National Consensus Development and Strategic Planning for Health Care Quality Measurement

Fall 2023 Advanced Illness and Post-Acute Care Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Advanced Illness and Post-Acute Care (PAC) on February 5, 2024, for discussion and voting on measures submitted to the committee for endorsement consideration for the Fall 2023 cycle.

Meeting participants, including Recommendations and Advisory Group committee members, joined virtually through the Zoom platform. The Recommendations Group was responsible for discussing the measures and both groups voted during the meeting using a virtual voting platform. Measure stewards/developers and members of the public were also in attendance.

The objectives of the meeting were to:

- Review and discuss candidate measures submitted to the committee for the Fall 2023 cycle;
- Review public comments received for the submitted candidate measures; and
- Render endorsement decisions for the submitted candidate measures.

This summary provides an overview of the meeting, the committee's deliberations, and the endorsement decision outcomes. Full measure information, including all public comments received, staff preliminary assessments, and committee independent reviews can be found on each respective measure page on the Partnership for Quality Measurement (PQM) website.

After the committee's endorsement meeting, measures and the committee's endorsement decisions enter an appeals period for three weeks, from February 26–March 18, 2024. Any interested party may submit an appeal, which will be reviewed for eligibility according to the criteria within the endorsement and maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will be convened to evaluate the appeal and determine whether to maintain or overturn the endorsement decision.

Welcome, Roll Call, and Disclosures of Interest

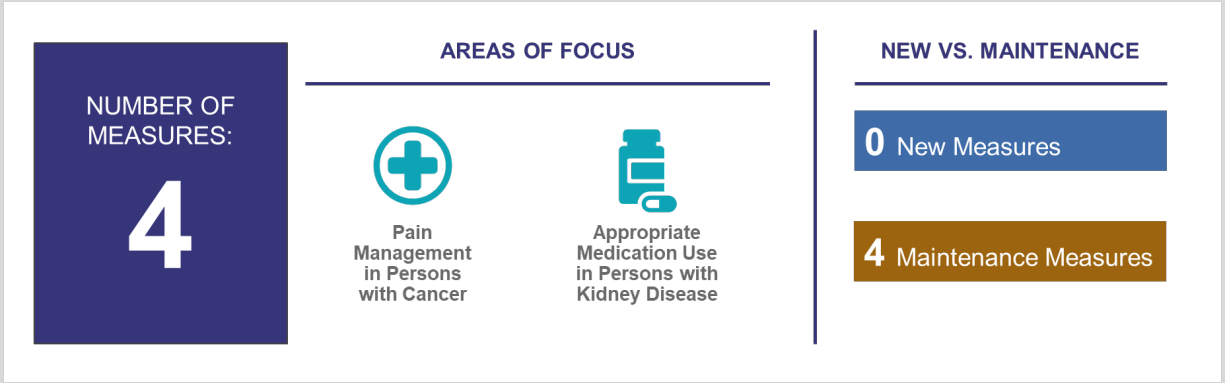
Nicole Brennan, Executive Director of PQM, welcomed the attendees to the meeting and introduced her co-facilitator Matt Pickering, Endorsement & Maintenance Technical Lead. Dr. Brennan also introduced the committee co-chairs, Kristin Seidl and Stephen Weed, who each provided welcoming remarks.

Dr. Pickering then conducted roll call and members disclosed any perceived conflicts of interest regarding the measures under review. No members were recused from voting based on Battelle's conflict of interest policy.

After roll call, Battelle facilitators established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum required the attendance of at least 60% of the active Recommendations Group members (at least 9 out of 14) during roll call. Voting quorum required at least 80% of active Recommendations and Advisory Group members (at least 32 out of 40) who had not recused themselves from the vote. Discussion quorum and voting quorum were established and maintained for all measure discussions except for CBE #0384e, in which an Advisory Group member had stepped away from the meeting shortly before voting, resulting in a loss of voting quorum. However, after the call, the member attested to hearing the committee's discussion of the measure and confirmed their vote of "Endorsed with Conditions."

Evaluation of Candidate Measures

Dr. Pickering provided an overview of the four measures under review, all of which were measures undergoing maintenance endorsement review (Figure 1). The measures focused on pain management in persons with cancer and appropriate medication use in persons with kidney disease. Dr. Pickering further noted that CBE #0383, #0384e, and #0384 are each specified at two levels of accountability: the clinician group/practice level and the individual clinician level. Therefore, the committee provided an endorsement vote for each level of accountability.



At least three weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group received the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the E&M team preliminary assessments.

Members of both groups were asked to review each measure, independently, against the PQM Measure Evaluation Rubric. Committee members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, committee members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the committee, and to the respective measure developers, and/or stewards, for review within one week of the endorsement meeting. These independent committee member ratings were compiled and used by Battelle facilitators and committee co-chairs to guide committee discussions.

During the endorsement meeting, the committee voted to endorse one measure and to endorse three measures with conditions (Table 1). Summaries of the committee's deliberations for each measure along with any conditions for endorsement are noted below.

Table 1. Fall 2023 Advanced Illness and Post Acute Care Measure Endorsement Decisions

CBE ID	Measure Title	New / Maintenance	Endorsement Decision	Endorse | N (%)	Endorse with Conditions | N (%)	Not Endorse/Remove Endorsement | N (%)	Recusals
1662	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	Maintenance	Endorse with Conditions	13 (40.62)	19 (59.38)	0 (0)	0
0383	Oncology: Medical and Radiation – Plan of Care for Pain (Clinician: Group/Practice level)	Maintenance	Endorse	27 (81.82)	5 (15.15)	1 (3.03)	0
0383	Oncology: Medical and Radiation – Plan of Care for Pain (Clinician: Individual Level)	Maintenance	Endorse	27 (79.41)	6 (17.65)	1 (2.94)	0
0384e	Oncology: Medical and Radiation – Pain Intensity Quantified (Clinician: Group/Practice Level)	Maintenance	Endorse with Conditions	19 (59.38)	13 (40.63)	0 (0.0)	0
0384e	Oncology: Medical and Radiation – Pain Intensity Quantified (Clinician: Individual Level)	Maintenance	Endorse with Conditions	18 (56.25)	13 (40.63)	1 (3.13)	0
0384	Oncology: Medical and Radiation – Pain Intensity Quantified (Clinician: Group/Practice Level)	Maintenance	Endorse with Conditions	20 (60.61)	12 (36.36)	1 (3.03)	0
0384	Oncology: Medical and Radiation – Pain Intensity Quantified (Clinician: Individual Level)	Maintenance	Endorse with Conditions	20 (60.61)	12 (36.36)	1 (3.03)	0

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy [Renal Physicians Association]

Specifications | Committee Independent Review Summary

Description: Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (Stages 1-5, not receiving Renal Replacement Therapy (RRT)) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.

Committee Final Vote: Endorse with Conditions

Conditions:

- Evaluate why the measure is not widely used and develop implementation guidance to support use of the measure.
- Conduct empirical validity testing at the entity level for both reliability and validity.

Vote Count: Endorse (13 votes; 40.62%), Endorse with Conditions (19 votes; 59.38%), Remove Endorsement (0 votes; 0%); recusals (0).

Measure Discussion:

No public comments were submitted for this measure. Mr. Weed noted that while the focus tends to be on diabetes patients, research shows the importance of these drugs for any kidney patients. He asked the developer how the measure structure works with other diseases, such as lupus or congenital issues. The developer stated that any kidney disease that results in proteinuria would be covered by this measure. Data over the past two decades has shown that ACE inhibitor (ACEi)/ARB are the best line of therapy to slow the progression of kidney disease. ACEi and ARB are considered equally effective in treating proteinuria. Certain side effects can present with ACEi use, which leads to treating patients with ARBs.

The developer addressed a committee member's question of whether patients are compliant with the medications prescribed. Data sources are limited to look at this in an automated way. The baseline checklist for physicians that this measure provides is the best tool at this point. A committee member also raised a question around prescription limitations and how this measure addresses that. The developer was not aware of any codified data sets around drug allergies or interactions with Epic or Cerner, although they are in development with other organizations. The physician will look at each patient's history to see what has been prescribed, why or why not, and if they should prescribe ACEi/ARB at the current time. Medication reconciliation is easily done across electronic health records (EHRs) but whether the patient takes the medications as directed is more difficult to track. The consensus of the Renal Physicians Association is that societal benefit of custom EHR reporting is far greater than the burden on providers. The developer and committee members agreed that patients would be better served with fewer exclusion criteria. The developer further noted that nephrology's influence on the internet technology systems is crucial to improving automated reporting.

A committee member asked Battelle team for clarification on the validity requirements. Dr. Pickering answered that face validity was acceptable at initial development, and at maintenance there should be empirical testing at the entity level or, at a minimum, the data element level. The expectations are the same in the new E&M process. The committee can apply conditions as needed for maintenance.

Mr. Weed commented that there is a known racial disparity issue with chronic kidney disease (CKD), because 40% of patients are not using ACEi/ARB medications, which speaks to access concerns. He wanted to know if part of the issue was also rural vs. urban settings. Dr. Seidl asked if primary care providers can use this measure for patients who do not have access to a nephrologist. The developer noted that it can be used equally by primary care. The goal of this measure is to offer the physician a checklist of things to address irrespective of any demographics, so the hope is to see ongoing minimization of disparities by offering this framework. A committee member offered her experience as a patient that the additional financial cost of seeing a specialist can contribute to access even though the actual drug costs are low. Age is also a disparity due to mobility issues and other factors.

A committee member acknowledged that the measure has been around for 10 years but asked if it has it been used the entire time. The member also asked if any registries or qualified clinical data registries (QCDRs) have implemented this measure and made it available for the target population. The members noted that implementation feedback or questions from these measure registries could be an entity-level testing data source. The developer noted that usability is a data/IT problem. The main questions being: how do we get the right information at the system level, how do we get the reporting, and how do we share that reporting at the right place in the workflow of the physician? The developer stated that endorsement allows users to advocate for the needed reporting capabilities with IT departments.

Additional Recommendations: Not discussed.

CBE #0383 – Oncology: Medical and Radiation – Plan of Care for Pain [American Society of Clinical Oncology]

Specifications | Committee Independent Review Summary

Description: This measure looks at the percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain. This measure is to be submitted at each denominator-eligible visit occurring during the performance period for patients with a diagnosis of cancer and in which pain is present who are seen during the performance period / measurement period. The time period for data collection is intended to be 12 consecutive months.

Clinician: Group/Practice Level

Committee Final Vote: Endorse

Vote Count: Endorse (27 votes; 81.82%), Endorse with Conditions (5 votes; 15.15%), Remove Endorsement (1 votes; 3.03%); recusals (0).

Clinician: Individual Level

Committee Final Vote: Endorse

Vote Count: Endorse (27 votes; 79.41%), Endorse with Conditions (6 votes; 17.65%), Remove Endorsement (1 votes; 2.94%); recusals (0).

Measure Discussion:

No public comments were submitted for this measure. The developer began by stating that measures CBE #0383 and #0384 are paired. The intent of the currently endorsed pain measures is to improve pain management among cancer patients and subsequently improve the function and quality of life of those cancer patients. Pain is one of the most common and debilitating symptoms reported among cancer patients. The International Classification of Diseases (ICD) 11 contains a new classification for chronic cancer-related pain caused by the cancer/metastases or its treatment, which demonstrates a global recognition of the problem. Chemotherapy and radiation are specifically associated with several distinct pain symptoms. Severe pain affects quality of life in many ways including increased anxiety and depression, sleep deprivation, interference with relationships, and worse employment and financial outcomes. The developer addressed committee comments around patient input on the meaningfulness of the measure. ASCO received comments from the patient and caregiver perspective that this is an important measure. The developer also cited a study that noted an improvement in pain as a priority. The patient and caregiver panel put emphasis on routine pain screening management and follow-up. Measures #0383 and #0384 are not being combined at this time because of the potential loss of the electronic clinical quality measure (eCQM). There is not a feasible way to capture plan of care in the EHR. Some comments asked why equity and disparities were not addressed. This measure is in the Merit-based Incentive Payment System (MIPS) program, and CMS has not yet made that data available. The application included a study showing that African American and Hispanic patients were less likely than Caucasian patients to receive opioids.

A committee member suggested specifically including palliative care in the numerator. The developer responded that it would take this feedback to the technical expert panel (TEP). Another committee member asked how “documented plan of care” is defined. The developer answered that, in the numerator, documented plan of care may include use of opioids, non-opioids, psychological support, patient and/or family education, referral to a pain clinic, reassessment of pain, or any other care appropriate for the patient. The denominator is broad, including all patient visits where chemotherapy or radiation is administered and the patient reports having pain. Another committee member asked about the definition of pain and how to distinguish between cancer-related pain versus other causes. The developer responded that it is all pain, but the denominator exclusions should narrow the scope. If a patient has non-cancer-related pain, the plan of care could include referrals to appropriate pain clinics or providers to manage that pain, falling under patient education. A patient committee member offered their perspective, stating that one provider who oversees a patient’s pain management for any type of pain ensures there’s less room for error with medication reconciliation.

The developer noted that the measure allows for patient education and family support. They also added that there is potential to improve by making this part of a combined measure, e.g., with depression, tobacco, or body mass index (BMI) screenings. The developer acknowledged that making measures more comprehensive is happening in other areas, and it will discuss this suggestion with the ASCO membership. A committee member asked if the developer could comment on the topic of entering a care plan into the EHR. The developer responded that the measure is an attestation measure, and they have worked with EHR vendors to include a discrete field for attesting that a plan is in place, whereas the detail will be in physician notes. The developer noted that in the MIPS program, providers need to opt in and choose to report on this measure, which affects the implementation rate. The developer added that the measure’s implementation is not as high as it would like it to be.

With respect to scientific acceptability, the developer noted that it attempted to conduct concurrent validity testing by correlating this measure with CBE #0384, the pain assessment measure. However, there is an overestimation bias with this correlation because the populations

are so similar, so it was not included in the report. Mr. Weed asked about the varying results. This is an encounter-based measure so sample size influences the score differences at clinician versus facility-level results. The developer noted that it is always looking for harmonization in other MIPS measures.

Regarding equity, the committee noted that African Americans and Hispanic patients are less likely than Caucasians to be prescribed opioids. A committee member commented that using the geocode of the physician or practice may enable some analysis to identify disparities.

Lastly, the committee acknowledged that the measure is already in use in the MIPS program. This measure is not stratified for cancer stage or degree of pain. These things would need to be taken into consideration when looking at combining measures. A committee member asked if data could be collected in a way other than attestation. ASCO is actively lobbying for more data elements via the United States Core Data for Interoperability Plus (UCDI+).

Additional Recommendations: Not discussed.

CBE #0384e – Oncology: Medical and Radiation – Pain Intensity Quantified [American Society of Clinical Oncology]

Specifications | Committee Independent Review Summary

Description: This measure looks at the percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified. This eCQM is an episode-based measure. An episode is defined as each eligible encounter for patients with a diagnosis of cancer who are also currently receiving chemotherapy or radiation therapy during the measurement period. The time period for data collection is intended to be 12 consecutive months. There are two population criteria for this measure: 1) All patient visits for patients with a diagnosis of cancer currently receiving chemotherapy OR 2) All patient visits for patients with a diagnosis of cancer currently receiving radiation therapy. This measure is comprised of two populations but is intended to result in one reporting rate. This is a proportion measure and better quality is associated with a higher score.

Clinician: Group/Practice Level

Committee Final Vote: Endorse with Conditions

Conditions:

- Explore, with the developer's TEP, adding mention of other specific measurement tools that can be used to support the measure.
- Include additional guidance for caregivers, namely for patients with cognitive impairment. For instance, adding additional guidance to note alternative methods of assessment, such as observations, behavioral cues, or care plans may be employed.

Vote Count: Endorse (19 votes; 59.38%), Endorse with Conditions (13 votes; 40.63%), Remove Endorsement (0 votes; 0%); recusals (0).

Clinician: Individual Level

Committee Final Vote: Endorse with Conditions

Conditions:

- Explore, with the developer's TEP, adding mention of other specific measurement tools that can be used to support the measure.
- Include additional guidance for caregivers, namely for patients with cognitive impairment. For instance, adding additional guidance to note alternative methods of assessment, such as observations, behavioral cues, or care plans may be employed.

Vote Count: Endorse (18 votes; 56.25%), Endorse with Conditions (13 votes; 40.63%), Remove Endorsement (1 votes; 3.13%); recusals (0).

Measure Discussion:

No public comments were submitted for this measure. The developer reiterated that measures CBE #0383 and #0384 are paired, which means they are endorsed to be used together as a unit but result in individual scores. The intent is for the provider to report on this measure first, then CBE #0383. The difference between CBE #0384e and #0384 is the reporting modality. Dr. Pickering asked if ASCO had any comments on the performance gap between the group and individual levels. The developer replied that because reporting is voluntary, certain physicians may elect to report on their own if their individual scores are higher. A committee member commented that it is customary to see individual submissions when they are higher than the group scores within the MIPS program.

Regarding feasibility of the measure, the developer clarified that the documentation should be done face to face at each patient encounter and should be documented at that time by the provider/physician, not ancillary staff.

For reliability and validity, the developer reiterated that measures CBE #0383 and #0384 have a correlation bias. The denominator is intentionally without exclusions to apply to as many cancer patients as possible, which leads to a higher quality of care. Several committee members requested to include additional guidance to be included for caregivers, especially for caregivers of patients with cognitive impairment. A committee member noted that simpler scales can be used to assess pain in patients with cognitive issues. The developer will take this feedback to its TEP and provide and updated for future maintenance endorsement cycles. With respect to equity, one committee member suggested the developer consider cognitive impairment as a disparity.

Lastly, the developer commented that the pain intensity should be quantified using a standard instrument, but the instrument is not specified. Not all tools are codified but, as an eCQM, the recommendation given in the measure specifications is PROMIS-Pain. The committee suggested the developer explore, with its TEP, adding mention of additional tools within the measure.

Additional Recommendations: Not discussed.

CBE #0384 – Oncology: Medical and Radiation – Pain Intensity Quantified [American Society of Clinical Oncology]

Specifications | Committee Independent Review Summary

Description: This measure looks at the percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified. This measure is to be submitted at each denominator eligible visit

occurring during the performance period for patients with a diagnosis of cancer who are seen during the performance period/measurement period. The time period for data collection is intended to be 12 consecutive months. There are two submission criteria for this measure: 1) All patient visits for patients with a diagnosis of cancer currently receiving chemotherapy OR 2) All patient visits for patients with a diagnosis of cancer currently receiving radiation therapy. This measure is comprised of two populations but is intended to result in one reporting rate. This is a proportion measure and better quality is associated with a higher score.

Clinician: Group/Practice Level

Committee Final Vote: Endorse with Conditions

Conditions:

- Explore, with the developer's TEP, adding mention of other specific measurement tools that can be used to support the measure.
- Include additional guidance for caregivers, namely for patients with cognitive impairment. For instance, adding additional guidance to note alternative methods of assessment, such as observations, behavioral cues, or care plans may be employed.

Vote Count: Endorse (20 votes; 60.61%), Endorse with Conditions (12 votes; 36.36%), Not Endorse/Remove Endorsement (1 votes; 3.03%); recusals (0).

Clinician: Individual Level

Committee Final Vote: Endorse with Conditions

Conditions:

- Explore, with the developer's TEP, adding mention of other specific measurement tools that can be used to support the measure.
- Include additional guidance for caregivers, namely for patients with cognitive impairment. For instance, adding additional guidance to note alternative methods of assessment, such as observations, behavioral cues, or care plans may be employed.

Vote Count: Endorse (20 votes; 60.61%), Endorse with Conditions (12 votes; 36.36%), Not Endorse/Remove Endorsement (1 votes; 3.03%); recusals (0).

Measure Discussion:

No public comments were submitted for this measure. The developer reiterated that the measure uses chemo administration codes, which include drugs or biologics that qualify for those codes, including immunotherapy. The terms "chemo" and "radiation" are not all-inclusive of types of therapy that are considered in this measure.

Regarding its feasibility, the developer clarified that this measure applies to both medical and radiation oncologists. Specific codes are provided to delineate between the populations. With respect to scientific acceptability, the developer commented the decline in CBE #0384, though not fully backed by data, is attributed the uptick in use of the eCQM, CBE #0384e, due to the increased functionality of EHRs versus the burden of manual abstraction. The committee requested the same conditions for this measure as those applied to CBE #0384e. With respect to equity, neither the developer nor the committee had additional comments about equity.

Lastly, Mr. Weed asked about the order in which to consider these paired measures, CBE #0383 and #0384 and #0384e. The developer clarified that despite the number sequence, CBE #0384e and #0384 should be reported prior to #0383. This is a function of the CBE number convention; in MIPS the numbers are sequential. A committee member commented that they considered the increased use of the eCQM to be a sign of progress. The developer replied that smaller practices appreciate the ability to still report on this measure manually. The developer anticipated that the registry version will be eventually retired, and data will be solely collected as an eCQM.

Additional Recommendations: Not discussed

Opportunity for Public Comment

A member of the public expressed appreciation for the work the committee has done. The commenter noted that the CKD measure (CBE #1662) fits into a larger scale system of care and agreed with the committee's comments.

Next Steps

Dr. Pickering noted that Battelle will post the meeting summary to the E&M committee project page by February 26, 2024. The summary will include any conditions placed on any of the measures. He noted that the appeals period for this cycle will begin on February 26, 2024, and end on March 18, 2024. He explained that any endorsement decision rendered by the committee can be appealed by any interested party based on the eligibility criteria, which can be found in the E&M Guidebook. The standing Appeals Committee meeting date is March 27, 2024. The Appeals Committee consists of all co-chairs from all project committees. Dr. Pickering closed the meeting by thanking participants, including committee members, members of the public, and the measure developers and stewards.