Partnership for Quality Measurement
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Response to Public Comments on the 2024 Measure Set Review (MSR): List of Measures

Battelle published the draft 2024 MSR List of Measures for public comment from Wednesday May 15-Friday, May 31. Public comments received are listed below with editing for grammatical or typographical errors only. We have provided a response to each comment. Public comments on measures will be summarized for MSR Recommendation Group members as they prepare to discuss and develop recommendations on the continued use of each measure. Comments on Battelle's process for developing the MSR List and selecting measures are being taken under consideration as we improve our process for the next cycle.

1. Name or Organization: Stephen Weed

Subject: CMIT Measure ID: 253

Comment: As someone who just scheduled a colonoscopy yesterday, this measure leaves me speechless. My first 3 colonoscopies were trouble free and I think I am actually tolerating the prep better. I support this measure especially after reading the statistics.

> **Response:** Thank you for indicating your support for this measure, *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy* (00253-01-C-ASCQR, -HOQR, and -REHQRP). Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

2. Name or Organization: Stephen Weed

Subject: CMIT Measure ID: 1304 Hemodialysis Access Creation

Comment: I quickly reviewed the measure, especially the numerator and denominator definition. It seems to focus on cost effectiveness, one facility vs. a mean.

There needs to be more in play even for a measure that is about cost effectiveness. Whether the access is a fistula, port or other access, it is the long-term viability of the access that will determine how cost effective it is. To that point:

1. Emergency access needs to be evaluated separately.

2. I have had two fistulas and one port access while on dialysis. My first fistula did not work effectively after 3 years, which is not unusual. However, I used another vascular surgeon who was able to temporarily repair that access. She also created a fistula on my other arm. I received a transplant eventually. Three years later without being used, I could still feel the thrill. So, my point is that there is a substantive difference in the skill of vascular surgeons. Their skills determine not only dialysis adequacy but whether care is needed because of that diminished adequacy AND whether additional surgery is needed.

While I have not looked extensively, there does not seem to be a closely related measure. So, if not, this factor needs to be considered in future measures.

> ← **Response:** Thank you for articulating the importance of the skill of vascular surgeons in determining patient outcomes and cost.

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3. Name or Organization: Stephen Weed

Subject: CMIT Measure ID: 434 (MSPB) – Hospital

Comment: I have mixed opinions on this but, overall, there is more harm to continuing this measure.

Pro: I had a kidney transplant at one hospital and then a second transplant 8 years later. I saved copies of the hospital billing from both operations and it was startling. The second hospital's billing was 8% lower than the first hospital's billing. I cannot imagine that costs would be lower 8 years later for many reasons. So, there needs to be a system to monitor costs.

Con: There may be reasons why larger hospitals have better efficiencies than smaller facilities. In an age where there are concerns about rural and underserved communities needing to continue to have health care, I am concerned that such measures make this measure hazardous to this goal.

> ← **Response:** Thank you for sharing the pros and cons associated with continuing to use this measure, 00434-01-C-MIPS *Medicare Spending Per Beneficiary (MSPB) Clinician,* from your perspective. Although this measure was not prioritized for further MSR review, will be asking the MSR Recommendation Group to consider any potential disproportionate impacts on rural facilities for the measures that are under review.

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4. Name or Organization: Chisa Nosamiefan

Subject: Public Comments on Proposed Measures

Comment: I am in favor of the choice to focus on the cycle measures. From the patient and health equity perspective, I think it holds the potential to reform how we access and experience health care, setting a precedent for improved health outcomes and financial security for all. It directly resolves the issues of actionability and impact.

> ← **Response:** Thank you for expressing your support for this year's focus on Cycle C measures, which includes measures that address cost-effectiveness and efficiency in health care utilization.

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5. Name or Organization: American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, GI Quality Improvement Consortium

Subject: 2024 MSR Cycle (00039-01-C-MIPS) Age Appropriate Screening Colon

Comment: Please see the attached letter regarding the inclusion of (00039-01-MIPS) Age Appropriate Screening Colonoscopy in the 2024 MSR Cycle submitted on behalf of the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), and GI Quality Improvement Consortium (GIQuIC).

Thank you. Best, Eden

Eden Essex, Assistant Director, Quality Practice, and Health Policy, American Society for Gastrointestinal Endoscopy.

Attachment: https://p4qm.org/sites/default/files/comment_files/2024-05/2024%20MSR%20GI%20Org%20Letter_0.pdf

> **Response:** Thank you for expressing your support for 00039-01-C-MIPS *Age Appropriate Screening Colonoscopy*, noting its inclusion in the Core Quality Measures Collaborative Gastroenterology Measures Set and the candidate GI Care MIPS Value Pathway (MVP). Based on the selection considerations for the 2024 MSR Cycle, we believe that this measure has been appropriately prioritized for discussion; however, we appreciate your expression of support for continuation of this measure as one of a limited number of GI specialty-specific measures available in MIPS. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

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6. Name or Organization: American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, and GI Quality Improvement Consortium

Subject: 2024 MSR Cycle – Age Appropriate Screening Colonoscopy

Comment: Attached are comments relative to inclusion in the 2024 MSR Cycle of (00039-01-C-MIPS) Age Appropriate Screening Colonoscopy submitted on behalf of the American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, and GI Quality Improvement Consortium.

Attachment: https://p4qm.org/sites/default/files/comment_files/2024-05/2024%20MSR%20GI%20Org%20Letter_0.pdf

> **Response:** See response to comment 5.

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7. Name or Organization: American Academy of Otolaryngology – Head and Neck Surgery

Subject: AAO-HNSF (000033-01-C-MIPS)

Comment: The Academy of Otolaryngology – Head and Neck Surgery opposes the proposal to eliminate high-priority quality measure 331, Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse), from the Quality Payment Program. This measure is fully endorsed and in alignment with the Clinical Practice Guidelines (Update) for Adult Sinusitis, which emphasizes

symptom relief as the primary goal of managing viral rhinosinusitis (VRS). Antibiotics are not recommended for VRS treatment due to their inefficacy against viral illnesses and lack of direct symptom relief. Additionally, antibiotic use may cause patient harm and foster antibiotic resistance. The measure aims to facilitate sound clinical judgment in distinguishing between viral and bacterial sinusitis and evaluating symptom timelines.[1] It encourages adherence to published clinical practice guidelines to mitigate antibiotic overuse.

In the latest Historical MIPS Quality Benchmark file for 2024, this measure neither reaches the topped-out threshold nor meets the criteria for being classified as a 7-point cap. Analysis of historical benchmarks spanning from 2019 to 2024 indicates an improvement in performance rates (inverse), declining from 61.5 percent to 23.32 percent over the past five years. However, a significant portion of patients still receive unnecessary antibiotic prescriptions, highlighting the ongoing need for quality improvement efforts. The decrease in average performance rate found within the 2024 Historical Benchmark file may be artificially low due to the leniency of reporting due to the Public Health Emergency for the 2022 performance year.

Based on CDC data, the treatment of bacterial infections in the US may incur an additional cost of approximately $1,400 per patient due to antibiotic resistance. Global projections suggest that by 2050, the annual economic burden of antimicrobial resistance (AMR) could range from $300 billion to over $1 trillion.[2]

1. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, Brook I, Ashok Kumar K, Kramper M, et al. Clinical practice guideline (update): adult sinusitis. Otolaryngol Head Neck Surg. 2015; 152: S1–S39.
2. Dadgostar P. Antimicrobial Resistance: Implications and Costs. Infect Drug Resist. 2019 Dec 20;12:3903-3910. doi: 10.2147/IDR.S234610. PMID: 31908502; PMCID: PMC6929930.

🡐 **Response:** Thank you for expressing support for continued use of 000033-01-C-MIPS *Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)* Please note that inclusion on the 2024 MSR List is not a proposal to eliminate any measure; rather, through the MSR process, measures will be discussed and evaluated for continued use in their designated Medicare quality programs. All measures in CMS Medicare quality reporting programs will be evaluated for inclusion in the MSR process over the next 4 years, as described in section 3.4 of the 2024 Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR). The MSR process considers the measure's meaningfulness (accounting for the recent performance data that you mentioned in your comment), data stream parsimony (i.e., redundancy in reporting), and its location in the patient's health care journey. We thank you for voicing your support for continuation of this measure. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

8. Name or Organization: American Medical Rehabilitation Providers Association (AMRPA)

Subject: AMRPA comments on the PQM MSR list of measures for removal

Comment: The American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to submit comments on the PQM MSR list of measures under consideration for removal from CMS quality programs. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation facilities and rehabilitation units of acute-care general hospitals (IRFs).[1] The vast majority of our members are Medicare-participating providers with quality measure information publicly reported on the CMS Care Compare website. AMRPA has always looked to be a partner to regulating agencies and other key quality stakeholders in promoting meaningful and effective quality reporting in the IRF program, and we look forward to continuing this type of partnership with Battelle and the PQM moving forward.

AMRPA recognizes the importance of a consensus-based entity (CBE) and the processes "to inform the selection and removal of health care quality and efficiency measures, respectively, for use in the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicare quality programs." AMRPA believes that the PQM MSR process is essential and must facilitate an effective identification and removal of quality measures that are administratively burdensome, do not distinguish high-quality care in and among IRFs, or do not result in better patient outcomes. AMRPA stands ready to work with the PQM in the next PQM MSR cycle and ensure that the PQM has sufficient information to remove existing IRF QRP measures that create unnecessary administrative burden for IRFs and their patients without delivering meaningful information to patients or policymakers.

AMRPA comments on the list of measures up for removal, and suggestions for alternative/replacement measures listed in the 2024 Measure Set Review List are detailed in the attached document.

AMRPA thanks Battelle and the PQM for allowing us the opportunity to provide feedback on the Partnership for Quality Measurement (PQM) Measure Set Review (MSR) list of measures under consideration for removal from the CMS QRPs. In sum, AMRPA supports the PQM MSR process and urges PQM to include the IRF QRP measures currently identified in the MSR list as well as the additional ones we have included in our comments. AMRPA stands ready to work with Battelle and the PQM to help ensure meaningful quality measures continue to be considered for use in CMS quality programs.

Should you wish to discuss the AMRPA comments further, please contact Troy Hillman, AMRPA Director of Quality and Health Policy (thillman@amrpa.org / (202) 207-1129), or Kate Beller, JD, AMRPA President (kbeller@amrpa.org / 202-207-1132).

Attachment: https://p4qm.org/sites/default/files/comment_files/2024-05/May%202024%20AMRPA%20PQM%20MSR%20Comments_0.pdf

> **Response:** Thank you for your support of the MSR process. We also note your support for the inclusion of two specific measures in the draft 2024 MSR List: 00575-01-C-IRFQR *Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program* and 00576-01-C-IRFQR *Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program.* These measures will be discussed and evaluated for continuation in the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) based on their

meaningfulness, data stream parsimony, and location in the patient health care journey. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group. The two additional measures that AMRPA has put forward for inclusion in the 2024 MSR List (CMIT Measure ID 01699 *COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date* and CMIT Measure ID 00180 *COVID-19 Vaccination Coverage among Healthcare Personnel [HCP]*) are not in the Cycle C set that focuses on the Cascade of Meaningful Measures priority of Affordability and Efficiency, and so are not eligible for MSR this year.

9. Name or Organization: Emergency Department Practice Management Association (EDPMA)

Subject: EDPMA request to maintain emergency medicine MIPS measures

Comment: On behalf of the Emergency Department Practice Management Association (EDPMA), we are writing to provide feedback on the Partnership for Quality Measurement's (PQM) 2024 Measure Set Review (MSR) list of measures under consideration for removal from Centers for Medicare & Medicaid Services (CMS) quality programs. EDPMA is the only professional physician trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all ownership models and sizes, many of whom serve rural communities, as well as billing, coding, and other professional support organizations that assist health care providers in our nation's emergency departments. Together, EDPMA's members deliver (or directly support) health care for about half of the 146 million patients that visit U.S. emergency departments each year.

EDPMA appreciates that the annual MSR process aims to optimize the CMS measure portfolio by allowing interested stakeholders to consider the purpose of each program's measures and to weigh the impact of these measures against the burden of implementation. At the same time, we are concerned about three measures currently under consideration for removal from the Merit-Based Incentive Payment System (MIPS), which are important to and commonly used by emergency department practices. These measures are discussed below.

#331: Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)

This measure is under consideration for removal by the PQM due to questions surrounding actionability (i.e., do measured entities have a well-articulated path to improvement?) and/or questions about whether there is still an opportunity for impact.

We remind the PQM that this measure currently has a benchmark, which demonstrates that it is commonly reported by MIPS participants. Unlike many other measures in the MIPS inventory, #331 also does not have topped-out performance according to the 2024 MIPS historic benchmarks, which suggests that gaps in performance still exist in terms of antibiotic prescribing for acute viral sinusitis. Additionally, CMS recently included this measure in the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MIPS Value Pathways (MVP). CMS has clearly stated its intent to eventually move all MIPS participants into MVPs and to retire traditional MIPS. With MVPs being CMS's preferred future participation

pathway, it is important that CMS preserve this measure as an option for MVP reporting. Overall, this measure targets the important goal of ensuring appropriate use of antibiotics and based on existing benchmarks; it is clear there is still room for performance improvement.

#415: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

#416: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

These two measures are under consideration for removal by the PQM due to questions surrounding actionability and impact and/or because they are potentially duplicative and candidates for harmonization.

Similar to #331, measures #415 and #416 have historic performance benchmarks in 2024, indicating wide use among MIPS participants. While #415 is topped out, #416 is not topped out and continues to target an important and ongoing gap in performance. Both #415 and #416 are also included in the Emergency Medicine MVP, demonstrating that CMS continues to find value in these measures and envisions them playing an important role in the future of the program.

Emergency medicine practices face unique challenges when it comes to MIPS compliance. They manage a wide range of often unpredictable clinical scenarios and disparate patient populations. They also struggle with data capture due to a lack of control over the facility's EHR system, which limits their reporting options and poses challenges in regard to QCDR participation. Overall, if CMS wants to incentivize movement towards MVPs, then it must ensure that a diverse set of quality measures are available so that practices of all sizes and levels of resource can take advantage of this new, more streamlined reporting pathway.

EDPMA appreciates the opportunity to provide feedback on these important measures. We recognize that measure performance data were not reviewed as part of this initial selection process, but that they will be reviewed as part of the MSR process. We look forward to reviewing and providing additional feedback on these assessments when available for public comment. In the meantime, should you have any questions, please do not hesitate to contact EDPMA Executive Director Cathey Wise at cathey.wise@edpma.org.

> ← **Response:** Thank you for expressing your support for continued use of 00033-01-C-MIPS *Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)*, 00237-01-C-MIPS *Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older*, and 00237-02-C-MIPS *Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years*. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group. Thank you also for correctly noting that performance data were not reviewed as part of the initial selection process; performance data are summarized in the forthcoming preliminary assessments, which will also be posted for public comment.

10. Duplicate of comment 7.

11. Name or Organization: Encompass Health

Subject: 2024 Measure Set Review (MSR) Public Comment

Comment: Dear Partnership for Quality Measurement,

We appreciate the opportunity to submit comments regarding the Partnership for Quality Measurement (PQM) Measure Set Review (MSR) measures considered for removal from Centers for Medicare & Medicaid Services ("CMS") quality program.

Encompass Health is the nation's leading provider of inpatient rehabilitation hospital care and services. We operate 162 freestanding rehabilitation hospitals in 37 states and Puerto Rico. In 2023, our hospitals had over 220,000 inpatient discharges, more than 80% of whom were Medicare beneficiaries.

MSR Procedural Comments

From a procedural perspective, it is unclear how measures were selected from the workbook presented at the PQM Measure Strategy Summit in Baltimore on April 11th to be reviewed as part of the 2024 MSR cycle. The workbook, titled "MSR-Breakout-Cycle-C-Measures" divided the 114 measures across Group 3 "measures to review," Group 2 "measures to potentially review," and Group 1 "measures not to review." The final posted list of measures to review does not include all measures from the initial "measures to review" listing, and it is unclear how measures were selected to review from the Group 2 "measures to potentially review" listing. To further the confusion, the final list of measures to review is also divided into Measures Group 1 and 2 based on different selection considerations; however, there is not information related to why each measure was selected for review.

Measure Group 2 Measure Comments

27. (00210-05-C-HHQR) Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

28. (00575-04-C-HHQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program

29. (00575-01-C-IRFQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

30. (00576-01-C-IRFQR) Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

31. (00210-03-C-LTCHQR) Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

32. (00575-02-C-LTCHQR) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

33. (00210-02-C-SNFQRP) Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

34. (00575-03-C-SNFQRP) Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

We do not recommend removing Discharge to Community or Potentially Preventable 30-Day Post-Discharge Readmissions or Potentially Preventable Within Stay Readmission Measure from the Home Health, LTCH, SNF, or IRF Quality Reporting Programs. While not specified by the Measure Set Review listing, the measures appear to be on the list regarding “questions surrounding actionability” because the measures have strong impact in the public reporting program and are not duplicative with existing measures. Discharge to Community, Potentially Preventable Within Stay Readmissions, and Potentially Preventable 30-Day Post-Discharge Readmissions are important outcomes and relevant measures in the post-acute care continuum. These measures are not only beneficial to consumers when making decisions regarding their health care (rates of Discharge to Community and Potentially Preventable Readmissions vary widely not only between PAC settings but amongst individual providers) but also important quality indicators on which providers work to improve. The primary opportunity to improve these measures’ “actionability” is providing PAC settings, like they do with acute care hospitals. Patient-level data would allow providers to understand the results of the measure, which is critical to driving improvement. PAC settings should receive the same level of detail in their quality measures as is provided to acute care hospitals.

> ← **Response:** Thank you for your expression of support for continued use of the *Discharge to Community or Potentially Preventable 30-Day Post-Discharge Readmissions* and *Potentially Preventable Within Stay Readmission Measures* in the Home Health, Long-Term Care Hospital, Skilled Nursing Facility, and Inpatient Rehabilitation Facility Quality Reporting Programs. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group. We also appreciate your comments on the MSR List selection process and the potential for confusion in our labeling of measure groups. We intentionally did not include measure-level information about which considerations or set of considerations led to a measures inclusion on the list, as we wanted to avoid a premature evaluation of measures; however, we understand the desire for increased transparency and plan to present the 2025 MSR List differently so that interested parties have a clearer understanding—at the measure level—of why a measure was prioritized for the MSR process.

12. Name or Organization: American College of Physicians

Subject: (00039-01-C-MIPS) Age Appropriate Screening Colonoscopy

Comment: The ACP supports the removal of this measure from the MIPS program.

The proportion of patients above 85 years old who get a colonoscopy is very small. Moreover, there is no performance gap data to demonstrate that the measure addresses an opportunity for improvement. The specifications for the measures are confusing and the age range where overuse is more likely is 76 to 85 years of age.

> **Response:** Thank you for expressing your support for discontinuation of 00039-01-C-MIPS *Age Appropriate Screening Colonoscopy* from the MIPS program. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

13. Name or Organization: American College of Physicians

Subject: 00076-02-E-MIPS: Appropriate Use of DXA Scans in Women Under 65

Comment: ACP supports the removal of this measure from the MIPS program.

The harms of overuse from dual-energy x-ray absorptiometry (DXA) scans are relatively low and this performance measure does not fill a performance gap. The denominator exclusion criteria do not follow current guidelines and the exclusion criterion combinations are too stringent for physicians, adding unnecessary burden. If this measure were to remain in the program, ACP recommends clarifying the risk factor language and defining “osteoporotic fracture” more specifically.

> **Response:** Thank you for expressing your support for discontinuation of 00076-02-E-MIPS *Appropriate Use of DXA Scans in Women Under 65* from the MIPS program. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group

14. Name or Organization: Covered California and CalPERS

Subject: Comments on the 2024 Measure Set Review (MSR) for Cycle C Measure

Comment: To Whom It May Concern,

Covered California and CalPERS appreciate the opportunity provided by the Pre-Rulemaking Measure Review (PRMR) process to comment on the proposed measures for the 2024 Measure Set Review (MSR). We recognize the importance of this annual review in enhancing the quality and efficiency of health care delivery across the United States. After careful consideration of the measures outlined for Cycle C, focusing on cost-effectiveness and efficiency in health care utilization, we wish to express our perspectives and recommendations.

Themes for Consideration:

Significant Measurement Burden: The health care landscape faces a significant challenge with the inclusion of 34 measures, potentially expanding with public input, creating a substantial measurement burden on providers. This extensive list of measures risks diluting the focus on areas crucial for enhancing patient care and reducing costs. These additional measures are not clearly aligned with the CMS Universal Measure Set and may introduce added complexity and hinder alignment efforts across health care settings. Furthermore, measure misalignment

between PQM and Medicaid Core Set interferes with the ability to successfully align across payers.

Total Cost of Care and Quality Reporting: As highlighted in a recent JAMA article (Saraswathula, et al., JAMA Vol. 329, No. 21, pp 1840-47) on the impact of hospital quality reporting on the total cost of care, it is imperative that quality measures are evaluated not only on their immediate clinical impact but also on their broader financial implications. Measures should be assessed for the potential cost of data collection with a preference for electronic metrics and their ability to contribute to cost efficiency while maintaining or enhancing the quality of care.

Gaps in Measure Development: If new measures are to be created, we recommend a focus on domains with gaps such as utilization-based measures, coordination across care settings (e.g., emergency room/urgent care to primary care transitions), and specialty care quality. Development of measures should ensure comprehensive coverage of quality and efficiency in health care delivery rather than duplicate or create redundant metrics.

Focus on Performance Improvement: With the current set of measures, there has not been meaningful or sustained improvement across all populations. In fact, several areas have witnessed a decline during the pandemic. A number of measures such as CIS-10 and Well Child Visit rates have yet to recover to pre-pandemic performance levels, underscoring the need not for more measures but rather attention to improvement and implementation of an equity lens.

In conclusion, Covered California and CalPERS are committed to collaborating with PQM, CMS, and other stakeholders to approach the development of new measures with caution and care. Our collective goal is to enhance health care quality and efficiency, ultimately benefiting patients and the health care system at large. We look forward to engaging in further discussions and contributing to the development of a focused, impactful measure set. Thank you for considering our comments.

Sincerely,

S. Monica Soni, MD
Chief Deputy Executive Director
Chief Executive Officer
Covered California

Marcie Frost
Chief Medical Officer
CalPERS

Attachment: https://p4qm.org/sites/default/files/comment_files/2024-05/Comment%20on%20Proposed%20Measures%20for%20the%202024%20Measure%20Set%20Review%20%28MSR%29%20Cycle%205.31.24.pdf

> **Response:** Thank you for comments on the draft 2024 MSR List. We note that the list is composed of measures that will be discussed and evaluated for continued use in CMS quality reporting programs. MSR Recommendation Group members may recommend that the measure continue in the program or that it be removed from the designated program. We appreciate the perspectives you have shared in terms of measurement burden and

performance improvement. These concepts are reflected in the MSR evaluation considerations of data stream parsimony and meaningfulness, respectively, against which measures will be evaluated during the MSR process.

15. Name or Organization: American Geriatrics Society

Subject: AGS Comments on Proposed Measures for Removal

Comment: The American Geriatrics Society (AGS) greatly appreciates the opportunity to review and comment on the measures up for removal for the 2024 Measure Set Review (MSR) process.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

We agree with the removal of this measure. According to the measure specifications, there is no evidence available for this measure. While the rationale states that there is no significant peer-reviewed literature specific to potentially preventable readmissions post SNF discharge, most readmissions are due to five potentially preventable conditions: heart failure, electrolyte imbalance, respiratory infection, sepsis, and urinary tract infection (MedPAC, 2007). We believe it may be beneficial to create measures around care processes for these common preventable conditions that could ultimately lead to reduction in readmissions.

Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

AGS recommends clarifying the rationale for proposing to remove this measure. While there may be some concerns, it seems there is evidence for specific interventions that could have an impact on this measure. Further, care coordination between settings is critically important and can be conducted with care processes via telehealth, particularly for specific diseases such as diabetes mellitus, chronic obstructive pulmonary disease, and congestive heart failure.

Hospital Visits After Orthopedic and Urology Ambulatory Surgical Center Procedures and Hospital Visits After Urology Ambulatory Surgical Center Procedures

We recommend keeping these measures as they provide actionable data that is meaningful to the patient experience after specific outpatient surgical procedures and do not appear to be duplicative. It would be important to provide a balance to the incentive for providers to refer to emergency rooms as many of the Current Procedural Terminology (CPT) codes employed at ambulatory surgical centers would be 10- or 90-day globals. While some of the emergency room visits assigned to the numerator of the measure specification will be unrelated to the procedure, the performance benchmark will naturally include unrelated visits for all providers.

Thank you for taking the time to review our feedback and recommendations.

← **Response:** Thank you for expressing your support for discontinuation of 00575-03-C-SNFQRP *Potentially Preventable 30-Day Post-Discharge Readmissions Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)* and expressing your support for

continued use of 00210-05-C-HHQR *Discharge to Community – Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)*, 000345-02-C-ASCQR *Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures*, and 00346-02-C-ASCQR *Hospital Visits After Urology Ambulatory Surgical Center Procedures*. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

16. Name or Organization: American Society of Clinical Oncology (ASCO)

Subject: ASCO Comments on 2024 MSR

Comment: See attached.

Attachment: https://p4qm.org/sites/default/files/comment_files/2024-05/2024MSRPublicComment_ASCO_5.29.24_0.pdf

Response: Thank you for expressing your support for continued use of 00543-01-C-MIPS *Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life* and 00021-02-C-HOQR and 00021-01-C-PCHQR *Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy* in the Hospital Outpatient Quality Reporting (HOQR) Program and the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, respectively. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

17. Duplicate of 16.

18. Duplicate of 16.

19. Name or Organization: Gail Grant, MD

Subject: (00419-01-C-MIPS) Maternity Care: Elective Delivery

Comment: This is the same measure that was recently retired by both CMS (for the IQR program) and TJC due to it being topped-out. Hence, this retirement appears to be a good rationale for NOT including this measure in the MIPS program.

Response: Thank you for expressing your support for discontinuation of 00419-01-C-MIPS *Maternity Care: Elective Delivery.* Your comment will be summarized in the meeting materials referenced by the MSR Recommendation Group.

20. Name or Organization: American Medical Association

Subject: MSR Measures

Comment: The American Medical Association (AMA) appreciates the opportunity to comment on the 2024 Measure Set Review (MSR): List of Measures. Our comments are on the overall process and selection considerations used to identify which measures will be discussed as well as the individual measures in the groups.

The measure removal process is intended to identify those measures that should be no longer included in a specific quality program, yet the report does not address that question for any of the measures included in Groups 1 or 2 and more specifically the selection considerations used to evaluate the measures make no mention that this objective will be a part of the discussion. We believe that it is critical that the individuals reviewing these measures understand the overall purpose of this process and fully understand the scope and intent of the programs in which each measure is included. Without this understanding, we do not believe that they will be able to appropriately evaluate each measure.

Furthermore, the selection considerations included in the report are extremely subjective and if the review only included the measure description, numerator, denominator, and exclusions, then it is not clear what information confirmed that a measure was not actionable, based on established clinical guidelines, and/or was duplicative to another measure. While we do not believe that this review should be a repeat of the endorsement process, it should be grounded in a set of criteria that were vetted and approved using multi-stakeholder input and clearly articulated with detailed information on how a measure was selected for discussion and ultimately recommended for removal.

As a result, we question why a measure was proposed for Group 1 versus Group 2 nor is it clear what were the reasons for proposing that the measures in Appendix B were not appropriate for review. For example, the AMA has repeatedly notified CMS of concerns with the continued use of the Total Per Capita Cost measure in the Merit-based Incentive Payment System (MIPS) but the selection considerations are not designed to identify those measures with concerns regarding attribution, reliability, validity, or other unintended consequences. Other examples are the hospital-level risk-standardized payment measures for acute myocardial infarction, heart failure, pneumonia, and elective primary total hip arthroplasty and/or total knee arthroplasty. The FY2025 Inpatient Prospective Payment System proposed rule includes potential removal of these measures from the Hospital Inpatient Quality Reporting Program – the last program in which they are implemented. If a measure is no longer in use in a program, it would seem logical to consider removing them from the portfolio of possible measures.

The AMA believes that the Partnership for Quality Measurement must clearly articulate the reason for the removal discussion, the criteria against which these measures should be evaluated, and the process by which these decisions are made. Until these actions are taken, we do not believe that this work will result in meaningful and actionable decisions that can be supported by stakeholders.

Thank you for the opportunity to comment.

> 🡐 **Response:** Thank you for your comments on the MSR process. The considerations that were applied to measures in Cycle C, Affordability and Efficiency, to prioritize measures for MSR were developed with input from PRMR/MSR committees at the 2024 PQM Measure

Strategy Summit. We intentionally did not include measure-level information about which considerations or set of considerations led to a measure's inclusion on the list, as we wanted to avoid premature evaluation of measures; however, we understand the desire for increased transparency and plan to present the 2025 MSR List differently so that interested parties have a clearer understanding—at the measure level—of why a measure was prioritized for the MSR process. We agree with your assertion that MSR should not be duplicative of the endorsement process; however, implementation experience allows for assessment of whether the measure still aligns with goals and priorities, demonstrates reliability and validity, retains feasibility, and can be used for improvement. The meaningfulness in the context of use criteria for MSR is meant to surface concerns about reliability, validity, importance, and feasibility that may have been initially addressed through an endorsement process or rulemaking. Performance data, evidence, and argument are all used during the MSR process to evaluate measures under discussion for continued use in CMS programs.

21. Name or Organization: Stephen Weed

Subject: CMIT Measure ID 453 MRI Lumbar Spine

Comment: I strongly support this measure.

There needs to be a threshold for doctors to recommend an MRI or ultrasound. To pursue diagnostics may and does lead doctors to NOT pursue treatments that are often effective and easily done. Specifically in my case, my pain in the lumbar region would have been lessened considerably with a regime of stretching. In fact after diagnostics, the treatment included drugs, which in my case created more problems, prolonged my recovery by years, and significantly impacted my family as well.

Immediately after my MRI and x-rays, I visited a PT who was hesitant to do much since doctors had recommended x-rays and a more comprehensive approach. Now, after recovery from Lyrica toxicity, many visits to PT, and consultations with 2 neurologists, I am left believing that strengthening my core and legs along with stretching is my best approach to life.

I have not read all the details but I understand the MSR process. The challenge is how to incentivize facilities and doctors to properly access the need for MRIs. Doctors should not fear doing less-invasive approaches where there is no indication of prior injury or restrictions on mobility.

← **Response:** Thank you for expressing your support for continued use of 00453-01-C-HOQR *MRI Lumbar Spine for Low Back Pain*. Your comment will be summarized in the meeting materials referenced by the MSR Recommendation Group.

22. Name or Organization: Steven J. Schweon

Subject: Simple Pneumonia with Hospitalization 01508-01-C-MIPS

Comment: Pneumonia, “friend of the aged,” can be prevented in the inpatient hospital setting by encouragement to get out of bed sooner, ambulation, head of bed elevation, assessing for aspiration risk, assessing for vaccination against respiratory pathogens such as the pneumococcus, pneumonia prevention education, family engagement, encouraging deep breathing, frequent lung auscultation, preventing dehydration, hand hygiene, etc. This metric provides valuable information with basic, essential nursing and medical care practices to promote health and prevent mortality.

> ← **Response:** Thank you for your comment in support of continued use of 01508-01-C-MIPS *Simple Pneumonia with Hospitalization*. This measure was not prioritized for discussion during the 2024 MSR cycle, based on the selection considerations outlined in the draft 2024 MSR List of Measures.

23. Name or Organization: Janice Tufte

Subject: MSR Comments

Comment: Appreciate the feedback focus on actionability offering a path to improvement and alignment with respected clinical guidelines in Measure Group 1—I believe these measures should either be removed or edited to better measure antibiotic stewardship, safety regarding age-appropriate colonoscopy (86? or perhaps 75), unintentional overuse, and inappropriate screenings where harms potentially outweigh any benefits.

I am wondering though why MPF price accuracy is up for removal—is it because of fluctuating drug prices that impact Part D plan posted prices? Patients really would appreciate knowing how accurate their drug costs are before purchasing them—More explanation as to why this measure is up for removal here is important to some of us members of the public.

Regarding Measure Group 2 and the possible measure removal and questions surrounding measure actionability and/or impact and/or potentially duplicative measure focus (ED or Readmission may be candidates for alignment, harmonization, consolidation, or reduction as some are similar across same or different quality reporting programs) I believe it would be helpful to us patients/caregivers/community to have more information to better understand which measures currently are similar across programs with a chart with measures on lines. For instance, where one might list: “Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy” where the measure and the program would be listed in either the X or Y axis. It also seems to me that one measure such as the 7-day outpatient colonoscopy mentioned above appears to be the same, though I do understand depending on the facility setting the denominator and numerator would be different and this is why they are listed the way we are. Having any rationale for removal with any data would help us all. (CMS page does not offer measure maintainer information and/or much data on measures = seems misaligned at times. [*See example below.] With missing data it can be challenging to decide what exactly to provide insights on.)

*For instance I might be interested as a patient to search data and information as I am nervous or anxious to have a colonoscopy so I search AI = “7-day risk of being hospitalized after

outpatient colonoscopy" up pops Centers for Medicare & Medicaid Services Measures Inventory Tool (cms.gov) (00253-01-C-ASCQR). I find that this measure includes Fee for Service > 65 Medicare though does not share what is the upper recommended age limit nor anything about Medicaid or MA? Alas there are no exceptions listed. Looking deeper into the Cascade of Meaningful Measures data I read this:

Primary Priority is "Affordability and Efficiency"

Primary Goal is listed as "Reduced Readmissions Including Observation"

The Secondary Priority is Safety

Secondary Goal is "Reduced Preventable Harm"

In my patient-centered focused mindset it seems to me that patient safety should be the primary priority and primary goal should be reduced preventable harm—I recognize PQM's Cycle C is looking at cost and efficiency and I am hoping the patients and caregivers and clinicians as well as hospitals might rethink this "Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy" priority hierarchy. It appears to really have these be meaningful measures that 3 and 4 listed above should really be 1 and 2. We are all patients, and we like to save money as well as stay out of the hospital, so safety should be the priority, I believe. I am hoping CMS sees this :)

It could also be of help to us patients/caregivers/community if we had the CMIT-coded PQM's initial findings according to actionable path to improvement, impact factors, alignment opportunities, as well as duplicative measure focus. Perhaps this will come at the MSR meeting.

Thank you for your work.

Janice Tufte

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Patient/Public Involved

> 🡐 **Response*:*** Thank you for your comments and perspectives on what information may be most useful to patients/caregivers and the PQM community about measures on the 2024 MSR List. We intentionally did not include measure-level information about which considerations or set of considerations led to a measure's inclusion on the list, as we wanted to avoid premature evaluation of measures; however, we understand the desire for increased transparency and plan to present the 2025 MSR List differently so that interested parties have a clearer understanding—at the measure level—of why a measure was prioritized for the MSR process.

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24. Name or Organization: Conlee Fisher Clark

Subject: Quality Measures for chemo within the last 14 days of life

Comment: I would like this QM to remain in place. The patients are underserved in palliative care. Patients who undergo chemo without an opportunity for symptom management of their

disease process is a disservice to patients. All patients no matter what their treatment plan is should be offered palliative services to evaluate their status and make medication, treatment, end-of-life decisions. Currently cancer centers are not utilizing palliative services to determine end-of-life care. Physicians are not always symptom management experts and are very under-educated on this topic.

← **Response:** Thank you for your comment in support of continued use of measure 00543-01-C-MIPS *Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)*. Your comment will be summarized in the meeting materials referenced by the MSR Recommendation Group.

25. Name or Organization: Jade Moore

Subject: Proper training and education.

Comment: I feel like a lot of medical staff have had mediocre training and education over the past few years. We need to be ensuring staff are adequately trained to take care of patients. It seems like many are just pretending or trying to make it by out of fear of losing their jobs or being embarrassed. We need to promote an environment where learning is encouraged, asking questions is supported, and admitting to having a lack of knowledge is accepted and attempted to be resolved by leadership.

← **Response:** Thank you for your comments about the importance of health care staff training and education.

26. Name or Organization: PFCC Partners, Convergence, PQM

Subject: Proposed Measures Comments

Comment: The measures related to overuse are excellent. We must streamline and avoid overusing any system to the point where it becomes too costly. I believe all measures related to cancer are necessary. I would consider all other measures as secondary and not absolutely necessary.

← **Response:** Thank you for your comments in support of continuation for use of measures on overuse and cancer. Your comments will be summarized in the meeting materials referenced by the MSR Recommendation Group.

27. Name or Organization: Core Solutions

Subject: Public Comment on Current Review Process and Measures Selected

Comment: Hello – I reviewed the list of measures proposed for review for 2024 in the pdf document on this site. From being involved in similar processes in the past and having good knowledge of health care I find it quite amazing that there is not one measure in the list for 2024 that is focused on mental health, substance use, or IDD populations. Given our knowledge on

the importance of integrating behavioral health and medical services it would seem that at least one measure would have been identified for these populations. Thank You.

> ← **Response:** Thank you for your comment. Please note that all measures in the 2024 MSR List fall into Cycle C, the Affordability and Efficiency priority of the Cascade of Meaningful Measures. The 35 measures prioritized for discussion will be evaluated for continued use in CMS quality reporting programs. As noted in the draft 2024 MSR List for Public Comment and the Guidebook of Policies and Procedures for Pre-Rulemaking (PRMR) and Measure Set Review (MSR), Behavioral Health measures are included in Cycle A, slated for review next year.