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

Battelle virtually convened 147 attendees for spoken public comment and questions on **December 18, 2024 from 1:00–4:00 PM ET** for measures proposed for inclusion in the following programs:

- Ambulatory Surgical Center Quality Reporting Program (ASCQR)
- End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
- Hospital-Acquired Condition Reduction Program (HACRP)
- Hospital Inpatient Quality Reporting Program (HIQR)
- Hospital Outpatient Quality Reporting Program (HOQR)
- Hospital Readmissions Reduction Program (HRRP)
- Hospital Value-Based Purchasing Program (HVBP)
- Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
- Rural Emergency Hospital Quality Reporting Program (REHQR)

Attendees of this listening session included members of the public, developers and stewards of measures being discussed, representatives of the Centers for Medicare & Medicaid Services (CMS), 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 Pre-Rulemaking Measure Review (PRMR) listening session for Hospital measures. After reviewing the meeting agenda, Dr. Eastman encouraged participants to provide spoken comments during the listening session and written comments on the PQM website until December 30, 2024. In addition to written comments, these sessions are held as an opportunity for members of the public to provide comment on measures of interest proposed for hospital programs. During this time, CMS and developers will hear comments and answer questions. 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 (CCSQ) at CMS, expressed gratitude for the partnership with Battelle and welcomed participants to the Pre-Rulemaking Measure Review (PRMR) listening session for Hospital measures. Dr. Schreiber noted this is an opportunity for the public to ask questions and to make comments about the measures that CMS is considering for its various hospital programs. The purpose of the PRMR process is to make recommendations for measures to potentially be included in CMS value-based programs. Combined with the Measure Set Review

(MSR) that makes recommendations for measures to potentially not be included or removed from CMS programs, these processes are important ways of engaging a broader range of stakeholders such as patients, caregivers, providers, facilities, and other interested parties. These processes help shape the strategy, prioritization, and support not only for the measures but also the statutory programs that use them. Dr. Schreiber shared that CMS values this input, as extensive stakeholder engagement helps shape better policy, all of which is intended to support the highest quality and safety of health care in America.

Dr. Schreiber shared excitement regarding the inclusion of members of the public, the PRMR committee members, CMS, the measure developers, and Battelle (as the consensus-based entity) in this session. She reiterated that this session is the opportunity for public and PRMR committee members to provide spoken comments and ask questions, noting that no voting occurs during the listening session. Voting will occur in January 2025 at the pre-rulemaking committee meeting. However, the members of the committee will be thinking about their votes and formalizing their comments to vote in the future in part based on today's session, as well as on measure analysis done by Battelle and other ancillary information. Dr. Schreiber noted that anyone can submit measures to CMS for consideration for any of the 25 value-based programs, which cover almost all facility types and providers from post-acute care to dialysis to inpatient acute care to ambulatory surgical centers, and a wide range of clinicians including physicians, therapists, and other clinical professionals.

Dr. Schreiber reiterated that CMS is currently considering 41 unique measures, including 16 new measures and 15 measures that are already in use but have undergone significant changes, such as the addition of Medicare Advantage data[1]. In addition, 100% of the measures rely on data submissions using at least one digital source, while 78% rely on data submissions using only digital data sources, consistent with CMS's priority for the development of interoperable and digital quality measures. There are several hospital programs in which today's quality measures would be used, such as the hospital inpatient quality reporting (IQR) program, where new measures generally begin for hospital programs. After a period of use in the initial program, they can be moved to payment programs such as the Hospital Acquired Conditions Reporting Program (HACRP), the Hospital Value-Based Purchasing (HVBP) Program, the Hospital Readmissions Reduction Program (HRRP), and the Medicare Promoting Interoperability Program (PI). Non-acute care hospital programs include the Inpatient Psychiatric Facilities Quality Reporting Program (IRF QRP), or the 11 hospitals in the US in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, the Ambulatory Surgical Centers Quality Report (ASCQR) Program, the Hospital Outpatient Quality Reporting (HOQR) Program, Rural Emergency Hospital Quality Reporting (REHQR) Program, and the End-Stage Renal Disease (ESRD). All of these programs are based in statute, which sometimes mandates the use of specific measures. Dr. Schreiber noted that CMS staff and measure developers are available to help answer questions and to personally hear feedback. Dr. Schreiber thanked attendees for their engagement and thoughtful insights and reiterated how important this feedback is to CMS in its ability to help shape rule-writing and policy, with the

[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.

goal of shaping policy to make a better health care experience and better healthcare outcomes for our country.

Finally, Dr. Eastman provided an overview of the PRMR process, noting changes (e.g. increased Recommendation Group size from 18-20 to 25-30 to reduce the "consensus not reached" voting outcome, and the addition of an Advisory Group meeting to provide feedback to Recommendation Group co-chairs prior to voting) implemented since last year's PRMR cycle.

2024 PRMR Hospital Committee Measures

MUC2024-073 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)

One commenter expressed strong support for the inclusion of patient-reported outcome measures and patient-reported experiences, as they fill a gap in quality and safety. He also offered his support for CMS's overall strategy of adding such measures. The commenter spoke about underreporting and patients' desire for a method for providing feedback, especially when it comes to discharge experiences. The commenter was happy to see improvements in the oversight and reporting in the ambulatory surgery area and spoke in favor of giving the patient voice a bigger role in quality measurement.

MUC2024-060 In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Survey – Quality of Dialysis Center Care and Operations (QDCCO) measure

One commenter expressed support for the measure and noted it is a valuable data source. Further, the commenter stated that CAHPS surveys are an important tool for providing feedback on the patient experience and also improving health equity. The CMS CAHPS lead indicated that CMS has undertaken ongoing efforts to reexamine CAHPS questions to streamline them, reduce the number of items, and potentially combine them with home dialysis. More immediate changes include 1) improvements to the survey, 2) introducing web-based data collection, and 3) requiring a Spanish language option.

The same commenter stated patients are looking to provide feedback in real time (vs. a survey two weeks after an encounter, for example), through something like an app or other methodologies. CMS noted they will continue to explore different ways to facilitate receipt of patient feedback.

MUC2024-074 Median Time to Pain Medication for Patients with a Diagnosis of Sickle Cell Disease (SCD) with Vaso-Occlusive Episode (VOE)

Two commenters offered support for this measure. One commenter applauded the creation of the measure, and one applauded all the people who have worked so hard to put this together to help sickle cell patients get optimal care.

Several commenters requested clarification on the measure. One commenter noted that treatment and pain management guidelines state that patients should receive prompt

assessment and opioids as first medication. This commenter raised a concern regarding tracking the types of medication administered, noting that when discussing initial pain medication, clinicians are taught that opioids are not considered first line. Rather, clinicians would get credit on this measure if Tylenol or ibuprofen are administered, which may not be appropriate for sickle cell patients. She noted that the general approach is to start with lowest potency medication for pain and noted sickle cell is an exception in which pain medication would need to start with highest potency. CMS responded the plan is to leave the medication data field open noting that opioids may not be the best practice for all patients; further, the plan is to stratify opioid vs non-opioid medications. The measure developer recommends stratifying the measure by medication route. The developer also noted that having a broader medication list allows clinicians to make a judgment call about the appropriate treatment and provides data on what medications are being administered as patients come into the Emergency Department (ED).

One commenter indicated support for the measure, including the broad medication list, and stressed the importance of appropriate implementation that is informed by all the tools developed and existing robust research to-date. This commenter asked about the timeframe for reviewing data and if it was on a consistent basis to determine if the metric is met. CMS responded, noting that generally, data is reviewed on an annual basis, but this measure has a 2-year measurement period. The developer indicated the 2-year timeframe is needed to ensure sufficient volume of cases for reporting.

One commenter asked if this is a mandatory measure, and, if not, what would motivate EDs to report. CMS responded that once the measure is in the program, it is mandatory to report. Failure to report is non-compliant and subject to penalization. Payment is not tied to performance.

One commenter asked if the measure would capture whether a patient receives one medication and then is prescribed a second medication for pain. The measure developer responded that only the first medication would be factored in for the measure, noting that the current measure was designed to eventually be stratified into ‘parenteral,’ ‘oral,’ and ‘other’ routes. Preliminary data shows stratification of non-oral enteral or mucosal routes was only used in one instance across all testing. The developer is examining if stratification can be simplified to parenteral versus non-parenteral. The developer further clarified that a reporting ED would have a median score for all encounters and 2 or 3 separate scores for the median time by different medication routes.

The commenter asked a follow-up question regarding if a proportion would be calculated for visits where the first medicine received was an opioid. The measure developer responded that medication time, name of medication, and corresponding code will all be collected for the measure at the patient level for the encounter, so that data will be available for a closer look at what is prescribed.

MUC2024-067 Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life

One commenter offered support for this measure as well as MUC2024-068 and MUC2024-078, noting that expansion of measures with a proven track record in cancer-specific hospitals into

additional settings that treat cancer patients is an important strategy for promoting patient safety.

MUC2024-068 Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life

One commenter offered support for this measure as well as MUC2024-067 (above) and MUC2024-078 (below), noting that expansion of measures with a proven track record in cancer-specific hospitals into additional settings that treat cancer patients is an important strategy for promoting patient safety.

MUC2024-078 Proportion of Patients Who Died from Cancer Admitted to Hospice for Less than 3 Days

One commenter offered support for this measure as well as MUC2024-067 and MUC2024-068 (above), noting that expansion of measures with a proven track record in cancer-specific hospitals into additional settings that treat cancer patients is an important strategy for promoting patient safety.

MUC2024-069 Addressing Social Needs Assessment & Intervention

One commenter asked how this measure is different from other measures already in place that assess social determinants. CMS responded that this measure will replace the current measure (01664-01-C-HIQR Screening for Social Drivers of Health), noting the difference between the measures is that the new one (MUC2024-069) closes the loop and goes beyond screening to ensure that if there is a positive determination (i.e., a patient reports an issue with one of the social drivers of health), there is follow-up action.

This commenter asked a follow-up question about the prioritization of other social determinants of health (e.g., disability, job insecurity). CMS responded that the National Committee for Quality Assurance (NCQA) measure has three social determinants, noting personal patient safety is a distinct determinant from food, housing, and transportation. CMS is exploring other areas such as social isolation, but there is nothing yet at the proposal level for this social driver of health.

MUC2024-085 Hospital Harm – Anticoagulant-Related Major Bleeding

CMS stated that this new measure is part of the plan to move to digital measures to allow organizations to receive real-time data on safety.

One commenter expressed support for CMS's stated strategy to transition more patient safety measures to electronic clinical quality measures (eCQMs), especially with the current crisis in emergency care. This commenter also expressed support for all outcome measures (MUC2024-085, MUC2024-042, MUC2024-043) on the Measures Under Consideration (MUC) List for hospital programs, noting reporting on more outcomes will improve and health care quality.

Another commenter noted there is excitement in the field for using the eCQM format for patient safety measures such as the other hospital harm measures on hyperglycemia and hypoglycemia, which were implemented and voluntarily reported on by over 100 organizations in 2023.

MUC2024-027 Patient Safety Structural Measure

CMS stated that this measure was finalized by CMS and begins its reporting period a few weeks from now. It is going back through pre-rulemaking because of the addition of two new attestation statements related to drug shortages. CMS requested that focus remain on these changes related to drug shortage rather than re-adjudicating the measure as a whole, because the measure has already been through the formal pre-rulemaking and rule-writing processes.

One commenter expressed support for the measure updates, noting that since implementation, the measure is having an impact in the field. Further, the commenter noted the structural measure strategy is a game changer from a patient point of view and encourages hospitals to look at their policies and leadership structures and how they support frontline workers on patient safety, health equity, social determinants, and maternal health.

MUC2024-075 Emergency Care Capacity and Quality (ECCQ) (for the Hospital Outpatient Quality Reporting Program) and MUC2024-095 Emergency Care Capacity and Quality (ECCQ) (for the Rural Emergency Hospital Quality Reporting Program)

Two commenters expressed appreciation and support for these measures. One commenter specifically applauded the addition of the ECCQ measures to the MUC List as it is important to both reduce the wait time and reduce reporting burden. Another commenter acknowledged the need for these measures due to patients, especially those with diagnosed chronic conditions, experiencing such long wait times. The commenter expressed concern with a 4-hour recommended timeframe from admittance to transfer. This timeframe may be too long for patients with diagnosed rare and chronic conditions (e.g., adrenal insufficiency, hemophilia).

One commenter asked for clarification on which organizations had collaborated on measure MUC2024-095. Specifically, the commenter asked if ACEP (American College of Emergency Physicians) and ENA (Emergency Nurses Association) were involved. CMS indicated that this measure has received a lot of positive feedback on addressing the ED boarding crisis. The developer added that the measure underwent numerous public comment periods and received input from 3 technical expert panels (TEPs). The first public comment period yielded 677 supportive comments (300 were from patients and caregivers). ACEP provided feedback that was incorporated into the numerator (i.e., component related to wait times [time from arrival and treatment room was longer than 1hr would be captured in numerator]). The measure developer also noted that ACEP provided feedback stating they want to ensure that the treatment area has audio/visual privacy to take the patient's history.

The same commenter also asked if the measure is going to be a monitoring measure (vs. a measure associated with a penalty). CMS responded that it will start in monitoring, then CMS has the option of moving the measure into a pay-for-performance program.

One commenter noted they would supply written public comment to this effect, as well, and asserted that measurement is essential to problem solving and supported penalization and making a requirement in the future. CMS noted that they realize the severity of ED boarding, seeing it as both an operationalization and safety issue. CMS is taking a multipronged approach to improvement and stated there will be more to come on accountability in the future.

Another commenter noted that they did not support penalization because it is a hospital and a health care system failure, not just an ED issue. This commenter also asked if this measure applies only to rural emergency facilities or if this applies to all facilities. CMS responded that measure MUC2024-075 is for outpatient hospital departments.

MUC2024-034 Influenza Vaccination Coverage Among Healthcare Personnel

This measure did not receive public comment during this session.

MUC2024-042 Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

One commenter expressed support for all outcome measures (MUC2024-085, MUC2024-042, MUC2024-043) on the MUC List for hospital programs, noting reporting on more outcomes will improve and health care quality.

Another commenter asked if the developer had done testing including both the Medicare Advantage and Medicare Fee-for-Service (FFS) population. The measure developer confirmed they performed reliability and validity testing including the Medicare Advantage cohort, noting that adding the cohort increased the reliability the measure.

MUC2024-043 Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity

One commenter expressed support for all outcome measures (MUC2024-085, MUC2024-042, MUC2024-043) on the measures under consideration (MUC) List for hospital programs, noting reporting on more outcomes will improve and health care quality.

The hospital-level risk-standardized readmission rate (RSRR) measures that follow are grouped together because they are included on the 2024 MUC List for the same substantive change: the addition of the Medicare Advantage population. Thus, public comments and questions on this change are relevant to each of the RSRR measures.

MUC2024-041 Hospital-Level, 30-Day, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

This measure did not receive public comment during this session.

MUC2024-046 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery

One commenter asked if the CABG measure (MUC2024-046) is being submitted without changes for a different program per the materials posted with the MUC List. CMS confirmed that since the measure is part of the Hospital Readmissions Reduction Program, Medicare Advantage data will be included, the same as for the other measures.

MUC2024-030 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization

This measure did not receive public comment during this session.

MUC2024-032 Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization

This measure did not receive public comment during this session.

MUC2024-040 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization

This measure did not receive public comment during this session.

MUC2024-045 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization

One commenter asked if CMS is looking at reporting Medicare Advantage and Fee-for-Service populations separately or together. CMS responded they do not have plans to report separately because of data issues that would make it technically difficult to separate these populations.

One commenter asked about patient volumes for all the risk-standardized readmission rate (RSRR) measures. CMS noted that published volume data does not include the Medicare Advantage population at this time, thought it will in the future.

Additional Comments

One commenter asked if measure submission materials will be available in addition to the preliminary assessments. Battelle responded that all documents that developers submitted to the MUC Entry/Review Information Tool (MERIT) are on the Measures Management System (MMS) hub, guiding members to the pre-rulemaking tab for a downloadable zip file of all documents.

One commenter noted challenges with reimbursement rates after the Affordable Care Act came out, specifically noting that CMS data became public information. CMS reporting showed that all providers are paid at the same rate, regardless of experience. An important insight is to know how many procedures a specialist has completed. Regarding cost, physicians tend to get more efficient the more of a given procedure they complete, as the actual price of services drop. However, the payment mechanism in place does not take frequency or experience into consideration. We normalize the outcomes and the payment is same. The commenter asked if CMS is looking at reimbursing differently for those that are doing better. CMS responded with an example of paying a novice provider vs. a highly experienced provider differently for interventional cardiology services, noting that hasn't been the typical thought track on services and provider payment. Relatedly, CMS has started publishing data on provider service volume so consumers can choose their care on a data-driven basis. These value-based payment programs are meant to reward physicians and facilities for quality. CMS also noted they reward excellent care for underserved populations by identifying those caring for underserved

populations and awarding bonus points and funneling dollars to them. CMS looks forward to more comments on how this could potentially be thought of differently.

Next Steps

Kate Buchanan shared next steps following the listening session. Ms. Buchanan encouraged participants to log on to the PQM website to provide written public comments on the proposed measures through December 30. She shared the timeline for the next steps in the process, stating that it is currently in the public comment and listening session phase and committee members will also be providing written feedback on the measures. In addition, Pre-meeting Initial Evaluation (PIE) Forms are due December 23. An Advisory Group meeting, where members will discuss feedback on measures with the Recommendation Group co-chairs, is scheduled for January 8. The in-person hospital Recommendation Group meeting January 15-16 is open to the public to register online to listen in. Public comment on the final recommendations will be February 3-17. Comments received during this period will not change the recommendations, but they do provide CMS with additional feedback on the measures.

Closing Remarks

Dr. Michelle Schreiber thanked all participants on the call and CMS staff for their expertise, developers for answering questions, and Battelle as the consensus-based entity. CMS restated that all comments are important and shape which measures go in (or are excluded), which guides how we shape programs and forward the best policy to advance quality and safety for the country.