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Fall 2023 Advanced Illness and Post Acute Care Committee Endorsement Meeting

February 5, 2024

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Welcome

Meeting Objectives

The purpose of today's meeting is to:

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

Housekeeping Reminders for Recommendations Group*

- The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
- Please raise your hand and unmute yourself when called on
- Please lower your hand and mute yourself following your question/comment
- Please state your first and last name if you are a Call-In User
- We encourage you to keep your video on throughout the event
- Feel free to use the chat feature to communicate with Battelle staff
- If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

*Advisory Group members are asked to refrain from using the chat and the raise hand feature, as Advisory Group members will be listening to the Recommendations Group discussions and will cast their vote once discussions cease.

Meeting Ground Rules

- Be prepared, having reviewed the meeting materials beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure evaluation rubric
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

Project Team

- Nicole Brennan, MPH, DrPH, Executive Director
- Brenna Rabel, MPH, Deputy Director
- Jeff Geppert, Measure Science Team Lead
- Quintella Bester, PMP, Senior Program Manager
- Matthew Pickering, PharmD, Principal Quality Measure Scientist
- Beth Jackson, Social Scientist IV
- Amanda Overholt, MPH, Social Scientist III
- Stephanie Peak, Social Scientist III
- Isaac Sakyi, MSGH, Social Scientist III
- Lydia Stewart-Artz, PhD, Social Scientist III
- Jessica Ortiz, MA, Social Scientist II
- Olivia Giles, MPH, Social Scientist I
- Elena Hughes, MS, Social Scientist I
- Sarah Rahman, Social Scientist I

Agenda

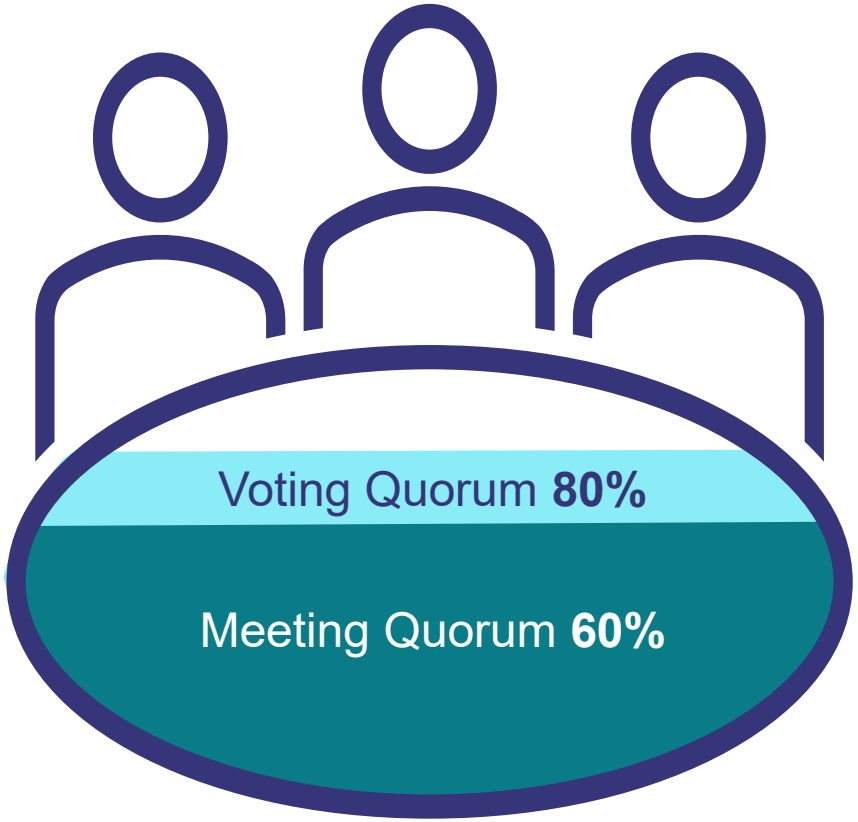
- Welcome and Review of Meeting Objectives
- Roll Call with Disclosures of Interest
- Overview of Evaluation Procedures and Measures for Endorsement Consideration
- Test Vote
- Evaluation of Candidate Measures
- Additional Measure Recommendations Discussion (if time permits)
- Opportunity for Public Comment
- Next Steps
- Adjourn

Roll Call with Disclosures of Interest

Quorum

- Meeting quorum requires that 60% of the Recommendations Group members are present during roll call at the beginning of the meeting.

- Endorsement decisions are rendered via a vote after Recommendations Group discussions. Voting quorum is at least 80% of active committee members (Recommendations Group + Advisory Group), who are not recused.



Advanced Illness and Post Acute Care Fall 2023 Cycle Committee – *Recommendations Group*

- Kristin Seidl, PhD, RN (***Non-Patient Co-Chair***)
- Stephen Weed, MA (***Patient Co-Chair***)
- Barbara Winters - Todd, DNP, RN, CRRN
- Brigette DeMarzo, DrPH, MPH, BS
- Cardianle Smith, MD, PhD
- Cher Thomas, RDH
- Dima Raskolnikov, MD
- Donna Woods, EdM, PhD
- Erin Crum, MPH
- Ginette Ayeni, FNP-BC
- Margherita Labson, BSN, MSHSA, CCM, CPHQ
- Morris Hamilton, PhD
- Paul Galchutt, MDiv, MPH, BCC
- Paul Tatum, MD, MSPH, FAAHPM, AGSF

**Denotes committee member is under Inactive status for the current cycle.*

Advanced Illness and Post Acute Care Fall 2023 Cycle Committee – *Advisory Group*

- Alicia Staley, MBA, MSIS
- Andrew Kohler, MD, MBA, CPE
- Brenda Groves, LPN, CADDCT, CDP
- Carol Siebert, OTD, OT/L, FAOTA
- Donna Sternberg, RN, BSN
- Emily Martin, MD, MS, FAAHPM
- Gerri Lamb, PhD, RN
- Heather Thompson, LMSW, CPHQ, CPXP
- Jonathan Nicolla, MBA
- Karie Fugate
- Kyle Matthews
- Lama El Zein, MD, MHA
- Lea Dooley, DHA, MPH
- Maria Regnier, MSN, BSN, RN, CNN
- Milli West, MBA, CPHQ
- Nicole Keane, MSN, RN, CPHQ
- Omar Latif, MD
- Raina Josberger, MS
- Rebecca Swain-Eng, MS, CAE
- Sarah Thirlwell, MSc, MSc(A), RN, AOCNS, CHPN, CHPCA, CPHQ
- Sassy Outwater-Wright
- Sheila Clark
- Shelby Moore, MPA, CFRE
- Soojin Jun, PharmD, BCGP, CPPS, CPHQ
- Stephanie Wladkowski, PhD, LMSW, APHSW-C
- Yaakov Liss, MD

**Denotes committee member is under Inactive status for the current cycle.*

Overview of Evaluation Procedures

Roles of the Committee During the Endorsement Meeting

- **Evaluate** each measure against each domain of the Partnership for Quality Measurement Measure Evaluation Rubric
- **Indicate** the extent to which each criterion is met and the rationale for the rating
- **Review** comments submitted during the public comment period
- **Render endorsement decisions** for candidate measures

Roles of the Committee Co-Chairs During the Endorsement Meeting

	Collaborate with Battelle
• **Co-facilitate** virtual endorsement meetings, along with Battelle staff	●
• **Participate on the committee** as a full voting member for the entirety of your term	
• **Serve on the Appeals committee** ▪ Includes attending the half- to full-day virtual Appeals committee meeting at the end of every E&M cycle (contingent upon whether an appeal is received)	
• Work with Battelle staff to **achieve the goals** of the project	●
• Assist Battelle staff in **anticipating questions and identifying additional information** that may be useful to the committee	●

Roles of the Committee Co-Chairs During the Endorsement Meeting, *Continued 1*

Patient Representative Co-Chair

Ensure the patient community voice is considered

Non-Patient Representative Co-Chair

Ensure the Advisory group voice is considered

Evaluation and Voting Process

Non-consensus Measures

Step	Description	Interested Party
1	**Introduction of the measure in which consensus was lacking** • Presentation of the PQM Rubric domain rating results from the committee independent assessments and a summary of the committee's independent review, noting both strengths and limitations, and any potential conditions, as appropriate. • Summation of any public comments received prior to the endorsement meeting.	Battelle Staff
2	**Floor is open for any additional public comments with respect to the measure under review** • Commenters are kindly asked to keep their comments to two (2) minutes or less. • The committee does not respond directly to commenters, rather comments are shared for the committee's endorsement discussion.	Battelle Staff and Co-chairs
3	**Three-to-five (3-5) minute, high-level overview of the measure** • Presenters will kindly be asked to stop presenting if the time is over five (5) minutes. • Please refrain from using slides or screensharing of materials. • Overview may include initial Reponses to committee independent reviews and/or public comments	Developer and/or Steward

Evaluation and Voting Process

Non-consensus Measures, Continued 1

Step	Description	Interested Party
4	**Round-robin for clarifying questions** • Non-patient representative co-chair to confirm whether questions from A-group members (via independent assessments) have been considered. • Patient representative co-chair to confirm whether the patient partner questions have been considered. • After all questions have been collected, the developer/steward addresses measure-specific questions.	R-group discusses A-group listens Battelle Staff to facilitate with Co-chairs Developer and/or Steward
5	**Committee discussion of the measure elements in which consensus was lacking** • Facilitated discussion measure strengths and limitations based on PQM Measure Evaluation Rubric domain. • Determine potential resolutions that lead to committee consensus and any recommendations placed on the measure for the developer/steward to consider in the future. • The developer/steward may respond to questions posed by the committee. • Subject matter experts (SMEs) are called upon, accordingly, to address committee questions and to provide context and relevance about the measure for to the committee's consideration.	R-group discusses A-group listens Battelle Staff to facilitate with Co-chairs Developer and/or Steward SMEs

R-group: Recommendations group; A-group: Advisory group

Evaluation and Voting Process

Non-consensus Measures, Continued 2

Step	Description	Interested Party
6	**Responses to committee discussion** • After the committee discussion has concluded, prior to voting, the developer/steward is given a final opportunity to respond to the committee's discussion before the committee moves to a vote on endorsement. • Please try to keep responses brief, referring to information in the measure submission, as appropriate. • Please refrain from using slides or screensharing of materials.	Developer and/or Steward
7	**Committee vote** • Any conditions or recommendations are summarized prior to voting. • If consensus is not reached, based on the 75% threshold, the measure is not endorsed.	R-group and A-group Battelle Staff and Co-chairs summarize voting conditions

R-group: Recommendations group; A-group: Advisory group

Evaluation and Voting Process

Conditions for Voting Example

Step	Description	Interested Party
7	**Committee vote** • Any conditions or recommendations are summarized prior to voting. • If consensus is not reached, based on the 75% threshold, the measure is not endorsed.	R-group and A-group Battelle Staff and Co-chairs summarize voting conditions

Example: Some committee members raised concern with the measure testing occurring in only two or three U.S. states and recommended to see additional testing across are larger, more generalizable population, then:

- A vote to **Endorse** the measure means the committee agrees that the evidence provided to support the measure fully substantiates the measure claims.
- A vote to **Endorse with Conditions**, means the committee agrees that the evidence provided to support the measure doesn't fully substantiate the measure claims due to limited testing within 2-3 states. Therefore, the committee votes to endorse the measure with the condition that additional testing across a larger, more generalizable population be conducted by the next maintenance review.
- A vote to **Not Endorse/have Endorsement Removed**, means the committee agrees that the evidence provided to support the measure does not substantiate the claims for scientific acceptability due to the limited testing in only 2-3 U.S. states. Therefore, the committee raised concern with respect to the generalizability of the testing results. In addition, there are no reasonable changes to the measure (e.g., specifications, testing, evidence) that would allow the measure to receive conditional endorsement.

Evaluation and Voting Process

Consensus Measures

Step	Description	Interested Party
1	**Introduction of the measure in which consensus was reached** • Presentation of the PQM Rubric domain rating results from the committee independent assessments and a summary of the committee's independent review, noting both strengths and limitations, and any potential conditions, as appropriate. • Summation of any public comments received prior to the endorsement meeting.	Battelle Staff
2	**Floor is open for any additional public comments with respect to the measure under review** • Commenters are kindly asked to keep their comments to two (2) minutes or less. • The committee does not respond directly to commenters, rather comments are shared for the committee's endorsement discussion.	Battelle Staff and Co-chairs
3a	**Committee discussion of measures with consensus to endorse** • Confirm the measure strengths outweigh any limitations identified • Confirm if any conditions for endorsement • Co-chairs confirm the Advisory Group and the patient community voice have been considered (via independent assessments)	R-group discusses A-group listens Battelle Staff to facilitate with Co-chairs

Evaluation and Voting Process

Consensus Measures, Continued 1

Step	Description	Interested Party
3b	**Committee discussion of measures with <u>consensus to not endorse/remove endorsement</u>** • Confirm the measure limitations outweigh the strengths • Identify potential recommendations for the developer to improve the limitations • Co-chairs confirm the Advisory Group and the patient community voice have been considered (via independent assessments) • After the committee discussion, the developer/steward is given the opportunity to respond to the committee's review and discussion.	R-group discusses A-group listens Battelle Staff to facilitate with Co-chairs Developer and/or Steward
4	**Committee vote** • Any conditions or recommendations are summarized prior to voting. • If consensus is not reached, based on the 75% threshold, the measure is not endorsed.	R-group and A-group Battelle Staff and Co-chairs summarize voting conditions

Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** There is 75% or greater agreement for endorsement by the E&M committee	Measures undergo maintenance of endorsement reviews every 5 years with an annual update review at 3 years.
Endorsed with Conditions	**Applies to new and maintenance measures**. There is 75% or greater agreement that the measure can be endorsed as it meets the criteria, but there are recommendations/areas committee reviewers would like to see when the measure comes back for maintenance. If these recommendations are not addressed, then a rationale from the developer/steward should be provided for consideration by the E&M committee review.	Measures undergo maintenance of endorsement reviews every 5 years with an annual update at 3 years, unless the condition requires the measure to be reviewed earlier. The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
Not Endorsed	**Applies to new measures only.** There is 75% or greater agreement to not endorse the measure by the E&M committee.	None
Endorsement Removed	**Applies to maintenance measures only.** Either: • There is 75% or greater agreement for endorsement removal by the E&M committee; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance and there is no response from the steward after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has plateaued (i.e., no significant change in measure results for accountable entities over time)	None

Decision Outcomes:
Endorsed with Conditions

The types of conditions that may be placed on a measure include:

- Conducting/providing additional testing across a larger population, accountable entity-level, and/or different level of analysis
- Expanding the measure use beyond quality improvement and into an accountability application
- Providing implementation guidance or a near-term path forward for implementing the measure; providing clear system requirements for implementation of the measure

Battelle has identified several non-negotiable areas, meaning if a measure meets one or more of the following criteria, the measure cannot be endorsed, even with conditions:

- Lack of or unclear business case
- Lack of evidence supporting the business case
- Significantly poor feasibility for the measure to be implemented due to challenges, e.g., data availability or missingness
- Inappropriate methodology, calculations, formulas, or testing approach used to demonstrate reliability or validity
- Specifications, testing approach, results, or data descriptions are insufficient
- If a measure with an “Endorsed with Conditions” designation is evaluated for maintenance, but it has not met the prior conditions

What is the PQM Measure Evaluation Rubric?

The PQM Measure Evaluation Rubric (Rubric) consists of five (5) major domains:

1. **Importance** - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

2. **Feasibility** - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

3. **Scientific Acceptability [i.e., Reliability and Validity]** - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

4. **Equity (optional)** - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

5. **Use and Usability** - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Consensus Voting for Final Determinations

Endorse (A)	Endorse with Conditions (B)	Do Not Endorse (C)	Consensus Voting Status
75% or More	0%	Less than 25%	A
75% or More		Less than 25%	B
Less than 25%		**75% or More**	C
26% to 74%		26% to 74%	No consensus

If no consensus is reached, based on the 75% threshold, the measure is not endorsed.

Overview of Fall 2023 Measures for Endorsement Consideration

Fall 2023 Measures for Committee Review

Four measures were submitted to the Advanced Illness and Post Acute Care committee for endorsement consideration.

NUMBER OF MEASURES:

4

AREAS OF FOCUS

- **Pain Management in Persons with Cancer**
- **Appropriate Medication Use in Persons with Kidney Disease**

NEW VS. MAINTENANCE

- **0** New Measure
- **4** Maintenance Measures

Fall 2023 Measures for Committee Review

CBE ID	Title	Importance (n)	Feasibility (n)	Scientific Acceptability (n)	Equity (n)	Use & Usability (n)
1662	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	**No Consensus (15)** • 67% Met • 33% Not Met, but Addressable • 0% Not Met	**No Consensus (15)** • 20% Met • 73% Not Met, but Addressable • 7% Not Met	**Consensus (15)** • 13% Met • 87% Not Met, but Addressable • 0% Not Met	**No Consensus (15)** • 13% Met • 67% Not met but addressable • 20% Not Met	**Consensus (15)** • 0% Met • 93% Not met, but Addressable • 7% Not Met
0383	Oncology: Medical and Radiation - Plan of Care for Pain	**No Consensus (15)** • 60% Met • 33% Not Met, but Addressable • 7% Not Met	**No Consensus (15)** • 67% Met • 20% Not =Met, but Addressable • 13% Not Met	**No Consensus (15)** • 67% Met • 27% Not met, but Addressable • 7% Not Met	**No Consensus (15)** • 7% Met • 33% Not met, but Addressable • 60% Not Met	**No Consensus (15)** • 20% Met • 73% Not met, but Addressable • 7% Not Met
0384e	Oncology: Medical and Radiation - Pain Intensity Quantified	**Consensus (16)** • 75% Met • 19% Not Met, but Addressable • 6% Not Met	**Consensus (16)** • 81% Met • 19% Not Met, but Addressable • 0% Not Met	**Consensus (16)** • 88% Met • 13% Not Met, but Addressable • 0% Not Met	**No Consensus (16)** • 6% Met • 31% Not Met, but Addressable • 63% Not Met	**No Consensus (16)** • 44% Met • 56% Not met, but Addressable • 0% Not Met

Legend:
n – number of committee independent reviews

Fall 2023 Measures for Committee Review, continued 1

CBE ID	Title	Importance (n)	Feasibility (n)	Scientific Acceptability (n)	Equity (n)	Use & Usability (n)
0384	Oncology: Medical and Radiation - Pain Intensity Quantified	**No Consensus (13)** • 31% Met • 69% Not Met, but Addressable • 0% Not Met	**Consensus (16)** • 77% Met • 23% Not Met, but Addressable • 0% Not Met	**Consensus (16)** • 77% Met • 23% Not Met, but Addressable • 0% Not Met	**No Consensus (16)** • 8% Met • 38% Not Met, but Addressable • 54% Not Met	**No Consensus (16)** • 46% Met; • 54% Not Met, but Addressable; • 0% Not Met

Legend:
n – number of committee independent reviews

Test Vote

Consideration of Candidate Measures

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy

Item	Description
Measure 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.
Developer/Steward	• Renal Physicians Association
New or Maintenance	• Maintenance
Current or Planned Use	• Payment Program • Public Reporting

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Process	Adults 18 years and older with a diagnosis of CKD	Clinician Office/Clinic	Clinician: Individual

CBE #1662
Public Comments

No comments received

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, continued 1

Importance - Extent to which the measure is evidence-based AND is important for making significant gains in health care quality or cost where there is variation in or overall, less-than-optimal performance.

Importance (n=15)	Strengths	Limitations
No Consensus 67% Met 33% Not Met, but Addressable 0% Not Met	• **CKD as a Public Health Problem:** CKD affects 37 million Americans. Efforts to increase ACEi/ARB use have reduced kidney failure incidents. • **ACE Inhibitors and ARBs in CKD:** ACEi and ARBs are key for anti-hypertension in CKD and slowing disease progression. • **Performance Gap:** There is a clear performance gap in the usage of ACEi and ARB among patients with CKD. Data show a gap in ACEi/ARB prescription among physicians and CKD patients. • **Quality Measure is Useful:** Expressed need for quality measures to improve the use of ACE inhibitors and ARBs in patients with CKD. The measure is crucial for high-quality nephrology care and is supported by various organizations.	• **Current Data:** Data are outdated. More recent data are needed, expected from MIPS 2022-2023. • **Measure Limitations:** Identified limitations, including lack of empirical demonstration of outcome association and concerns about accounting for hyperkalemia after RAAS initiation. Request for clarification and mitigation approaches for patients placed on very low doses of RAS blockade rather than having the dose properly titrated. • **Proteinuria and Treatment:** The amount of proteinuria that necessitates treatment has different thresholds, depending on the source: (> 300 mg/g on UACR or UPCR for this metric; other sources suggest UACR > 300 mg/g or UPCR > 500 mg/g others might say > 1000 mg/g).

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, continued 2

Feasibility - Extent to which the measure specifications (i.e., numerator, denominator, exclusions) require data that are readily available OR could be captured without undue burden AND can be implemented for performance measurement.

Feasibility (n=15)	Strengths	Limitations
No Consensus 20% Met 73% Not Met, but Addressable 7% Not Met	• **Measure Specifications:** There are clearly defined values and definitions for the numerator, denominator, exclusion, and exceptions.	• **Measure Specifications and ICD-10 Codes:** Request for clarification on identifying ICD-10 codes for CKD, the degree of proteinuria, erroneous ICD-10 code entry, and if the patient is being prescribed an ACE/ARB. • **Data Collection:** A significant portion of the measure definition requires manual chart review to determine measure outcome scores. Chart review is very difficult. • **Exclusion Criteria:** Some committee members mention the need for a detailed, near-universal method for identifying denominator exclusions. Measure developers did not address the potential burden of identifying criteria for exclusion from the denominator based on medical contraindications or patient choice. It also raises questions about specific ICD-10 codes (like N18.6) and their role as automatic exclusions.

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, continued 3

Scientific Acceptability [i.e., Reliability and Validity] - Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

Scientific Acceptability (n=15)	Strengths	Limitations
Consensus 13% Met 87% Not Met, but Addressable 0% Not Met	• **Measure Specifications:** The measure is well-defined and specified. • **Reliability Testing:** Significant gap in performance, which may suggest high entity-level reliability. The measure submission indicates a high level of reliability. • **Face Validity Testing**: The developer provided adequate evidence of face validity. • **Support for the Measure:** The measure is supported by various medical entities.	• **Outdated Data:** The comments repeatedly mention that the data used to support the measure's validity and reliability are outdated, specifically from 2007 and 2008. It suggests that the measure should have been retested given changes in EHRs and medical practice. • **Entity-Level Reliability and Validity:** Entity-level reliability and validity have not been assessed. Concerns are raised about the potential for low entity-level reliability, especially for entities with low denominator size, if the gap in performance has narrowed. While face validity is clearly strong, there should be more empirical testing connecting the measure to outcomes. • **Entity-Level Testing:** Comments discuss the lack of entity-level reliability testing and the potential impact of this on the measure. • **Sample Size:** Committee members mention the small sample size used in the data and suggest that this is a limitation of the measure. It also mentions the need for a larger sample size for enrollment.

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, continued 4

Equity (optional) - Extent to which the measure can identify differences in care for certain patient populations, which can be used to advance health equity and reduce disparities in care.

Equity (n=15)	Strengths	Limitations
No Consensus 13% Met 67% Not met but addressable 20% Not Met	• **Chronic Kidney Disease (CKD) and ACEi/ARB Use**: Committee members mention a gap in ACEi/ARB use among CKD patients, with 40% not using it. It also discusses efforts to increase ACEi/ARB use in certain populations. • **Disparities in Health Outcomes:** Comments repeatedly mention disparities in health outcomes, particularly in relation to race and gender. Comments also mention disparities in hypertension control among persons with early CKD.	• **Measure Performance and Current Data:** The comments discuss the need for current performance data to explore possible disparities in the measure. Comments mention that data on its performance have not yet been released by CMS and suggest that new performance data could be used to explore possible disparities. • Consider evidence linking social risk factors directly to the use of ACEi/ARB and showing data in the current dataset. • **Measure Impact and Outcomes:** The measure proposal indicates an opportunity to impact improved outcomes for various populations. However, given that this measure is a process measure and does not address outcomes, it is unclear as to whether or not this measure will truly impact patient care outcomes.

CBE #1662 - Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy, continued 5

Use and Usability - Extent to which potential audiences (e.g., consumers, purchasers, providers, and policymakers) are using or could use measure results for both accountability and performance improvement to achieve the goal of high quality, efficient health care for individuals or populations.

Use and Usability (n=15)	Strengths	Limitations
Consensus 0% Met 93% Not met, but Addressable 7% Not Met	• **Measure Currently In Use:** Measure currently in use in MIPS (eligible entities can receive performance-based incentives).	• **Need for Current Performance Data:** There's a need for more current performance data. The measure developer did not provide evidence of how this maintenance measure has been used to improve the quality of care for patients with CKD and did not address how it sought/responded to feedback from end users. • **Measure Evaluation and Usefulness:** Need for more detail in evaluating RAAS treatments and the importance of follow-up measures. There is a lack of direction in the measure, rendering it marginally useful to practitioners. • **Patient Education and Understanding:** Patients, especially in the early stages of CKD, are not well-educated. They will tend to follow the regime of their nephrologist. If there was a way to certify that urea, liver panel, potassium levels, and renal panel labs were checked, it would be easier to sign on for this measure. Without evidence of follow-up lab work to monitor the start of a RAAS protocol, CMS will not have a clear picture of its usefulness.

CBE #383 – Oncology: Medical and Radiation - Plan of Care for Pain

Item	Description
Measure 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.
Developer/Steward	• American Society of Clinical Oncology
New or Maintenance	• Maintenance
Current or Planned Use	• Payment Program • Professional certification or recognition program • Quality Improvement with Benchmarking

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Process	Individuals receiving chemotherapy or radiation	Clinician Office/Clinic	Clinician: Group/Practice Clinician: Individual

CBE #383
Public Comments

No comments received

CBE #383 - Oncology: Medical and Radiation - Plan of Care for Pain, continued 1

Importance (n=15)	Strengths	Limitations
No Consensus 60% Met 33% Not Met, but Addressable 7% Not Met	• **Incidence of Cancer:** Comments mention the incidence rate of over 1.9 million cancer cases in 2023 and emphasizes the importance of the measure given the incidence of cancer. • **Pain Management in Cancer Patients:** Comments discuss the importance of pain management in cancer patients, the challenges faced due to the subjective nature of pain, and the impact of the opioid crisis on the reduction of valid medications for cancer patients. Need for a documented plan of care to address pain in cancer patients undergoing chemotherapy or radiation. • **Performance Rates in Pain Management:** Comments note a decline in performance rates from the MIPS-quality program data reflecting calendar years 2019-2021. Comments also mention high performance rates for practices and individual clinicians asking about pain levels, despite pain being a persistent, unmanaged issue for a large percentage of patients with cancer.	• **Quality Measures for Pain Management:** Need for more relevant quality measures to assess both pain intensity and the plan of care for pain, or a patient-reported outcome measure indicating pain improvement within a certain time period of follow up. Developers could consider expanding this measure to include other sub-groups of oncology patients as additional populations in the reported rate of this measure. • **Pain Management Plan:** Lack of clarity on whether having any plan, even if it's medically wrong, is better than not having a plan. • It's not clear that having any plan in place to treat the patient's pain, even if it is medically the wrong plan, is any better than not having a plan. • Instead of two process measures (0383 and 0384) combine into one measure; pain assessed and on the plan of care.

CBE #383 - Oncology: Medical and Radiation - Plan of Care for Pain, continued 2

Feasibility (n=15)	Strengths	Limitations
No Consensus 67% Met 20% Not Met, but Addressable 13% Not Met	• **Data and Measure Implementation:** All measure data elements can be documented in discrete fields within most EHRs. Easy adoption of the measure by numerous healthcare practices, as evidenced by the considerable number of practices reporting this measure to the Centers for Medicare and Medicaid Services (CMS) via the Merit-based Incentive Payment System (MIPS) program. • **Feedback:** Comments note that feedback from EHRs, cancer registries, and oncology practices provides compelling evidence that the measure is easy to implement.	• **Implementation and Effectiveness of Measures:** Measure developers have not updated measure specifications for the numerator to reflect the stated NCCN clinical practice guideline recommendations. • The measure lacks enough rigor to evaluate whether the pain plans represent an important step in treatment. • Discussion needed on whether and how data can be collected to make this measure more meaningful.

CBE #383 - Oncology: Medical and Radiation - Plan of Care for Pain, continued 3

Scientific Acceptability (n=15)	Strengths	Limitations
No Consensus 67% Met 27% Not Met, but Addressable 7% Not Met	• **Reliability and Validity of the Measure:** Comments note reliability scores ranging from 0.804 to 1.000 across all years analyzed at individual clinician and practice levels. • 100% of clinicians and practices had measure scores with reliabilities of 0.70 or higher, a commonly accepted reliability threshold. • No concerns with validity testing, noting that the measure has sufficient validity. • **Measure Definition and Specification:** Comments note the measure as well-defined and precisely specified. All data elements for both numerator and denominator exist in structured fields. • **Validity Testing and Results: A**ll data elements for both the numerator and denominator were tested for validity. The Kappa coefficients for both the denominator and numerator data elements indicate high accuracy.	• **Interpretation**: Some comments express a lack of understanding about how the numerator is determined to be met. Measure developers do not address how numerator elements coded to reflect a documented plan of care for pain were tested for reliability. A “plan of care” can be carried over from visit to visit almost automatically. • **Additional Validity Testing:** Given the length of time this measure has been in use and the number of practices choosing to report it, are other measures of concurrent and construct validity available?

CBE #383 - Oncology: Medical and Radiation - Plan of Care for Pain, continued 4

Equity (n=15)	Strengths	Limitations
No Consensus 7% Met 33% Not Met, but Addressable 60% Not Met	• **Recognition of Disparities:** The developer cites disparities in opioid access and dosage among different racial groups. General information about disparities is provided in the importance section. • **Data Collection Opportunities:** Opportunities exist for cross-referencing additional patient demographics and characteristics in the electronic medical record with pain management care planning outcomes to identify areas of equity opportunity.	• **Lack of Information/Data:** Equity was not addressed at this time, but not required. • The lack of demographics in the MIPS data and the masking of demographics in the McKesson data means inequities are not recognized or addressed. • CMS did not capture nor provide any patient-level socio-demographic variables and therefore no patient demographic data is available. • Measure developers indicated that differences could exist and that care settings are encouraged to track additional data that could reflect differences in health equity but these have not been included in measure specifications and analyses according to those data were not reported.

CBE #383 - Oncology: Medical and Radiation - Plan of Care for Pain, continued 5

Use and Usability (n=15)	Strengths	Limitations
No Consensus 20% Met 73% Not Met, but Addressable 7% Not Met	• **Use in Multiple Programs:** The measure is already in use in the CMS Merit-based Incentive Payment System (MIPS). • **Data/Outcomes:** Data/outcomes are actionable and address effective pain assessment as well as effective pain management care planning. • **Feedback Mechanisms:** Providers can send feedback via the CMS Helpdesk or via email to ASCO.	• **Performance Rates and Decline:** The comments discuss the decline in performance rates from MIPS-quality program data reflecting calendar years 2019-2021. Comments further note the lack of sufficient explanation for the decline and the need for more data on the decline in quality and how improvements will be implemented. • **Clarification:** Need for clearer guidance within the measure specification, particularly around the definition of pain and situations where a patient is under the care of multiple oncologists. • **Impact on Patient Care and Practices:** Some comments question the measure's impact on patients and practices, suggesting that it may not be as helpful to guide practice changes and may not do much for the patient.

Lunch

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified

Item	Description
Measure 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.
Developer/Steward	• American Society of Clinical Oncology
New or Maintenance	• Maintenance
Current or Planned Use	• Payment Program • Professional Certification or Recognition Program • Quality Improvement with Benchmarking

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Process	Individuals receiving chemotherapy or radiation	Clinician Office/Clinic	Clinician: Group/Practice Clinician: Individual

CBE #384e
Public Comments

No comments received

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified , continued 1

Importance (n=16)	Strengths	Limitations
Consensus 75% Met 19% Not Met, but Addressable 6% Not Met	• **Pain Management in Cancer Patients:** The evidence provided emphasizes the importance of pain management in cancer patients, especially in the context of the current opiate crisis. The developer also notes the National Comprehensive Cancer Network's clinical practice guideline recommendations for comprehensive pain assessment and control. • **Performance Benchmarks and Unmanaged Pain:** The developer highlights disparities in opioid access and dosage among different racial groups. There is room for improvement in practice-level performance scores. • **Importance of Measure:** The importance of the measure is clearly outlined and supported by the literature. It discusses encounters with cancer patients receiving chemotherapy or radiation and evaluates their pain intensity.	• **Lack of Direct Patient Input:** The measure does not include direct patient input on its meaningfulness. However, a 2022 study emphasized the importance of routine pain screening, management, and follow-up. • **Need for Plan of Care for Pain:** Comments mention the inadequacy of merely asking patients about their pain intensity without requiring clinicians to develop a plan to address elevated pain. • **High Performance Rates:** There appears to be little room for improvement in clinician-level performance scores. Developers note that participants may select measures reflecting high performance rates, potentially masking a drop-in practice-level performance.

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified , continued 2

Feasibility (n=16)	Strengths	Limitations
Consensus 81% Met 19% Not Met, but Addressable 0% Not Met	• **Data Collection:** The necessary data elements required for the numerator and denominator can be found within structured fields and are recorded using commonly accepted coding standards. Data elements can easily be collected and are easily obtained from existing entries in the electronic medical record. • **Integration with Existing Systems:** The measure's data capture can be seamlessly integrated into existing physician workflows and data collection tools without requiring any significant modifications. The feasibility of using defined areas in EMRs is achievable. • **Precedent for Implementation:** This measure is fully implemented for the Oncology Care Model and Enhancing Oncology Care Model. This sets a precedent that the pain intensity and pain care plan measures could be combined to create a single, more comprehensive measure.	• **Combining Measures:** It also discusses the possibility of combining the pain intensity and pain care plan measures to create a single, more comprehensive measure. • **Lack of Specificity in Documentation:** The measure specifications do not specify who documents the pain intensity or collect information regarding who documented the score in the electronic health record. Differences in scores across different physician practices or clinicians may reflect differences in which oncology team member, from a medical assistant to the oncologist, asked the patient's score.

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified , continued 3

Scientific Acceptability (n=16)	Strengths	Limitations
Consensus 88% Met 13% Not Met, but Addressable 0% Not Met	• **Reliability:** The measure has strong reliability scores. The reliability of this measure was evaluated with signal-to-noise analyses from recent data, all of which were in acceptable limits. The developers present signal-to-noise ratios, with estimated entity-level reliability exceeding conventional standards of reliability when at 0.826 and above. There is evidence of strong inter-rater reliability. • **Validity:** The sample size is statistically valid and data element-level testing is robust. Validity was evaluated using a recent (2022) data set. Kappa statistics were used to compare manual abstraction and an automated algorithm. With very high kappa values, encounter-level validity is satisfied. The elements of the measure appear accurately measured. The measure met validity tests. Measure developers provide evidence of validity testing and strong validity. • **Importance of Measure:** The importance of the measure is clearly outlined and supported by the literature. It discusses encounters with cancer patients receiving chemotherapy or radiation and evaluates their pain intensity. • **Measure Specifications:** Measure is well-defined and specified.	• **Lack of Specificity in Documentation:** The measure specifications do not specify who documents the pain intensity or collect information regarding who documented the score in the electronic health record. Differences in scores across different physician practices or clinicians may reflect differences in which oncology team member, from a medical assistant to the oncologist, asked the patient's score. • **Lack of Exclusions:** The measure specifications do not include any exclusions. This decreases the burden of data collection but does not allow for capture of differences in scores and/or exclusions according to patients' cognitive ability to respond to a standard pain instrument or account for patients' choice to decline to provide a rating.

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified , continued 4

Equity (n=16)	Strengths	Limitations
No Consensus 6% Met 31% Not Met, but Addressable 63% Not Met	• **Acknowledgement of Disparities:** The developer cites disparities in opioid access and dosage among different racial groups.	• **Stratification of Measure by Race and Ethnicity:** Measure developer is encouraged to stratify the measure by race and ethnicity, noting importance of reporting per category to link it to the care plan and use of opioids appropriately. Need to address disparities and the quality-of-care gap. • **Lack of Equity Information:** No subsequent data relevant to equity specifically for this measure are provided. • Drilling down on demographics may not yield much gain, as many people already understand these links. • **Suggestion for Further Investigation:** Additional literature review and/or review of existing data utilizing other patient identifying factors could be performed to further investigate opportunities for equity improvement.

CBE #384e - Oncology: Medical and Radiation - Pain Intensity Quantified , continued 5

Use and Usability (n=16)	Strengths	Limitations
No Consensus 44% Met 56% Not Met, but Addressable 0% Not Met	• **Use of Measure in Programs:** The measure is currently in use in the Enhancing Oncology Model (EOM-4), where eligible entities can receive performance-based incentives. The measure is also in use in the CMS Merit-based Payment System (MIPS). No unexpected findings are reported. • **Quality Improvement Tools:** Other tools for Quality Improvement (QI) include Practice Insights by McKesson, a performance analytics tool used by subscribing providers, and the Patient-Centered Cancer Care Standards ASCO Certification. • **Performance Gap:** A performance gap remains at the practice level, where there could be meaningful improvements in at least the bottom 8 deciles. Data can be used to identify gaps in care related to pain management. • **Feedback Mechanism:** Providers can send feedback via the CMS Helpdesk or via email to ASCO.	• **Use of Measure in Programs:** The current use in MIPS and EOM models do not show improvement, which may be due to variables other than the effectiveness of this measure. • **Performance Gap:** Based on the review of the logic model/testing attachment, meaningful improvement in the clinician-level measure is probably limited to the bottom 4 deciles, and no improvement has been made from 2019-2021. The mean performance at the practice level falls between 2019 and 2021 (0.68 to 0.50), however, the developer does not provide a rationale for this decline. • **Pain Assessment:** There is a desire for more clarity on how pain is being assessed and potential endorsement of a universal measurement tool (e.g., PROMIS-Pain). More guidance is needed on how this should be measured: pain or just cancer-related pain? What is the justification for the scale that is used? Users would benefit from clarification around the definition of pain.

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified

Item	Description
Measure 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.
Developer/Steward	• American Society of Clinical Oncology
New or Maintenance	• Maintenance
Current or Planned Use	• Payment Program • Professional Certification or Recognition Program • Quality Improvement with Benchmarking

Measure Type	Target Population(s)	Care Setting	Level of Analysis
Process	Individuals receiving chemotherapy or radiation	Clinician Office/Clinic	Clinician: Group/Practice Clinician: Individual

CBE #384
Public Comments

No comments received

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified, continued 1

Importance (n=13)	Strengths	Limitations
No Consensus 31% Met 69% Not Met, but Addressable 0% Not Met	• **Pain Management:** The comments emphasize the importance of routine pain screening, management, and follow-up. Assessing and managing pain has strong evidence. • **Cancer Patients:** Comments not the incident rate of over 1.9 million cancer cases in 2023 and the prevalence of pain among cancer patients during treatment. They also mention the importance of this measure for patients with a cancer diagnosis undergoing chemo or radiation each year. • **Business Case:** There is a business case supported by credible evidence depicting a link between health care processes to desired outcomes for cancer patients. The literature review provides supporting evidence of measure importance	• **Pain Assessment and Control:** Comments suggest that pain assessment should not be limited to only the scales listed but should also include assessment of pain impact on function. • Measurement of pain intensity may be necessary but not sufficient to adequate pain control. • **Performance Gap:** Comments question if the performance gap appears closed and if the existence of the measure is keeping the gap closed. It is also unclear if measure variation remains as participants are allowed to self-select measures and may select those reflecting high performance rates, which could potentially mask a drop in performance. • **Expanding the Measure Scope:** The text suggests that the measure developers could consider expanding this measure to include cancer patients receiving other treatment modalities, such as those receiving oral chemotherapy agents or “maintenance” chemotherapy once a month or less.

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified, continued 2

Feasibility (n=13)	Strengths	Limitations
Consensus 77% Met 23% Not Met, but Addressable 0% Not Met	• **Data Accessibility:** The necessary data elements required for the measure can be found within structured fields and are recorded using commonly accepted coding standards. Items needed are from existing fields. • **Integration with Workflow:** The measure can be easily incorporated into workflow and can be readily measured. The measure's data capture can be seamlessly integrated into existing physician workflows and data collection tools without requiring any significant modifications. • **Cost:** There are no fees for not-for-profit hospitals, healthcare systems, or practices to use the measure.	• **Documentation:** The measure specifications do not specify who documents the pain intensity or collects information regarding who documented the score in the electronic health record. • **Unclear Reporting Process:** It's unclear how doctors and practices are documenting pain intensity numerically and how information is being taken out of the medical record for reporting purposes. • **Specialty Application:** It's unclear if this metric applies to medical oncologists and radiation oncologists.

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified, continued 3

Scientific Acceptability (n=13)	Strengths	Limitations
Consensus 77% Met 23% Not Met, but Addressable 0% Not Met	• **Reliability:** The reliability scores are high, much above the threshold. The developers present entity-level reliability using signal-to-noise ratios, which meet or exceed 0.859. This exceeds conventional standards for reliability. Measure developers provide evidence of reliability testing and strong inter-rater reliability. The Kappa coefficient threshold for reliability is met. • **Validity:** The developer tested the validity of the data elements (both numerator and denominator) using a random sample of 500 patient encounters across 10 test sites. The Kappa coefficient for the denominator data element was 0.96, indicating almost 100% accuracy. The Kappa coefficient for the numerator data element was 1.00, indicating 100% accuracy. The validity scores are high per Kappa coefficients. With very high kappa values, encounter-level validity is satisfied. The elements of the measure appear accurately measured. Measure developers provide evidence of validity testing and strong validity. • **Agree With the Staff Assessment:** Several comments agreed with the staff assessment and rating of Met.	• **Entity-level Validity is Not Provided:** As a maintenance measure that has been in existence for several years, the submission should also include measures of concurrent validity. How correlated is this measure to other measures related to patient quality for pain or cancer? Are the correlations reasonable? • **Decline of Events:** Although the aggregated numbers do not show a statistically different picture, there is a concern about the decline in events and a request for the developer to offer some ideas about the decline in events pulled into the data.

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified, continued 4

Equity (n=13)	Strengths	Limitations
No Consensus 8% Met 38% Not Met, but Addressable 54% Not Met	• **Standardized Pain Assessment:** The comments emphasize the importance of quantifying pain intensity using standard instruments such as a 0-10 numerical rating scale, visual analog scale, a categorical scale, or the pictorial scale. • **Recognition of Inequity:** The comments acknowledge the existence of disparities in pain treatment and access to pain treatment across ethnic groups.	• **Opportunities for Further Exploration:** Further exploration is possible by cross-referencing other patient identifying factors readily available in the electronic medical record with these measure outcomes. • **Absence of Health Equity Data in Measure Specifications:** Comments note that measure developers indicated that differences could exist and that care settings are encouraged to track additional data that could reflect differences in health equity, but these have not been included in measure specifications and analyses according to those data were not reported.

CBE #384 - Oncology: Medical and Radiation - Pain Intensity Quantified, continued 5

Use and Usability (n=13)	Strengths	Limitations
No Consensus 46% Met 54% Not Met, but Addressable 0% Not Met	• **Measure Use:** The measure is in use in two federal programs. • **Improvement**: There has been a reported improvement of 3 percentage points from 2020-2021 at the clinician level.	• **Decline in Practice-Level Performance:** There is an unexplained decline in the practice-level performance scores. • **Topping Out:** The measure seems to be topping out, especially as a clinician-level measure. • **Alternative Pain Assessment Scales:** The measure may unintentionally promote the use of simple pain scales when there is growing evidence that a more comprehensive and person-centered assessment of pain is warranted. • **Justification for Continued Use:** Further justification should be provided to support the continued use of this measure in MIPS and other quality performance programs. • **Evidence of Improvement:** The evidence of improvement is muddled due to the lack of a stable cohort to compare across years.

Break

Additional Measure Recommendations Discussion

Based on the measure discussions today, are there additional recommendations or solutions the developer can use to overcome any potential measure limitations?

Opportunity for Public Comment

Next Steps

Next Steps for Fall 2023

Meeting Summary

- Meeting summary will be posted to the E&M committee project page by February 26, 2024.

Appeals Period

- **Appeals Period:** February 26 – March 18
- Appeals committee will meet on March 27, 2024 to review eligible appeals. Please refer to the E&M Guidebook for more information about the appeals process.

Technical Report

- At the conclusion of the appeals period, a final technical report will be posted to the E&M Committee project page in April 2024.

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Thank You!

Have questions? Contact us at
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