Pre-Rulemaking Measure Review (PRMR) — December 2024 Clinician Committee Listening Session Meeting Summary

Battelle virtually convened 160 attendees for the Clinician Committee Listening Session on **Tuesday, December 17, 2024, from 1:00-4:00 PM ET**. During this session, attendees provided spoken public comment and asked questions on measures proposed for inclusion in the Merit-based Incentive Payment System (MIPS) and Medicare Part C Star Ratings.

Attendees of the listening session included members of the general public, developers and stewards of measures being discussed, Centers for Medicare & Medicaid Services (CMS) staff, and interested PRMR committee members. Measures discussed are from the 2024 Measures Under Consideration (MUC) List, a list of quality and efficiency measures under consideration through the rulemaking process.

Welcome and Introductions

Dr. Meridith Eastman, PRMR task lead, welcomed participants to the listening session and explained that the purpose of the session was to provide feedback on measures proposed for MIPS and Medicare Part C Star Ratings. After reviewing the meeting agenda, Dr. Eastman encouraged participants to provide spoken comments during the listening session and written comments on the PQM website by December 30. Dr. Eastman shared the guidelines for the session, provided instructions on the Zoom interface, and defined common acronyms that might be used throughout the session.

Opening Remarks from the Centers for Medicare & Medicaid Services

Dr. Michelle Schreiber, deputy director for quality and value at the Center for Clinical Standards and Quality for the Centers (CCSQ), expressed gratitude for the partnership with Battelle and welcomed participants to the listening session. Dr. Schreiber emphasized the importance of the session as an opportunity for public comments and questions about the measures under consideration for clinician programs. Dr. Schreiber explained that the PRMR and Measure Set Review (MSR) processes engage a broad array of interested parties including patients, caregivers, and providers to discuss and develop consensus on quality measures. This ultimately helps shape the strategy, prioritization, and support for measures and for the statutory programs that use them. Dr. Schreiber stated that CMS truly values this input, as extensive engagement helps shape better policy, which supports the highest quality and safest health care for Americans.

Dr. Schreiber noted that anyone can submit measures for consideration to CMS for any of the 25 value-based programs that use the pre-rulemaking process. This year, CMS is considering 41 unique measures including: 16 new measures and 15 measures that are already in use but

reflect significant changes, such as the addition of Medicare Advantage data[1]. Dr. Schreiber reported that 100% of the measures rely on data submissions using at least one digital data source while 78% rely on data submissions using only digital data sources. This is consistent with CMS' priority for the development of interoperable and digital quality measures.

Dr. Schreiber stated that statutory language of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) mandates that there are measures specific to all types of clinicians and specialties as well as cost measures, which, together, cover 50% of Medicare Part A and B spending. Dr. Schreiber indicated that the session participants might see measures specific to certain specialties, cost measures, and other measures of programmatic importance. She stated that CMS is continuing to advance MIPS by transitioning to the MIPS Value Pathways (MVPs), which are cohesive measures sets that consist of a curated and limited set of quality measures, improvement activities, and cost measures that are related and are a foundation of promoting interoperability. Each MIPS Value Pathway has a choice of quality measures and improvement activities aimed at reducing burden and providing a slate of measures that are meaningful and impactful for both clinicians and patients. Dr. Schreiber reported that this past year was the first opportunity for reporting MVPs, and clinicians appear to be increasingly selecting measures more in line with their practices.

She added that CMS has standardized MVP measures for primary care using the CMS Universal Foundation and has aligned these measures with accountable care organization (ACO) reporting under the Medicare Shared Savings Program. CMS also linked payment for a new proactive billing code for care coordination in primary care with the reporting of the MVP in primary care. Altogether, these enhancements advance value-based care and accountability for the highest-quality safety, cost, and performance linked to payment.

Dr. Schreiber again expressed her thanks to Battelle, PRMR committee members, the public, measure developers, and CMS staff and reiterated the session's purpose to answer questions and hear feedback from participants.

2024 Clinician and Health Plan Measures

MUC2024-052 Social Need Screening and Intervention

One commenter expressed strong support for the measure, emphasizing its importance across all care settings. The commenter stated that collecting social determinants of health information for the hospital based measure is widely perceived to be helpful, citing support they heard at a recent IHI annual meeting. The commenter received overwhelming support from conference attendees for this actionable information that improves patient care for patients that are too often neglected. CMS indicated that they have introduced social drivers of health measures in their other programs. The present measure is a National Committee for Quality Assurance (NCQA) measure and is at the plan level, which accounts for its inclusion in Part C Star Ratings. The measure is slightly different than the measures CMS has introduced in other programs and includes three SDOHs: food, housing, and transportation. The CMS measure, on the other

[1] The 2024 Measures Under Consideration (MUC) List also includes 3 measures that were previously submitted but not included on the MUC List and 7 that are being submitted without substantive changes for use in a different program or programs.

hand, included two SDOHs: utilities and personal safety. CMS stated this measure also ensures a corresponding intervention, “closing-the-loop,” that takes place when an insecurity is identified. CMS hopes that, over time, the measures will align more fully. The commenter noted that the “closing-the-loop” component of the measure is a significant step forward that will shine a light on the resources available to clinical practices and patients.

Another commenter asked if it would be possible to divide the measure into two separate measures, as the measure currently is examining at two different components: 1) the percentage of persons who are being screened and 2) how many of those who screened positive received a corresponding intervention. They also inquired about the settings for measure use, asking if it is being deployed in any visit, hospital encounter, or patient encounter or only for well visits as part of primary care. Regarding the number of rates reported for the measure, the measure developer stated that measure users report screening rates for each of the three SDOH measures (food, housing, and transportation) and the corresponding interventions for each of the SDOH measured, which totals six rates. CMS indicated they combine the two measures together because it is important not to just screen but also to take the action to follow up. The measure steward stated that the denominator for the first screening indicator is individuals of all ages. It is not tied to a specific care setting and is used at the health plan level. The measure steward said that individuals who are in the first indicator will be the same individuals included in the intervention indicator. Initially, measure users are screening the whole population to identify who is at high risk and if they screen positive, that is where any corresponding intervention happens within 30 days.

A commenter raised concerns about human bias in screening and the importance of privacy; they indicated that patients will not share if they feel ashamed. The commentator shared their recommendation that the questions be sent to patients to complete in private and the questions be written at an appropriate literacy level to allow for wide access. CMS indicated that while they are not prescriptive about how a clinician might ask the questions, guidance documents are available. However, these documents are not in the measure specifications.

A few commenters expressed concerns about patient burden and the measure requiring information duplicative with MUC2024-074. Two commenters noted that the same information could potentially be collected at different levels (for the health plan and at the provider level). Kate Buchanan, deputy PRMR task lead, noted that these concerns would be addressed in a written follow-up.

MUC2024-081 Adult Immunization Status (AIS-E)

A commenter asked why the COVID-19 vaccine was excluded from the measure. The measure steward explained that the measure was developed in 2018, before the COVID-19 pandemic. They indicated that they are considering the development of a COVID-19 vaccine measure and will assess the COVID vaccine’s inclusion in the future. CMS noted the challenge of frequently changing vaccination recommendations, which makes including COVID-19 in the measure difficult.

MUC2024-088 Depression Screening and Follow-Up for Adolescents and Adults (DSF)

One commenter asked for clarification on what constitutes follow-up and how MUC2024-088 differs from the depression screening and follow-up measure already in the CMS Universal Foundation. The measure developer explained that follow-up includes telephone and virtual check-ins, case management, behavioral health encounters, and medication management. The measure developer will follow up on the question of the difference between this and the existing measure. CMS noted that MUC2024-088 is specified at the health plan level of analysis and similar measures currently in the CMS portfolio apply to clinicians and facilities.

MUC2024-026 Person-Centered Outcome Measures: Goal-Identification, Follow-Up, and Goal Achievement

This measure did not receive any comments during the listening session.

MUC2024-082 Cancer Screening and Counseling Patient-Reported Outcome-Based Measure (PRO-PM)

One commenter thanked CMS for including patient-reported outcome-based performance measures (PRO-PM) like MUC2024-082. The commenter indicated that they are part of Patients for Patient Safety US and noted PRO-PMs can help increase feedback to clinicians on what matters to patients. They expressed their support for the measure. CMS stated that they are prioritizing PRO-PMs because they believe hearing from patients directly “is fundamentally important when it comes to assessing health care outcomes and ensuring the best care."

One commenter inquired how “clinician” is defined in the measure. The commenter raised concerns about the potential for the screening and counseling not to be reported on if the screening is performed by non-physician staff, such as nurses or navigators. CMS indicated that the intent is for the qualified clinician to be whoever is seeing the patient, so that screenings and counseling conducted by non-physician staff are less likely to be missed.

2024 Clinician Measures

MUC2024-080 Patient Reported Falls and Plan of Care

This measure did not receive any comments during the listening session.

MUC2024-084 Quality of Life Outcome for Patients with Neurologic Conditions

This measure did not receive any comments during the listening session.

MUC2024-051 Prevalent Standardized Waitlist Ratio (PSWR)

A commenter asked for clarity between the proposed measure and a similar measure already in use. CMS said that MUC2024-051 is complementary to CMIT #1701 First Year Standardized Waitlist Ratio (FYSWR) which assesses the number of newly initiated patients listed on the kidney or kidney-pancreas transplant waitlist or received a living donor transplant within the first year of initiating dialysis. MUC2024-051 focuses on patients who have been on dialysis for 2 or more years and decided they want to pursue a transplant or incentivizing patients who now are

medically able to have a transplant. CMS stated that the goal of the measure is to encourage collaboration and coordination and to maintain the overall health of dialysis patients.

MUC2024-072 Addressing Social Needs Assessment & Intervention

One commenter asked whether MUC2024-072 measure would replace the existing social drivers of health measures in MIPS (CMIT #1662 Driver of Screen Positive Rate and CMIT #1664 Screening for Social Drivers of Health). CMS explained that MUC2024-072 expands the current measures through the introduction of a "close-the-loop" action step and would eventually replace the existing measure. CMS noted that MIPS aims to enhance its measure inventory by considering more robust measures discussed through the PRMR process or on the Measures Under Consideration (MUC) List for implementation, potentially replacing current measures in the program.

A commenter stated that Patients for Patient Safety US strongly supports this measure. They stated that better information about SDOH in all practice settings is important in the work to reduce health disparities and achieve health equity.

MUC2024-025 Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care

CMS noted that MUC2024-025 is the first MUC List measure focused on diagnostic excellence, the process of optimizing the diagnostic process and protecting against diagnostic errors. The developer provided an overview of the measure, stating that it focuses on the rate of delayed diagnosis of venous thromboembolism (VTE) in adults, 18 years or older, in primary care. The measure uses electronic health record codes to identify patients who have had a VTE within 30 days of a visit. The measure developer indicated that the accuracy was greater than 96% across the various codes. Testing showed a delayed diagnosis rate of over 70% across three systems. They evaluated the relationship between delayed diagnosis and mortality, and longer delay was associated with an increased mortality risk. They found the measure to be feasible to implement.

Several commenters stated their support for the measure. Patients for Patient Safety US strongly supports the measure and are pleased to see a measure that has the potential to advance diagnostic safety excellence, particularly in ambulatory care settings. The commenter reported that members of the organization have lost loved ones to lower-limb VTE, reinforcing the connection between this measure and preventable death.

Another commenter stated that the intent of the measure is excellent, and they support the goals. They asked if the measure developer considered applying the measure to all clinicians and including urgent care centers. The measure developer hopes to expand to urgent care, as preliminary data show similar issues in that setting. They indicated that the testing data used to develop the measure was based on primary care. The commenter also raised concerns that primary care physicians who do not have immediate access to ultrasound machines could be financially penalized. The measure developer recommends the measure for integrated care delivery systems where primary care physicians might have the support of their systems to get the resources they need. CMS noted that MIPS measures are voluntary, and clinicians choose to participate in them. The commenter noted that the measure may increase emergency

department visits. The measure developer indicated that patients are already being referred to the emergency department so it may not make a quantitative difference.

Another commenter asked if obtaining a D-dimer test is sufficient for the measure instead of an ultrasound. They expressed concern that ultrasounds will lead to emergency department overcrowding as prior authorization for an imaging study in the ambulatory setting can take more than 24 hours. The measure developer responded that a D-dimer test is a screening for those with a low or moderate pretest probability of DVT or PE. If the test result is negative, the likelihood of VTE is very low; if it is positive, a confirmatory test is mandatory.

One commenter noted that a measure such as this could help improve patient care for oncology and hematology as many chemotherapeutic agents are a precursor to hematologic incidents. The measure developer agreed and indicated that this is an area for further research. The measure developer indicated that a registry measure might be feasible in the future to look at patients who may see specialty providers who may not be in their integrated care delivery network. CMS noted that if the measure is implemented in MIPS, they will look at ways it can be expanded and given this measure's impact on mortality and morbidity.

MUC2024-028 Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

One commenter representing the Diabetes Advocacy Alliance (DAA) expressed their support of this measure. They stated that one of the ongoing advocacy priorities of the DAA is to increase access to and use of evidence-based diabetes-prevention programs, such as those offered by suppliers in the CMS Medicare Diabetes Prevention Program (MDPP). To be eligible for the MDPP, Medicare beneficiaries must show a recent blood glucose value in the range for prediabetes from a diabetes screening. The commenter indicated that the proposed measure would increase the likelihood of Medicare beneficiaries being screened. It also would help to identify more individuals who have prediabetes. They said that the need is great, citing the Centers for Disease Control and Prevention estimates that while 48.8% of all older adults have prediabetes, only 23% are aware. The commenter emphasized the importance of identification of prediabetes for effective interventions, such as the Medicare Diabetes Prevention Program, to decrease the likelihood of progression to type 2 diabetes. Screening older adults at risk of developing diabetes will also identify individuals with formerly undiagnosed type 2 diabetes who can then be offered appropriate treatment and care. The commenter indicated that this measure would address a recommendation from the National Clinical Care Commission report to Congress, and the Secretary of the Department of Health and Human Services, which called for adopting the screening measure developed by the American Medical Association (AMA) as part of a strategy to prevent diabetes among individuals who are high risk of diabetes. They expressed DAA's belief that the measure specifications are feasible to implement by most health care organizations, as most organizations routinely capture the data elements in their electronic health records. Additionally, they indicated that this measure is both valid and reliable as demonstrated in the testing results. CMS expressed their appreciation for the evidence-based comments and acknowledged the AMA's efforts in developing the measure.

One commenter raised concerns about the measure's lack of specificity regarding who should be screened and how often. The measure developer indicated that the materials supporting the measure submission include a description of the patients who should be screened and how

often they should be screened. Battelle shared the link to the measure submission materials in the chat.

MUC2024-031 Hepatitis C Virus (HCV): Sustained Virological Response (SVR)

This measure did not receive any comments during the listening session.

MUC2024-079 Assessment of Autonomic Dysfunction and Follow-Up

This measure did not receive any comments during the listening session.

MUC2024-049 Breast Cancer Screening

This measure did not receive any comments during the listening session.

MUC2024-100 Non-Pressure Ulcers

The measure received several comments from organizations and experts that served on the measure's expert workgroup. The American Podiatric Medical Association indicated that they strongly support a measure of this type; however, they do not support this measure in its current form. They indicated that the measure does not distinguish between good and poor performance and needs to more accurately address the role of the clinician. The commenter also indicated that there are challenges with sub-grouping that need to be addressed. Additionally, the measure does not appropriately account for the cost of treating multiple ulcers. The commenter stated that they requested another round of field-testing following changes to the specification and this testing did not take place. They expressed a concern that building the MIPS cost measure portfolio was prioritized over developing a sound measure, which may lead to unfair penalties and disincentives to provide appropriate care.

Another commenter representing the American College of Clinical Wound Specialists echoed the concern that this measure could lead to unfair penalties. They indicated that the cost performance category of the MIPS needs to accurately reflect that wound care is not a disease state but rather a symptom of other underlying disease processes. The commenter raised concerns that clinicians will be held accountable for the work of other clinicians. They also noted that wound care is listed as a specialty, but podiatry is the only clinical group listed in the measure documents and inquired if podiatrists are the only group required to report on the measure. CMS stated that the specialties that report on it are podiatry, nurse practitioner, family practice, general surgery, and internal medicine.

One commenter representing the Alliance of Wound Care Stakeholders agreed with the previous comments, stating that they do not support the measure as it is detrimental to clinicians. Their primary concern was with the field testing, which demonstrated that the attribution methodology incorrectly attributes costs and that the cost for each ulcer category is incorrectly calculated. The commenter reported that the field-testing report showed dramatic variation in calculations that were supposed to be national averages, and the methodology testing document did not explain the reasons for the discrepancies. They expressed concerns about the developer's assertion of measure validity, given the results of field testing. They expressed their concern that the measure methodology was "fatally flawed," such that the

measure cannot be successfully implemented. The commenter also shared concerns with how the feedback from the workgroup that reviewed the measure was incorporated. They expressed their interest in working CMS to create a more clinically appropriate measure.

In response to questions about the measure calculation, the measure developer reported that the measure is calculated using CMS administrative claims. They indicated they identify specialty based on the CMS specialty code associated with a clinician. The measure is reported for any MIPS-eligible clinician or participating MIPS clinician who met the case minimum. The measure developer clarified that wound care specialists would still be considered for the measure. The measure developer provided additional testing results in their MUC List submission.

A commenter asked why the measure excludes patients with extremely low episode costs. The measure developer replied that is a way to mitigate the impact of outliers.

Several commenters had questions about the preliminary assessment (PA) and measure testing. The commenter did not agree with conclusions following the statement from the PA that drivers of worse performance were costs for ambulatory/minor procedures imaging services, and durable medical equipment (DME). In the PA, the developer stated that the same factors were also associated with higher-adverse events costs and concluded that reducing such costs may be linked with reducing adverse events. The measure developer indicated that both certain treatment services and adverse events are associated with worse measure performance. Thus, taking steps to reduce hospitalizations (an adverse event), for example, could improve performance on the cost measure.

The same commenter also asked the measure developer to elaborate on the reliability of the measure and what is meant by the term “misclassification” in the PA. Battelle clarified that misclassification refers to an ability to distinguish between high quality and low quality of care. Thus, 20% of entities have potentially less ability to distinguish between good and poor-quality care with this measure.

Another commenter reiterated the request for the measure developer to rerun the data to address inconsistencies. They noted that many of the non-pressure ulcer codes are described by two codes, not just one. The commenter also indicated that there are significant cost differences between the types of ulcers and asked if that is addressed by the measure as suggested by the work group. The measure developer reported that the measure is stratified based on ulcer type. They initially had a preliminary stratification based on diagnosis code for ulcer type and used field testing and work group input to improve the stratification by ulcer type (e.g., diabetic ulcer or arterial ulcer). The updated stratification is reflected in the final measure specification and supplemental materials. The commenter indicated they did not see the modifications made and they will review again.

Another commenter echoed that they did not see the ulcer type grouping update in the supplemental materials and expressed concern that these updated results were not shared with the expert work group in a timely fashion. The measure developer reported that they discussed the changes and presented data in their third meeting with the work group. They referred commenters to the indicated that table 9 of the measure justification form in the supplemental materials contains the requested information about the ulcer type grouping.

A few commenters reiterated their continued frustration with the measure and how feedback from the expert work group was incorporated into the current measure.

The measure developer emphasized that the measure was developed with input from a clinical expert work group and empirical testing. They indicated that the measure addresses a significant clinical area, as chronic non-pressure ulcers are prevalent in older adults and can lead to poor outcomes. The measure developer acknowledged opportunities for improvements to the measure. The developer reiterated that information about the work group, field testing, and measure development is publicly available on the CMS website. The measure developer invited additional questions from participants, indicating a willingness to provide further clarification.

CMS emphasized the importance of the comments and noted that the purpose of the listening session is to voice concerns for the full committee to consider before making a final recommendation. CMS indicated that they take comments very seriously and will discuss them with the measure developer. CMS thanked participants for their input.

MUC2024-101 Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS)

This measure did not receive any comments during the listening session.

Next Steps

Kate Buchanan shared next steps following the listening session. Ms. Buchanan encouraged participants to provide written public comments on the proposed measures by December 30. She shared the timeline for the next steps in the process. On January 7 from 1-3 PM ET, Advisory Group members will meet and provide feedback on the measures to the Recommendation Group co-chairs. The public and CMS are invited to listen in on the Advisory Group meeting. The Clinician Recommendation Group meeting will be held virtually on January 21 from 10 AM-4:30 PM ET and January 22 from 10:00 AM-3:15 PM ET. Following the Recommendation Group meeting, a second public comment period will take place February 3-17. While this public comment period will not change the Recommendation Group votes, it allows for further feedback and data points for CMS to consider in their rulemaking process.

Ms. Buchanan encouraged participants to become PQM members and utilize available resources on the PQM website, CMS MMS Hub, and CMIT, where they can look up measure information.

Closing Remarks

Dr. Eastman expressed gratitude for the valuable comments, feedback, and dialogue from participants, CMS, and measure developers.

Dr. Schreiber thanked Battelle for facilitating the meeting and acknowledged the valuable insights from participants. Dr. Schreiber indicated that the committee will make recommendations in January, which will be considered in the rule-writing process scheduled for spring 2026. She extended appreciation to measure developers and CMS staff for their expertise.