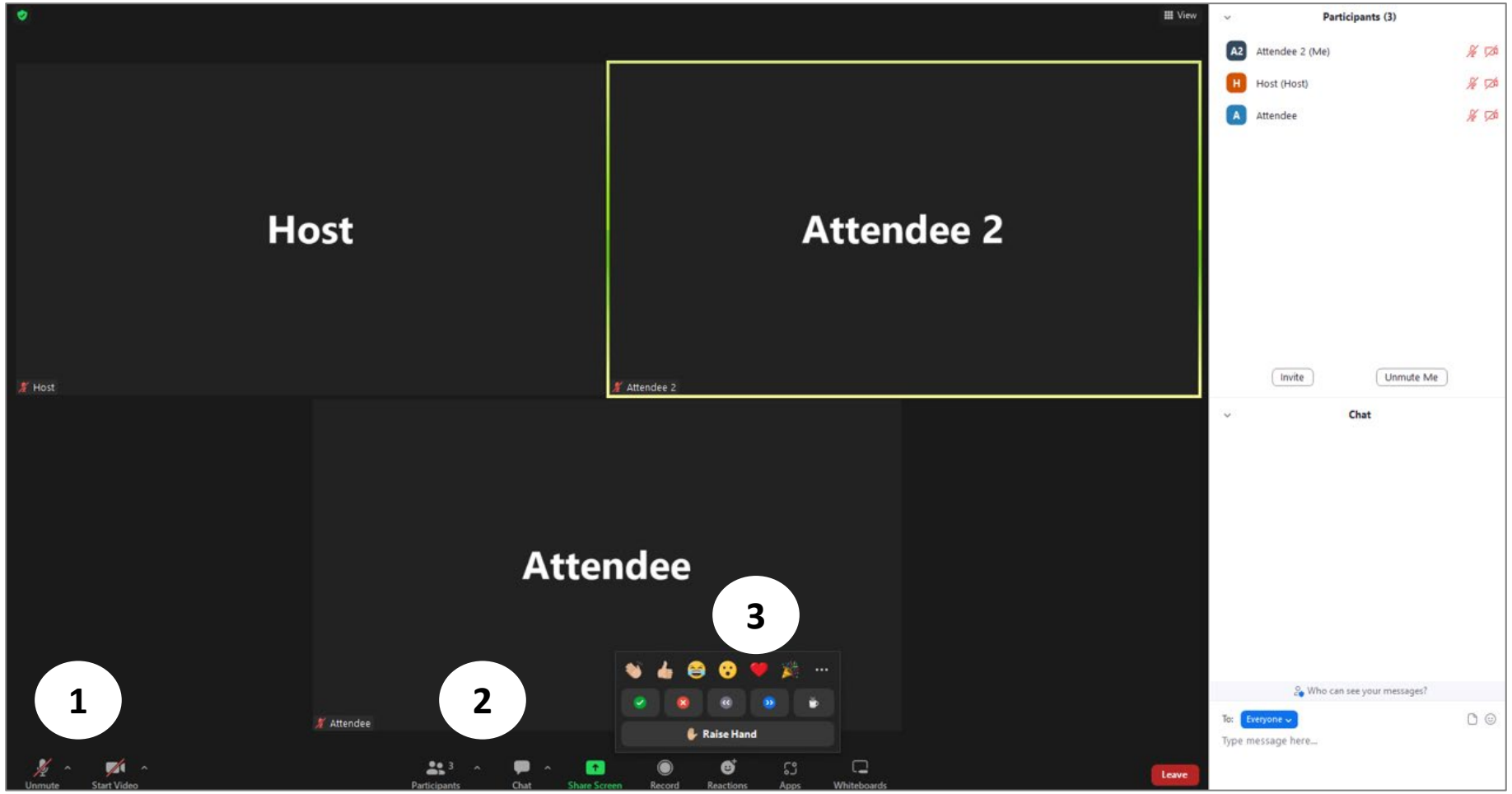
Centers for Medicare & Medicaid Services (CMS) Staff

- 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

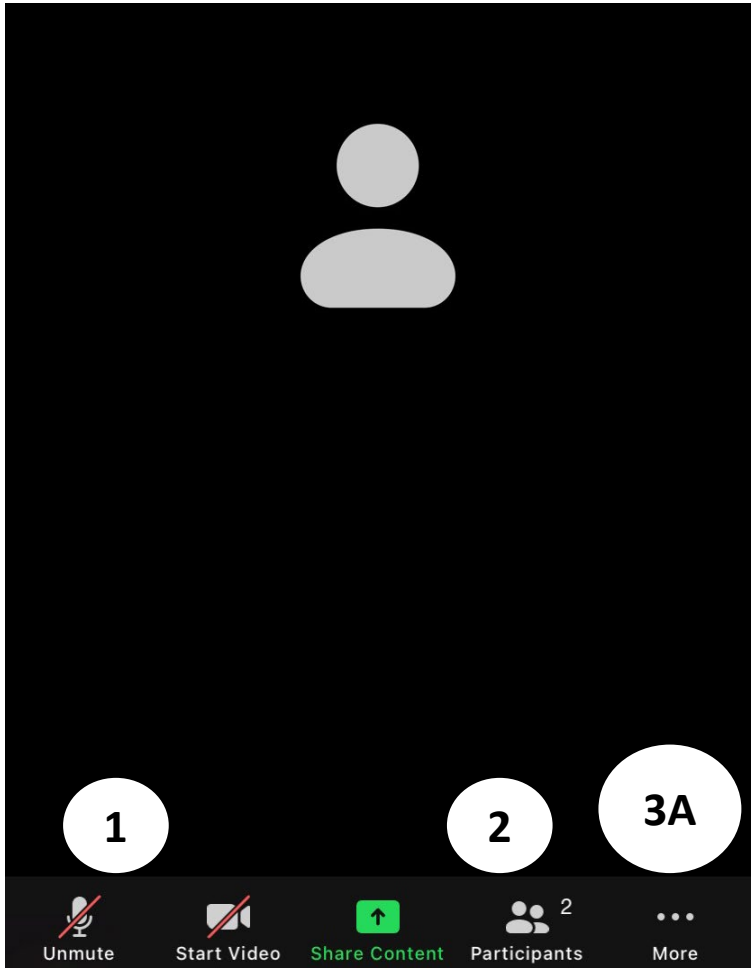
- Housekeeping reminders:
  - Review webinar settings for attendees
  - Please state your first and last name if you are a call-in participant
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with Battelle staff
- If you are experiencing 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

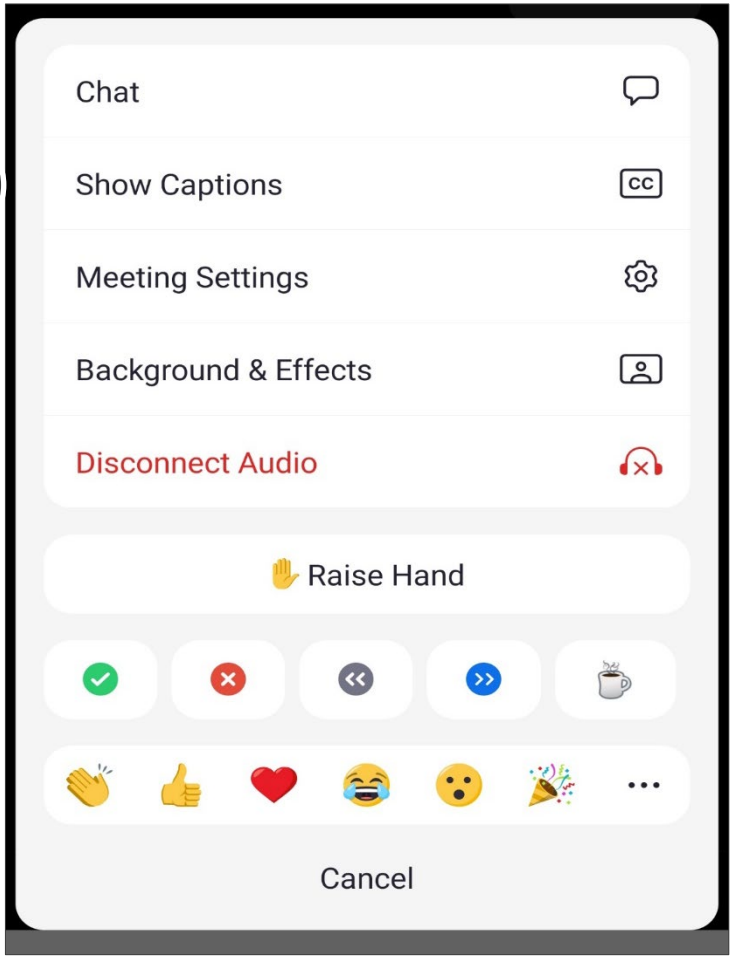
Using the Zoom Platform (Phone View)



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: Martin Hatlie & Kamyar Kalantar-Zadeh

- Akinluwa Demehin
- Amy Minnich
- David Kroll
- Erin O'Malley
- Isis Zambrana
- Ivory Harding
- James Moore
- John Bott
- Kamyar Kalantar-Zadeh
- Lara Musser
- Marc Gruner
- Melissa Danforth
- Michael Lane
- Nikolas Matthes
- Rosie Bartel
- Susan Runyan
- Tilithia McBride
- Virginia Irwin-Scott
- Wei Ying

PRMR Co-Chair Introductions

Brenna Rabel

CMS Opening Remarks

Michelle Schreiber

PRMR Process and Evaluation Criteria

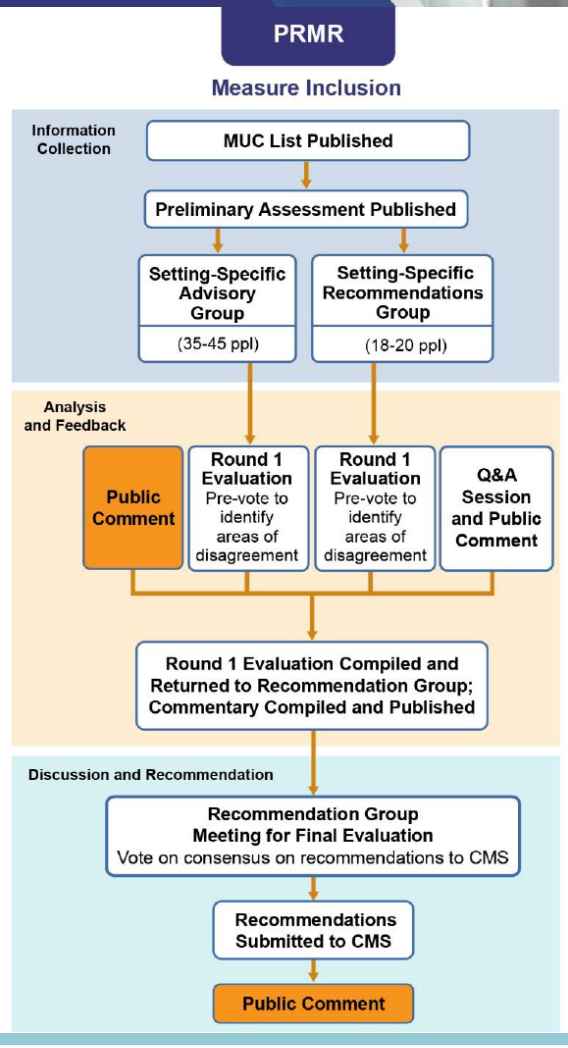
Kate Buchanan

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.

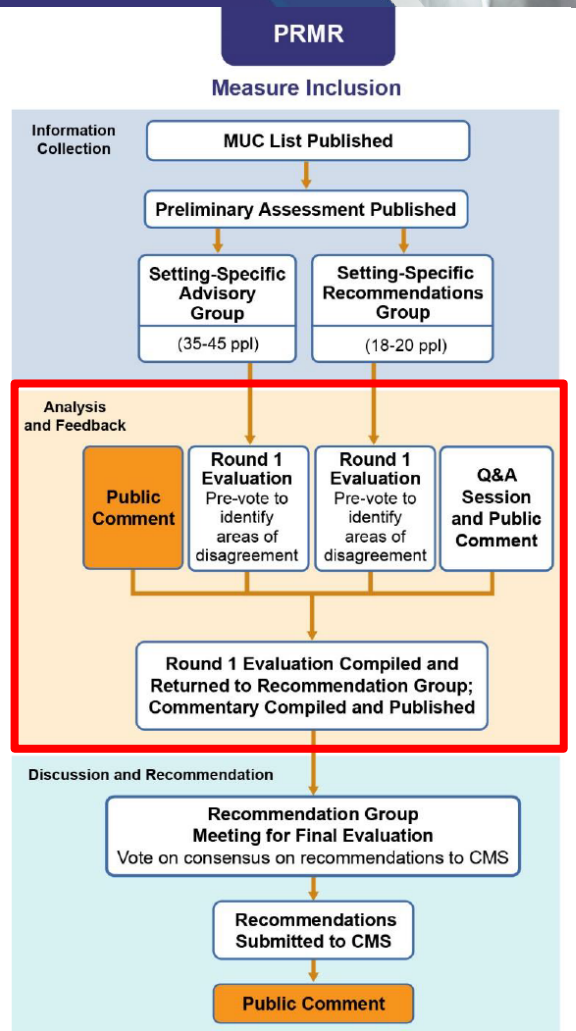
Three major phases:

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



PRMR Process: Analysis and Feedback

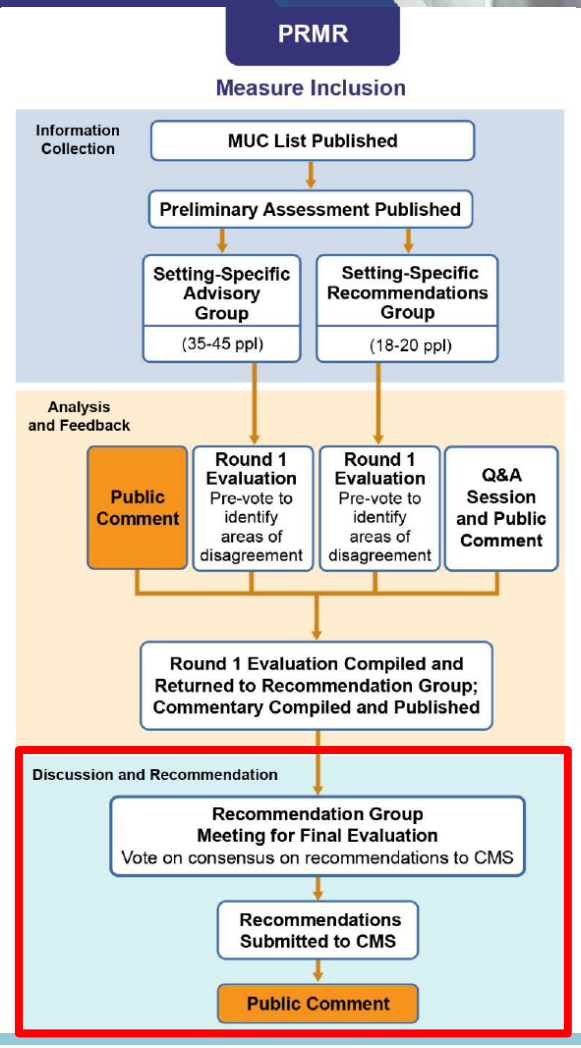
- **Round One Evaluation**
  - Advisory group and recommendation group members review preliminary assessments (PAs). They submit initial ratings on the measures with explanations. On average we received:
    - 31 responses per Hospital measure.
    - 20 responses per Clinician measure.
    - 34 responses 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

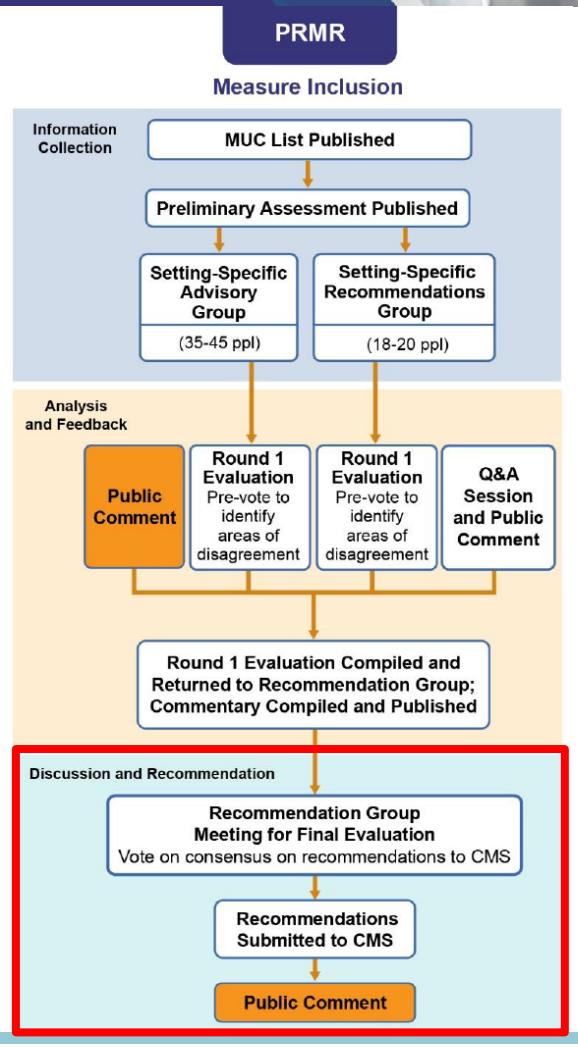
Today's Meeting: Recommendation Group Meeting for Final Evaluation

- 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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Hospital Committee Measure Review

All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge

MUC2023-181 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge (IPF ED Visit measure)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This measure assesses the proportion of patients ages 18 and older with an emergency department (ED) visit, including observation stays, for any cause within 30 days of discharge from an IPF, without subsequent admission.

Proposed for Inpatient Psychiatric Facility Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Medicare Part A and B FFS recipients ages 18+ who were admitted to an IPF with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Not Endorsed	Facility

MUC2023-181 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution across the assertions, which indicates areas of non-consensus among members.
- Concerns:
  - Measure's scientific acceptability.
  - Unclear how measure will lead to improved care.

Public Comment

- Received 2 public comments, 1 support and 1 support with conditions.
- Support:
  - Patients discharged from inpatient psychiatric care are at greater risk than the rest of the population for adverse outcomes. This measure will support better follow-up care after discharge and improved cooperation between caregivers.
- Concern:
  - The measure should be reviewed by a CBE.

MUC2023-181 Discussion Topics

- What potential negative unintended consequences might arise from the implementation of this measure?
- Does the strength of the scientific acceptability evidence support the use of this measure in a CMS program? Or is additional review (e.g., CBE endorsement) needed?
- How strong is the evidence linking this measure to its desired outcomes?
  - Leapfrog supports this measure. Patients discharged from inpatient psychiatric care are at greater risk than the rest of the population for adverse outcomes. This measure will support better follow-up care after discharge and improved cooperation between caregivers.

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Voting

To place your vote, please follow the link provided via email

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

Patient Experience and Patient-Reported Measures

MUC2023-138 ESRD Dialysis Patient Life Goals Survey (PaLS)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The PaLS is a patient self-report survey that includes eight items related to dialysis facility care team discussions about patient life goals. Six of the items are Likert-type items that are used to generate a “quality of facility care team discussion” score. The remaining two items on the PaLS are checklist items: (1) a list of patient-reported life goals; and (2) a patient-reported list of dialysis care team members that the patient reports has talked with them about their life goals. These items are not scored. Instead, these items serve to provide contextual information for both the patient and the facility to guide care team discussions.

Proposed for End-Stage Renal Disease (ESRD) Quality Incentive Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Process	All prevalent adult chronic dialysis patients treated by the facility (both In-Center and Home Dialysis) for greater than 90 days during the reporting period, who read and understand English.	Submitted for Endorsement	Population: Community, County, or City

MUC2023-138 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 members.
- Concerns:
  - Data collection is burdensome: manual, paper surveys.
  - Inclusion of only English speakers.
  - Lack of testing in various settings; not risk adjusted.

Public Comment

- Received 14 public comments, 2 support, 3 support with conditions, and 9 oppose.
- Support:
  - Promotes shared decision-making in treatments that impact quality of life and engagement in meaningful activities.
  - Patient surveys allow patients to communicate about the quality of their experiences.
- Oppose:
  - Patients experience survey burnout and are frustrated by surveys with no follow-up.
  - Patients were unclear how information gathered through this survey could improve treatment.
  - The survey excludes patients who are not proficient in English.

MUC2023-138 Discussion Topics

- Does this measure fill an important gap for the ESRD program?
- Do the perceived benefits of discussing patient life goals outweigh the perceived burdens associated with completing the survey? (Consider from both the patient and provider perspectives)
- What, if any, potential negative unintended consequences might be associated with the implementation of this measure?

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Voting

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MUC2023-172 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)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The Information Transfer PRO-PM collects information from patients aged 18 years or older who had a surgery or procedure at a hospital outpatient department (HOPD). The measure reports the average score patients rated the hospitals' ability to communicate clear, personalized discharge instructions using a 9-item survey.

Proposed for Hospital Outpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
PRO-PM or Patient Experience of Care	All Payer	Not Endorsed	Facility

MUC2023-172 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:
  - Burden on facilities (timing of administration) and patients (repetitive/overlapping topics).
  - Not risk adjusted.
  - Gaps in implementation of the data elements.

Public Comment

- Received 2 written public comments, both in support.
- Support:
  - Provides people the ability to compare care received in these settings. Will help people decide where they would like to receive care.
  - Addresses gap in current measurement strategies by providing patient-defined information on best practices during recovery.
  - Support for the intent and relevance of this measure with additional translations requested for broader multilingual use.

MUC2023-172 Discussion Topics

- How do the burden concerns raised by committee members in Round 1 stack up against the supportive comments related to meaningfulness and usability from the public?

- Does this measure fill an important need or gap in the HOQRP?

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Voting

To place your vote, please follow the link provided via email

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

Lunch Break

Meeting resumes at 1:15 pm ET

Standardized Infection Ratio Safety Measures

MUC2023-219 Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations

- **Measure Steward:** Centers for Disease Control and Prevention (CDC)
- **Brief Description of Measure:**
  - Annual risk-adjusted standardized infection ratio (SIR) of central line-associated bloodstream infections (CLABSI) among adults and children hospitalized as inpatients at acute care hospitals, oncology hospitals, and long-term acute care hospitals. SIR is reported annually and is calculated by dividing the number of observed CLABSIs by the number of predicted CLABSIs.

Proposed for Hospital Inpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Inpatients at acute-care hospitals on oncology units	Endorsed	Facility

MUC2023-220 Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations

- **Measure Steward:** CDC
- **Brief Description of Measure:**
  - Annual risk-adjusted standardized infection ratio (SIR) of catheter-associated urinary tract infections (CAUTI) among adults and children hospitalized as inpatients at acute care hospitals, oncology hospitals, long-term acute care hospitals, and acute care rehabilitation hospitals. SIR is reported annually and is calculated by dividing the number of observed CAUTIs by the number of predicted CAUTIs.

Proposed for Hospital Inpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Inpatients at acute-care hospitals on oncology units	Endorsed	Facility

MUC2023-219 & 220 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Committee responses on both measures indicated strong support. For both measures, around 70% of returned evaluations rated the assertions as “evidence is complete and adequate.”
- Concerns:
  - Burden of manual abstraction.
  - Both measures’ scientific acceptability.
  - Consistency across settings.

Public Comment

- Received 8 public comments, 4 support and 4 support with conditions.
- Support:
  - This measure addresses an important patient safety concept.
  - There was support for stratifying the measure for oncology locations.
- Concern:
  - Measures should not be risk adjusted because infections are preventable.
  - Requested additional testing to determine if volume bias exists.

MUC2023-219 & 220 Discussion Topics

- Strong support for both measures based on Round 1 Evaluations and public comment. Do any of the following concerns outweigh the perceived benefits?
  - Manual abstraction burden
  - Performance in low-volume facilities compared to higher volume facilities
  - Scientific acceptability (Note: both measures have undergone and passed endorsement review, which involved thorough assessment of validity and reliability)

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Voting

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Coordination Measures Excess Days in Acute Care (EDAC) after Hospitalization

MUC2023-117 Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for acute myocardial infarction (AMI). The acute care outcomes include 1) ED visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visit counted as 1 day and OBSs are counted by hours and rounded up to 1 day. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or Veterans Health Administration (VA) facilities.

Proposed for Hospital Readmissions Reduction Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Patients 65 years or older and enrolled in Medicare fee-for-service (FFS) and hospitalized in non-federal hospitals.	Endorsed	Facility

MUC2023-119 Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for heart failure (HF). The acute-care outcomes include 1) ED visits, 2) observation stays (OBSs), and 3) unplanned readmissions.

Proposed for Hospital Readmissions Reduction Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Patients 65 years or older and enrolled in FFS Medicare and hospitalized in non-federal hospitals.	Endorsed	Facility

MUC2023-120 Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia (PN)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for pneumonia (PN). The acute care outcomes include 1) ED visits, 2) observation stays (OBSs), and 3) unplanned readmissions. Unplanned readmissions are defined using the planned readmission algorithm (PRA). ED visit counted as 1 day and OBSs are counted by hours and rounded up to 1 day.

Proposed for Hospital Readmissions Reduction Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Patients 65 years or older and enrolled in FFS Medicare and hospitalized in non-federal hospitals.	Endorsed	Facility

MUC2023-117; 119; 120 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Of comments received for all three measures around 75-80% of the committee members rated the assertions as “evidence is complete and adequate” or “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - The measure’s scientific acceptability.
  - Risk that beneficiaries from underserved communities may lack the resources to gain from this measure.
  - Question if HRRP permits CMS to use the EDAC measures in the program since ED visits/observation stays are not readmissions.

Public Comment

- Received 19 written comments, 7 support, 1 support with considerations, 11 oppose
- Support:
  - Outcome measures related to harm are important and meaningful for the public and patients.
  - Replacing the current AMI readmissions measure with the EDAC measure would reduce excess utilization from ED visits and observation stays. This would help prevent patients from boarding to avoid counting as a readmission.
- Oppose:
  - Evidence the window of impact for preventing readmissions or returns to the ER may be as short as 7 days; may hold entities accountable for factors outside their control.
  - Asked if HRRP permits CMS to use the EDAC measures in the program since ED visits/observation stays are not readmissions.

MUC2023-117; 119; 120 Discussion Topics

- What impacts will these measures have on beneficiaries in underserved communities? Will they likely improve, worsen, or have no effect on health care inequity?
  - The Kansas Hospital Association questions the validity of the excess days in acute care (EDAC) measures - 117 - After Hospitalization for Acute MI (AMI); 119 - After Hospitalization for Heart Failure (HF); and 120 - After Hospitalization for Pneumonia (PN) with the readmissions being for all causes. If the measure is specific to a diagnosis, we believe that the readmission measure should be specific to the diagnosis as well.
- Do these EDAC measures fill a gap for the program(s)? How do they stack up against the existing readmissions measures?
  - Recommend. Replacing the current AMI readmissions measure with the EDAC measure would reduce excess utilization from ED visits and observation stays and ensure that patients are not subject to boarding to avoid counting as a readmission.

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Voting

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Break

Meeting resumes at 3:40 pm ET

Age Friendly Hospital Measure

MUC2023-196 Age Friendly Hospital Measure

- **Measure Steward:** American College of Surgeons (ACS), American College of Emergency Physicians (ACEP), and Institute for Healthcare Improvement (IHI)
- **Brief Description of Measure:**
  - This programmatic measure assesses hospital commitment to improving care for patients >= 65 years of age receiving services in the hospital, operating room, or emergency department.

Proposed for Hospital Inpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Structure	All Payer, patients 65 and older	Not Endorsed	Facility

MUC2023-196 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Relatively equitable distribution across the assertions, which indicates areas of non-consensus among members.
- Concerns:
  - Question if structural measures can improve quality of care.
  - Needs further testing.

Public Comment

- Received 25 public comments, 16 in support, 5 support with conditions, and 4 oppose.
- Support:
  - Captures evidence-based best practices in providing clinically effective and patient-centered care for older patients.
  - Combines and streamlines two measures previously reviewed by a CBE.
  - Components of the measure have been implemented nationally, demonstrating its feasibility.
- Oppose:
  - Attestations with ambiguous and/or statements should be clarified.
  - Concern that attestation measures do not have the same level of significance as measures that display performance in terms of discrete data.

MUC2023-196 Discussion Topics

- Is this structure measure likely to lead to the intended downstream outcomes, based on the evidence provided?

- How will this measure impact beneficiaries across settings? Is it likely to improve, worsen, or have no impact on the equity of care delivered across settings and populations?
  - The measure assesses hospital commitment to improving care for patients >= 65 years of age receiving services in the hospital, operating room, or emergency department. To the extent that this is a hospital measure and includes development of protocols to implement several individual measures, please consider a requirement for Domain 5 (Age-Friendly Care Leadership) that a geriatrician be required at the hospital to lead the work.

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Voting

To place your vote, please follow the link provided via email

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Hospital Safety Measures

MUC2023-188 Patient Safety Structural Measure

Measure Steward: CMS

- **Brief Description of Measure:**
  - 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.

Proposed for Hospital Inpatient Quality Reporting Program & PPS-Exempt Cancer Hospital Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Structure	Hospitals in the Hospital Inpatient Quality Reporting (HIQR) and PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)	Not Endorsed	Facility

MUC2023-188 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- The comments received had relatively equitable distribution of assertion ratings, indicating areas of non-consensus among members.
- Concerns:
  - Does not offer opportunity for improvement.
  - Not a strong correlation between safety culture and outcomes.
  - Additional burden for little/no benefit.

Public Comment

- Received 97 written public comments, 81 in support, 10 support with conditions, and 6 oppose. Most commented-on measure on the 2023 MUC list.
- Support:
  - Patient safety improvements are crucial, and the measure focuses on robust hospital leadership/active engagement of staff.
  - The requirement for hospitals to establish a culture of safety where systems are put in place to prevent and learn from medical errors.
  - Patients and family members shared experiences with medical system and preventable harms to emphasize the importance of the measure.
  - Aligns with other national guidance such as Safer Together: The National Action Plan to Advance Patient Safety.
- Oppose:
  - The measure lacks visible mechanisms for audit and public accountability.
  - Could lead to a rapid high-performance rate with unclear links to actual quality.

MUC2023-188 Discussion Topics

- Strong agreement from public comment and Round 1 Evaluations that patient safety is important to measure, but lack of consensus surrounding:
  - The evidence tying a culture of safety to improved outcomes
  - Whether this measure will “top out” too quickly
- How do the potential benefits of implementing this measure weigh against the perceived burdens?
- Are there any notable potential unintended consequences?

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MUC2023-049 Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)

Measure Steward: CMS

- **Brief Description of Measure:**
  - Percentage of surgical inpatients who experienced a complication and then died within 30 days from the date of their first “operating room” procedure. Failure-to-rescue is defined as the probability of death given a postoperative complication.

Proposed for Hospital Inpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	• Medicare FFS • Medicare Advantage	Not Endorsed	Facility

MUC2023-049 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Of comments received, approximately 80-85% of members rated the assertions either “evidence is complete and adequate” or
  “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Not enough of an improvement on PSI-04.

Public Comment

- Received 11 written public comments, 1 support, 4 support with conditions, and 6 oppose
- Support:
  - Commenters expressed support for measuring patient outcomes.
- Oppose:
  - Limited evidence to support broadening the measure to 30 days after discharge.
  - Concerns about the measure’s appropriateness for low volume sites.

MUC2023-049 Discussion Topics

- How might this measure lead to or resolve inequities in care delivery?
- Does this measure fill a gap in the programs?

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MUC2023-048 Hospital Harm - Falls with Injury

Measure Steward: CMS

- **Brief Description of Measure:**
  - This ratio measure assesses the number of inpatient hospitalizations where at least one fall with a major or moderate injury occurs among the total qualifying inpatient hospital days for patients aged 18 years and older.

Proposed for Hospital Inpatient Quality Reporting Program & Medicare Promoting Interoperability Program for Eligible Hospitals (EH) or Critical Access Hospitals (CAHs)

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

MUC2023-050 Hospital Harm - Postoperative Respiratory Failure

Measure Steward: CMS

- **Brief Description of Measure:**
  - This electronic clinical quality measure (eCQM) assesses the proportion of elective inpatient hospitalizations for patients aged 18 years and older without an obstetrical condition who have a procedure resulting in postoperative respiratory failure (PRF).

Proposed for Hospital Inpatient Quality Reporting Program & Medicare Promoting Interoperability Program for Eligible Hospitals (EH) or Critical Access Hospitals (CAHs)

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

MUC2023-048 & 050 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Ratings for both measures were evenly spread between complete evidence and “evidence is either incomplete or inadequate, but gaps are addressable”
- Concerns:
  - Testing and model development occurred with sophisticated electronic medical record not often found in hospitals in small, rural, or medically underserved areas.
  - Risk adjustment is challenging.

Public Comment

- Received 19 written public comments, 4 support, 8 support with conditions, and 7 oppose
- Support:
  - Falls are a serious and preventable harm for which hospitals should be held accountable.
  - Will encourage assessing patients for risk and putting them under the correct protocols early.
- Oppose:
  - Concern about the measures’ scientific acceptability, specifically for low-volume sites.
  - Implementation may reduce opportunities for patient mobilization, which is critical for recovery (048).
  - May result in the use of inappropriate therapies or avoidance of using necessary procedures for high-risk patients (050).

MUC2023-048 & 050 Discussion Topics

- Commenters and committee members have raised concerns about feasibility and scientific acceptability for these measures in rural or low volume facilities. How will that impact the usability of these measures?
- Do these measures fill an important gap in the programs?
- What are the potential unintended consequences associated with these measures?

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Close of Day 1

- Thank you for your hard work today!
- We will reconvene at 10:00 am 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) Hospital Recommendation Group Meeting

Nicole Brennan | Battelle
Brenna Rabel | Battelle

January 19, 2024

Contract Number 75FCMC23C0010

Welcome and Roll Call

Nicole Brennan

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

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Hospital Committee Measure Review

Patient Experience and Patient-Reported Measures

MUC2023-146 – 149 Hospital Patient Experience of Care

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The measure is comprised of four newly developed sub-measures to be added to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.
    - MUC2023-146 Care Coordination
    - MUC2023-147 Restfulness of Hospital Environment
    - MUC2023-148 Responsiveness of Hospital Staff
    - MUC2023-149 Information about Symptoms

Proposed for Hospital Inpatient Quality Reporting Program, Hospital Value-Based Purchasing Program, & PPS-Exempt Cancer Hospital Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
PRO-PM or Patient Experience of Care	All Payer	Not Endorsed: 146, 147, 149 Endorsed: 148	Facility

MUC2023-146 – 149 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- Of members that submitted feedback, over 90% rated the assertions as “evidence is complete and adequate” or “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Additional questions may be a burden.
  - Factors outside of hospital’s control could affect scores.
  - Low response rate in rural setting.

Public Comment

- Received 24 written public comments, 8 support, 12 support with conditions, and 4 oppose.
- Support:
  - When patients have a positive experience of care, they are more likely to follow clinical guidelines and have better outcomes.
  - These sub-measures align with CMS’s goal of fostering engagement and bringing patient voices to the forefront.
  - HCAHPS measures are well established in hospital workflows.
- Oppose:
  - HCAHPS survey response rates are low and have been decreasing due to survey fatigue.

MUC2023-146 – 149 Discussion Topics

- Do these measures fill an important gap in the programs for which they are being considered?
- How might low response rates impact the usability of the survey results? How might that impact hospitals' interpretation of the patient voice?
- What potential unintended consequences might arise as a result of the use of these measures?

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Voting

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Break

Meeting resumes at 11:40 am ET

Social Drivers of Health (SDOH) Measures

MUC2023-175 Facility Commitment to Health Equity

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level.

Proposed for Ambulatory Surgical Center Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Structure	Medicare FFS	Not Endorsed	Facility

MUC2023-176 Hospital Commitment to Health Equity

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Hospitals will receive one point each for attesting to five different domains of commitment to advancing health equity for a total of five points.

Proposed for Hospital Outpatient Quality Reporting Program & Rural Emergency Hospital Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Structure	Medicare FFS	Not Endorsed	Facility

MUC2023-175 & 176 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- For both measures, between 80-90% of members that provided comments rated the assertions or distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Increase in data collection burden.
  - Lack of resources for screening.
  - Not sure if the measure will make an impact.

Public Comment

- Received 20 written public comments, 3 support, 11 support with conditions, 6 oppose.
- Support:
  - Encourages hospital commitment to improving health equity through substantive changes to infrastructure, policy, and capabilities.
  - Could promote better collection of demographic data and monitoring for health care disparities.
- Concern:
  - Commitment to health equity is evidenced by the actions of the organization, and these may or may not be effectively captured through attestations of those actions through this measure.
  - Hospital associations already have a variety of programs underway for addressing equity.
  - Structural measures lack mechanisms for audit and public accountability or any indication that the intent is to support development of outcome measures.

MUC2023-175 & 176 Discussion Topics

- Health equity is a known priority at CMS and in the U.S. healthcare system more broadly. Do these structure/attestation measures help to address that priority?
- Would implementing these measures result in any unintended negative consequences?
- How might patients use these measures to make decisions about where to seek care?

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Voting

To place your vote, please follow the link provided via email

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Lunch Break

Meeting resumes at 1:15 pm ET

Social Drivers of Health (SDOH) Measures cont.

MUC2023-139 Hospital Equity Index (HEI)

- **Measure Steward:** CMS
- **Brief Description of Measure:**
  - The HEI is a prototype method for a single score that summarizes several measurements of disparity in care at a hospital. The final score, centered around a value of 0.00 due to the method of standardization used, will summarize results of the Centers for Medicare and Medicaid Services (CMS) Disparity Methods (stratified measure results) across a range of measures and social and demographic risk factors, to provide more accessible information about variations in healthcare disparity across hospitals.

Proposed for Hospital Inpatient Quality Reporting Program

Measure Type	Target Population	Endorsement Status	Level of Analysis
Outcome	Medicare FFS	Not Endorsed	Facility

MUC2023-139 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 members.
- Concerns:
  - Difficult for facilities/areas with low patient volume.
  - Facilities may not have resources for implementation.
  - Unclear how facility improves.

Public Comment

- Received 10 written public comments, 3 support, 1 support with conditions, and 10 oppose.
- Support:
  - Health equity measures are difficult to establish and should remain a focus in health care.
  - The index could be expanded in the future to include other indicators of health equity
  - The measure does not rely on imputed race and ethnicity data.
- Oppose:
  - Concern the measure could cause readmission rates to be “double counted.”
  - The Area Deprivation Index has limitations for identifying differences in risk factors for some communities.
  - It is not clear how hospitals could improve their performance on the measure.

MUC2023-139 Discussion Topics

- Are the resources needed to implement this measure likely to be available at facilities across geographic (urban/rural) and high/low resource settings?
- To what extent will facilities be able to use the data from this measure to improve their processes and outcomes?
- What are the potential unintended consequences associated with this measure?
  - Comment: The index only includes the seven readmission and two mortality measures, which does not provide a full picture of the care provided by a hospital.

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Voting

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MUC2023-156 Screening for Social Drivers of Health (SDOH)

Measure Steward: CMS

- **Brief Description of Measure:**
  - The Screening for SDOH is a process measure that assesses the total number of patients, who were 18 years or older on the date of service, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during their outpatient facility, Ambulatory Surgical Center (ASC), and rural emergency hospital (REH) care.

Proposed for Ambulatory Surgical Center Quality Reporting Program, Hospital Outpatient Quality Reporting Program & Rural Emergency Hospital Quality Reporting Program

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

MUC2023-171 Screen Positive Rate for Social Drivers of Health (SDOH)

Measure Steward: CMS

- **Brief Description of Measure:**
  - The Screen Positive Rate for SDOH is a process measure that provides information on the percent of patients receiving care at an outpatient facility, Ambulatory Surgical Center (ASC), and rural emergency hospital (REH), who were 18 years or older on the date of service, who were screened for all five health-related social needs (HRSNs), and who screened positive for one or more of the following five HRSNs: food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Proposed for Ambulatory Surgical Center Quality Reporting Program, Hospital Outpatient Quality Reporting Program & Rural Emergency Hospital Quality Reporting Program

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

MUC2023-156 & 171 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- For both measures, around 80% of members that provided comments rated the assertions or distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Increase in data collection burden.
  - Lack of resources for screening.

Public Comment

- Received 26 written public comments, 6 support, 11 support with conditions, 7 oppose.
- Support:
  - Identifying and addressing social needs will help reduce health inequities.
  - This measure is consistent with recommendations by clinician organizations and by other health care providers related to the need for national uniform standards of quality measures to reduce the burdens on providers.
- Concern:
  - There is no demonstration collecting these data drives improvements in health outcomes.
  - Unclear how this measure would be used in payment and public reporting programs.
  - Does not account for geographic variations in communities and therefore may be missing an opportunity to prioritize screening for needs that are relevant to the community.

MUC2023-156 & 171 Discussion Topics

- Though similar, these two measures assess different things. 156 assesses the total percentage of patients who were screened for SDOH, whereas 171 assesses the percentage of screened patients who screened positive to one or more health-related social needs.
  - Do both measures address a gap in the programs for which they are being considered?
  - Is the ratio of burden vs. benefit the same for each measure?
  - What potential unintended consequences might be associated with one or both measures?

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Break

Meeting resumes at 2:55 pm ET

Social Drivers of Health (SDOH) Measures cont.

MUC2023-114 Global Malnutrition Composite Score (GMCS)

- **Measure Steward:** Academy of Nutrition and Dietetics
- **Brief Description of Measure:**
  - This measure assesses the percentage of hospitalizations for adults aged 18 years and older at the start of the measurement period with a length of stay equal to or greater than 24 hours who received optimal malnutrition care during the current inpatient hospitalization where care performed was appropriate to the patient's level of malnutrition risk and severity.

Proposed for Hospital Inpatient Quality Reporting Program & Medicare Promoting Interoperability Program for Eligible Hospitals (EH) or Critical Access Hospitals (CAHs)

Measure Type	Target Population	Endorsement Status	Level of Analysis
Intermediate Outcome	Inpatient hospitalizations with a length of stay of 24 hours or more among individuals 18 years of age and older	Endorsed	Facility

MUC2023-114 Overview of Round 1 Evaluation and Public Comment

Round 1 Evaluation Feedback

- More than 80% of members that provided comments rated the assertions or distribution of assertion ratings between “evidence is complete and adequate” and “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Potential burden on smaller hospitals, rural hospitals and systems, and the possibility they will be penalized for having fewer resources and a more malnourished population.
  - Unclear if screening and plan development will impact malnutrition.

Public Comment

- Received 31 public comments, 14 support, 16 support with conditions, and 1 oppose.
- Support:
  - The proposed expansion to encompass all adults aged 18 years and older is welcomed.
  - Reviewers appreciate GMCS's potential in improving health care outcomes, enhancing nutrition support, and reducing hospital admissions and expensive morbidities.
  - A significant number of commentators believe that the GMCS can ensure early action against malnutrition, reduce the incidence of the disease, and prevent hospital admissions.
- Oppose:
  - Reviewers voiced concerns about overlapping measures, suggesting that this measure may be duplicative with other frailty screening metrics.

MUC2023-114 Discussion Topics

- Does this measure address an important gap in the programs for which it is being considered?
- To what extent will this measure positively impact care across settings, especially between urban/rural where the causes and contributors to malnutrition might differ?
- Does this measure reflect patient perspectives and/or patient choice?

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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.

Proposed for Hospital Inpatient Quality Reporting Program

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

- Majority rated as “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns
  - The burden and feasibility of data collection is unclear and there are questions on the ability to collect data efficiently.
  - Effectiveness might vary based on the availability of community resources and the socioeconomic status of the region.
  - Data needed to show association of connecting with community service provider with positive outcomes.

Public Comment

- Received 15 public comments, 2 support, 2 support with conditions, 11 oppose.
- Support:
  - Connecting patients to community providers is an important step in addressing SDOHs.
  - Opportunity to standardize measures for documenting the work that occurs in multi-specialty teams.
- Oppose:
  - More clarity on key constructs needed.
  - More validity and reliability testing needed.

MUC2023-199 Discussion Topics

- To what extent will feasibility challenges likely impact the successful implementation of this measure?
  - While the American Medical Association (AMA) supports the intent of this measure, we do not believe that the implementation of this process measure at the hospital level in the Hospital Inpatient Quality Reporting (IQR) program is appropriate, particularly due to the absence of any resources or tools that would be widely and readily available. .
- Community resource availability varies across geographic settings. How do patterns of resource availability across rural/urban areas impact the expected efficacy of the measure?

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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.

Proposed for Hospital Inpatient Quality Reporting Program

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

- Majority rated as “evidence is either incomplete or inadequate, but gaps are addressable.”
- Concerns:
  - Data collection burden.
  - Not clear that providers have sufficient control over the determinants of the measure to influence it.
  - Need more validity testing and pilot in hospital settings.
  - Reliability testing needed.

Public Comment

- Received 17 public comments, 3 support, 1 support with considerations, 13 oppose.
- Support:
  - Can assist patients in achieving positive health outcomes.
  - Captures existing health system efforts to complete social risk screening, provide referrals, and offer assistance.
- Oppose:
  - Concerns around validity, specification, and feasibility for use in program settings.
  - Equity concern for potential challenges for rural facilities.

MUC2023-210 Discussion Topics

- To what extent are the measure outcomes within the control of the measured entity?
  - while hospitals can and should screen for health-related social needs and make appropriate patient referrals, we should not be held responsible for the safety net of an entire region.

- 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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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.
- Starting February 1, the public will have another chance to provide comments on each measure and the recommendation results.
  - 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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