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Pre-Rulemaking Measure Review Measures Under Consideration

2023 RECOMMENDATIONS REPORT

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) sponsors and oversees an annual Pre-Rulemaking Measure Review (PRMR) process to provide recommendations to the Department of Health and Human Services (HHS) on the selection of quality and efficiency measures under consideration (MUC) for use by HHS. As a CMS-recognized consensus-based entity (CBE), Battelle managed the PRMR process for the 2023–2024 cycle, relying on a large group of interested parties organized under the Partnership for Quality Measurement (PQM).

Through a series of meetings and other communications (Figure 1), the PRMR process results in consensus recommendations regarding the inclusion of measures under consideration for CMS quality reporting and value-based programs. In the context of a specific CMS program and population of Medicare beneficiaries, the measure is appropriate for use if it is meaningful, tailored to specific program or population needs, balanced in terms of benefits and harms, scaled to meet program-specific goals, and if the measure demonstrates a clear vision of near- and long-term program impacts.

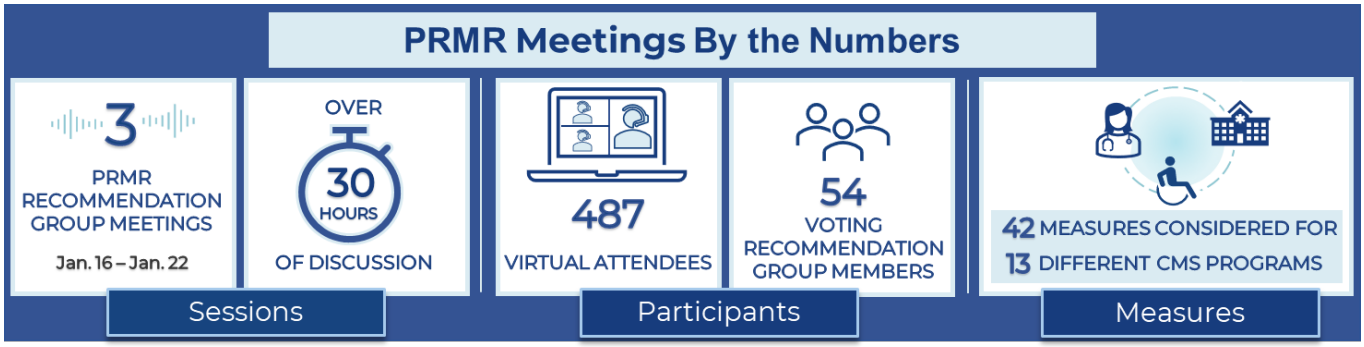

Figure 1. PRMR 2023 Meetings by the Numbers

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

Public Engagement: With the release of the MUC List on December 1, 2023, Battelle held a 21-day call for public comment via the PQM website along with a series of setting-specific listening sessions held virtually over Zoom.

Preliminary Measure Assessment: Battelle staff conducted a preliminary assessment (PA) for each measure to inform and guide committee members' reviews of the MUC List measures assigned to their committee. The goal of the PA reports was to provide committee members with a thorough and standardized baseline evaluation of the measures under consideration, consolidated to enable more efficient review of the measures.

Committee Evaluation: Advisory and Recommendation Group members reviewed the PAs and participated in Round 1 Evaluations to assess initial strengths and areas of concern and generate a starting point for discussion during the Recommendation Group meetings.

Recommendation Group Discussion: In three meetings spanning five days, Battelle convened the Recommendation Group members of the Clinician, Hospital, and Post-Acute Care/Long-Term Care (PAC/LTC) committees together with CMS leadership and measure developers to evaluate the 42 measures under consideration for 13 CMS programs.

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

Table 1. PRMR Recommendations for 2023 Measures Under Consideration by Program

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Ambulatory Surgical Center Quality Reporting Program (ASCQR)	**MUC2023-156**	Screening for Social Drivers of Health (SDOH)	Recommend with conditions	The committee did not provide program specific conditions.
	MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	Consensus not reached	N/A
	MUC2023-175	Facility Commitment to Health Equity	Recommend	N/A
End-Stage Renal Disease Quality Incentive Program (ESRD QIP)	**MUC2023-138**	ESRD Dialysis Patient Life Goals Survey (PaLS)	Consensus not reached	N/A
Hospice Quality Reporting Program (HQRP)	**MUC2023-163**	Timely Reassessment of Pain Impact	Recommend with conditions	Conditions included further testing of the HOPE tool as well as endorsement of the measure by a consensus-based entity[1].
	MUC2023-166	Timely Reassessment of Non-Pain Symptom Impact	Recommend with conditions	Conditions included further testing of the HOPE tool as well as endorsement of the measure by a consensus-based entity[1].
	MUC2023-183, 191, 192	CAHPS® Hospice Survey [Consumer Assessment of Healthcare Providers and Systems]	Consensus not reached	N/A

[1] Based on information provided during measure submission and discussion with CMS, the HOPE has been beta tested and testing is now complete. The HOPE tool has not been proposed in rulemaking at this point. The committee expressed interest in testing or sharing of additional testing results beyond what was provided in the MERIT submission in future.

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Hospital Inpatient Quality Reporting Program (Hospital IQR Program)	**MUC2023-048**	Hospital Harm - Falls with Injury	Recommend with conditions	Conditions included the measure obtaining consensus-based entity endorsement and ongoing monitoring of unintended consequences such as use of patient restraints and avoidance of life-saving procedures with higher risk for respiratory failure.
	MUC2023-049	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement and the collection of data to evaluate possible unintended consequences.
	MUC2023-050	Hospital Harm - Postoperative Respiratory Failure	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement and ongoing monitoring of unintended consequences such as use of patient restraints and avoidance of life-saving procedures with higher risk for respiratory failure.
	MUC2023-114	Global Malnutrition Composite Score	Recommend with conditions	Conditions included adding hospital-acquired malnutrition and high-risk nutritional practices in screening and assessment and the involvement of more patient groups in further work on this measure.
	MUC2023-139	Hospital Equity Index (HEI)	Consensus not reached	N/A

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Hospital Inpatient Quality Reporting Program (Hospital IQR Program) (cont.)	**MUC2023-146, 147, 148, 149**	Hospital Patient Experience of Care	Recommend with conditions	Conditions included endorsement by a consensus-based entity, consideration to not extend survey length and remove overlapping items as the measures progress in the program, the use of adaptive questions in computerized administration to minimize items, and the use of a mechanism to monitor trends in performance data over time.
	MUC2023-188	Patient Safety Structural Measure	Recommend with conditions	Conditions included publication of an implementation guide that clearly documents how safety is measured and using data to narrow the scope before approving the measure for programs.
	MUC2023-196	Age-Friendly Hospital Measure	Consensus not reached	N/A
	MUC2023-199	Connection to Community Service Provider	Consensus not reached	N/A
	MUC2023-210	Resolution of At Least 1 Health-Related Social Need	Consensus not reached	N/A
	MUC2023-219	Central Line-Associated Bloodstream Infection (CLABSI) (Stratified for oncology locations)	Recommend with conditions	Conditions included encouraging CMS to evaluate data by oncology unit type and increase reporting time to allow lower patient volume facilities to report.
	MUC2023-220	Catheter-Associated Urinary Tract Infection (CAUTI) (Stratified for oncology locations)	Recommend with conditions	Conditions included encouraging CMS to evaluate data by oncology unit type and increase reporting time to allow lower patient volume facilities to report.

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Hospital Outpatient Quality Reporting Program (Hospital OQR Program)	**MUC2023-156**	Screening for Social Drivers of Health (SDOH)	Recommend with conditions	Conditions included that IQR and OQR programs report one set of measures per calendar year per facility.
	MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	Consensus not reached	N/A
	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)	Recommend with conditions	Conditions included specifying that the survey be administered at the time of the procedure so as not to conflict with collection of pain and function outcome measures.
	MUC2023-176	Hospital Commitment to Health Equity	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement, added instructions and information around attestation requirements, and ongoing data collection for further measure testing in low patient volume settings.
Hospital Readmissions Reduction Program (HRRP)	**MUC2023-117**	Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI)	Consensus not reached	Conditions included encouraging CMS to consider monitoring for unintended consequences and further testing related to health equity.
	MUC2023-119	Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF)	Recommend with conditions	Conditions included exploring monitoring for unintended consequences and conducting further testing related to health equity.

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Hospital Readmissions Reduction Program (HRRP) (cont.)	**MUC2023-120**	Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia (PN)	Recommend with conditions	Conditions included encouraging CMS to consider conditions such as monitoring for unintended consequences and further testing related to health equity.
Hospital Value-Based Purchasing Program (HVBP)	**MUC2023-146, 147, 148, 149**	Hospital Patient Experience of Care	Recommend with conditions	Conditions included endorsement by a consensus-based entity, consideration to not extend survey length and remove overlapping items as the measures progress in the program, the use of adaptive questions in computerized administration to minimize items, and the use of a mechanism to monitor trends in performance data over time.
Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)	**MUC2023-181**	30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge (IPF ED Visit measure)	Recommend with conditions	Consensus-based entity endorsement
Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)(PI)	**MUC2023-048**	Hospital Harm - Falls with Injury	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement and ongoing monitoring of unintended consequences such as use of patient restraints and avoidance of life-saving procedures with higher risk for respiratory failure.

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs)(PI) (cont.)	**MUC2023-050**	Hospital Harm - Postoperative Respiratory Failure	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement and ongoing monitoring of unintended consequences such as use of patient restraints and avoidance of life-saving procedures with higher risk for respiratory failure.
	MUC2023-114	Global Malnutrition Composite Score	Recommend with conditions	Conditions included adding hospital-acquired malnutrition and high-risk nutritional practices in screening and assessment and the involvement of more patient groups in further work on this measure.
Merit-based Incentive Payment System (MIPS)	**MUC2023-141**	Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy	Recommend with conditions	Conditions included additional testing to examine measure performance and feasibility.
	MUC2023-161	Appropriate Germline Testing for Ovarian Cancer Patients	Recommend with conditions	Consensus-based entity endorsement.
	MUC2023-162	Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer	Recommend with conditions	Conditions included encouraging CMS to consider implementation at the clinician group-level only until further testing and improvements can be made at the individual clinician level.
	MUC2023-164	Adult COVID-19 Vaccination Status	Consensus not reached	N/A
	MUC2023-190	Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer	Consensus not reached	N/A

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Merit-based Incentive Payment System (MIPS)	**MUC2023-201**	Cataract Removal with Intraocular Lens (IOL) Implantation	Recommend with conditions	While the committee did not provide a formal list of conditions, they advocated more examination of how implementation of cost measures may impact patient outcomes.
	MUC2023-203	Chronic Kidney Disease	Consensus not reached	N/A
	MUC2023-204	End-Stage Renal Disease	Consensus not reached	N/A
	MUC2023-205	Inpatient (IP) Percutaneous Coronary Intervention (PCI)	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement, to assess the scientific properties of the measure with rigor. Analyze longitudinal data to assess the stability of the measure.
	MUC2023-206	Kidney Transplant Management	Consensus not reached	N/A
	MUC2023-207	Prostate Cancer	Consensus not reached	N/A
	MUC2023-208	Respiratory Infection Hospitalization	Consensus not reached	N/A
	MUC2023-209	Rheumatoid Arthritis	Do not recommend	N/A
	MUC2023-211	Melanoma: Tracking and Evaluation of Recurrence	Consensus not reached	N/A
Part C & D Star Ratings (Part C and D)	**MUC2023-137**	Initial Opioid Prescribing for Long Duration (IOP-LD)	Consensus not reached	N/A
	MUC2023-179	Initiation and Engagement of Substance Use Disorder Treatment (IET)	Consensus not reached	N/A
	MUC2023-212	Level I Denials Upheld Rate Measure	Recommend	N/A

Program	MUC ID	Measure Title	Recommendation	Conditions (if specified)
Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQRP)	**MUC2023-146, 147, 148, 149**	Hospital Patient Experience of Care	Recommend with conditions	Conditions included endorsement by a consensus-based entity, consideration to not extend survey length and remove overlapping items as the measures progress in the program, the use of adaptive questions in computerized administration to minimize items, and the use of a mechanism to monitor trends in performance data over time.
	MUC2023-188	Patient Safety Structural Measure	Recommend with conditions	The committee encouraged publication of an implementation guide that clearly documents how safety is to be measured and using data to narrow the scope before approving the measure for programs.
Rural Emergency Hospital Quality Reporting Program (REHQRP)	**MUC2023-156**	Screening for Social Drivers of Health (SDOH)	Recommend with conditions	Conditions included that IQR and OQR programs report one set of measures per calendar year per facility.
	MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	Consensus not reached	N/A
	MUC2023-176	Hospital Commitment to Health Equity	Recommend with conditions	Conditions included the measure undergoing consensus-based entity endorsement, added instructions and information around attestation requirements, and ongoing data collection for further measure testing in low patient volume settings.

1. Pre-Rulemaking Measure Review (PRMR) Overview

1.1 PRMR Overview

The goal of the PRMR process is to inform the selection of health care quality and efficiency measures for use in CMS Medicare quality programs. Per statute[2], HHS annually publishes (by December 1) a list of measures under consideration (MUC) for future federal rulemaking. The PRMR process makes consensus recommendations regarding the inclusion of measures being considered for CMS quality reporting and value-based programs. PRMR's review focuses on a measure's appropriateness for a specific program. It assesses if, within the proposed program, the measure is meaningful, tailored to the program's unique needs, balanced, and scaled to meet program-specific goals, and if the measure demonstrates a clear vision of near- and long-term program impacts.

1.2 2023 PRMR Advisory and Recommendation Group Composition

The cornerstone of a transparent and inclusive consensus-based process is effective engagement of interested parties. This ensures that CMS has access to meaningful feedback on all measures proposed for inclusion in CMS quality programs. The PRMR process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and efficiency measures. Interested parties come from a variety of places (Figure 2) and represent a diverse group of people.

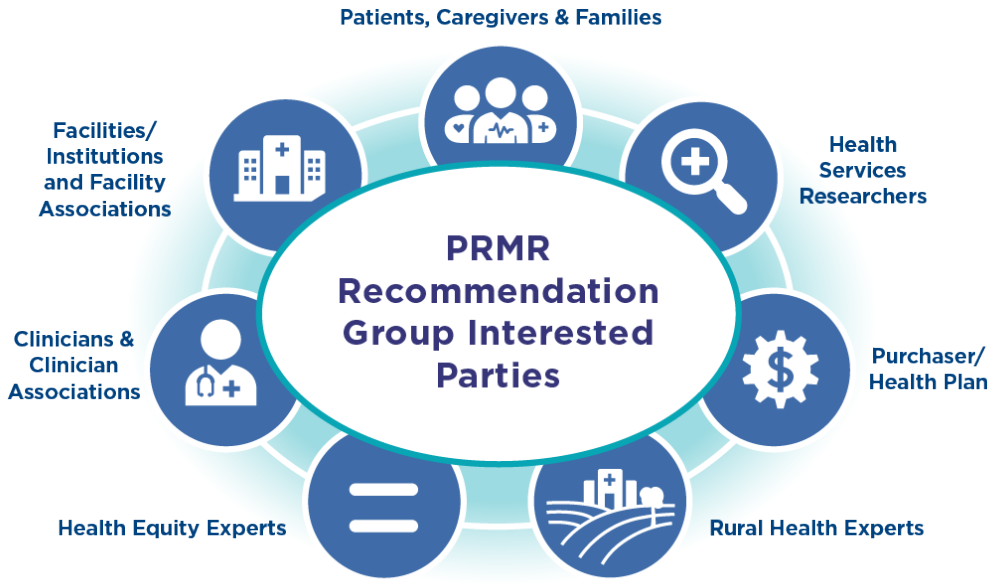

Figure 2. PRMR Interested Parties

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

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

Figure 3. PRMR Committees

These committees included a diverse membership of individuals from traditionally underrepresented groups such as patients/recipients of care and caregivers, people who belong to racial/ethnic minority groups, rural health providers, and experts in health disparities (Figure 4). The goal was to create inclusive committees that balanced experience, expertise, and perspectives. Once appointed, all committee members attested to a Measure declaration of interest (DOI) form at the start of the PRMR review process and were recused from voting on measures potentially affected by a conflict of interest (COI). While a list of committee members is provided in Appendix A, full committee rosters and bios are posted on the PQM website.

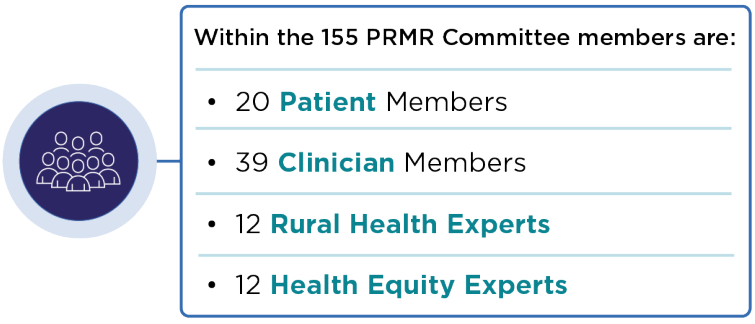

Figure 4. PRMR Committee Members

Each committee includes two groups of reviewers—a Delphi group (hereafter referred to as an Advisory Group) and a nominal group (hereafter referred to as a Recommendation Group)—consistent with the principles of the Novel Hybrid Delphi and Nominal Group (NHDNG) Technique.[3] This technique relies on balancing broad representation with committee and subcommittee discussion to support better policy outcomes. The purpose of this technique is to

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

significantly increase the number of interested parties participating in the consensus building process and to ensure that one voice does not dominate the committee's advice and recommendations. Advisory Group input guides the Recommendation Groups' final consensus recommendations to CMS. Both groups work in tandem to provide meaningful impact on measures at different points of the PRMR process. This process is outlined in detail in the PRMR & MSR Guidebook.

1.3 Public Engagement

Each PRMR cycle begins with the publication of the MUC List. The PRMR process engages a diverse group of interested parties in making consensus-based recommendations regarding the inclusion of considered measures (Figure 5). With the release of the MUC list on December 1, 2023, Battelle held a 21-day call for public comment along with a series of setting-specific listening sessions.

Battelle received a total of 495 written comments from 147 professional organizations and 49 patients/patient representatives. Alongside comments and feedback from the Advisory and Recommendation Groups, insights from public comment helped to identify areas of non-consensus to focus on during the setting-specific Recommendation Group meetings and ensure that the voices of many interested parties were adequately represented in Pre-Rulemaking. Reports from each of the setting-specific committees are linked below:

Hospital Public Comment Summary

PAC/LTC Public Comment Summary

Clinician Public Comment Summary.

1.4 PRMR Preliminary Assessments

To inform and guide committee member review of the MUC list, Battelle staff conducted a preliminary assessment (PA) for each measure. The goal of the PA reports was to provide committee members with a thorough and standardized baseline evaluation of the measures under consideration. PAs functioned as a tool to support members as they examined and discussed measure suitability for the proposed CMS program before and during the Recommendation Group Meetings.

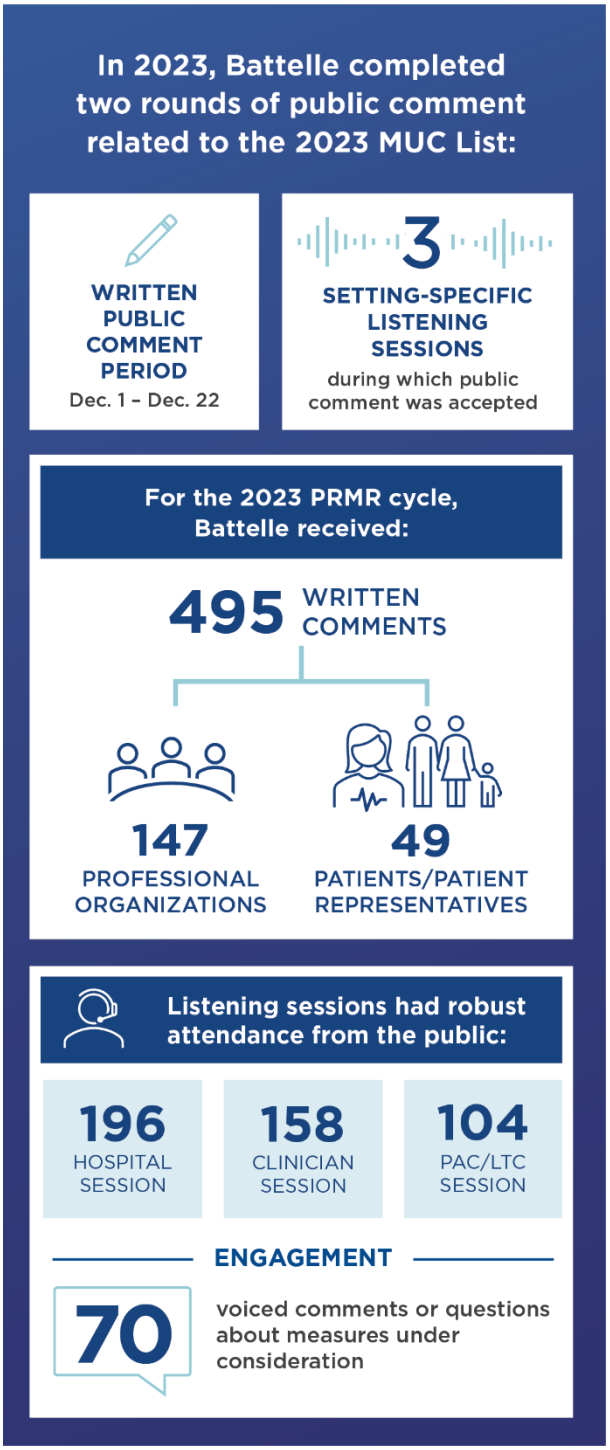

Figure 5. Overview of Public Engagement for PRMR 2023

A team of experienced measure evaluators reviewed submission documentation in the MUC Entry/Review Information Tool (CMS MERIT) system including: CMS MERIT Submission Form, Measure Information Forms, peer-reviewed literature, clinical practice guidelines, validity and reliability testing methods and results, and electronic clinical quality measure (eCQM) feasibility testing information, as needed. This information was compared against evaluation criteria as outlined in the PRMR Guidebook with an emphasis on importance, conformance, feasibility, reliability, validity, and usability (i.e., meaningfulness). Summaries of the findings based on the evaluation criteria that described the likelihood that each measure met the "meaningfulness" requirements for use in a CMS program were created and sent to CMS staff and PRMR committee members and were posted on the PQM website.

1.5 PRMR Round 1 Evaluation

Each PRMR Committee consisted of an Advisory Group and a Recommendation Group. Each group has a specific role and function with respect to evaluating and voting on measures. Due to statutory time constraints, while both the Advisory and Recommendation Group members review and evaluate measures, only the members of Recommendation Groups meet and vote on them. The purpose of this technique is to significantly increase the number of interested parties participating in the consensus-building process and to ensure that one voice does not dominate the committees' decision-making process, while also ensuring that the Recommendation Group is small enough to enable robust and inclusive discussion.

In addition to the PAs, Advisory and Recommendation Group members received guidance on how to provide feedback for each measure as part of Round 1 Evaluations. Committee members were provided with links to measure-specific Microsoft Forms that included 18 questions with a mix of free text, Likert scale ratings, and categorical responses, as well as a detailed instruction guide. These questions focused on the three domains of Meaningfulness, Appropriateness of Scale, and Time to Value Realization as outlined in the PRMR Guidebook. The goals of these Round 1 Evaluations were to assess initial strengths and areas of concern for each measure and generate a starting point for discussion during the Recommendation Group meetings.

Battelle staff compiled and synthesized the information collected from the public comment process, listening sessions, and Round 1 Evaluations to aid in the Recommendation Group meetings. These materials helped identify areas of non-consensus for focus during the meetings.

1.6 Recommendation Group Meetings

In three meetings spanning five days, Battelle convened the Recommendation Group members of the Clinician, Hospital, and PAC/LTC Committees together with CMS leadership and measure developers to evaluate the 42 measures under consideration for 13 CMS programs. Each session was devoted to one of the three settings and was conducted virtually via the Zoom platform. Meeting summaries with detailed discussion notes are posted on the PQM website.

Recusals due to conflicts of interest were again collected and documented during roll call at the start of each day's meeting. Following opening remarks, Battelle facilitators outlined the procedures for discussing and voting on measures. The discussion quorum required the attendance of at least 60% of the Recommendation Group members during roll call at the beginning of the meeting. The voting quorum required at least 80% of active Recommendation Group members who had not recused themselves from the vote. During five meeting days, some members stepped away temporarily, so Battelle collected voting counts for each measure

to ensure quorum was retained. For the determination of a vote outcome, a majority of greater than or equal to 75% of voting members was required. For votes of Recommend and Recommend with Conditions, a combination of 75% of voting members split between those two options would result in a determination of Recommend with Conditions. Voting was conducted using the web platform Voteer and committee members could provide any conditions for recommendation via the Zoom chat or verbally if desired.

At the beginning of each measure discussion, Battelle introduced the measure, then a CMS program lead representative gave an overview of the measure and rationale for inclusion in one or more CMS programs. Battelle provided a summary of the public comments and Round 1 Evaluations and opened the discussion up to Recommendation Group members.

2. Pre-Rulemaking Measure Review (PRMR) Recommendations

2.1 Clinician Committee Measures

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

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

Description: 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.

Summary of Public Comments: 7; Support (1); Support with Considerations (0); Oppose (6)

Measure Review Final Vote: Consensus not reached for inclusion in Part C and D Star Ratings.

Vote Count: Recommend (1) 7%, Recommend with conditions (8) 57%, Do not recommend (5) 36%, Recusals (1).

Discussion Themes	Recommendation Group Member Discussion
Evidence for Measure	• The committee expressed concern for the adequacy of evidence and alignment with current clinical guidelines for opioid prescribing.

Discussion Themes	Recommendation Group Member Discussion
Measure Specifications	• Committee members discussed measure specifications at the plan level and considered sources of potential variation across reporting facilities. • The committee sought clarification around measure exclusions for patients with complex medical needs. Clarification was provided on the exclusion for individuals provided with methadone, Suboxone, and buprenorphine for treatment of substance use disorder. • The committee considered the utility of additional exclusions for patient choice and flexibility for addressing medical needs on case-by-case basis. • The committee considered a suggested inclusion of telehealth services with the caveat that some states do not offer telehealth counseling for SUDs.
Unintended Consequences	• The committee discussed the potential impacts of measure implementation in the program extensively and included unintended consequences such as clinician hesitancy to prescribe as well as poorer quality pain management for patients. • The committee considered a patient perspective concern, that the measure may create harm for patients who need long-term opioids and that the exclusions do not go far enough. CMS expressed that the measure is not intended to guide clinical decision-making for individual patients, and it does not represent a prescribing limit.
Measure Importance/Relevance	• Committee members repeatedly acknowledged the importance of having a measure that assesses opioid prescriptions as a method of harm reduction.
Program Suitability	• Members expressed that this measure fills a gap in opioid safety in the Star Ratings program. • Committee members questioned the impact of pay-for-performance models on measure implementation and impact and considered alternative methods to achieve this goal.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include exploring ways to build in flexibility for patient and provider choice and working with clinicians to improve understanding of potential unintended consequences of this measure on prescribing patterns.

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

2.1.2. MUC2023-179 Initiation and Engagement of Substance Use Disorder Treatment (IET) [National Committee for Quality Assurance (NCQA)]

(Proposed for Part C and D Star Ratings)

Description: The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: (1) 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. (2) Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. The definition of an episode follows the NCQA HEDIS specification for this measure.

Summary of Public Comments: 6; Support (1); Support with Considerations (1); Oppose (4)

Measure Review Final Vote: Consensus not reached for inclusion in Part C and D Star Ratings.

Vote Count: Recommend (2) 14%, Recommend with conditions (8) 57%, Do not recommend (4) 29%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Evidence for Measure	• The committee discussed changes to the measure since the last CBE endorsement in 2018 and how changes to specifications align with overall measure intent.
Data Collection	• The committee cited data collection burden as a challenge to measure feasibility given interoperability barriers with electronic health record (EHR) systems across providers and specialties. However, this concern was not shared by all committee members; one member pointed out that data issues are common and there is nothing specific about this measure that would lead to data issues.
Patient Choice	• Patient representatives on the committee supported the measure, though one patient member suggested that some patients may choose not to initiate treatment for a variety of reasons and that the measure should include flexibility for patient choice without negatively impacting providers.
Measure Specifications	• Committee members reviewed current exclusions for treatment delivered in acute-care settings or same-day care and evaluated implications for the measured population. • The committee considered a suggested inclusion of telehealth services with the caveat that some states do not offer telehealth counseling for SUDs.

Additional Considerations for CMS and Future Directions

Several committee members were interested in seeing this measure again pending the results of CBE review and endorsement. Additional considerations for CMS and measure developers from this discussion include considering how community-level barriers to efficient referral such as data interoperability challenges across providers, limited behavioral health providers within certain regions or socio-economic settings, and patient hesitancy or stigma around engagement in SUD treatment may contribute to delays in treatment engagement within the specified time window for this or future measures.

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

2.1.3 MUC2023-212 Level I Denials Upheld Rate Measure [Federation of American Hospitals (FAH)]

(Proposed for Part C and D Star Ratings)

Description: 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.

Summary of Public Comments: 11; Support (8); Support with Considerations (1); Oppose (2)

Measure Review Final Vote: Recommend inclusion for Part C and D Star Ratings.

Vote Count: Recommend (13) 87%, Recommend with conditions (1) 7%, Do not recommend (1) 7%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance/Relevance	• The committee noted that this measure may reduce burden and improve transparency for patients and beneficiaries. They acknowledged the measure's importance for patients and its potential implications for reducing patient anxiety and frustration related to blanket denials.
Implementation Benefits	• The committee noted several benefits to measured entities and program beneficiaries including that this measure will: ○ Complement the existing Level 2 measure in the Star Ratings program. ○ Reduce frustration of obtaining unnecessary prior authorizations with Medicare Advantage. ○ Reduce delays and alleviate undue patient anxiety. ○ Provide denial information that could help beneficiaries with making future health plan selections.
Scientific Acceptability	• The committee noted the high reliability of this measure during testing. • The committee reviewed measure testing and was satisfied with the validity of the measure.
Program Suitability	• The committee discussed how this measure will complement the existing Level 2 measure in the Star Ratings program. Despite initial concerns about duplicating the existing measure, the committee ultimately concluded that the measure is not duplicative since it addresses is a different step in the coverage determination process than currently measured, and as such it fills a gap in the program.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include exploring other measures that may prevent or reduce delays in coverage for beneficiaries given the robust support for the importance of this measure among committee members.

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

Based on the robust engagement in public comment as well as feedback from Advisory and Recommendation Group members during the Round 1 evaluation of measures, CMS pulled MUC2023-199, Connection to Community Service Provider, and MUC2023-210, Resolution of At Least 1 Health-Related Social Need, from consideration for the Medicare Shared Savings Program prior to the Clinician Recommendation Group meeting. The Hospital Recommendation Group discussed these two measures, as featured later in this report. Thus, no measures were discussed for the Shared Savings Program in this cycle.

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

2.1.4 MUC2023-164 Adult COVID-19 Vaccination Status [CMS]

(Proposed for MIPS – Quality)

Description: 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 Centers for Disease Control and Prevention (CDC) guidelines on current vaccination.

Summary of Public Comments: 8; Support (3); Support with Considerations (1); Oppose (4)

Measure Review Final Vote: Consensus not reached for inclusion of this measure in MIPS.

Vote Count: Recommend (0) 0%, Recommend with conditions (5) 29%, Do not recommend (12) 71%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Barriers to Vaccine Use	• The committee raised concerns about the changing CDC recommendations and varying rates of vaccine hesitancy based on geography, political affiliation, ethnicity, and income.
Implementation and Data Collection Barriers	• The committee had concerns about data collection for vaccines administered through off-site locations such as pharmacies and the potential for system interoperability challenges.
Equity	• A committee member also highlighted the cost of vaccine delivery, which can prevent some primary care clinics from administering the vaccine in their practices. • Viewing this measure through an equity lens, the committee discussed ways in which community-level resources may impact vaccine delivery.

Discussion Themes	Recommendation Group Member Discussion
Clinician Role	• Committee members agreed with CMS that physicians have a significant impact on vaccination rates overall, citing influenza vaccination rates as an example. However, despite strong support for vaccines in general, several committee members did not support this measure for accountability at the physician level, citing a general concern that many factors outside of the clinician's control such as vaccine hesitancy and use of off-site locations like pharmacies for vaccination may limit usability of this measure. • Relatedly, one committee member shared a concern about the measure being at the physician level of analysis instead of at the health plan or system level to capture the community-level picture. They indicated that the measure does not provide useful information for physicians, and expressed their doubts that this measure will "move the quality needle" on COVID vaccination specifically.
Patient Voice	• A patient representative shared their support of the measure to improve patient safety, though they acknowledged the unpopular opinions around the topic of COVID vaccines.
Program Suitability	• A committee member expressed their organization's strong support of this measure within the MIPS program but would like to see another vote if it becomes part of other programs in future. (Note: as is standard in the PRMR process, this measure would be required to come back through the MUC list and PRMR review if it were to be proposed for use in another CMS program.)

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include consideration of the level of attribution for this measure and inclusion in the MIPS measure set. The committee encouraged CMS to explore alternate attribution levels, exclusions or adjustments that reflect the real-world barriers to COVID-19 vaccination, particularly in regions or patient populations with high rates of vaccine hesitancy.

2.1.5 MUC2023-211 Melanoma: Tracking and Evaluation of Recurrence [American Academy of Dermatology (AAD)]

(Proposed for MIPS – Quality)

Description: 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.

Summary of Public Comments: 1; Support (1); Support with Considerations (0); Oppose (0)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (4) 24%, Recommend with conditions (6) 35%, Do not recommend (7) 41%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee reviewed measure testing data and expressed concern about low reliability scores, but acknowledged that, based on the wide confidence interval, reliability might improve with a larger sample size. As such, the committee considered how measure performance may vary across clinicians based on patient volume and implications of this variation for clinician payment. • The committee noted that this measure has been operationalized for two years and would like to see an update to the available reliability and validity testing data.
Measure Intent	• The committee considered whether the measure's specification aligns with its intent. They questioned whether recurrence is the best way to track outcomes or if it would be better to assess the number of people who are getting annual skin exams after melanoma.
Feasibility	• Committee members questioned the feasibility for an excising clinician to collect data and report on the measure, listing several scenarios that might make data collection challenging, for example, the patient moving or a different provider conducting follow-up from the one removing the melanoma.
Conditions for Recommendation	• While the committee ultimately did not reach consensus, members who voted to recommend with conditions were interested in the measure undergoing consensus-based entity endorsement and receiving updated testing data with a larger sample size.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include providing updated and sufficient sample testing data in subsequent reporting or submission of this measure. Additionally, CMS should consider feasibility studies for this measure to ensure that the specifications align with real-world care that may involve multiple specialists across networks.

MIPS Quality Measures Under Review – Chronic Conditions Measures

2.1.6 MUC2023-141 Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy [Society for Immunotherapy of Cancer (SITC)]

(Proposed for MIPS – Quality)

Description: 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.

Summary of Public Comments: 2; Support (1); Support with Considerations (1); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for MIPS.

Vote Count: Recommend (6) 37.5%, Recommend with conditions (10) 62.5%, Do not recommend (0), No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Measure Specifications	• The committee had concerns around small denominator size and ability to compare across populations and clinicians.
Scientific Acceptability	• A committee member noted that while the overall measure reliability was high (greater than 0.9), the interrater reliability was low and wondered why there were disparities in performing this testing. • The committee expressed concern that this measure has not undergone CBE endorsement.
Feasibility and Usability	• Committee members strongly supported the intent of the measure but sought more evidence to support its feasibility and usability across disparate populations.
Importance/Relevance	• The committee expressed support for the goals of this measure to educate providers about testing for this biomarker before therapy is offered and increase access to immune checkpoint inhibitor therapy. • Clinician knowledge around immunotherapy is expanding rapidly and it was noted that, without a measure like this, clinicians might have trouble keeping up with the latest science.
Equity	• The committee considered how this measure may impact disparities in biomarker testing. In a discussion with the developer, the committee learned that while there is anecdotal evidence that immunotherapy is prescribed less frequently in rural areas, differences between urban and rural communities were not explored during testing. • Several committee members voiced support for further exploration of how this measure performs in rural and low-patient volume settings as well as among a diverse patient population stratified by racial/ethnic and income groups.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include expanding testing to consider measure performance disparities across rural and low patient volume settings as well as by patient demographics. CMS is also encouraged to consider undertaking feasibility studies in the future to identify and address barriers to implementation, particularly in rural settings.

2.1.7 MUC2023-161 Appropriate Germline Testing for Ovarian Cancer Patients [American Society of Clinical Oncology (ASCO)]

(Proposed for MIPS – Quality)

Description: 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.

Summary of Public Comments: 3; Support (2); Support with Considerations (1); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for MIPS.

Vote Count: Recommend (6) 38%, Recommend with conditions (9) 56%, Do not recommend (1) 6%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Measure Importance/Relevance	• The committee expressed interest and support in the intent of this measure and found the measure to be important and relevant to MIPS program beneficiaries.
Scientific Acceptability	• The committee discussed measure performance and expressed concern around the small sample size and low validity testing scores. The committee explored the implications of measure performance based on the provided testing scores.
Equity	• The committee was encouraged to think about the impact to patients on a broader scale and to consider equity more in these discussions. • A committee member asked how this measure promotes equity and the committee considered how measures like this might promote equitable care through a more universal testing approach.
Conditions for Recommendation	• The committee expressed interest in this measure undergoing CBE endorsement.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include pursuing endorsement for this measure from a CBE and conducting additional scientific acceptability testing with a larger sample size.

MIPS Quality Measures Under Review – Person-Centered Care Measures

2.1.8 MUC2023-162 Patient-Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer [Purchaser Business Group on Health (PBGH)]

(Proposed for MIPS – Quality)

MUC2023-162 Description: The PRO-PM will assess pain interference following chemotherapy administered with curative intent to adult patients with breast cancer.

Summary of Public Comments: 11; Support (9); Support with Considerations (2); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for MIPS.

Vote Count: Recommend (1) 6%, Recommend with conditions (11) 69%, Do not recommend (4) 25%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Measure Importance/Relevance	• The committee commended the measure's focus on symptom impact, emphasizing the importance of understanding how pain affects an individual beyond numerical scores.
HOPE tool	• The committee noted the Hospice Outcomes and Patient Evaluation (HOPE) tool was not currently ready for implementation. While the HOPE tool has had partial testing that is now complete, the committee requested additional testing or sharing of additional completed testing results. Two committee members underscored the significance of implementing the HOPE tool, suggesting its potential to transform hospices, particularly in monitoring and addressing pain levels. • Committee members debated the value of the measure's reliance on clinician assessment via the HOPE tool rather than incorporating patient perspectives via a patient reported outcomes measure (PROM).
Measure Type	• Committee members expressed concern about this being a process measure, instead of a potentially more impactful outcome measure, encouraging the developer to consider alternatives that were not so "check box" in nature. They asked how this measure compares to CBE #0209, Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment, and the rationale for replacing it with this process measure. In response, the developer noted that MUC2023-162 seeks to adjust how pain is addressed and managed and to overcome limitations from previous measures.
Feasibility	• The committee considered the response rate provided in testing data and explored what evidence on survey refusal and low response rates may mean for implementation in the MIPS program. • The committee noted potential reporting burden due to lack of EHR integration, and the impact of low response rates for facilities with smaller patient volume as elements that might impact feasibility. In discussions, CMS clarified
Scientific Acceptability	• The committee reviewed testing data and expressed interest in seeing more thorough testing at the individual clinician level in a large sample. Due to this concern, the committee considered recommending with the condition that it only be implemented at the clinician group level until further testing can be conducted.
Potential for Bias	• The committee noted that, unlike patient-reported outcome measures where the information comes directly from the patient, this measure derives information from the clinicians providing care, which means clinicians make determinations based on their perceived impact of the pain the patient is experiencing. The committee weighed this concern against the feasibility advantages cited above.

Discussion Themes	Recommendation Group Member Discussion
Conditions for Recommendation	• Committee members encouraged CMS to consider implementation at the clinician group level only until further testing and improvements can be made at the individual clinician level.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include exploring how this measure, and related measure, MUC2023-190, may evolve in the MIPS measure set in the future. There was also robust interest in having more information about the HOPE tool and that tool undergoing scientific acceptability testing. The committee encouraged CMS to implement both measures at the clinician group level only until further testing can be conducted at the individual clinician level, with special consideration for how this measure performs in low volume settings.

2.1.9 MUC2023-190 Patient-Reported Fatigue Following Chemotherapy among Adults with Breast Cancer [Purchaser Business Group on Health (PBGH)]

MUC2023-190 Description: The PRO-PM will assess fatigue following chemotherapy administered with curative intent to adult patients with breast cancer.

Summary of Public Comments: 13; Support (11); Support with Considerations (1); Oppose (1)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (0), Recommend with conditions (11) 69%, Do not recommend (5) 31%, No Recusals.

Combined Discussion: Measures MUC2023-162 and MUC2023-190 were discussed as a group. See discussion table under MUC2023-162.

MIPS Cost Measures Under Review – Affordability and Efficiency Measures

2.1.10 MUC2023-201 Cataract Removal with Intraocular Lens (IOL) Implantation [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 6; Support (0); Support with Considerations (2); Oppose (4)

Measure Review Final Vote: Recommend this measure with conditions for MIPS.

Vote Count: Recommend (9) 56%, Recommend with conditions (5) 31%, Do not recommend (2) 13%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Rural Performance and Equity	• The committee discussed how patient volume may influence measure performance for this and other cost measures, with consideration given to rural and low patient volume settings. The committee examined performance across factors such as patient volume, urban vs rural settings, and populations with different social determinants of health. • The committee also reviewed concerns about the stability of this measure year over year, especially for small clinics. • A committee member noted that MIPS adjustments may not affect practice patterns because the adjustments are small.
Unintended Consequences	• A committee member asked the group to consider whether, if implemented, this measure will disincentivize providers from performing the procedure and explore other potential unintended consequences. In response, the developer re-emphasized that they do not see variation in performance based on the volume of procedures performed. Since the original measure was implemented in 2019, they have not seen the overall number of procedures performed change over time.
Cost Measures	• A committee member noted that in other MIPS cost measures, variation exists between dual (Medicare and Medicaid) enrollees and non-dual enrollees. Much of this variation comes from Part B medications and prescribing around chronic conditions. Clinicians do not have the control to mitigate these costs if they are treating more complex patients. This was a consideration across the cost measures (MUC2023-201-209) discussed during this session.

Additional Considerations for CMS and Future Directions

While the committee did not provide a formal list of conditions, there was interest in more examination of how implementation of cost measures in general may impact patient outcomes. CMS and the developer should consider further examination of measure performance across facilities with small and large patient volumes as well as monitoring for any unintended consequences.

2.1.11 MUC2023-205 Inpatient (IP) Percutaneous Coronary Intervention (PCI) [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 2; Support (0); Support with Considerations (1); Oppose (1)

Measure Review Final Vote: Recommend this measure with conditions for MIPS.

Vote Count: Recommend (8) 50%, Recommend with conditions (4) 25%, Do not recommend (4) 25%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee discussed concerns around the reliability of this measure and implications of measure implementation, given the reliability testing results at the individual and clinician group level. They debated whether performance was acceptable and aligned with MIPS program goals. (Note: MIPS has a reliability threshold of 0.4, though some committee members advocated that measures should be held to a higher standard of at least 0.75.)
Measure Specification	• The committee considered whether there are significant differences in cardiac level of care between PCI providers and non-PCI providers and the implications for excluding transfer cases. • Committee members examined measure exclusions and considered impact on measure performance and impact to clinicians.
Conditions for Recommendation	• The committee encouraged the measure to receive CBE endorsement and undergo additional testing to gather performance data over a longer period.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS, Battelle, and the measure developers from this discussion include reviewing the 0.4 reliability threshold for the MIPS measure set and exploring ways to center discussions of reliability in real-world examples for additional clarity.

2.1.12 MUC2023-203 Chronic Kidney Disease [CMS]

(Proposed for MIPS – Cost)

Description: 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 CKD. This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a CKD episode.

Summary of Public Comments: 6; Support (0); Support with Considerations (2); Oppose (4)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (1) 7%, Recommend with conditions (8) 53%, Do not recommend (6) 40%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance/Relevance	• The committee recognized the importance of the measure to patients and providers as a means of improving affordability.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee discussed the reliability of the measure at the individual and group clinician level and evaluated potential implications of implementing the measure as currently specified.
Risk Adjustment Variation	• The committee considered the diagnosis-specific billing codes utilized in the risk-adjustment model and discussed how variation in use of ICD-10 codes may result in unplanned variation in risk-adjustment model performance and suitability.
Equity	• The committee noted that geographic or economic factors may make accessing appropriate kidney care difficult for some populations, potentially creating variation in measure performance due to non-clinician attributable factors. • Committee members examined evidence on disparities in performance and suitability of algorithms for placing patients on the kidney care transplant lists; it was unclear how patients impacted by outdated algorithms might be impacted by this measure, or how their inclusion might impact the data for this measure.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include examining equity issues for this measure and exploring inclusion of additional factors into risk adjustment models.

2.1.13 MUC2023-204 End-Stage Renal Disease [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 6; Support (0); Support with Considerations (3); Oppose (3)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (3) 20%, Recommend with conditions (3) 20%, Do not recommend (9) 60%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The scores from reliability testing were a source of concern, with committee members discussing the real-world interpretation of the scores in the context of the MIPS program.
Risk Adjustment	• The committee considered concerns about the appropriateness of the risk-adjustment model, outlining examples of groups that were included and walking through how that adjustment may impact measure performance.

Discussion Themes	Recommendation Group Member Discussion
Equity	• Patients and non-patient committee members were concerned about the historical use of an algorithm that systematically underestimated risk of CKD severity and eligibility for transplant among Black patients, and how patients impacted by that algorithm might be affected by the implementation of this measure.

Additional Considerations for CMS and Future Directions

Additional considerations for CMS and measure developers from this discussion include pursuing endorsement for this measure from a CBE.

2.1.14 MUC2023-206 Kidney Transplant Management [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 5; Support (0); Support with Considerations (3); Oppose (2)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (2) 14%, Recommend with conditions (4) 29%, Do not recommend (8) 57%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• The group discussed the measure's focus on the maintenance phase of treatment, 90 days following transplantation, to assure appropriate care management.
Scientific Acceptability	• Committee members expressed concerns they did not have sufficient information to assess the measure's scientific acceptability. • The committee raised concerns about the required case minimum, noting that reliability increased based on the number of patients included.

Additional Considerations for CMS and Future Directions

The committee provided an additional consideration for CMS and measure developers to pursue endorsement for this measure from a CBE. Committee members were uncomfortable making recommendations without this assurance about the scientific merits of the measure.

2.1.15 MUC2023-207 Prostate Cancer [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 4; Support (1); Support with Considerations (1); Oppose (0)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (2) 14%, Recommend with conditions (2) 14%, Do not recommend (10) 71%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee was concerned that the measure does not differentiate between high-risk localized or locally advanced patients and low-to-intermediate risk localized patients. • The measure was developed using a consensus-based process that included national field testing. Results show opportunities for improvement based on reduced adverse events. • It is not clear adherence to evidence-based treatment guidelines would improve performance on the measure.
Unintended Consequences	• The committee discussed concerns the measure might incentivize providers to prioritize patients expected to have better outcomes.
Risk Adjustment	• The measure developer asserted that concerns about the impact of stage, race, and age were addressed through risk adjustment.
Equity	• The committee noted that Black patients are disproportionately affected by prostate cancer and that episodic care and long-term outcomes are influenced by many social determinants of health. They are concerned that clinicians or clinician groups with larger volumes of Black patients may have lower performance on this measure.

Additional Considerations for CMS and Future Directions

An additional consideration for CMS and measure developers is the committee's desire for the risk-adjustment model to account for cancer stage. While the measure developer explained that procedure is used as a proxy for stage, committee members believed they did not have enough information to evaluate the validity of the measure.

2.1.16 MUC2023-208 Respiratory Infection Hospitalization [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 4; Support (0); Support with Considerations (2); Oppose (2)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in MIPS.

Vote Count: Recommend (1) 7%, Recommend with conditions (5) 33%, Do not recommend (9) 60%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
History	• A previous version of this measure was removed from MIPS for the 2024 performance period due to coding changes. The current version has been adjusted to reflect those coding changes. • Although the measure has been used in MIPS, there have been delays in receiving and processing data due to COVID-19.
Scientific Acceptability	• The committee raised concerns that data from 2021 were used for measure development and 2022 data were used for testing, especially considering how the COVID-19 public health emergency impacted data in 2020 and 2021. • There were also concerns about the case minimum for the measure.
Exclusions and Risk Adjustment	• When asked for clarification on whether the measure had been evaluated for regional differences in performance due to emergencies like hurricanes or wildfires, the measure developer clarified that physicians may be excluded due to regional emergencies. • The measure is not adjusted for specialty but is adjusted using Medicare severity-diagnosis-related groups (MS-DRGs) to account for condition and complexity.
Unintended Consequences	• The committee noted that the measure may be "gameable" due to variation in diagnosis codes and how visits are handled in routine office visit vs. urgent care.

Additional Considerations for CMS and Future Directions

The committee provided an additional consideration for CMS and measure developers: it would be helpful to provide information on the previously implemented version of this measure to help inform decision making.

2.1.17 MUC2023-209 Rheumatoid Arthritis [CMS]

(Proposed for MIPS – Cost)

Description: 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.

Summary of Public Comments: 6; Support (0); Support with Considerations (2); Oppose (4)

Measure Review Final Vote: Do not recommend this measure for MIPS.

Vote Count: Recommend (1) 6%, Recommend with conditions (3) 19%, Do not recommend (12) 75%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee believed this measure shares the same issues as other cost measures under review (e.g., concerns around how cost measures impact patient outcomes). • Public comments suggest the measure is not accepted by large rheumatology associations. The measure developer ascribed this to a general resistance to cost measures.
Importance	• The committee acknowledged that there are wide differences in costs to manage rheumatoid arthritis by provider group.
Specifications	• The measure is stratified by Part D enrollment to account for differences in drugs prescribed.
Similar Measures	• This measure will be used alongside an additional global cost measure. It is intended to provide a specific cost measure for rheumatoid arthritis as required by MIPS.
Conditions for Recommendation	• The measure should undergo endorsement review and receive CBE endorsement.

Additional Considerations for CMS and Future Directions

The committee recommended that CMS and measure developers provide stronger justification of cost measures. While the measure developer explained that 50% of measures in the MIPS program must be cost measures, the committee did not find that to be a compelling reason for this measure to move forward.

2.2 Hospital Committee Measures

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

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

(Proposed for Hospital Readmissions Reduction Program)

Description: 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 is 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 aged 65 years or older, enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals.

Summary of Public Comments: 8; Support (3); Support with Considerations (1); Oppose (4)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the Hospital Readmissions Reduction Program.

Vote Count: Recommend (11) 58%, Recommend with conditions (3) 16%, Do not recommend (5) 26%, No Recusals.

Combined Discussion: MUC2023-117, MUC2023-119, and MUC2023-120 were discussed together. The discussion themes identified below apply to all three measures, unless otherwise specified.

Discussion Themes	Recommendation Group Member Discussion
Measure Specifications	• Committee members inquired about the choice of 30 days as the post-discharge window for identifying unplanned returns to care associated with the hospitalization. The developer explained that using a 30-day window was supported by their analysis and the literature. • The committee wanted to know why the EDAC measures addressed only three conditions; CMS explained that other conditions would be addressed in future measures.
Measure Implementation	• The committee expressed concern about potential "double counting" readmissions if both the EDAC and current HRRP readmission measures were to be collected at the same time; CMS clarified that the intent would be to remove overlapping measures.
Unintended Consequences	• Patients might be pressured to accept hospice to prevent their return to the ED.
Equity	• Regarding possible inappropriate hospice referrals, the committee was concerned that some populations would be more likely to receive hospice referrals than others and urged the developer to account for this possibility in the specifications. • The committee inquired whether the proposed measures would utilize the HRRP's peer-grouping methodology (i.e., stratification by dual eligibility) and whether other social risk factors could be applied; CMS explained that dual eligibility has been shown to be a good proxy for a range of risk factors, but they were open to other stratification approaches in the future.
Conditions for Recommendation:	• Monitor for the possible unintended consequence of inappropriate referrals to hospice (MUC2023-119 & 120). • Conduct further testing to evaluate health equity (MUC2023-119 & 120).

Additional Considerations for CMS and Future Directions

In response to the committee's questions, CMS indicated there are plans to develop EDAC measures addressing additional conditions currently covered by HRRP readmission measures, and they also confirmed that they planned for the respective HRRP readmission measures to be replaced by the EDAC measures currently being proposed.

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

(Proposed for Hospital Readmissions Reduction Program)

Description: 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. Unplanned readmissions

are defined using the planned readmission algorithm (PRA). ED visit is 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 aged 65 years or older, enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals.

Summary of Public Comments: 5; Support (2); Support with Considerations (0); Oppose (3)

Measure Review Final Vote: Recommend this measure with conditions for the Hospital Readmissions Reduction Program.

Vote Count: Recommend (11) 58%, Recommend with conditions (4) 21%, Do not recommend (4) 21%, No Recusals.

Combined Discussion: MUC2023-117, MUC2023-119, and MUC2023-120 were discussed together. The themes identified apply to all three measures, unless otherwise specified. See discussion themes and future directions summarized for MUC2023-117.

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

(Proposed for Hospital Readmissions Reduction Program)

Description: 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 is 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 aged 65 years or older, enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals.

Summary of Public Comments: 6; Support (2); Support with Considerations (0); Oppose (4)

Measure Review Final Vote: Recommend this measure with conditions for the Hospital Readmissions Reduction Program.

Vote Count: Recommend (11) 58%, Recommend with conditions (4) 21%, Do not recommend (4) 21%, No Recusals.

Combined Discussion: MUC2023-117, MUC2023-119, and MUC2023-120 were discussed together. The themes identified apply to all three measures, unless otherwise specified. See discussion themes and future directions summarized for MUC2023-117.

Hospital Safety Measures

2.2.4 MUC2023-188 Patient Safety Structural Measure [CMS]

(Proposed for Hospital Inpatient Quality Reporting Program and PPS-Exempt Cancer Hospital Quality Reporting Program)

Description: The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety. The Patient Safety Structural Measure comprises five domains, each containing multiple statements that aim to capture the most salient structural and cultural elements of patient safety. This measure is designed to discern hospitals that practice a systems-based approach to safety,

as demonstrated by leaders who prioritize and champion safety; a diverse group of patients and families meaningfully engaged as partners in safety; and practices indicating a culture of safety and continuous learning and improvement.

Summary of Public Comments: 97; Support (81); Support with Considerations (10); Oppose (6)

Measure Review Final Vote:

- Recommend with conditions for inclusion in the Hospital Inpatient Quality Reporting Program.
- Recommend with conditions for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting Program.

Vote Count:

- Hospital Inpatient Quality Reporting Program: Recommend (8) 50%, Recommend with conditions (5) 31%, Do not recommend (3), Recusals (3) 19%.
- PPS-Exempt Cancer Hospital Quality Reporting Program: Recommend (9) 56%, Recommend with conditions (4) 25%, Do not recommend (3) 19%, Recusals (3).

Discussion Themes	Recommendation Group Member Discussion
Validity	• Committee members were concerned that domains included in this structural measure were difficult to assess objectively, and as a result entities might be able to attest to them without fulfilling the measure's intent; CMS explained that a detailed guidance document outlines specific activities in each domain and provides instructions.
Measure Scope	• Committee members discussed the breadth of the domains and activities, and whether a narrower scope for some would be beneficial; CMS explained that collecting data on the measure would help narrow the measure's scope over time.
Reporting	• Committee members expressed concern about the reporting of a single score rather than domain-specific scoring, as it would limit facilities' ability to use measure information to improve performance. Developers clarified that while the measure is reported as a single score, entities will receive data on their performance in individual domains to assist with quality improvement efforts. CMS will consider also making data on individual domains available via Care Compare.
Conditions for Recommendation	• Publication of an implementation guide that clearly documents how safety domains are to be measured. • Collect data to narrow the scope before using the measure in programs.

Additional Considerations for CMS and Future Directions

The committee recommended CMS and measure developers consider including the implementation guide, intended to guide organizations on how to score each element, which is currently in process. In addition, CMS will consider making individual attestation scores available to the public.

2.2.5 MUC2023-048 Hospital Harm - Falls with Injury [CMS]

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

Description: 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.

Summary of Public Comments: 11; Support (1); Support with Considerations (6); Oppose (4)

Measure Review Final Vote:

- Recommend with conditions for inclusion in the Hospital Inpatient Quality Reporting Program.
- Recommend with conditions for inclusion in Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAH).

Vote Count:

- Hospital Inpatient Quality Reporting Program: Recommend (12) 63%, Recommend with conditions (6) 32%, Do not recommend (1) 5%, No Recusals.
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs): Recommend (12) 63%, Recommend with conditions (7) 37%, Do not recommend (0), No Recusals.

Combined Discussion: MUC2023-048 and MUC2023-050 were discussed together. The discussion themes identified below apply to both measures, unless otherwise specified.

Discussion Themes	Recommendation Group Member Discussion
Unintended Consequences	• Committee members urged anticipation and monitoring of unintended consequences such as increased use of patient restraints to prevent falls or avoidance of life-saving procedures that may increase risk of respiratory failure, including potential inequities in such consequences.
Similar Measures	• When asked about the overlap of MUC2023-050 with existing measures, the developer clarified that the proposed measure differs from Patient Safety Indicator 11 (PSI 11; Postoperative Respiratory Failure Rate) by addressing a different population and using EHR data rather than claims data. • Committee members emphasized the desirability of harmonizing MUC2023-048 (Falls with Injury) with other falls measures.
Measure Specifications	• Committee members requested additional details about how numerator events were defined, including the specific ICD-10 codes used to identify falls and how mechanical ventilation was specified.
Measure Testing	• The committee raised a concern about the small number of testing sites used. The developer explained that their testing, though limited, demonstrated variation in performance and room for improvement.

Discussion Themes	Recommendation Group Member Discussion
Conditions for Recommendation	• Committee members recommended CBE endorsement. • Monitoring of unintended consequences, such as use of patient restraints and avoidance of life saving procedures, in addition to potential inequities in their use.

Additional Considerations for CMS and Future Directions

The committee did not discuss additional considerations or future directions beyond the committee's conditions for recommendation.

2.2.6 MUC2023-050 Hospital Harm - Postoperative Respiratory Failure [CMS]

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

Description: 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).

Summary of Public Comments: 8; Support (3); Support with Considerations (2); Oppose (3)

Measure Review Final Vote:

- Recommend with conditions for inclusion in the Hospital Inpatient Quality Reporting Program.
- Recommend with conditions for inclusion in the Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs).

Vote Count:

- Hospital Inpatient Quality Reporting Program: Recommend (12) 63%, Recommend with conditions (5) 26%, Do not recommend (2) 11%, No Recusals.
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs): Recommend (12) 63%, Recommend with conditions (5) 26%, Do not recommend (2) 11%, No Recusals.

Combined Discussion: MUC2023-048 and MUC2023-050 were discussed together. The themes identified apply to both measures, unless otherwise specified. See discussion themes and future directions summarized for MUC2023-048.

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

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: 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.

Summary of Public Comments: 11; Support (1); Support with Considerations (4); Oppose (6)

Measure Review Final Vote: Recommend this measure with conditions for the Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (11) 61%, Recommend with conditions (5) 28%, Do not recommend (2) 11%, Recusals (1).

Discussion Themes	Recommendation Group Member Discussion
Improvement on Existing Measure	• Measure would replace PSI 04 (Death Rate among Surgical Inpatients with Serious Treatable Complications). • The measure levels the playing field between urban and rural hospitals by attributing deaths to the hospital where the index procedure was performed rather than to the hospital where the death occurred.
Unintended Consequences	• Committee members raised the issue of potential gaming and whether patients might be pressured to accept hospice or to sign a do-not-resuscitate (DNR) order. The measure developer acknowledged that DNR status on admission is not always available in claims data.
Measure Specifications	• When questioned about the choice of 30 days for counting attributable deaths, the developer explained that a hazard analysis was used to identify the most likely time frame when deaths could be attributed to the index procedure and not another cause.
Scientific Acceptability	• The committee sought additional information about the development of the measure. They learned from the developer that, to improve reliability, developers used a 2-year reporting period and a minimum denominator of 25 cases, which aligns with other CMS mortality measures. • Risk models established that race/ethnicity was not an independent risk factor after controlling for clinical risk factors, and the measure is therefore not stratified.
Conditions for Recommendation	• The committee recommended CBE endorsement. • Collection of data to evaluate possible unintended consequences, such as hospitals encouraging patients to sign a DNR order or to enter hospice.

Additional Considerations for CMS and Future Directions

The committee did not discuss additional considerations or future directions beyond the committee's conditions for recommendation.

Standardized Infection Ratio Safety Measures

2.2.8 MUC2023-219 Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations [Centers for Disease Control and Prevention (CDC)]

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: 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.

Summary of Public Comments: 4; Support (2); Support with Considerations (2); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (14) 14%, Recommend with conditions (4) 21%, Do not recommend (1) 5%, No Recusals.

Combined Discussion: MUC2023-219 and MUC2023-220 were discussed together. The discussion themes identified below apply to both measures, unless otherwise specified.

Discussion Themes	Recommendation Group Member Discussion
Relationship to Existing Measures	• The proposed measures are intended for reporting in oncology settings specifically and complement two other measures for CLABSI and Catheter-Associated Urinary Tract Infection (CAUTI), which are reported in acute-care units other than oncology units. • Proposed measures will not affect existing standardized infection ratio (SIR) reporting.
Measure Importance	• The committee was overall very supportive of the general CLABSI and CAUTI measures used in acute care units, and strongly supported the effort to expand their use into oncology units.
Unintended Consequences	• Committee members discussed possible unintended consequences, such as blood cultures not being ordered to avoid raising the CLABSI rate.
Scientific Acceptability	• Committee members commented on low reliability of the measures for some entities, and CDC explained that lower reliability scores when testing in oncology units were expected compared to SIR reporting overall. • Committee members suggested the measures account for dialysis patients with catheters in stratification, and to evaluate different types of oncology units, e.g., hematology-oncology vs. solid organ.
Reporting	• Committee members asked about the ability of smaller or rural facilities with lower case volumes to report the measures, and whether the reporting period could be expanded to improve reliability rates. CMS clarified that cancer-exempt hospitals use the same set of measures, and that hospitals without oncology units simply would not report on the measures.
Conditions for Recommendation	• Measures should evaluate data by oncology unit type. • Increase the reporting time to allow smaller rural facilities to report the measures.

Additional Considerations for CMS and Future Directions

The committee provided CMS and measure developers with the additional considerations of investigating possible unintended consequences and considering stratification for dialysis patients with catheters.

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

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: 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.

Summary of Public Comments: 4; Support (2); Support with Considerations (2); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (14) 74%, Recommend with conditions (4) 21%, Do not recommend (2) 5%, No Recusals.

Combined Discussion: MUC2023-219 and MUC2023-220 were discussed together. The themes identified apply to both measures, unless otherwise specified. See discussion themes and future directions summarized for MUC2023-219.

Patient Experience and Patient Reported Measures

2.2.10 MUC2023-138 ESRD Dialysis Patient Life Goals Survey (PaLS) [CMS]

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

Description: 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 have 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.

Summary of Public Comments: 14; Support (2); Support with Considerations (3); Oppose (9)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the End-Stage Renal Disease (ESRD) Quality Incentive Program.

Vote Count: Recommend (2) 11%, Recommend with conditions (10) 56%, Do not recommend (6) 33%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Measure Specification	• Committee members discussed the measure scoring methodology, which requires a response to only one of six scored survey items (out of eight items total) for the score to be calculated, expressing concern that a response to only one item might not effectively capture the patient perspective or support quality improvement efforts.
Survey Language and Equity	• Committee members discussed the survey's language options in detail. The developer explained that they plan to translate the survey into Spanish. Some committee members raised the potential equity issues if the instrument is available only in limited languages and encouraged its translation into additional languages beyond English and Spanish.
Patient Goals	• Committee members overall supported the intent of the measure, indicating that more data on patients' perspectives were needed in this area. • One committee member expressed that a challenge with dialysis patients can be that their goals may not align with clinical requirements and that patient education should accompany the survey. • In recognition of the public comment submitted that questioned whether the selected life goals accurately reflected priorities for patients, the committee heard from patient members about where the measure fit with goals and where it may potentially be misaligned with patient goals.
Burden	• One committee member mentioned survey burden as a problem for dialysis patients, while another committee member felt that the benefits of the measure would outweigh the potential burden.

Additional Considerations for CMS and Future Directions

The committee provided additional considerations for CMS and measure developers, which were to submit the measure for CBE endorsement and test the measure at the facility level. The committee also discussed the developer's plans to translate the survey instrument into Spanish, and eventually make the instrument available in languages in addition to English and Spanish.

2.2.11 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)

(Proposed for Hospital Outpatient Quality Reporting Program)

Description: 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 assigned to the hospital's ability to communicate clear, personalized discharge instructions using a nine-item survey. Patients are asked to answer a brief electronic survey, consisting of three domains: applicability, medications, and daily activities. The survey was designed for patients to receive the survey within 2 to 7 days post-procedure. Surveys with fewer than five questions answered are considered incomplete

and are removed from facility score calculation. Individual scores are calculated using a top-box approach, which accounts for the percentage of the total number of items where respondents selected the most favorable responses out of the total number of items respondents deemed applicable to their surgery/procedure.

Summary of Public Comments: 2; Support (2); Support with Considerations (0); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for the Hospital Outpatient Quality Reporting Program.

Vote Count: Recommend (9) 50%, Recommend with conditions (5) 28%, Do not recommend (4) 22%, Recusals (1).

Discussion Themes	Recommendation Group Member Discussion
Importance	• Patient committee members supported the measure, agreeing that promoting detailed discharge instructions should be a priority, with one stating they would prioritize responding to such a survey.
Survey Administration	• To improve response rates, one committee member suggested that the survey be administered at the time of the procedure instead of waiting 2 to 7 days. • Committee members discussed language and survey mode options, and the concern that patients might receive multiple surveys. CMS clarified the survey is available in English and Spanish and can be administered on paper or electronically. The developer explained that during testing, the measure survey was not administered to patients receiving the Outpatient and Ambulatory Surgery (OAS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
Integration with CAHPS	• Committee members asked about possible integration of the survey items with CAHPS to help feasibility and improve alignment across similar survey items. CMS explained that the review timeline for CAHPS would not allow for integration of the proposed measure at this time, but this was a future possibility.
Expansion to ASCs	• One committee member observed that discharge instructions are not addressed in CAHPS and felt it would be beneficial for the measure to be tested in ambulatory surgery centers (ASCs) and expanded to the ASCQR.
Risk Adjustment	• The developer explained that statistical testing performed did not demonstrate an empirical need for risk adjustment and that because the measure's intent is for patients to receive discharge instructions that address their specific needs, risk adjustment would not be appropriate.
Conditions for Recommendation	• The survey should be administered at the time of the procedure to avoid conflict with collection of pain and function outcomes measures.

Additional Considerations for CMS and Future Directions

The committee provided additional considerations for CMS and measure developers including the possibility for integration or alignment of survey items with OAS CAHPS and possible testing in ASCs.

Age Friendly Hospital Measure

2.2.12 MUC2023-196 Age Friendly Hospital Measure [American College of Surgeons (ACS), American College of Emergency Physicians (ACEP), and Institute for Healthcare Improvement (IHI)]

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: This programmatic measure assesses hospital commitment to improving care for patients 65 years of age or older receiving services in the hospital, operating room, or emergency department. The clinical measure consists of five domains, each of which addresses an essential aspect of clinical care for the older patient. The number of eligible domains (5) serves as the denominator. The verifiable attestation is met when all domain components are met for the majority of patients ≥ 65 years. The numerator is the number of domains for which a hospital meets all attestations.

Summary of Public Comments: 25; Support (16); Support with Considerations (5); Oppose (4)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (14) 74%, Recommend with conditions (0), Do not recommend (5) 26%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Measure Importance/Relevance	• The committee supported the measure's intent, discussing the value of this measure in signaling to hospital leadership that caring for a vulnerable elderly population should drive hospital priorities.
Measure Specification	• The committee discussed concerns with several aspects of the measure, including the generality of most domains (e.g., they are not specific to elderly patients; domains are not tightly scoped) and discussed implications of the broad domains for patients and measured entities (see Usability below). • The committee viewed the measure title as respectful to older adult patients and encouraged similarly neutral language in future measures.
Usability	• The committee also discussed the value of reporting performance scores separately in addition to combining the domains into one score to best enable facilities to identify gaps in performance and improve over time. • The committee noted that the broad domains of this measure provide flexibility in use, which has the potential to serve as "roadmaps" that hospitals can follow to improve on those metrics as processes change.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee examined testing data provided and discussed the validity of the measure domains, expressing some concern that the broad scope of the domains may limit validity.

Additional Considerations for CMS and Future Directions

Based on committee discussion, CMS and developers should review ways in which this measure offers both a measurement tool and a potential "roadmap" with flexibility for use meeting facility-specific goals. The committee encouraged developers to explore ways to bring this "roadmap" ability to other, newer measurement areas where facilities are still growing their processes and fine-tuning their equity lens for improvement.

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

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

(Proposed for Inpatient Psychiatric Facility Quality Reporting Program)

Description: 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.

Summary of Public Comments: 2; Support (1); Support with Considerations (1); Oppose (0)

Measure Review Final Vote: Recommend this measure with conditions for the Inpatient Psychiatric Facility Quality Reporting Program.

Vote Count: Recommend (11) 58%, Recommend with conditions (7) 37%, Do not recommend (1) 5%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• The committee considered that siloed medical and psychiatric care can contribute to patients in inpatient psychiatric facilities not receiving adequate medical care.
Scientific Acceptability	• The committee expressed concerns about the ability of Medicare claims to capture patients aged 18 to 64 years. The measure developer explained that 56% of patients in their Medicare claims data set were 18 to 64 years old, which allayed that concern. • Integrated systems can influence their performance by increasing collaboration with primary care and intensive outpatient programs.

Discussion Themes	Recommendation Group Member Discussion
Unintended Consequences	• The measure developer explained their literature review found no evidence of potential unintended consequences. • There is already an incentive for psychiatric units not to admit patients with medical conditions. • The measure would not disincentivize medical care during treatment because transfers and ED visits within 72 hours of discharge are excluded.
Conditions for Recommendation	• The measure should be endorsed by a CBE prior to implementation.

Additional Considerations for CMS and Future Directions

The committee asked CMS and measure developers if 72-hour transfers to the ED are included in the measure. The measure developer later confirmed that 72-hour transfers to the ED are indeed included in the measure.

Patient Experience and Patient Reported Measures

2.2.14 MUC2023-146 – 149 Hospital Patient Experience of Care [CMS]

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, and PPS-Exempt Cancer Hospital Quality Reporting Program)

Description:

Sub-measure 1: The Care Coordination – Hospital Patient Experience of Care sub-measure is a newly developed sub-measure to be added to the HCAHPS Survey measure and is composed of the 3 following new survey questions, which are also referred to as survey items:

- During this hospital stay, how often were doctors, nurses, and other hospital staff informed and up to date about your care?
- During this hospital stay, how often did doctors, nurses, and other hospital staff work well together to care for you?
- Did doctors, nurses, or other hospital staff work with you and your family or caregiver in making plans for your care after you left the hospital?

Sub-measure 2: The Restfulness of Hospital Environment – Hospital Patient Experience sub-measure is a newly developed sub-measure to be added to the HCAHPS Survey measure and is composed of the 3 following survey questions (2 new items and one individual item on current survey), which are also referred to as survey items:

- During this hospital stay, how often were you able to get the rest you needed?

- During this hospital stay, did doctors, nurses, and other hospital staff help you to rest and recover?
- During this hospital stay, how often was the area around your room quiet at night?

Sub-measure 3: The Responsiveness of Hospital Staff – Hospital Patient Experience of Care sub-measure is a revised sub-measure in the HCAHPS Survey measure and is composed of the 2 following survey questions (1 new item and one item on the current survey), which are also referred to as survey items:

- During this hospital stay, when you asked for help right away, how often did you get help as soon as you needed it?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

Sub-measure 4: The Information About Symptoms – Hospital Patient Experience of Care Standalone Item sub-measure is a new sub-measure in the HCAHPS Survey measure and consists of one new item:

- During this hospital stay, did doctors, nurses, or other hospital staff give your family or caregiver enough information about what symptoms or health problems to watch for after you left the hospital?

Summary of Public Comments: 24; Support (8); Support with Considerations (12); Oppose (4)

Measure Review Final Vote:

- Recommend with conditions for inclusion in the Hospital Inpatient Quality Reporting Program.
- Recommend with conditions for inclusion in the Hospital Value-Based Purchasing Program.
- Recommend with conditions for inclusion in the PPS-Exempt Cancer Hospital Quality Reporting Program.

Vote Count:

- Hospital Inpatient Quality Reporting Program: Recommend (9) 47%, Recommend with conditions (8) 42%, Do not recommend (2) 11%, No Recusals.
- Hospital Value-Based Purchasing Program: Recommend (10) 53%, Recommend with conditions (7) 37%, Do not recommend (2) 10%, No Recusals.
- PPS-Exempt Cancer Hospital Quality Reporting Program: Recommend (11) 58%, Recommend with conditions (6) 32%, Do not recommend (2) 10%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• Committee members representing patient perspectives emphasized the importance of having a quiet and restful environment. • Committee members representing patient perspectives appreciated the distinction between items about providing information to patients and providing information to caregivers.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The measures may not be ideal for high-volume, high-acuity settings like emergency departments. • The committee requested additional data on survey response rates for longer surveys, which the measure developer provided. Additional changes to the HCAHPS survey in 2025 (e.g., web and phone-based delivery) are expected to increase response rates. • To address concerns about the restfulness sub-measure (MUC2023-147), the measure developer explained that the goal is sufficient rest for patients to be discharged in a timely manner and that patients are generally understanding of planned disruptions. • There were concerns the questions may not be specific enough to capture the patient's reason for being hospitalized.
Feasibility	• Committee members believed the value of patient perspective must be balanced against the burden of survey fatigue.
Conditions for Recommendation	• The measures should be endorsed by a CBE prior to implementation. • The measure developer should consider removing overlapping items to avoid extending the length of the survey. • The measure developer should consider adaptive questions in computerized administration to minimize items. • CMS should monitor trends in performance over time.

Additional Considerations for CMS and Future Directions

Changes planned for 2025 to improve response rate include expanding survey modes and follow-up protocols, lengthening the data collection window, requiring administration in Spanish, and limiting supplemental questions.

Social Drivers of Health (SDOH) Measures

2.2.15 MUC2023-175 Facility Commitment to Health Equity [CMS]

(Proposed for Ambulatory Surgical Center Quality Reporting Program)

Description: 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, queer, intersex, asexual (LGBTQIA) community; individuals with limited English proficiency; rural populations; religious minorities; and people living near or below poverty level. Facilities will receive one point each for attesting to five different domains of commitment to advancing health equity for a total of five points.

Summary of Public Comments: 9; Support (1); Support with Considerations (5); Oppose (3)

Measure Review Final Vote: Recommend this measure for the Ambulatory Surgical Center Quality Reporting Program.

Vote Count: Recommend (15) 79%, Recommend with conditions (2) 10.5%, Do not recommend (2) 10.5%, No Recusals.

Combined Discussion: MUC2023-175 and MUC2023-176 were discussed together. The discussion themes identified below apply to both measures, unless otherwise specified.

Discussion Themes	Recommendation Group Member Discussion
Importance	• The committee expressed support for a measure that captures commitment to health equity consistently across settings.
Scientific Acceptability	• Reliability and validity testing are limited for structural measures. • The committee suggested the measures need to provide hospitals with a roadmap for how they should demonstrate their commitment to health equity. • The committee indicated domain criteria need to be clearly specified. CMS has developed a guidance document for implementing the measures.
Specification	• The committee recommended that CMS require hospitals to collect and report data on patient race/ethnicity, gender, and payer, then receive credit for reporting rather than rely on structural measures. • The committee discussed the benefits of reporting SDOH data for quality improvement purposes as an alternative.
Usability	• The committee expressed concerns that smaller entities may not be able to participate in the data collection and analysis domains.
Conditions for Recommendation	• The measure should be endorsed by a CBE prior to implementation. • Additional specificity around attestation requirements is needed. • The data collected should be used for measure testing.

Additional Considerations for CMS and Future Directions

The committee encouraged CMS and measure developers to undertake additional testing of this measure, with emphasis on performance across settings of varying patient volume and with examination of how added specificity of attestations impacts measure performance.

2.2.16 MUC2023-176 Hospital Commitment to Health Equity [CMS]

(Proposed for Hospital Outpatient Quality Reporting Program and *Rural Emergency Hospital Quality Reporting Program)*

Description: 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, queer, intersex, asexual (LGBTQIA) 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.

Summary of Public Comments: 11; Support (2); Support with Considerations (6); Oppose (3)

Measure Review Final Vote:

- Recommend this measure with conditions for inclusion in the Hospital Outpatient Quality Reporting Program.
- Recommend this measure with conditions for inclusion in the Rural Emergency Hospital Quality Reporting Program.

Vote Count:

- Hospital Outpatient Quality Reporting Program: Recommend (12) 63%, Recommend with conditions (4) 21%, Do not recommend (3) 16%, No Recusals.
- Rural Emergency Hospital Quality Reporting Program: Recommend (13) 68%, Recommend with conditions (3) 16%, Do not recommend (3) 16%, No Recusals.

Combined Discussion: MUC2023-175 and MUC2023-176 were discussed together. The discussion themes for MUC2023-175 apply to both measures.

2.2.17 MUC2023-139 Hospital Equity Index (HEI) [CMS]

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: The HEI is a prototype method for a single score that summarizes several measurements of disparity in care at a hospital. The final score, normalized around a value of 0.0, will summarize results of the CMS Disparity Methods (stratified measure results) across nine measures and social and demographic risk factors, to provide more accessible information about variations in health care disparity across hospitals. The current HEI methodology includes seven readmission measures and two mortality measures, dual eligibility and the Area Deprivation Index (ADI). The readmission measures included in the HEI currently have stratified results by DE confidentially reported to hospitals and are listed here: HEI readmission measure components. The HEI also includes the HF and PN mortality measures and the ADI.

Summary of Public Comments: 10; Support (3); Support with Considerations (1); Oppose (6)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (4) 21%, Recommend with conditions (2) 10%, Do not recommend (13) 69%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• Committee members expressed support for the measure's intent. • Mortality measures are important to patients.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• The committee expressed concerns that measure indexing results across measures could conceal disparities, making it harder for hospitals to identify areas where improvements are needed. The measure developer indicated hospitals will receive aggregate and individual measure data stratified by dual-eligibility status beginning in the spring. • Scores may not be fully comparable across hospitals. • Committee members indicated they would like more information on the methodology used to calculate the measure.
Usability	• It was not clear how the measure would be of value to patients. • Because the measure is a prototype, it should be used as a learning and feedback tool. • Critical access hospitals, which are often small rural facilities, may not be able to report the measure.
Consensus-based Entity Endorsement	• The measure is not endorsed and has not been submitted for endorsement.

Additional Considerations for CMS and Future Directions

The committee communicated to CMS and measure developers that more work is needed to plan how the measure scores should be reported and used.

2.2.18 MUC2023-156 Screening for Social Drivers of Health (SDOH) [CMS]

(Proposed for Ambulatory Surgical Center Quality Reporting Program, Hospital Outpatient Quality Reporting Program, and Rural Emergency Hospital Quality Reporting Program)

Description: The Screening for SDOH is a process measure that assesses the total number of patients, who were aged 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), or rural emergency hospital (REH) care.

Summary of Public Comments: 14; Support (4); Support with Considerations (7); Oppose (3)

Measure Review Final Vote:

- Recommend this measure with conditions for inclusion in the Ambulatory Surgical Center Quality Reporting Program.
- Recommend this measure with conditions for inclusion in the Hospital Outpatient Quality Reporting Program.
- Recommend this measure with conditions for inclusion in the Rural Emergency Hospital Quality Reporting Program.

Vote Count:

- Ambulatory Surgical Center Quality Reporting Program: Recommend (14) 74%, Recommend with conditions (3) 16%, Do not recommend (2) 10%, No Recusals.

- Hospital Outpatient Quality Reporting Program: Recommend (12) 63%, Recommend with conditions (4) 21%, Do not recommend (3) 16%, No Recusals.
- Rural Emergency Hospital Quality Reporting Program: Recommend (13) 68%, Recommend with conditions (3) 16%, Do not recommend (3) 16%, No Recusals.

Combined Discussion: MUC2023-156 and MUC2023-171 were discussed together. The discussion themes identified below apply to both measures.

Discussion Themes	Recommendation Group Member Discussion
Scientific Acceptability	• Committee members questioned how the five included domains were selected. Committee members representing patient perspectives indicated they would like the measure to expand to other domains such as disabilities support. • In the evaluation of the Accountable Health Communities model, screening for SDOH did not demonstrate an impact on drivers of health other than ED visits. • Committee members were concerned about the interpretation of the positive-screen measure and raised concerns that high positive screening rates may be interpreted as low quality of care.
Feasibility	• Committee members wanted clarity around whether the measures would essentially require hospitals to partner with community service providers in the future. This would be burdensome for hospitals and may be especially challenging for small rural facilities or facilities in other areas where community service providers are limited.
Usability	• Committee members expressed uncertainty about how the measure would be reported and used, namely because (1) patients' data would be reported in multiple settings and (2) they were unsure about whether screen positive rates would be communicated to entities by domain in addition to the overall rate. • Some members noted that domain-level findings could be used to support grant applications.
Conditions for Recommendation	• Reporting burden should be reduced by allowing entities to report data to the IQR and OQR programs simultaneously (condition was only relevant for vote on HOQR program inclusion only).

Additional Considerations for CMS and Future Directions

An additional consideration for CMS and measure developers from this discussion is that the five selected domains are a starting point and can be tailored.

2.2.19 MUC2023-171 Screen Positive Rate for Social Drivers of Health (SDOH) [CMS]

(Proposed for Ambulatory Surgical Center Quality Reporting Program, Hospital Outpatient Quality Reporting Program, and Rural Emergency Hospital Quality Reporting Program)

Description: 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), or rural emergency hospital (REH), who were aged 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.

Summary of Public Comments: 12; Support (4); Support with Considerations (4); Oppose (4)

Measure Review Final Vote:

- Consensus not reached on inclusion of this measure in the Ambulatory Surgical Center Quality Reporting Program.
- Consensus not reached on inclusion of this measure in the Hospital Outpatient Quality Reporting Program.
- Consensus not reached on inclusion of this measure in the Rural Emergency Hospital Quality Reporting Program.

Vote Count:

- Ambulatory Surgical Center Quality Reporting Program: Recommend (13) 68%, Recommend with conditions (1) 5%, Do not recommend (5) 25%, No Recusals.
- Hospital Outpatient Quality Reporting Program: Recommend (11) 58%, Recommend with conditions (2) 10%, Do not recommend (6) 32%, No Recusals.
- Rural Emergency Hospital Quality Reporting Program: Recommend (13) 68%, Recommend with conditions (0), Do not recommend (6) 32%, No Recusals.

Combined Discussion: MUC2023-156 and MUC2023-171 were discussed together. The discussion themes identified in MUC2023-156 apply to both measures.

Additional Considerations for CMS and Future Directions

Committee members expressed concern about possible ambiguity in interpretation of data from the screen positive rate measure, as well as potential expectations regarding entities' responsibilities for addressing HRSNs.

2.2.20 MUC2023-114 Global Malnutrition Composite Score [Academy of Nutrition and Dietetics]

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

Description: 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. Malnutrition care best practices recommend that for each hospitalization, adult inpatients be screened for malnutrition risk by a nursing professional, registered dietitian (RD), or registered dietitian nutritionist (RDN); assessed by an RD/RDN to confirm findings of malnutrition risk; and if identified with a "moderate" or "severe" malnutrition status in the current performed malnutrition assessment, receive a current "moderate" or "severe" malnutrition diagnosis by a

physician/eligible clinician as defined by CMS, and have a current nutrition care plan performed by an RD/RDN.

Summary of Public Comments: 31; Support (14); Support with Considerations (16); Oppose (1)

Measure Review Final Vote:

- Recommend this measure with conditions for inclusion in the Hospital Inpatient Quality Reporting Program.
- Recommend this measure with conditions for inclusion in the Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs).

Vote Count:

- Hospital Inpatient Quality Reporting Program: Recommend (14) 74%, Recommend with conditions (3) 16%, Do not recommend (2) 90%, No Recusals.
- Medicare Promoting Interoperability Program for Eligible Hospitals (EHs) or Critical Access Hospitals (CAHs): Recommend (13) 68%, Recommend with conditions (3) 16%, Do not recommend (3) 16%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• The committee considered ways in which the measure could draw attention to problematic practices like withholding food from patients prior to procedures and failing to offer food when procedures are delayed. • Patient representatives echoed this point and highlighted the importance of capturing hospital-acquired malnutrition.
Scientific Acceptability	• There were concerns about the quality of evidence for expanding the measure to cover adults aged 18 to 64 years.
Unintended Consequences	• The measure could create a conflict of interest by promoting hiring more dietitians. The measure developer explained that dietitians do not bill for inpatient services.
Conditions for Recommendation	• Screening and assessment should include hospital-acquired malnutrition and high-risk nutritional practices in hospitals, such as prolonged fasting for rescheduled procedures; obtain more feedback from patient groups.

Additional Considerations for CMS and Future Directions

CMS and measure developers are encouraged to explore other ways to measure hospital-acquired malnutrition or timing of patient meals based on discussion among patient members that highlighted the implications of delays in meal provision on patient wellbeing.

2.2.21 MUC2023-199 Connection to Community Service Provider [OCHIN]

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: Percent of patients aged 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 had contact with a Community Service Provider (CSP) for at least one of their HRSNs within 60 days after discharge.

Summary of Public Comments: 15; Support (2); Support with Considerations (2); Oppose (11)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (7) 37%, Recommend with conditions (2) 10%, Do not recommend (10) 53%, No Recusals.

Combined Discussion: MUC2023-199 and MUC2023-210 were discussed together. The discussion themes identified below apply to both measures.

Discussion Themes	Recommendation Group Member Discussion
Importance	• Committee members supported the measures' intent.
Scientific Acceptability	• Measure scores might be heavily dependent on resources available in the community, which are outside a hospital's control.
Feasibility	• The committee expressed concerns about the availability and capacity of community service providers (CSPs) to accept referrals, especially in rural areas. • There was concern about the expectation for hospitals to identify when an HRSN is resolved following referral to a CSP, given that building an information exchange to track resolution of HRSNs is burdensome. • Unhoused patients and patients who do not speak English can be hard to reach for follow-up, meaning that the most vulnerable patients may be least likely to benefit from the measure.
Unintended Consequences	• Hospitals with low scores on these measures might be perceived negatively because they operate in low-resource communities.

Additional Considerations for CMS and Future Directions

The committee recommended CMS give further thought to clarifying through the language of the measures or providing context that hospitals are being accountable when they make referrals to community resources.

2.2.22 MUC2023-210 Resolution of At Least 1 Health-Related Social Need [OCHIN]

(Proposed for Hospital Inpatient Quality Reporting Program)

Description: Percent of patients aged 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 one of their HRSNs was resolved within 12 months after discharge.

Summary of Public Comments: 17; Support (3); Support with Considerations (1); Oppose (13)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the Hospital Inpatient Quality Reporting Program.

Vote Count: Recommend (4) 21%, Recommend with conditions (2) 10%, Do not recommend (13) 68%, No Recusals.

Combined Discussion: MUC2023-199 and MUC2023-210 were discussed together. The discussion themes identified in MUC2023-199 apply to both measures.

2.3 PAC/LTC Committee Measures

Hospice Quality Reporting Program Measures Under Review – Person-Centered Care Measures

2.3.1 MUC2023-163 Timely Reassessment of Pain Impact [CMS]

(Proposed for Hospice Quality Reporting Program)

Description: The Timely Reassessment of Pain Impact measure captures the percent of hospice patient assessments that have a pain reassessment within 2 days when pain impact was initially assessed as moderate or severe. Data for this measure are collected by hospice clinicians using the Hospice Outcomes and Patient Evaluation (HOPE) instrument. Symptom impact assessments are administered at fixed timepoints during a hospice election: at admission (ADM) and in conjunction with the first and second interdisciplinary group (IDG) meetings. When pain symptom impact is assessed as moderate or severe, a HOPE Symptom Reassessment (SRA) is to occur within 2 calendar days of the initial/triggering assessment. For the purposes of this measure, a quality episode is defined as the period from the date of the symptom impact assessment to two calendar days thereafter.

Summary of Public Comments: 3; Support (1); Support with Considerations (1); Oppose (1)

Measure Review Final Vote: Recommend this measure with conditions for HQRP.

Vote Count: Recommend (8) 40%, Recommend with conditions (11) 55%, Do not recommend (1) 5%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• The committee commended the measure's focus on symptom impact and recognition of how pain affects patients. • Committee members emphasized the importance of the HOPE tool and the need additional testing and implementation nationwide.
Feasibility	• While committee members supported reassessment of pain by a registered nurse, there were concerns this may not be feasible in rural hospice settings. • There were concerns about delays in reassessment over weekends and holidays; however, the measure accounts for these delays.

Discussion Themes	Recommendation Group Member Discussion
Measure Specification	• There was concern about the HOPE tool's readiness for implementation, given the lack of testing or widescale implementation efforts. • Committee members questioned the choice to rely on care team assessment (via the HOPE tool) rather than attaining the patient's assessment (via a PROM).
Measure Type	• The committee expressed concerns about the measure being a process measure rather than a patient-reported outcome measure.
Conditions for Recommendation	• The measure should undergo review and receive endorsement from a consensus-based entity.

Additional Considerations for CMS and Future Directions

An additional consideration for CMS and measure developers from this discussion is that committee members would like to see the HOPE tool tested and implemented.

2.3.2 MUC2023-166 Timely Reassessment of Non-Pain Symptom Impact [CMS]

(Proposed for Hospice Quality Reporting Program)

Description: The Timely Reassessment of Non-Pain Symptom Impact measure captures the percent of hospice patient assessments that have non-pain symptom(s) reassessment within 2 days from when symptom impact was initially assessed as moderate or severe. Data for this measure are collected by hospice clinicians using the Hospice Outcomes and Patient Evaluation (HOPE) instrument. Symptom impact assessments are administered at fixed timepoints during a hospice election: at admission (ADM) and in conjunction with the first and second interdisciplinary group (IDG) meetings. When non-pain symptom impact is assessed as moderate or severe, a HOPE Symptom Reassessment (SRA) is to occur within 2 calendar days of the initial/triggering assessment. For purposes of this measure, a quality episode is defined as the period from the date of the symptom impact assessment to two calendar days thereafter.

Summary of Public Comments: 2; Support (0); Support with Considerations (1); Oppose (1)

Measure Review Final Vote: Recommend this measure with conditions for the HQRP

Vote Count: Recommend (10) 50%, Recommend with conditions (9) 45%, Do not recommend (1) 5%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Importance	• Committee members stressed the importance of assessing symptoms for effective interventions in hospice care.
Measure Specification	• There was concern about how individual symptoms are assessed in the Hospice Outcomes and Patient Evaluation (HOPE) tool used for measure calculation, given that symptoms are not patient-reported.
Caregiver Experience	• While patients may find these symptoms distressing, in some cases their illness reduces their awareness of the symptoms. The perspectives of caregivers should be considered in such situations.

Conditions for Recommendation	• The measure should undergo review and receive endorsement from a CBE.

Additional Considerations for CMS and Future Directions

An additional consideration for CMS and measure developers from this discussion is that committee members would like to see the HOPE tool tested and implemented.

Hospice Quality Reporting Program Measures Under Review – CAHPS® Hospice Survey

2.3.3 MUC2023-183,191,192 CAHPS® Hospice Survey

MUC2023-183 CAHPS® Hospice Survey Care Preferences

MUC2023-191 CAHPS® Hospice Survey Hospice Team Communication

MUC2023-192 CAHPS® Hospice Survey Getting Hospice Care Training

(Proposed for Hospice Quality Reporting Program)

Description: Sub-measure 1: Care Preferences is a multi-item measure derived from the CAHPS® Hospice Survey, Version 9.0, a 39-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice decedents and their primary caregivers. Survey respondents are the primary informal caregivers (i.e., family members or friends) of patients who died while receiving hospice care. The Care Preferences measure is composed of responses to the following two survey items:

- Did the hospice team make an effort to listen to the things that mattered most to you or your family member?
- Did the hospice team provide care that respected your family member's wishes?

Sub-measure 2: Hospice Team Communication is a multi-item measure derived from the CAHPS® Hospice Survey, Version 9.0, a 39-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice decedents and their primary caregivers. Survey respondents are the primary informal caregivers (i.e., family members or friends) of patients who died while receiving hospice care. The Hospice Team Communication measure is composed of responses to the following five survey items:

- How often did the hospice team let you know when they would arrive to care for your family member?
- How often did the hospice team explain things in a way that was easy to understand?
- How often did the hospice team keep you informed about your family member's condition?
- How often did the hospice team listen carefully to you when you talked with them about problems with your family member's hospice care?
- While your family member was in hospice care, how often did the hospice team listen carefully to you?

Sub-measure 3: Getting Hospice Care Training is a single-item measure derived from the CAHPS® Hospice Survey, Version 9.0, a 39-item standardized questionnaire and data collection methodology. The survey is intended to measure the care experiences of hospice decedents and their primary caregivers. Survey respondents are the primary informal caregivers (i.e., family members or friends) of patients who died while receiving hospice care. The Getting Hospice Care Training measure is composed of responses to the following survey item:

- Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs. Did the hospice team teach you how to care for your family member?

Summary of Public Comments: 5; Support (0); Support with Considerations (5); Oppose (0)

Measure Review Final Vote: Consensus not reached on inclusion of this measure in the HQRP.

Vote Count: Recommend (7) 37%, Recommend with conditions (7) 37%, Do not recommend (5) 26%, No Recusals.

Discussion Themes	Recommendation Group Member Discussion
Survey Language	• Committee members expressed concern with the language used in the survey, noting the potential for misunderstandings between clinicians and patients/families. Further, the language used may not be appropriate for disadvantaged populations and people with low literacy levels.
Burden	• There were concerns about the length of the survey, especially in light of other surveys that patients are asked to complete.
Bias	• Survey measures often capture extremes of satisfaction and dissatisfaction, underrepresented experiences in between.

Additional Considerations for CMS and Future Directions

An additional consideration for CMS and measure developers from this discussion is that the committee requested in future years, CAHPS sub-measures be voted on separately rather than together.

3. Common Themes and Future Considerations

During the series of PRMR meetings, Recommendation Group members expressed several recurring themes for where they would like to see measures or measure sets be revised and improved moving forward. Figure 6 shows the topics that members would like to see measure developers and CMS dedicate resources to addressing in future CMS programs during pre-rulemaking.

Figure 6. Growth Opportunities for CMS Programs

Encourage Consensus-Based Entity (CBE) Endorsement

A recurring theme during measure discussions was committee uncertainty around measure performance and scientific acceptability based on the information submitted to MERIT at the start of the PRMR cycle. During voting, the most common condition of recommendation was that measures undergo CBE endorsement. Multiple committees emphasized the importance of CBE endorsement for ensuring scientific rigor, highlighting how endorsement committees are better suited to evaluate concerns such as reliability and validity based on their subject matter expertise in measurement science. While it is not currently a requirement that measures under consideration have the CBE endorsement "stamp of approval" before submitting materials to be considered for a CMS program, CMS should consider emphasizing the importance of CBE endorsement in promoting effective program discussions.

Examine Performance in Rural and Low Patient Volume Settings

Interested parties representing rural communities encouraged PRMR committees across the sessions to reflect on how measure implementation and performance may vary across settings. Committee members examined measure specifications and walked through examples of how certain measures might have unintended consequences or lower performance in facilities with low patient volume. Continuing the emphasis on engaging rural perspectives that emerged during the Fall 2023 Measure Set Review meeting, CMS and measure developers are encouraged to explore the unique implementation considerations needed for successful measure use in rural areas. Beyond inclusion of rural perspectives among those serving on Technical Expert Panels (TEPs), future measure development should also include rural and/or low patient volume testing sites. It was noted in discussions that while low patient volume is often due to a facility serving a rural area, there are other socio-economic factors that may result in low patient volume and that should be considered during measure specification and testing. CMS is further encouraged to explore implementation guides and supports for rural and low patient volume settings to address barriers to implementation and performance variation resulting from measures having historically not considered the unique needs of these settings.

Empower Measured Entities through "Roadmap" Measures

In discussion of many of the equity-centered measures on the 2023 MUC list, committee members often commented on the importance of the measure intent but cited barriers in implementing the measure such as lack of institutional support, limited flexibility in how the specific measure is implemented, and hesitancy to recommend "first step" measures in a new area of measurement. For MUC2023-196 Age Friendly Hospital measure, the broadly defined domains were viewed as encouraging some degree of flexibility for implementing at the facility level. One committee member suggested that this measure might serve as a "roadmap" for hospitals to become age friendly while also measuring progress. Given the concerns expressed for the other equity-centered measures that sought to begin the needed work of measuring how the health care system addresses and responds to SDOH, CMS and developers are encouraged to explore the ways in which future measures can also serve as a roadmap for facilities and clinicians that may otherwise be hesitant or lacking the resources needed to start this work. Hallmarks of a roadmap measure may include 1) offering flexibility in how a measured entity may achieve high performance within each domain to allow for customization based on patient population or setting-specific concerns, 2) using attribution models that reflect real-world delivery of care and external risk factors that may impact performance, and 3) framing these measures early on in development as tools to empower measured entities to expand work and measurement in new areas of focus to better serve communities.

Explore New Attribution Models for Social Determinants of Health Measures

The 2023 MUC list included several measures that were equity-centered and expanded measurement into the area of SDOH in meaningful ways. While PRMR committees voiced support for the intent of these measures and recognized from the patient, clinician, and facility perspective the ways in which SDOH impact outcomes, committees failed to reach consensus on a recommendation for most of these measures. One of the most common reasons for opposition and concern about these measures was the attribution level. It was frequently stated that clinicians and hospitals are not solely responsible for addressing SDOH concerns and, in the absence of a robust community service provider system, they may face undue challenges in implementing these measures or have publicly reported poor performance. CMS and measure developers are encouraged to explore new models for attribution of performance that better reflects the multi-provider and community-level work being undertaken to address SDOH.

Expand Education on Cost Measures

The cost measures proposed for MIPS had robust Q&A with CMS and developers during the clinician session. Areas of concern expressed for these measures included fundamental questions about the impact of cost measures on quality of care and patient outcomes as well as the utility of cost measures for clinicians in improving their processes over time. While CMS program leads and measure scientists discussed the role and statutory requirement for cost measures in programs such as MIPS, there is room for broader discussion and education around cost measures. CMS is encouraged to expand education for measured entities on the "why" and "how" of cost measures so that they are better understood by those most impacted by them. Additionally, PQM will explore ways to improve committee members' understanding of cost measures as part of the next PRMR cycle to ensure robust and measure-relevant discussions.

Appendix. PRMR Interested Parties

PRMR Committee Members

Clinician Committee

Member	Organization	Advisory or Recommendation Group
Amir Qaseem	American College of Physicians	Recommendation
Brandon Hawkins	Stockdale Podiatry Group	Recommendation
Chisa Nosamiefan	Self	Recommendation
Deidre Wheat	Independent Health	Recommendation
Jean Drummond	HealthCare Dynamics International	Recommendation
Jennifer Gasperini	National Association of ACOs	Recommendation
Jill Shuemaker	American Board of Family Medicine	Recommendation
Koryn Rubin & Heidi Bossley[4]	American Medical Association	Recommendation
Lisa Hines	Pharmacy Quality Alliance	Recommendation
Lucas Beffa	Cleveland Clinic	Recommendation
Megan Reyna	National Association of Accountable Care Organizations	Recommendation
Michelle Dardis	The Joint Commission	Recommendation
Reginald Barnes	Autoimmune Registry	Recommendation
Robert Fields	Self	Recommendation
Robert Rauner	HealthyLincoln.org (NE)	Recommendation
Shani Francis	Self	Recommendation
Shawn Griffin	Utilization Review Accreditation Commission	Recommendation
Teresa Lubowski	IPRO	Recommendation
Valarie Oji	MedCentre PLLC	Recommendation
Wendy Holness	Pragmedic Health Solutions	Recommendation
Angelic Rivera-Edwards	Montefiore	Advisory
Anita Bemis-Dougherty	American Physical Therapy Association	Advisory
Bradford Tinloy	Vituity	Advisory
Carlene MacMillan	Osmind	Advisory
Cary B Shames	AHIP	Advisory
David Seidenwurm	American College of Radiology	Advisory
Deirdre Mylod	Press Ganey	Advisory
Eileen Morgan	Self	Advisory
Geoffrey Rose	American College of Cardiology	Advisory
Gwendolyn Moore	Self	Advisory
Jennifer Brockman	Iowa Healthcare Collaborative	Advisory
Jennifer Woodward	American Academy of Family Physicians	Advisory
Jonathan French	Healthcare and Information Management Systems Society	Advisory
Julie Sonier	MN Measurement Collaborative	Advisory
Matthew Cerasale	Society of Hospital Medicine	Advisory

[4] During day one of the Clinician committee meeting, Heidi Bossley served as the AMA organizational representative.

Member	Organization	Advisory or Recommendation Group
Michael Lardieri	Core EHR Solutions	Advisory
Miklos Kertai	Vanderbilt University Medical Center	Advisory
Peggy Thompson	Self	Advisory
Puneet Bajaj	University of Texas Southwestern	Advisory
Richard Friedland	Hudson Valley Radiologists, P.C.	Advisory
Richard Heller	Radiology Partners	Advisory
Sai Ma	Elevance Health	Advisory
Sarah Eakin	College of American Pathologists	Advisory
Scott Cowan	Thomas Jefferson University	Advisory
Sepheen Byron	National Committee for Quality Assurance	Advisory
Sheila Roman	Johns Hopkins University School of Medicine	Advisory
Sunny Jhamnani	TriCity Cardiology	Advisory
Tipu Puri	Self	Advisory
Zeeshan Butt	American Psychological Association	Advisory

Hospital Committee

Member	Organization	Advisory or Recommendation Group
Akinluwa Demehin	American Hospital Association	Recommendation
Amy Minnich	Geisinger	Recommendation
David Kroll	Brigham and Women's Hospital; American Psychiatric Association	Recommendation
Erin O'Malley	America's Essential Hospitals	Recommendation
Isis Zambrana	Jackson Health System	Recommendation
Ivory Harding	National Kidney Foundation	Recommendation
James Moore	UCLA Health; American Society of Anesthesiologists	Recommendation
John Bott	Independent Consultant	Recommendation
Kamyar Kalantar-Zadeh	Harbor-UCLA Medical Center; National Forum of ESRD Networks	Recommendation
Lara Musser	NYC Health + Hospitals/Jacobi/North Central Bronx	Recommendation
Marc Gruner	Aligned Orthopedic & Sports Therapy at OrthoBethesda; American Academy of Physical Medicine and Rehabilitation	Recommendation
Martin Hatlie	Self	Recommendation
Melissa Danforth	The Leapfrog Group	Recommendation
Michael Lane	Parkland Health	Recommendation
Nikolas Matthes	IPRO	Recommendation
Rosie Bartel	Self	Recommendation

Member	Organization	Advisory or Recommendation Group
Susan Runyan	Runyan Health Care Quality Consulting	Recommendation
Tilithia McBride	Federation of American Hospitals	Recommendation
Virginia Irwin-Scott	ChenMed	Recommendation
Wei Ying	Blue Cross Blue Shield of Massachusetts	Recommendation
Allison Luu	Los Angeles County	Advisory
Anna Legreid Dopp	American Society of Health-System Pharmacists	Advisory
Ben McGaugh	Mountain Pacific Quality Health	Advisory
Benjamin Pollock	Mayo Clinic	Advisory
Coumba Dianka	Self	Advisory
David Baker	The Joint Commission	Advisory
David Basel	Avera Health	Advisory
Edward Pollak	Henry Ford Health	Advisory
Elizabeth McKnight	Intermountain Healthcare	Advisory
Hal McCard	Spencer Fane	Advisory
Holly Varnell	Dream Big Health, cognAIzant dx	Advisory
Jeffrey Buck	Self	Advisory
Jeffrey Silberzweig	The Rogosin Institute	Advisory
Julie Marcinek	OhioHealth; American Academy of Family Physicians	Advisory
Kathleen Rauch	Health Care Association of New York State	Advisory
Kathy Wilson	ASC Quality Collaboration	Advisory
Kristine Thompson	Mayo Clinic	Advisory
Lisa McGiffert	Self	Advisory
Marissa Carvalho	Duke University Health System; American Physical Therapy Association	Advisory
Mark Parker	MaineHealth	Advisory
Michael Lynch	UPMC Health Plan	Advisory
Michelle Doll	VCU Health System	Advisory
Nadja Kadom	Emory University School of Medicine; American College of Radiology	Advisory
Nishant Anand	Altais	Advisory
Phoebe Ramsey	Association of American Medical Colleges	Advisory
Rachel Brodie	Purchaser Business Group on Health	Advisory
Sandi Hyde	Lifepoint Health	Advisory
Shari Michl	Filmore County Hospital	Advisory
Subashnie Devkaran	Mayo Clinic	Advisory
Tejal Gandhi	Press Ganey	Advisory
Thomas Frederickson	Society of Hospital Medicine	Advisory
Wendy Fitts	University of Pennsylvania Health System (Penn Medicine) - Lancaster General Health	Advisory
Zahid Butt	HIMSS	Advisory

PAC/LTC Committee

Member	Organization	Advisory or Recommendation Group
Carol Siebert	The Home Remedy	Recommendation
Caroline Blaum	National Committee for Quality Assurance	Recommendation
Cathy Lerza	State of Kentucky	Recommendation
Crystal Ukaegbu	Self	Recommendation
Danielle Grotzky	Madonna Rehabilitation Hospitals	Recommendation
Donna Bednarski	American Nephrology Nurses Association	Recommendation
J Coomes	Advent Health	Recommendation
Janet Pue	Atrium Health	Recommendation
Janice Tufte	Hassanah Consulting	Recommendation
Jeremy Benton	Indiana Family and Social Services Administration (Medicaid)	Recommendation
Kate Lally	American Academy of Hospice and Palliative Medicine	Recommendation
Kimberly Rask	Alliant Health	Recommendation
Kiran Sreenivas	American Health Care Association	Recommendation
Lara Burrows	Aetna	Recommendation
Mary Ellen DeBardeleben	Encompass Health	Recommendation
Maureen Albertson	Millenium Home Care	Recommendation
Terrie Black	University of Massachusetts	Recommendation
Theresa Edelstein	New Jersey Hospital Association	Recommendation
Warren Jones	Diabetes Foundation of Mississippi	Recommendation
William Logan	Care More	Recommendation
Andrea Jersey	Ethica Health	Advisory
Andrew Jakubik	Mary Free Bed Rehab	Advisory
Annette Kiser	National Partnership for Healthcare & Hospice Innovations	Advisory
Anthony Sanchez	Self	Advisory
April Coxon	Healing Hands Healthcare	Advisory
Arion Lillard-Green	George Mason University	Advisory
Barbara Winters-Todd	Encompass Health	Advisory
Benjamin Getter	Compassus	Advisory
Brigette DeMarzo	Northwestern Medicine	Advisory
Christine Von Raesfeld	People with Empathy	Advisory
Heidi Ehle	Pro Medica	Advisory
Jodi Eyigor	LeadingAge	Advisory
Karl Sandin	American Medical Rehabilitation Providers Association	Advisory
Laura Haubner	Tampa General Hospital	Advisory
Laura Hofman	Leading Age Washington	Advisory
Lori Pearlmutter	American Physical Therapy Association	Advisory
Mamata Yanamadala	American Geriatric Society	Advisory
Melissa Butler	Amedisys Home Health	Advisory

Member	Organization	Advisory or Recommendation Group
Pamela Roberts	American Occupational Therapy Association	Advisory
Patricia Henwood	Thomas Jefferson University	Advisory
Peggy Luciano	Accura Health Care	Advisory
Rebecca Perez	Parthenon Management	Advisory
Robert Leffler	Synchrony Health Services	Advisory
Ronald Langham	Enhabit Home Health & Hospice	Advisory
Rosa Plasencia	Advancing States	Advisory
Shabina Khan	Self	Advisory
Starlin Haydon-Greatting	Illinois Pharmacists Association	Advisory
Steven Littlehale	Zimmet Health Care Services Group	Advisory
Steven Schweon	Self	Advisory
Susan Battaglia	Tara Cares	Advisory
Theresa Schmidt	Real Chemistry	Advisory

Federal Agencies

Centers for Medicare & Medicaid Services (CMS)
Centers for Disease Control and Prevention (CDC)
Health Resources and Services Administration (HRSA)

Partnership for Quality Measurement Organizations

Battelle
Institute for Healthcare Improvement
Rainmaker

Measure Stewards

Centers for Medicare & Medicaid Services
Centers for Disease Control and Prevention
Pharmacy Quality Alliance
Academy of Nutrition and Dietetics
Society for Immunotherapy of Cancer (SITC)
American Society of Clinical Oncology
Purchaser Business Group on Health
National Committee for Quality Assurance (NCQA)
American College of Surgeons (ACS)
American College of Emergency Physicians (ACEP)
Institute for Healthcare Improvement (IHI)
OCHIN
American Academy of Dermatology
Federation of American Hospitals


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Quality Measurement
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