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National Consensus Development and Strategic Planning for Health Care Quality Measurement

2023 Pre-Rulemaking Measure Review (PRMR) Meeting Summary:

Hospital Committee

Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
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Pre-Rulemaking Measure Review (PRMR)

Battelle staff convened the Hospital PRMR Recommendation Group on January 18 and 19, 2024, for discussion and voting on the Measures Under Consideration (MUC) for 2023. The goal of this meeting was to discuss the proposed addition of new or revised measures to CMS programs through the perspective of interested parties impacted by the program. This summary provides an overview of the meeting and its outcomes and will be followed by a comprehensive PRMR Meeting Recommendations Report and Recommendations Spreadsheet. For a comprehensive background and preliminary assessment for each measure discussed in this report, refer to the 2023 Pre-Rulemaking Measure Review (PRMR) Preliminary Assessment Report: Hospital Committee.

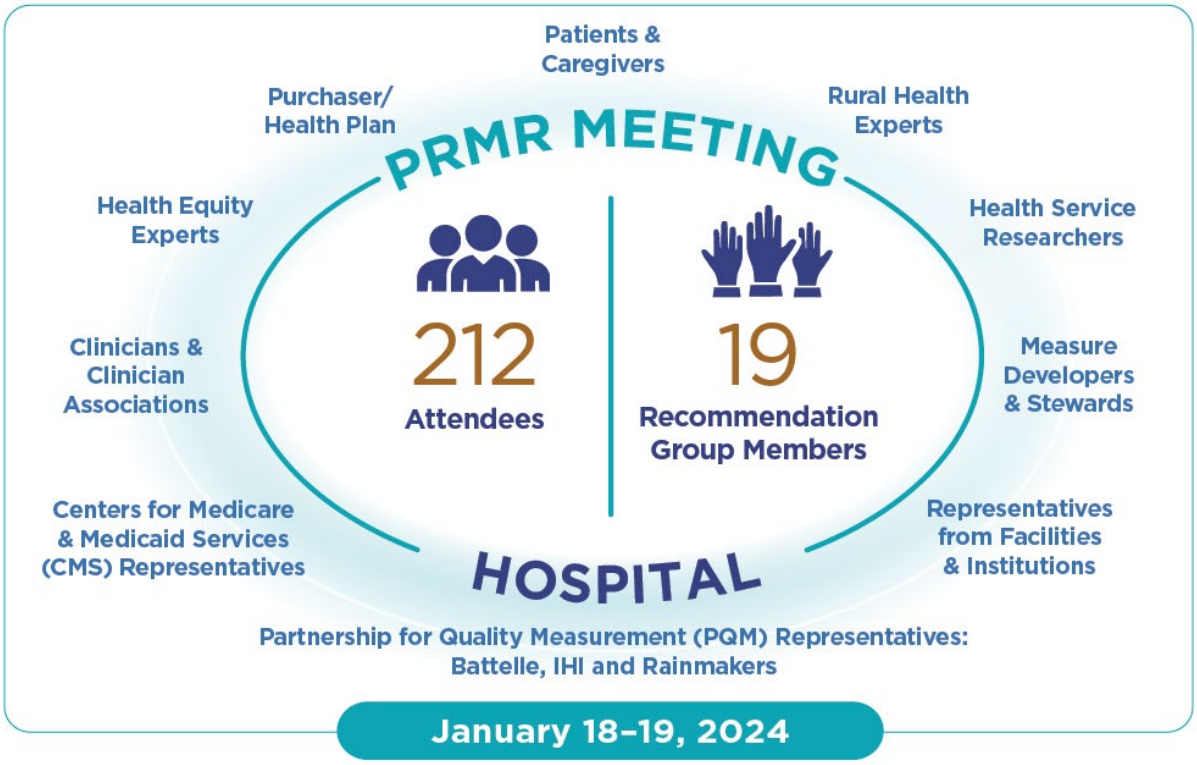

Figure 1. PRMR Meeting Attendance

Meeting participants joined virtually through the Zoom meeting platform. Figure 1 outlines overall meeting attendance, which included the PRMR Recommendation Group, the PRMR Advisory Group, the general public, and other interested parties. The PRMR Recommendation Group responsible for measure discussion and voting consisted of the 19 active Recommendation Group members in attendance. These members represented the interested parties shown in Figure 1 and were joined by CMS and Battelle's Partnership for Quality Measurement (PQM) representatives.

Overview and Purpose

Dr. Nicole Brennan, Executive Director of the Partnership for Quality Measurement, welcomed the attendees to the meeting and introduced her co-facilitator and PQM Technical Director Brenna Rabel. Recommendation Group co-chairs Martin Hatlie and Dr. Kamyar Kalantar-Zadeh each shared their relevant patient and clinician perspectives and motivation for serving in this role. After a brief overview of the day's objectives and agenda, Ms. Kate Buchanan, PQM Deputy Task Lead for Pre-Rulemaking, conducted roll call and Recommendation Group members disclosed any conflicts of interest regarding the measures under review. For measure MUC2023-188, three committee members were recused from voting due to serving on a technical expert panel (TEP) for the measure. Measures MUC2023-138, MUC2023-172, and MUC2023-049 each had one recusal, also due to TEP membership.

Several attendees represented the Centers for Medicare & Medicaid Services (CMS), including Dr. Michelle Schreiber, the Deputy Director of the Center for Clinical Standards and Quality for CMS. Dr. Schreiber noted that CMS was present to serve as a resource and welcomed Recommendation Group members and participants. Dr. Schreiber introduced key members of the CMS team in attendance, including CMS program leads, measure stewards, and representatives of external measure development teams.

MUC 2023 Hospital Committee Measure Discussion

After 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 the two-day meeting, some committee members stepped away temporarily, so Battelle collected voting counts for each measure to ensure that each vote met quorum. The variance in the voting tallies between measures were due to recusals.

PRMR Recommendation Group members voted for one of three options for each MUC 2023 measure for Hospital Committee-relevant programs: Recommend; Recommend with Conditions; Do Not Recommend. A majority of at least 75% of voting Recommendation Group members was required for determination of the vote outcome. For options Recommend and Recommend with Conditions, a combination of at least 75% of voting members split between those two options resulted in a determination of Recommend with Conditions. If a 75% majority was not achieved in this combination or in any single option, the result was Consensus Not Reached. Committee members voting to recommend a measure for a program "with conditions" provided their conditions(s) either verbally or through the chat feature in the webinar platform. Conditions indicated by a committee member are summarized in each measure section. At the beginning of each measure discussion, a CMS program lead representative gave an overview of the measure and its rationale for inclusion in CMS programs. Similar measures were grouped together for discussion, in which case CMS program leads summarized the group of measures at the beginning of the discussion.

Table 1 shows the voting results, recusals, and determinations by measure and program.

Table 1. PRMR Recommendation Group Voting Results by Measure and Program (Hospital Committee, MUC2023)

MUC ID	Measure Title	Program*	Determination	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N (%)	Recusals
MUC2023-181	30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge	IPFQR	Recommend with Conditions	11 (58%)	7 (37%)	1 (5%)	0
MUC2023-138	ESRD Dialysis Patient Life Goals Survey (PaLS)	ESRD QIP	Consensus Not Reached	2 (11%)	10 (56%)	6 (33%)	1
MUC2023-172	Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, PRO-PM	OQR	Recommend with Conditions	9 (50%)	5 (28%)	4 (22%)	1
MUC2023-219	Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations	IQR	Recommend with Conditions	14 (74%)	4 (21%)	1 (5%)	0
MUC2023-220	Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations	IQR	Recommend with Conditions	14 (74%)	4 (21%)	1 (5%)	0
MUC2023-117	Excess Days in Acute Care (EDAC) after Hospitalization for Acute Myocardial Infarction (AMI)	HRRP	Consensus Not Reached	11 (58%)	3 (16%)	5 (26%)	0
MUC2023-119	Excess Days in Acute Care (EDAC) after Hospitalization for Heart Failure (HF)	HRRP	Recommend with Conditions	11 (58%)	4 (21%)	4 (21%)	0

MUC ID	Measure Title	Program*	Determination	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N (%)	Recusals
MUC2023-120	Excess Days in Acute Care (EDAC) after Hospitalization for Pneumonia (PN)	HRRP	Recommend with Conditions	11 (58%)	4 (21%)	4 (21%)	0
MUC2023-196	Age Friendly Hospital Measure	IQR	Consensus Not Reached	14 (74%)	0 (0%)	5 (26%)	0
MUC2023-188	Patient Safety Structural Measure	IQR	Recommend with Conditions	8 (50%)	5 (31%)	3 (19%)	3
MUC2023-188	Patient Safety Structural Measure	PCHQR	Recommend with Conditions	9 (56%)	4 (25%)	3 (19%)	3
MUC2023-048	Hospital Harm - Falls with Injury	IQR	Recommend with Conditions	12 (63%)	6 (32%)	1 (5%)	0
MUC2023-048	Hospital Harm - Falls with Injury	IP EH CAH	Recommend with Conditions	12 (63%)	7 (37%)	0 (0%)	0
MUC2023-050	Hospital Harm - Postoperative Respiratory Failure	IQR	Recommend with Conditions	12 (63%)	5 (26%)	2 (11%)	0

MUC ID	Measure Title	Program*	Determination	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N (%)	Recusals
MUC2023-050	Hospital Harm - Postoperative Respiratory Failure	IP EH CAH	Recommend with Conditions	12 (63%)	5 (26%)	2 (11%)	0
MUC2023-049	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue)	IQR	Recommend with Conditions	11 (61%)	5 (28%)	2 (11%)	1
MUC2023-146—149†	Hospital Patient Experience of Care	IQR	Recommend with Conditions	9 (47%)	8 (42%)	2 (11%)	0
MUC2023-146—149	Hospital Patient Experience of Care	VBP	Recommend with Conditions	10 (53%)	7 (37%)	2 (11%)	0
MUC2023-146—149	Hospital Patient Experience of Care	PCHQR	Recommend with Conditions	11 (58%)	6 (32%)	2 (11%)	0
MUC2023-175	Facility Commitment to Health Equity	ASCQR	Recommend	15 (79%)	2 (11%)	2 (11%)	0
MUC2023-176	Hospital Commitment to Health Equity	OQR	Recommend with Conditions	12 (63%)	4 (21%)	3 (16%)	0

MUC ID	Measure Title	Program*	Determination	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N (%)	Recusals
MUC2023-176	Hospital Commitment to Health Equity	REHQR	Recommend with Conditions	13 (68%)	3 (16%)	3 (16%)	0
MUC2023-139	Hospital Equity Index (HEI)	IQR	Consensus Not Reached	4 (21%)	2 (11%)	13 (68%)	0
MUC2023-156	Screening for Social Drivers of Health (SDOH)	ASCQR	Recommend with Conditions	14 (74%)	3 (16%)	2 (11%)	0
MUC2023-156	Screening for Social Drivers of Health (SDOH)	OQR	Recommend with Conditions	12 (63%)	4 (21%)	3 (16%)	0
MUC2023-156	Screening for Social Drivers of Health (SDOH)	REHQR	Recommend with Conditions	13 (68%)	3 (16%)	3 (16%)	0
MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	ASCQR	Consensus Not Reached	13 (68%)	1 (5%)	5 (26%)	0
MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	OQR	Consensus Not Reached	11 (58%)	2 (11%)	6 (32%)	0

MUC ID	Measure Title	Program*	Determination	Recommend N (%)	Recommend with Conditions N (%)	Do not Recommend N (%)	Recusals
MUC2023-171	Screen Positive Rate for Social Drivers of Health (SDOH)	REHQR	Consensus Not Reached	13 (68%)	0 (0%)	6 (32%)	0
MUC2023-114	Global Malnutrition Composite Score	IQR	Recommend with Conditions	14 (74%)	3 (16%)	2 (11%)	0
MUC2023-114	Global Malnutrition Composite Score	IP EH CAH	Recommend with Conditions	13 (68%)	3 (16%)	3 (16%)	0
MUC2023-199	Connection to Community Service Provider	IQR	Consensus Not Reached	7 (37%)	2 (11%)	10 (53%)	0
MUC2023-210	Resolution of At Least 1 Health-Related Social Need	IQR	Consensus Not Reached	4 (21%)	2 (11%)	13 (68%)	0

Note. Due to rounding, percentages may not sum to 100.
*IPFQR: Inpatient Psychiatric Hospital Quality Reporting Program; ESRD QIP: End-Stage Renal Disease Quality Incentive Program; OQR: Hospital Outpatient Quality Reporting Program; IQR: Hospital Inpatient Quality Reporting Program; HRRP: Hospital Readmission Reduction Program; PCHQR: PPS-Exempt Cancer Hospital Quality Reporting Program; IP EH CAH: Medicare Promoting Interoperability Program for Eligible Hospitals or Critical Access Hospitals; VBP: Hospital Value-Based Purchasing Program; ASCQR: Ambulatory Surgical Center Quality Reporting Program; REHQR: Rural Emergency Hospital Quality Reporting Program.
†The four sub-measures, MUC2023-146, MUC2023-147, MUC2023-148, and MUC2023-149, were voted on as a group.

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

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.

Program: Inpatient Psychiatric Facility Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 7 (37%); Do Not Recommend, 1 (5%); no recusals

Measure Discussion:

CMS Opening Remarks: CMS stated that this new quality reporting measure fills an important gap because it captures patients presenting in the emergency department (ED) who are not admitted during the high-risk 30-day period following discharge from an IPF.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated areas of non-consensus among committee members, and concerns were with the measure's scientific acceptability and a lack of clarity regarding how the measure will lead to improved care. Two written public comments were received, one supporting the measure and one supporting with conditions. Commenters felt that patients discharged from inpatient psychiatric care are at greater risk than the rest of the population for adverse outcomes, and this measure will support better follow-up care after discharge and improved cooperation between caregivers. One commenter felt the measure should be reviewed by a CBE.

Discussion: A psychiatrist on the Recommendation Group agreed this measure fills an important quality gap because the siloing of medical and psychiatric care can contribute to patients in IPFs not receiving adequate medical care and coming back through the ED. This committee member thought the incentive for psychiatric units to avoid admitting patients with medical conditions was already present and that the measure would not make it worse. Another committee member expressed a concern that hospitals with patients who develop a medical condition that requires an unplanned transfer to an ED would be unfairly penalized; the developer clarified that transfers, specifically, ED visits within 72 hours of discharge, are not included in the measure.

One committee member raised an issue related to Medicare claims being able to capture patients in the 18-to-64-year age group; the developer stated that in their analysis of Medicare FFS Part A and B claims reflecting 194,000 patients, 56% were between the ages of 18 and 64, and 43% were age 65 and older, showing a wide range in the ages captured. The same committee member also felt the likelihood of an ED visit depended on the continuum of care post discharge. CMS responded that they are looking at whole-person-centered care, and a goal is to better understand patient needs that bring them back to the ED. The psychiatrist committee member argued that integrated systems can influence their performance on the measure through actions such as increased collaboration with primary care and intensive outpatient programs. A patient committee member expressed support for the idea that hospitals should value information about their patients who return. Additional clarifications provided by the developer: the literature review found no evidence of unintended consequences, although the TEP raised the concern; this claims-based measure would not require IPFs to collect data or calculate scores; observation stays are included in the measure; ED transfers within 72 hours

are not in the eligible population; and the measure does not capture other health care encounters during the timeframe.

Conditions: Consensus Based Entity (CBE) endorsement.

Future Directions: Not discussed.

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

Description: The PaLS is a patient self-report survey that includes eight items related to dialysis facility care team discussions about patient life goals.

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

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 2 (11%); Recommend with Conditions, 10 (56%); Do Not Recommend, 6 (33%); one recusal

Measure Discussion:

CMS Opening Remarks: CMS stated that the purpose of the measure is to align the patients and their care team around goals and to facilitate discussion and shared decision-making, because patient-level data show this is a gap. The instrument is currently available only in English but the developer plans to make it available in Spanish and to test the measure at the facility level.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated areas of non-consensus among committee members, and concerns raised were the burden associated with data collection, inclusion of only English speakers, lack of testing in varied settings, and lack of risk adjustment. Fourteen written public comments were received, two supporting, three supporting with conditions, and nine opposing the measure. Supporting comments asserted that the measure promotes shared decision-making in treatments that impact quality of life and engagement in meaningful activities, and that patient surveys allow patients to communicate about the quality of their experiences. Opposing comments focused on patients experiencing survey burnout and frustration with no follow-up; patients being unclear how information gathered through the survey could improve treatment; and the survey excluding patients who are not proficient in English.

Discussion: Several committee members agreed that patient perspectives and goals deserve more attention and supported the measure's intent but expressed concerns with the measure as specified. One committee member expressed it was a "low bar" if only one of the eight items needed to be answered by the patient to calculate a score; the developer clarified that six of the items are scored and confirmed patients must complete at least one of the items to be included in the numerator. Another committee member questioned the ability of a response to one of the items to capture the importance of measuring the patient perspective.

Several committee members expressed concern about potential equity issues if the instrument is available only in English and encouraged translation into Spanish and other languages. A patient committee member agreed that measuring patient goals is important and suggested the possibility of using translators to give the survey. One committee member mentioned survey burden as a problem with dialysis patients; another committee member believed the benefits of the measure outweigh the potential burden of implementing it. Two committee members questioned how results could be used to improve quality; CMS clarified that the goal of the measure was to start those discussions. A committee member mentioned that a challenge with dialysis patients is that their goals may not always align with clinical requirements and that patient education in the dialysis setting is important for setting expectations. A patient committee member felt the survey is important for surfacing bias clinicians may have around appropriate goals.

Conditions: While the Committee did not reach consensus on this measure, committee members who voted Recommend with Conditions were asked to provide their conditions. These conditions were: CBE endorsement; instrument should be available in languages in addition to English and Spanish.

Future Directions: Translation of the survey instrument into Spanish; measure testing at the facility level.

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) [CMS]

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 rated the hospitals' ability to communicate clear, personalized discharge instructions using a nine-item survey.

Program: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 9 (50%); Recommend with Conditions, 5 (28%); Do Not Recommend, 4 (22%); one recusal

Measure Discussion:

CMS Opening Remarks: CMS stated that this new measure is based on evidence showing that patients often do not fully understand their discharge instructions, which can contribute to readmission and complications, and addresses a measurement gap by reporting facilities' ability to communicate personalized discharge instructions. The measure has been submitted for CBE endorsement.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns with the burden on facilities and patients, gaps in implementation of data elements, and lack of risk adjustment. Two written public comments were received, both in support. Comments included: the measure provides people the ability to compare care received in these settings and decide where they would like to receive care; the measure addresses a gap in current measurement strategies by providing patient-defined information on best practices during recovery; support for the intent and relevance of this measure with additional translations requested for broader multilingual use.

Discussion: A patient committee member supported the measure, indicating discharge instructions are very important to patients and families and should be prioritized. Another committee member supported the measure but wanted to see the timing of administration moved up to the time of the procedure instead of waiting 2 to 7 days to improve response rates. Another patient committee member agreed the measure is important and stated they would prioritize a survey about discharge.

Two committee members asked whether the survey items could be added to one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) domains to improve feasibility and reduce confusion over multiple similar items across different surveys; CMS replied that such alignment may be possible in the future, but the program's need for the measure is high. Another committee member expressed concern about burden associated with having the measure as a separate survey when it could potentially be added to a program with existing PRO-PMs, resulting in some patients receiving up to three different surveys. Another committee member stated that discharge instructions are not addressed in CAHPS, and that the measure should be tested in ambulatory surgery centers (ASCs) and expanded to the Ambulatory Surgery Center Quality Reporting (ASCQR) Program.

Several committee members inquired about details of survey administration and measure implementation, including language and survey mode options, the timeline for the CAHPS

survey review, the probability of patients receiving multiple surveys, and the extent to which facilities should be allowed to select which patients received which surveys. CMS stated they had not received a timeline for CAHPS review and explained that the survey is in English and Spanish and can be administered electronically or on paper. The developer clarified that the facilities they used for testing utilized a method to ensure patients did not receive both the Outpatient and Ambulatory Surgery (OAS) CAHPS and the measure survey. A committee member asked whether the measure is risk adjusted, as CAHPS measures are; CMS clarified it is not risk adjusted. The developer explained that the statistical testing performed did not demonstrate an empirical need for risk adjustment, and that the intent of the PRO-PM is for providers to supply each patient with instructions that address their specific needs and conditions, and as such risk adjustment would be not appropriate.

Conditions: Survey should be administered at the time of procedure so as to not conflict with collection of pain and function outcomes measures.

Future Directions: Possible integration/alignment of survey items into OAS CAHPS; possible testing in ASCs.

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

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.

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 14 (74%); Recommend with Conditions, 4 (21%); Do Not Recommend, 1 (5%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-220, below.

CMS Opening Remarks: CMS stated that the purpose of the proposed measures (MUC2023-219, MUC2023-220) is to expand the portfolio of measures focused on cancer care by leveraging data CDC is already collecting to report SIRs in other settings.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated strong support for both measures, but they had concerns regarding the burden of manual abstraction, scientific acceptability, and consistency across settings. Eight written public comments were received, four supporting the measures and four supporting with conditions. Supporting comments asserted that the measure addresses an important patient safety concept and favored stratifying the measure for oncology locations. Concerns raised included that the measures should not be risk adjusted because infections are preventable, and some commenters requested additional testing to determine if volume bias exists.

Discussion: A committee member asked whether there is any proposed change to the overall SIR reporting; CDC explained the proposed measures add oncology units but the existing SIR reporting at almost 500 facilities will continue as it always has. CMS clarified there would now be two CLABSI and two Catheter-Associated Urinary Tract Infection (CAUTI) measures—one of each for oncology units and one of each in acute care units other than oncology units. An oncologist committee member raised the issue of unintended consequences related to blood culture orders being cancelled or not ordered to avoid raising the CLABSI rate, and another committee member recommended that dialysis patients with catheters should be accounted for in stratification; CDC responded that both issues are being considered for future efforts.

One committee member expressed concerns about the reporting period being too short for smaller or rural facilities with lower volumes to report the measures and asked whether the reporting period could be expanded. One committee member expressed concern about low reliability scores for some facilities; CDC explained that they expected lower reliability scores when testing in oncology units compared to SIR reporting overall. CMS explained that community hospitals without an oncology unit would not report the measure. One committee member suggested looking at different types of oncology units; CDC replied that they receive data from 10 different oncology units, and they agree this is worth considering. In response to a committee member question, CDC and CMS clarified that cancer-exempt hospitals use the same set of measures.

Conditions: Measures should evaluate data by oncology unit type, e.g., hematology-oncology vs. solid organ; increased reporting time to allow smaller rural facilities to report the measure.

Future Directions: Investigation into unintended consequences; consider stratification for dialysis patients with catheters.

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

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.

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 14 (74%); Recommend with Conditions, 4 (21%); Do Not Recommend, 1 (5%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-219; see measure discussion above.

Conditions: See conditions noted for MUC2023-219.

Future Directions: See future directions noted for MUC2023-219.

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

Description: This measure estimates days spent in acute care within 30 days post discharge from an inpatient hospitalization for acute myocardial infarction (AMI).

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 3 (16%); Do Not Recommend, 5 (26%); no recusals

Measure Discussion: This measure was discussed with MUC2023-119 and MUC2023-120, below.

CMS Opening Remarks: CMS stated that the set of proposed EDAC after hospitalization measures (MUC2023-117, MUC2023-119, MUC2023-120) would add three conditions (acute myocardial infarction, heart failure, pneumonia) to the Hospital Readmission Reduction Program (HRRP); the 30-day readmission window for the measures aligns with other readmission measures, and unlike existing readmission measures in HRRP for these conditions, the EDAC measures expand the care setting for readmissions by counting 1-day ED visits and observation stays as readmissions. The goal of the measures is to address the problem of undercounting EDACs, which are not adequately captured in the current readmission measures in HRRP.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns with the measures' scientific acceptability and the risk that beneficiaries from underserved communities may lack the resources to gain from the measures. Committee members also questioned if HRRP permits CMS to use the EDAC measures in the program, because ED visits/observation stays are not readmissions. Nineteen written public comments were received, seven supporting, one supporting with conditions, and 11 opposing the measures. Supporting comments mentioned the importance and meaningfulness of outcome measures related to harm for the public and patients, and that replacing the current AMI readmissions measure with the EDAC measure would reduce excess utilization from ED visits and observation stays, which would help prevent patients from boarding to avoid counting as a readmission. Opposing comments focused on evidence that the window of impact for preventing readmissions or returns to the ED may be as short as 7 days and the measure may hold entities accountable for factors outside their control. Like the committee members, opposing commenters also asked if HRRP permits CMS to use the EDAC measures in the program, because ED visits/observation stays are not readmissions.

Discussion: Committee members inquired about whether CMS had considered a 15-day vs a 30-day window; the developer explained that their analysis and the literature supported using 30 days for unplanned returns to hospital for acute care and stressed that only unplanned readmissions are included to avoid the possibility of intervening planned care being counted. Another committee member expressed concern that only some conditions were proposed for EDAC measures; CMS explained that measures for other conditions are in development. Another concern the committee member expressed is the possibility of "double-counting" readmissions if both the EDAC and current readmission measures were to be collected at the same time; CMS clarified that the intent would be to remove overlapping measures.

Several committee members discussed unintended consequences, including the potential that patients might be pressured to not return for care or to accept hospice in an attempt to prevent returns to the ED, and that some populations may be more likely to receive hospice referrals; the developer acknowledged that the risk model could be re-evaluated to adjust for referral of patients to hospice. Patient committee members were supportive of the measure and agreed that unintended consequences, such as inappropriate referral to hospice, should be accounted for.

One committee member inquired about whether there was evidence that hospitals that performed well on the current readmission measures had lower performance under the new measures, which could potentially indicate that the new measure is capturing events that the old one was not, e.g., putting a patient in an observation bed to avoid being counted as a readmission; the developer confirmed that this is the intent of the new measures. Committee members asked questions about whether the proposed measures would use the same peer-grouping methodology (i.e., stratification by dual-eligibility) that other HRRP measures used, and whether other social risk factors, such as homelessness, could be applied; CMS explained that dual eligibility for Medicare and Medicaid has been shown to be a good proxy for a range of equity issues, but there could be other stratification approaches considered in the future.

Conditions: Although consensus was not reached for MUC2023-117, a majority of committee members (14, 74%) voted to recommend it for use in the program, with a few conditions, which also applied to MUC2023-119 and MUC2023-120. Specifically, they wanted CMS to monitor for unintended consequences, including hospice referrals, and revise specifications as needed; they also sought further testing related to health equity.

Future Directions: Removal of overlapping readmission measures over time; development of EDAC following hospitalization measures for other conditions; reevaluation of risk model to account for referral of patients to hospice.

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

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.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 4 (21%); Do Not Recommend, 4 (21%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-117; see measure discussion above.

Conditions: See conditions noted for MUC2023-117.

Future Directions: See future directions noted for MUC2023-117

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

Description: This measure estimates days spent in acute care (i.e., time spent in ED, unplanned readmission and observation stays) within 30 days of discharge from an inpatient hospitalization for pneumonia.

Program: Hospital Readmissions Reduction Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 4 (21%); Do Not Recommend, 4 (21%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-117; see measure discussion above.

Conditions: See conditions noted for MUC2023-117.

Future Directions: See future directions noted for MUC2023-117.

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

Description: This programmatic measure assesses hospital commitment to improving care for patients => 65 years of age receiving services in the hospital, operating room, or emergency department.

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 14 (74%); Recommend with Conditions, 0 (0%); Do Not Recommend, 5 (26%); no recusals

A majority of committee members (74%) voted to recommend this measure, though not enough to meet the 75% consensus threshold for a recommendation. Those voting against recommending the measure expressed philosophical concerns related to structure measures in general, though they did support the measure intent.

Measure Discussion:

CMS Opening Remarks: CMS explained that the proposed measure combines five patient care domains (1. Eliciting Patient Health Care Goals; 2. Responsible Medication Management; 3. Frailty Screening and Intervention; 4. Social Vulnerability; 5. Age Friendly Care Leadership) that align with IHI's framework for age-friendly care, which the existing evidence base links with high-quality care for elderly patients. The measure requires organizations to attest to the five domains, and testing shows a gap in performance.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated areas of non-consensus among committee members, with committee members questioning whether structural measures and improve quality of care and desiring to see further testing performed. Twenty-five written public comments were received, 16 supporting, five supporting with conditions, and four opposing the measure. Supporting comments were that: the measure captures evidence-based best practices in providing clinically effective and patient-centered care for older patients; the measure combines and streamlines two measures previously reviewed by a CBE; components of the measure have been implemented nationally, demonstrating its feasibility. Opposing comments requested that the attestations with ambiguous and/or statements should be clarified, and expressed concern that attestation measures do not have the same level of significance as measures that display performance in terms of discrete data.

Discussion: Committee members raised 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 the validity of the attestations. The developer responded that while most domain goals apply to all patients, these areas are especially problematic for elderly patients. In addition, the measure domains were designed to be achievable as a place to start until they can standardize measures for elements such as frailty and vulnerability. The developer also asserted that stating more explicit outcomes or definitions for domains risks reducing feasibility and that including domains that broadly address both structure and process can drive improvement in a range of outcomes.

Some committee members, including one patient member, discussed the value of reporting performance scores separately instead of or in addition to combining the domains into one

score, so that people can see where the gaps lie. The developer acknowledged that scores for individual domains could be reported. Patient committee members and several other committee members supported the measure's intent; one patient committee member expressed its value in signaling to leadership that caring for a vulnerable elderly population should be driving hospital priorities. One committee member appreciated the flexibility of the measure domains in providing roadmaps hospitals can follow. Patient committee members also described the measure title as respectful to older adult patients, in response to a question about whether "Age Friendly" was an appropriate name for the measure.

Conditions: None voted to recommend with conditions; no conditions were stated.

Future Directions: Not discussed.

MUC2023-188 Patient Safety Structural Measure [CMS]

Description: The Patient Safety Structural Measure is an attestation-based measure that assesses whether hospitals demonstrate having a structure and culture that prioritizes patient safety.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 8 (50%); Recommend with Conditions, 5 (31%); Do Not Recommend, 3 (19%); three recusals

Program 2: PPS-Exempt Cancer Hospital Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 9 (56%); Recommend with Conditions, 4 (25%); Do Not Recommend, 3 (19%); three recusals

Measure Discussion:

CMS Opening Remarks: CMS stated that improving patient safety remains an important focus; research shows one in four Medicare beneficiaries will experience health care related harm and that safety performance declined during the pandemic, indicating that safety systems must be more resilient. The proposed measure addresses a gap not covered by other patient safety measures by focusing on building safety systems in the operational practices of hospitals. The domains (1. Leadership Commitment to Eliminating Preventable Harm; 2. Strategic Planning & Organizational Policy; 3. Culture of Safety & Learning Health System; 4. Accountability & Transparency; 5. Patient & Family Engagement.) were selected to reflect the evidence base connecting these practices with improved safety. The measure is closely aligned with several national initiatives to improve patient safety.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated areas of non-consensus among committee members, and concerns expressed were that the measure does not offer opportunity for improvement, there is not a strong correlation between safety culture and outcomes, and that the additional burden would achieve little or no benefit. Ninety-seven written public comments were received, 81 supporting, ten supporting with conditions, and six opposing the measure. Supporting comments focused on the importance of patient safety and the requirement for hospitals to establish systems to prevent and learn from medical error, the measure's focus on robust engagement between leadership and staff, and alignment with other national guidance. In addition, many patients and family members shared experiences with the medical system and preventable harms to emphasize the importance of the measure. Opposing comments asserted that the measure lacks visible mechanisms for audit and public accountability, and that it could lead to a rapid high-performance rate with unclear links to actual quality.

Discussion: One committee member stated they recognize the importance of safety but safety culture is hard to measure, and they expressed concerns that without additional guidance it would be easy to attest to the domains even though staff "on the ground" may not be knowledgeable. Another committee member expressed concern that some of the domains were check boxes that could be attested to without fulfilling the measure's intent. CMS explained that domains do reference specific activities rather than relying on a general sense of a safety culture, and they explained that the developer is working on a guidance document that will

provide definitions of terms and information on how domains were created. Developers must also attest they are doing each specific activity in a domain to achieve a positive score.

Similarly, one committee member questioned the reliability of attestations across 25 elements in five domains, as well as the challenge in identifying where the gaps exist, and urged narrowing of focus for elements. CMS replied that collecting data on the measure will help narrow the scope. A patient committee member, who is also a subject matter expert in patient safety, acknowledged that some gaming is possible, there is significant variation between hospitals in the work being done, and the measure elements provide a roadmap for hospitals looking for guidance on how they can improve. Regarding reporting, the developer confirmed that the reported measure score is determined by positively attesting to all elements in a domain, but hospitals will be provided with more granular data that let them see which elements were attested to. Two committee members commented on the value of making individual statement attestations more broadly available, and CMS noted they would consider making that information available through Care Compare.

Conditions: Publication of an implementation guide that clearly documents how safety is to be measured; using data to narrow the scope before approving the measure for programs.

Future Directions: An implementation guide is in process that is intended to guide organizations in how to score each element; CMS will consider making individual attestation scores available to the public.

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

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.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 6 (32%); Do Not Recommend, 1 (5%); no recusals

Program 2: Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 7 (37%); Do Not Recommend, 0 (0%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-50, below; both are new eCQMs.

CMS Opening Remarks: CMS stated that MUC2023-048 will enable organizations to track and monitor trends in falls with injury to improve intervention efforts over time and fill a key gap by focusing on falls with injury in acute care settings. CMS asserted that the potential unintended consequence of reduced patient mobility would be outweighed by the measure's benefits, and that programs have been able to successfully reduce falls without reducing mobility. CMS also noted the measure is proposed for IQR and the Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals because hospitals can receive credit for both programs with a single measure submission. CMS stated that MUC2023-050 will enable organizations to track and monitor trends in respiratory failure incidents to improve harm reduction efforts over time and fill a key gap by focusing on respiratory failure in acute care settings. CMS also noted the measure is proposed for IQR and the Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals because hospitals can receive credit for both programs with a single measure submission.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns that testing and model development occurred with sophisticated EHR systems not often found in hospitals in small, rural, or medically underserved areas and with the challenge of risk adjusting the measures. Nineteen written public comments were received, four supporting, eight supporting with conditions, and seven opposing the measures. Supporting comments mentioned that falls are a serious and preventable harm for which hospitals should be held accountable (MUC2023-048) and that the measures will encourage assessing patients for risk and putting them under the correct protocols early on. Opposing comments raised concern about the measures' scientific acceptability, specifically for low-volume sites, and argued that implementation may reduce opportunities for patient mobilization, which is critical for recovery (MUC2023-048), or may result in the use of inappropriate therapies or avoidance of using necessary procedures for high-risk patients (MUC2023-050).

Discussion: Committee members expressed overall support for these measures. Some 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, as well as the potential for inequitable use of different procedures (e.g., early movement during recovery can benefit patients). One committee member felt the proposed respiratory failure measure might overlap with Patient Safety Indicator 11 (PSI 11, Postoperative Respiratory Failure Rate); the developer clarified key differences, including that the proposed measure addresses a broader population and uses electronic data rather than claims. Committee members also brought up the need for risk adjustment and CBE review, harmonization of the falls measure, and clarification regarding how the measures were specified, including the ICD-10 codes used to define injuries resulting from falls and how mechanical ventilation was specified. The developer provided specification details for both measures and indicated that both measures were submitted for CBE review during the Fall 2023 cycle. One committee member raised a concern about the small number of testing sites; the developer explained that risk-adjusted scores obtained from testing showed variation in performance and room for improvement.

Conditions: CBE endorsement; monitoring of unintended consequences such as use of patient restraints and avoidance of life-saving procedures with higher risk for respiratory failure.

Future Directions: Not discussed.

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

Description: This 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).

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend (12 votes, 63.2%), Recommend with Conditions (5, 26.3%), Do Not

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 5 (26%); Do Not Recommend, 2 (11%); no recusals

Program 2: Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 5 (26%); Do Not Recommend, 2 (11%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-048; see measure above for the full discussion.

Conditions: See conditions noted for MUC2023-048.

Future Directions: Not discussed.

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

Description: Percentage of surgical inpatients who experienced a complication and then died within 30 days from the date of their first “operating room” procedure.

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 11 (61%); Recommend with Conditions, 5 (28%); Do Not Recommend, 2 (11%); one recusal

Measure Discussion:

CMS Opening Remarks: CMS stated the measure is intended to replace PSI 04 (Death Rate among Surgical Inpatients with Serious Treatable Complications), which is currently in IQR; differences are that the proposed measure collects all deaths within 30 days of the first qualifying surgical procedure regardless of the procedure site; is limited to patients with general, vascular, and orthopedic procedures; and excludes patients with procedures that follow complications. CMS cited improved reliability for the proposed measure compared with PSI 04 and risk adjustment for patients with COVID. The measure was submitted for CBE endorsement review in the Fall 2023 cycle.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, with the primary concern expressed that the measure was not a sufficient improvement over PSI 04. Eleven written public comments were received, one supporting, four supporting with conditions, and 6 opposing the measure. Supporting comments focused on the value of measuring patient outcomes. Opposing commenters cited limited evidence to support broadening the measure to 30 days after discharge, and concerns about the measure’s appropriateness for low volume sites.

Discussion: Some committee members requested additional information regarding how a patient’s do-not-resuscitate (DNR) order status is determined and whether this could be a source of gaming the measure. The developer acknowledged that DNR status on admission was not always available in claims data but asserted that the proposed measure improves on PSI 04 by creating a level playing field when comparing urban and rural hospitals, because the death is attributed to the hospital where the index procedure took place such that transferring hospitals cannot avoid being credited with the death. Some committee members raised issues related to reliability of the measure; the developer explained efforts undertaken to improve reliability and align the measure with other CMS mortality measures, such as using a 2-year reporting period for each hospital and a denominator threshold of 25 cases for reporting the measure.

One committee member questioned whether a 30-day window for identifying deaths attributable to the hospital was too long; the developer explained that a hazard analysis was used to estimate probability of death at different time points (e.g., 14, 21, and 28 days) with the goal of finding the point where deaths not related to surgery would be excluded and they determined that 30 days was an appropriate window. Another committee member asked about whether stratification of the measure was considered; the developer replied that stratification would reduce reliability, and their investigation of social risk factors showed that race/ethnicity was not

an independent risk after adjustment for other factors, indicating no need to stratify on race/ethnicity.

Conditions: CBE endorsement; collection of data to evaluate possible unintended consequences of hospitals encouraging patients to sign a DNR order or enter hospice.

Future Directions: Not discussed.

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

Description, MUC2023-146: The Care Coordination – Hospital Patient Experience of Care measure is a newly developed sub-measure to be added to the Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure and is composed of the three following new survey questions or items, 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?

Description, MUC2023-147: The Restfulness of Hospital Environment – 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 following three survey questions or items (two 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?

Description, MUC2023-148: 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 following two survey questions or items (one 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?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

Description, MUC2023-149: The Information About Symptoms – Hospital Patient Experience of Care Standalone Item sub-measure is a new sub-measure in the HCAHPS Survey measure and is composed of the following 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?

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 9 (47%); Recommend with Conditions, 8 (42%); Do Not Recommend, 2 (11%); no recusals

Program 2: Hospital Value-Based Purchasing Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 10 (53%); Recommend with Conditions, 7 (37%); Do Not Recommend, 2 (11%); no recusals

Program 3: PPS-Exempt Cancer Hospital Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 6 (32%); Do Not Recommend, 2 (11%); no recusals

Measure Discussion:

CMS Opening Remarks: CMS gave a brief description of the new (MUC2023-146, MUC2023-147, MUC2023-149) and revised (MUC2023-148) components ("sub-measures") proposed for HCAHPS and explained that the components were based on a literature review, TEP discussions, patient focus groups, and cognitive interviews with patients and caregivers.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns that additional questions may be a burden, that factors outside of hospital's control could affect scores, and that low response rates might be a limitation in rural settings. Twenty-four written public comments were received, eight supporting, 12 supporting with conditions, and four opposing the sub-measures. Supporting comments argued that patients who have a positive experience of care are more likely to follow clinical guidelines and have better outcomes, that the sub-measures align with CMS's goal of fostering engagement and bringing patient voices to the forefront, and that HCAHPS measures are well established in hospital workflows. Opposing comments asserted that HCAHPS survey response rates are low and have been decreasing due to survey fatigue.

Discussion: Committee members overall expressed that hearing the patient perspective is important but voiced concerns over survey fatigue and the possibility that the measures are not ideal for settings with high volume and high acuity (e.g., patients admitted through the ED), which might not perform well. CMS and the developer expressed they understand these concerns and have seen that patients with planned stays generally have better experiences than patients with unplanned stays. CMS also indicated that they would be collecting information on whether hospital stays were planned for potential use for patient case-mix adjustment.

Committee members requested additional detail on issues including survey response rates with longer surveys and the process for testing survey items, especially for MUC2023-147 (Restfulness of Hospital Environment). The developer described the testing process, which included focus groups and nationwide field testing, and explained that some items will replace existing items rather than add length; changes starting in 2025 to encourage better response rates will include expanded survey modes (including web and phone) and follow-up protocols, lengthening the data collection window by one week, requiring administration in Spanish (other languages are also available), and limiting supplemental questions to 12 (currently there is no limit).

Regarding concerns related to the restfulness sub-measure (MUC2023-147), the 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 to rest that are explained in advance (e.g., for medication administration). The developer also explained that the placement of items in the survey is purposeful to frame the questions. A patient committee member emphasized the importance of rest and having a quiet, secure environment where patients feel safe and do not feel punished for requesting a restful environment.

Committee members also raised concerns related to questions not being specific enough to the patient's reason for being hospitalized (currently, the measure is case mix adjusted by gender and medical, surgical, and maternity service lines). Committee members also questioned the inclusion of some items in MUC2023-149 that appeared to be duplicative of existing items. The developer explained that some added items focus specifically on caregivers to ensure their understanding of signs and symptoms to watch for. A patient committee member appreciated the distinction between informing patients and informing caregivers.

Conditions: CBE endorsement; consideration should be given to not extending the survey length and removal of overlapping items; use of adaptive questions in computerized administration to minimize items; use of a mechanism to monitor trends in performance data over time. Following the meeting, CMS confirmed that with the update, overlapping survey items have been deleted from HCAHPS. CMS also clarified that the web and computer-assisted telephonic interview (CATI) modes of the survey skip items per the instructions on the mailed survey.

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.

MUC2023-175 Facility Commitment to Health Equity [CMS]

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.

Program: Ambulatory Surgical Center Quality Reporting Program

Committee Final Vote: Recommend

Vote Count: Recommend, 15 (79%); Recommend with Conditions, 2 (11%); Do Not Recommend, 2 (11%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-176, below.

CMS Opening Remarks: CMS stated these measures (MUC2023-175, MUC2023-176) are important for driving equity-focused organizational competencies by highlighting a suite of activities in five domains (1. Equity is a Strategic Priority; 2. Data Collection; 3. Data Analysis; 4. Quality Improvement; 5. Leadership Engagement) to build a response to health disparities. Some committee members stated support for this measure for ASCQR, specifically citing alignment in equity across settings.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they raised concerns regarding an increased data collection burden and uncertainty whether the measure would have an impact. Twenty written public comments were received, three supporting, 11 supporting with conditions, and six opposing the measures. Supporting comments asserted that the measures will encourage entities' commitment to improving health equity through substantive changes to infrastructure, policy, and capabilities, and could also encourage expanded collection of demographic data and monitoring for health care disparities. Concerns expressed by commenters were that hospital associations already use a variety of programs underway for addressing equity, the attestations used in the measures would not effectively capture commitment to health equity, and structural measures lack mechanisms for audit and public accountability.

Discussion: One committee member raised the issue of validity testing for these measures; the developer acknowledged the limitations of testing structural measures and the reliance on agreements signed by entities attesting to the completeness and accuracy of the data they report; also, reliability testing is not possible for structural measures. Another committee member inquired whether a clear roadmap would be provided to avoid self-identification of committing to health equity without doing any of the work; CMS agreed consistency in measurement across all settings and programs is important and must rely on the existence of evidence-based steps entities can take to improve. CMS also shared that they see structural measures as a foundation that can eventually be tied to process and outcome measures. A patient committee member expressed appreciation for this approach.

One committee member inquired if CMS would be willing to consider making it a requirement for entities to collect and report data on race/ethnicity, gender, and payer, in turn allowing those entities to receive credit for reporting rather than via a structural measure; CMS explained that while CMS has some of the information described, without the measure they don't know whether entities are using the data for the purposes specified. The committee member also

called for greater specificity in the domain criteria; CMS shared that there is an accompanying guidance document for implementing the measures.

One committee member expressed concerns related to smaller entities' ability to participate in data collection and analysis domains and whether they would be at a disadvantage; CMS described a comprehensive guidebook released by the Department of Health and Human Services (HHS) and the White House with the aim of equipping entities with the tools needed for data collection, analysis, and QI activities. Participants also discussed the option for reporting demographic vs social drivers of health (SDOH) data and the availability of quality improvement (QI) activities in the SDOH domain. The developer explained that the selection of the measure domains was guided by evidence from the literature and from QI initiatives that link these domains with improved health outcomes.

Conditions: While the Committee's determination was to recommend this measure, committee members who voted Recommend with Conditions were asked to provide their conditions. These conditions were: CBE endorsement; additional specificity around attestation requirements; data collection for measure testing.

Future Directions: Not discussed.

MUC2023-176 Hospital Commitment to Health Equity [CMS]

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.

Program 1: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 4 (21%); Do Not Recommend, 3 (16%); no recusals

Program 2: Rural Emergency Hospital Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 13 (68%); Recommend with Conditions, 3 (16%); Do Not Recommend, 3 (16%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-175; see measure above for the full discussion.

Conditions: Consolidation of reporting for OQR with IQR reporting (applicable to OQR and MUC2023-176 only); see MUC2023-175 for additional conditions applicable across programs and measures.

Future Directions: Not discussed.

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

Description: The HEI is a prototype method for a single score that summarizes several measurements of disparity in care at a hospital.

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 4 (21%); Recommend with Conditions, 2 (11%); Do Not Recommend, 13 (68%); no recusals

Measure Discussion:

CMS Opening Remarks: CMS stated that the measure employs a prototype method, using a single score to capture equity gaps by summarizing stratified measure results across nine measures and social risk factors. The measure is not statutorily mandated.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated areas of non-consensus among committee members, and concerns were with that the measure would be difficult to use for facilities or settings with low patient volume, that facilities may not have resources for implementation, and a lack of clarity about how facilities can improve. Ten written public comments were received, three supporting, one supporting with conditions, and ten opposing the measures. Supporting comments focused on the importance of health equity measures for health care, and explained that the index could be expanded in the future to include other indicators of health equity and that the measure does not rely on imputed race and ethnicity data. Opposing comments expressed concerns that the measure could cause readmission rates to be “double counted”, that the Area Deprivation Index has limitations for identifying differences in risk factors for some communities, and argued it is unclear how hospitals could improve their performance.

Discussion: Patient committee members and other committee members expressed support for the measure intent and asked CMS to summarize key elements of the index and how it has been validated. CMS explained that the measure is intended to be a living index that can be populated with a range of different measures for future flexibility; the developer added that the prototype methodology is intended to be applicable to different measures and measure types as well as to different social risk factors; and the measures constituting the current index (mortality, readmissions) were selected in part because they are currently being stratified using CMS disparity methods. In response to a committee member’s question about variables used, the developer explained they update the methodology report annually, and all measures in the index have been separately validated and endorsed. A patient committee member stated that mortality measures are very important to patients.

One committee member expressed a concern that critical access hospitals (CAHs), which are often very small rural facilities, may not be able to report the measure; the developer acknowledged that hospitals need to meet a minimum threshold of cases to report on the measure; CMS reminded the group that CAHs are not required by statute to participate in IQR but may voluntarily submit their data for public reporting. Another committee member shared the concern about rural hospitals but focused on the mix of services. The committee member also expressed concern that “roll up” of the measure score (that is, reporting a single score for the index rather than reporting individual measure scores) could conceal some disparities and potentially inflate performance scores or make it more difficult for hospitals to identify areas needing improvement; the developer responded that the index includes individual measures that

are already reported, and confidential reports stratified by dual eligibility will be available in the spring. CMS confirmed that hospitals will receive aggregate and individual measure data, as the included measures will continue to be calculated independently.

A patient committee member asked about the value of the measure to patients; the developer explained that initially just the fact that hospitals reported the data would be public and that more thought is needed regarding how to publish the index for consumer use. Other committee members raised concerns about comparability of the index across hospitals and that having a high index could potentially mask poor performance across the board. The developer explained that hospitals are limited to those with at least 12 patients both with and without the demographic factors of interest and that the purpose of the index is to help hospitals learn how they can improve.

In response to a committee member's question, the developer confirmed that the HEI is not endorsed, nor has it been submitted for endorsement. Several committee members stated they would like to have more information on the methodology used, e.g., minimum thresholds and data clustering in the Area Deprivation Index (ADI) used to address social risk factors to evaluate its suitability for IQR.

Conditions: While the Committee did not reach consensus on this measure, committee members who voted Recommend with Conditions were asked to provide their conditions. These conditions were: As a prototype, the measure should be used as a learning and feedback tool.

Future Directions: More consideration is needed to plan how the measure scores should be reported publicly; the methodology is designed for future flexibility in incorporating measures and social risk factors.

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

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

Program 1: Ambulatory Surgical Center Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 14 (74%); Recommend with Conditions, 3 (16%); Do Not Recommend, 2 (11%); no recusals

Program 2: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 12 (63%); Recommend with Conditions, 4 (21%); Do Not Recommend, 3 (16%); no recusals

Program 3: Rural Emergency Hospital Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 13 (68%); Recommend with Conditions, 3 (16%); Do Not Recommend, 3 (16%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-171, below.

CMS Opening Remarks: CMS stated that the proposed measures (MUC2023-156, MUC2023-171) are important for capturing comprehensive assessments of patients in terms of five key health-related social need (HRSN) domains (1. food insecurity; 2) housing instability; 3. transportation needs; 4 utility difficulties; 5 interpersonal safety during their outpatient, ambulatory surgical, or rural emergency hospital care). that can drive disparities in health outcomes; the proposed measure allows for flexibility in how entities choose to implement screening.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they expressed concerns regarding increased data collection burden and lack of resources for screening patients. Twenty-six written public comments were received, six supporting, 11 supporting with conditions, and seven opposing the measures. Supporting comments asserted that identifying and addressing social needs will help reduce health inequities and that the measures are consistent with recommendations by clinician organizations and other health care providers related to the need for national uniform standards of quality measures to reduce the burdens on providers. Opposing comments argued there is no evidence that collecting these data drives improvements in health outcomes, it is unclear how this measures would be used in payment and public reporting programs, and the measures do not account for geographic variations in communities and therefore may be missing an opportunity to prioritize screening for needs that are relevant to the community.

Discussion: One committee member supported the measure but mentioned that the evaluation of the Accountable Health Communities (AHC) model, from which the five SDOH domains were

drawn, did not demonstrate an impact of the drivers on health outcomes other than ED visits. The committee member inquired about the process for validating the domains and also why some were not chosen. CMS briefly reviewed the five domains and stated that there is clear evidence of the relationship between unmet social needs and health outcomes and rigorous screening tools exist for the selected domains. The developer added that the specific domains were chosen to be broad-reaching, and in response to evidence of a gap in addressing the domains. One committee member encouraged the reporting of individual rates for the domains.

One committee member inquired about the value of the screen positive measure (MUC2023-171) and whether the presumption is that screening positive for SDOH reflected the quality of care; CMS acknowledged that a high score could be interpreted in different ways but that the objective was to incentivize collection of that data for these pay-for-reporting measures and to help identify patient needs and where resources constraints exist. Another committee member expressed support for the measures and indicated the Joint Commission has requested that hospitals begin screening patients for HRSNs, but they and other committee members also inquired about the likely expectation for hospitals to partner with community resources, expressing concern about the potential additional burden, especially on small rural facilities.

Patient committee members expressed support for both measures, and they would also like to see how the connection to community resources would be made, as well as expansion of the domains into areas such as disabilities, family support, and isolation. One committee member suggested that findings from the suggested domain could be used to apply for grants to address identified needs.

Committee members sought clarification on how the measures would be reported, including whether the same patients' data would be reported in multiple settings, and whether the screen positive rates would be communicated to entities individually by domain in addition to the overall rate. CMS clarified that a patient's data could be counted in more than one program if they were screened in more than one setting and confirmed that rates for screen positive would be provided by domain.

Conditions: Reduce reporting burden by allowing entities to report data to IQR and OQR simultaneously resulting in reporting in one set of measures per calendar year per facility within HQR (applicable to OQR only).

Future Directions: The five selected domains are a starting point and can be tailored.

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

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

Program 1: Ambulatory Surgical Center Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 13 (68%); Recommend with Conditions, 1 (5%); Do Not Recommend, 5 (26%); no recusals

Program 2: Hospital Outpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 11 (58%); Recommend with Conditions, 2 (11%); Do Not Recommend, 6 (32%); no recusals

Program 3: Rural Emergency Hospital Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 13 (68%); Recommend with Conditions, 0 (0%); Do Not Recommend, 6 (32%); no recusals

While committee members voted Recommend with Conditions for all programs for MUC2023-156, they were unable to reach consensus on MUC2023-171, with more votes for Do Not Recommend. Committee members expressed concern about possible ambiguity in interpretation of the screen positive rate measure, as well as potential expectations regarding entities' responsibilities for addressing HRSNs.

Measure Discussion: This measure was discussed together with MUC2023-156; see measure above for the full discussion.

Conditions: See conditions noted for MUC2023-156.

Future Directions: See future directions noted for MUC2023-156.

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

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.

Program 1: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 14 (74%); Recommend with Conditions, 3 (16%); Do Not Recommend, 2 (11%); no recusals

Program 2: Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals

Committee Final Vote: Recommend with Conditions

Vote Count: Recommend, 13 (68%); Recommend with Conditions, 3 (16%); Do Not Recommend, 3 (16%); no recusals

Vote Count: Recommend (13 votes, 68.4%), Recommend with Conditions (3, 15.8%), Do Not

Measure Discussion:

CMS Opening Remarks: CMS stated that the proposed eCQM calculates a score based on all aspects of interdisciplinary nutrition care, including screening, assessment, and interventions for hospitalized adults (ages 18 and above); hospitals may self-select for implementation of this measure.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns with the potential burden on smaller hospitals, rural hospitals and systems, and the possibility they will be penalized for having fewer resources and a more malnourished population. The Committee also felt it was unclear whether screening and treatment plan development would impact malnutrition. Thirty-one written public comments were received, 14 supporting, 16 supporting with conditions, and one opposing the measure. Supporting comments welcomed the measure's expansion to encompass all adults aged 18 years and older and appreciated the measure's potential to improve health care outcomes, enhancing nutrition support, and reducing hospital admissions and expensive morbidities. A substantial number of commentators believed that the measure can ensure early action against malnutrition, reduce the incidence of the disease, and prevent hospital admissions. The opposing commenter voiced concerns about overlapping measures and suggested that this measure may be duplicative with other frailty screening metrics.

Discussion: One committee member expressed concern about the quality of the evidence supporting expanding the measure to younger ages (i.e., 18-64), considering the likely expense that would be incurred in implementing the measure. The committee member believed the measure could create a conflict of interest by promoting hiring of more dietitians. The developer pointed out that it is not uncommon for nutrition research to use smaller samples than what is usually expected in epidemiological studies or for interventions for chronic conditions. They also explained that dietitians do not bill for inpatient services and the measure is unlikely to drive

staffing changes; the goal is to capture the work dietitians are doing rather than change the standard of care.

One committee member highlighted the potential for the measure to draw attention to deleterious effects on patients of practices such as withholding food from patients before procedures and then failing to offer adequate nourishment when procedures are delayed, sometimes repeatedly. Patient committee members of the committee emphasized the importance of this work and encouraged the developer and CMS to consider hospital acquired malnutrition as well through the timing of the survey during inpatient stays.

Committee members requested clarification about the scope of the measure, whether it was screening only or intended to measure hospital-acquired malnutrition. The developer explained that screening for malnutrition is an entryway for the measure, which is followed by assessment, diagnosis, and plan of care. The developer also clarified that the measure does not mandate a specific timeframe during a stay for the screening and assessment take place, e.g., on admission, and that hospitals may screen periodically for longer patient stays.

Conditions: 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.

Future Directions: Not discussed.

MUC2023-199 Connection to Community Service Provider [Oregon Community Health Information Network (OCHIN)]

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

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 7 (37%); Recommend with Conditions, 2 (11%); Do Not Recommend, 10 (53%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-211, below.

CMS Opening Remarks: CMS stated that the proposed measures (MUC2023-199, MUC2023-210) will support the agency's mission for equity and prioritize five key HRSN domains (1. food insecurity; 2. housing instability; 3. transportation problems; 4. utility help needs; 5. interpersonal safety) that can impact health outcomes; the measures address a gap.

Battelle Summary of Round 1 Evaluation Feedback and Public Comments: Committee feedback indicated that committee members felt the evidence was complete or that gaps could be addressed, but they had concerns with the burden and feasibility of data collection, felt that effectiveness of the measures would vary based on the availability of community resources and the socioeconomic profile of the region, and believed that data are needed to show an association between connecting patients with community service providers and positive outcomes. Fifteen written public comments were received, two supporting, two supporting with conditions, and 11 opposing the measures. Supporting comments expressed that connecting patients to community providers is an important step in addressing SDOHs, and that the measures presented an opportunity to standardize documentation of the work that occurs in multi-specialty teams. Opposing comments focused on the need for more clarity on key constructs as well as more validity and reliability testing.

Discussion: Committee members supported the measures' intent, but they also expressed a range of concerns related to the availability and capacity of community service providers (CSPs) to accept referrals, especially in rural areas, and whether hospitals alone would be expected to carry the burden of identifying when an HRSN is resolved following referral to a CSP. Committee members were also concerned that measure scores would depend heavily on sometimes scarce community resources, and that accountability would be misplaced on the hospital. The developer responded that the hospital's only responsibility would be to document a patient-reported resolution of the needs they were screened for, and that this work was already being done, albeit captured in a note field rather than a structured field. CMS emphasized that the measures are intended to drive discussion regarding capacity building and investment in social services.

One committee member representing a safety net hospital described their efforts to build an exchange, how challenging it is, and the inequitable distribution of burden. Another concern raised by committee members was potentially poor public perception of hospitals with low scores, and it was recommended that CMS ensure that education is paired with measure reporting to minimize misinterpretation of scores. Committee members also raised the

challenges associated with unhoused patients or patients not fluent in English, who are easily lost to follow up due to difficulty in contacting them, potentially removing the value of the measure for the most vulnerable patients.

Conditions: While the Committee did not reach consensus on this measure, committee members who voted Recommend with Conditions were asked to provide their conditions. These conditions were: CMS should 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.

Future Directions: Not discussed.

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

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

Program: Hospital Inpatient Quality Reporting Program

Committee Final Vote: Consensus Not Reached

Vote Count: Recommend, 4 (21%); Recommend with Conditions, 2 (11%); Do Not Recommend, 13 (68%); no recusals

Measure Discussion: This measure was discussed together with MUC2023-199; see measure above for the full discussion.

Conditions: See conditions noted for MUC2023-199.

Future Directions: Not discussed.

Next Steps

Dr. Brennan thanked all attendees for their active and enthusiastic participation and shared that they would be notified once the final 2023 PRMR recommendation report was created and posted online for public comment. Dr. Brennan also noted that Battelle is open and welcoming to feedback from everyone, including recommendations for future meetings. Battelle and CMS shared that they plan to reflect on this meeting's discussions, lessons learned, and recommendations from attendees to make decisions for future meeting timelines and schedules, with dates being sent out to committee members far in advance.

Closing Acknowledgments

In closing remarks, Battelle asked committee members to provide their perspectives on the PRMR process and suggestions for improvement during the next cycle. Dr. Schreiber thanked Battelle and Recommendation Group members and all participants for collegial discussion and participation in a successful day.

Battelle opened up the remainder of the meeting to committee members to share their feedback. Committee members shared areas of improvement and offered suggestions for future consideration:

- Provide additional clarity regarding which proposed measures were endorsed by a CBE, proposed for endorsement, or neither, including ensuring that the information provided is for the version of the measure under discussion.
- Provide additional information about what it means for a measure to undergo endorsement and how that information should be weighed in the pre-rulemaking process, perhaps to help expedite discussion.
- Give consideration in advance regarding the grouping of very similar measures to be discussed together, so committee members could review those measures as a group and submit one evaluation for the measure group instead of for individual measures, when appropriate (improved efficiency).
- When the number of measures to evaluate is large, consider dividing measures between committee members so that each measure receives sufficient attention, but committee members are not overtaxed by having to evaluate all the measures.
- The documenting of conditions for recommendations received considerable attention. Several committee members felt more attention is needed regarding what constitutes an appropriate condition and in communicating the criteria for conditions, how best to capture and display conditions for recommendation, and how best to incorporate conditions into the voting process. In addition, some committee members explained that they sometimes agreed with a condition stated by another but did not always verbally affirm their support.
- Enhancements to the measure evaluation entry tool were suggested, including the ability to edit entries and to review entries in preparation for the meeting, and to provide complex information, such as measure specifications, in tabs.

Committee members also shared successes from the meeting:

- Committee members appreciated the format, organization, and efficiency of the two-day meeting, including the opening comments that summarized the measure, evaluation findings, and public comments.

- Diversity of perspectives and the high level of engagement in the discussion was beneficial.
- Consistent attention to issues of rural, community, and small-volume providers was appreciated.
- Patient committee members felt the patient voice was heard.
- The streamlined voting process without repeated re-votes reduced frustration and allowed more time for discussion.

Dr. Brennan thanked everyone for their time, participation, and hard work, and adjourned the meeting.