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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Final Fall 2023 Cycle Endorsement and Maintenance (E&M) Technical Report

COST AND EFFICIENCY

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Executive Summary

Over the past 20+ years, the United States (U.S.) has been focused on improving health care quality for Americans. Health care quality measures have increasingly been developed and used to facilitate this goal by quantifying the quality of care provided by health care providers and organizations based on various standards of care. These standards relate to the effectiveness, safety, efficiency, person-centeredness, equity, and timeliness of care. [1]

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Quality measures are used to support health care improvement; benchmarking; accountability of health care services; and to identify weaknesses, opportunities, and disparities in care delivery and outcomes.[1,2]

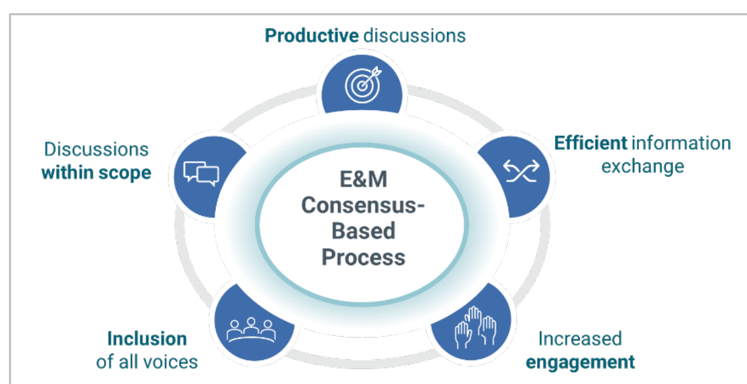

Figure ES-1. E&M Consensus-Based Process

Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. To support our consensus-based process, we formed the Partnership for Quality Measurement™ (PQM), which ensures informed and thoughtful endorsement reviews of quality measures across a range of focus areas that align with a person's journey through the health care system.

One of those focus areas is Cost and Efficiency, which includes measures that focus on health care resource use (e.g., hospitalizations, readmissions, emergency department use) and total health care spending for a health care service associated with a specified patient population, time period, and/or unit of clinical accountability. Hospitalizations are one of the most expensive types of health care resource uses, with an average cost of $14,101 per inpatient stay at community hospitals in 2019. [3] In addition, emergency department (ED) use in the U.S. has grown since 1996, exceeding hospital inpatient care. In 2017, 144.8 million ED visits totaled a cost of $76.3 billion. Measures in the Cost and Efficiency portfolio are essential to evaluate the efficiency of care (i.e., higher quality, lower cost) and improve value through changes in practice. Improving U.S. health system efficiency can simultaneously reduce cost growth and improve the quality of care provided. [4]

For this measure review cycle, six measures were submitted to the Cost and Efficiency committee for endorsement consideration. Three measures, up for maintenance endorsement review, were withdrawn by the measure steward prior to committee review (Table 4), which resulted in removal of their endorsement. Of the three measures reviewed by the Cost and

Efficiency committee (Figure ES-2), the committee endorsed one measure with conditions, removed endorsement from one measure, and did not endorse the last measure due to no consensus (Table ES-1).

Table ES-1. Measures Reviewed by the Cost and Efficiency Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
0695	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	Maintenance	American College of Cardiology	Removed Endorsement due to No Consensus
2687	Hospital Visits after Outpatient Surgery	Maintenance	Yale Center for Outcomes Research and Evaluation/CMS	Endorsed with Conditions *
4190	30-Day Risk Standardized All-Cause Department Visit Following an Inpatient Psychiatric Facility Discharge	New	Mathematica/CMS	Not Endorsed due to No Consensus

** Based on the committee vote, the measure was Endorsed with Conditions. However, during the endorsement meeting, the committee was asked what conditions they would want to apply, and none were mentioned. Some recommendations were provided to the measure developer, but as no conditions were specified, Battelle as the CBE is logging this measure as "Endorsed" in the measure database.*

Figure ES-2. Fall 2023 Measures for Committee Review

Endorsement and Maintenance (E&M) Overview

Battelle's E&M process ensures measures submitted for endorsement are evidence-based, scientifically sound, and both safe and effective, meaning use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge.

Each E&M cycle (e.g., Fall or Spring) has a designated Intent to Submit deadline, by which measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the Intent to Submit deadline (Table 1), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

The measures are then posted to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting. The intent of this 30-day comment period is to solicit both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (e.g., Fall or Spring). All public comments received during this 30-day period are posted to the respective measure page on the PQM website for full transparency. Summaries of the comments received for the measures submitted to the Cost and Efficiency committee are provided below. The committee considers all comments in its endorsement evaluation of the measures.

Table 1. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit *	Full Measure Submission *
Fall	October 1	November 1
Spring	April 1	May 1

**Deadlines are set at 11:59 p.m. (ET) of the day indicated. If the deadline ends on a weekend or holiday, the deadline will be the next immediate business day.*

E&M committees are composed of diverse PQM members, representing all facets of the health care system. There are five E&M projects, each has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. Each E&M project committee is divided into an Advisory Group and a Recommendations Group (Figure 1).

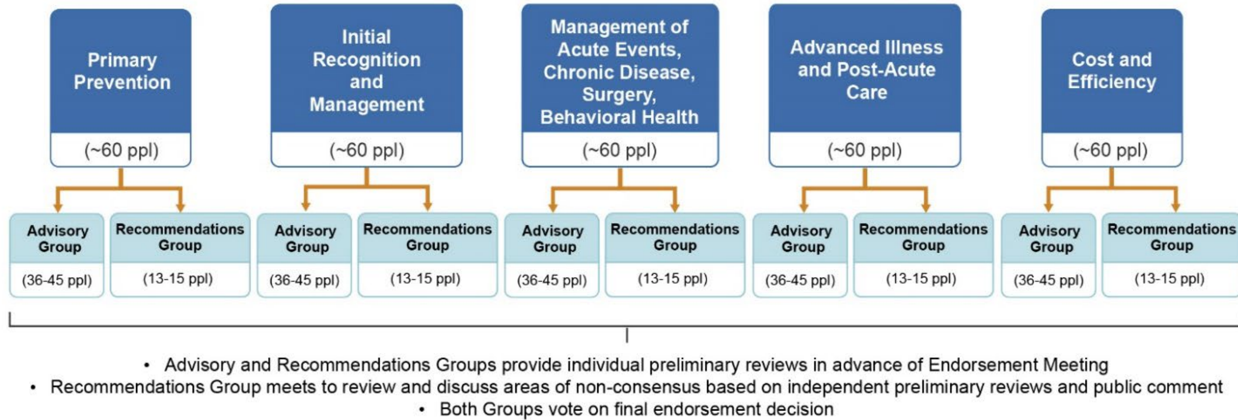

Figure 1. E&M Committee Structure

The goal is to create inclusive committees that balance experience, expertise, and perspectives. The E&M process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and cost/resource use who come from a variety of places and represent a diverse group of people and perspectives (Figure 2 and Figure 3).

Figure 2. E&M Interested Parties

With respect to the Cost and Efficiency committee, membership consisted of eight patient partners (i.e., patients, caregivers, advocates) and 17 clinicians, with specialties in community health, nursing, ambulatory care management, and others (Figure 3). The committee also included six experts in rural health and seven in health equity.

All committee members completed a measure-specific disclosure of interest (MS-DOI) form to identify potential conflicts with the measures under endorsement review for the respective E&M cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's COI policy. While a list of committee members is provided in Appendix A, full committee rosters and bios are posted on the respective project pages on the PQM website.

Figure 3. Cost and Efficiency Committee Members

During the endorsement meeting, Advisory Group members listen to the Recommendations Group discussions before both groups cast an endorsement vote (Figure 4). This structure ensures a larger number of voices contribute to the consensus-building process.

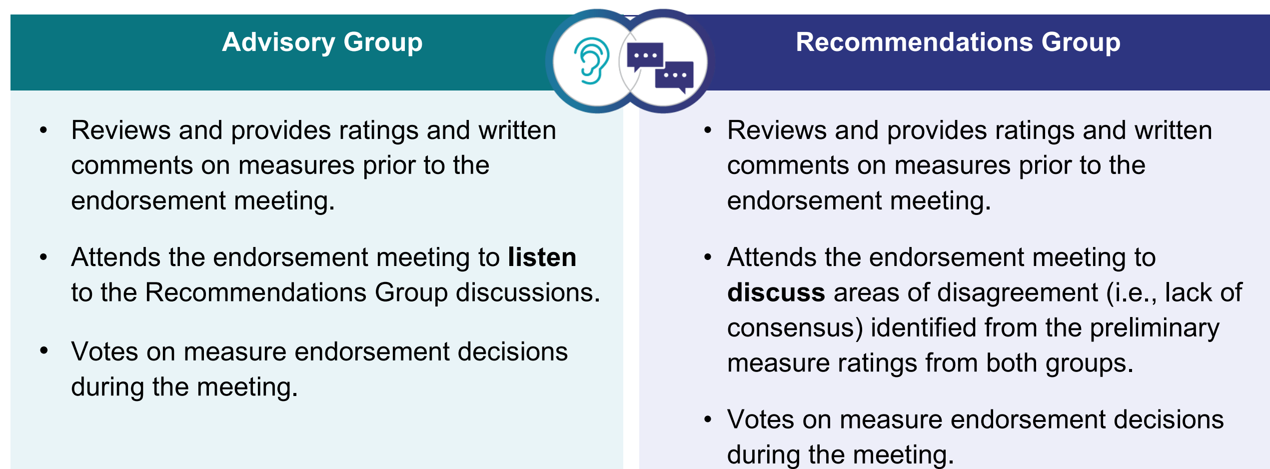

Figure 4. E&M Advisory Group vs. Recommendations Group

At least three weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group receive 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.

Under the Battelle process, measures reach their endpoint when an endorsement decision is rendered by the E&M project committees (Table 2).

Table 2. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** There is 75% or greater agreement for endorsement via a vote by the E&M committee.	Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (*see Status Report/Annual Update for more details*).±
Endorsed with Conditions*	**Applies to new and maintenance measures.** There is 75% or greater agreement via a vote by the E&M committee 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	Measures undergo maintenance of endorsement reviews every 5 years with a status report submission at 3 years (*see Status Report/Annual Update for more details*), unless the E&M committee assigns a condition requiring the

Decision Outcome	Description	Maintenance Expectations
	developer/steward should be provided for consideration by the E&M committee review.	measure to be reviewed earlier. At maintenance review, 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 via a vote by the E&M committee 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

±Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed.

**Conditions are determined by the E&M committee, with the consideration of what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

°Measures that fail to reach the 75% consensus threshold are not endorsed.

The "Endorsed with Conditions" category serves as a means of endorsing a measure, but with conditions set by the committee. These conditions take into consideration what is feasible and

appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, E&M committee endorsement decisions and associated rationales are posted to the PQM website for three weeks, which represents an appeals period, during which any interested party may request an appeal regarding any E&M committee endorsement decision. If a measure's endorsement is being appealed, including an "Endorsed with Conditions" decision, the appeal must:

- Cite evidence of the appellant's interests that are directly and materially affected by the measure, and the CBE's endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or information that was available by the cycle's Intent to Submit deadline but was not considered by the E&M committee at the time of the endorsement decision, which is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The CBE's measure evaluation criteria were not applied appropriately. For this rationale, the appellant must specify the evaluation criteria they believe was misapplied.
- The CBE's E&M process was not followed. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If an eligible appeal is received, we convened the Appeals Committee, consisting of the co-chairs from all five E&M project committees, to review and discuss the appeal. The Appeals Committee concludes its review of an appeal by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is determined to be 75% or greater agreement via a vote among members.

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For the Fall 2023 cycle, the appeals period opened on February 26 and closed on March 18, 2024. No appeals were received for the measures reviewed by the Cost and Efficiency committee.

Cost and Efficiency Measure Evaluation

For this measure review cycle, the Cost and Efficiency committee evaluated one new measure and two measures undergoing maintenance review against standard measure evaluation criteria. During the endorsement meeting, the committee voted to endorse one measure with conditions, to remove endorsement from one measure, and to not endorse one measure due to no consensus (Table 3).

Brief summaries of the committee's deliberations for each measure, along with any conditions for endorsement, are noted under the measure's evaluation summary below. The committee's endorsement meeting summary can be found on the respective E&M project page on the PQM website.

Table 3. Number of Fall 2023 Cost and Efficiency Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	5	1	6
Number of measures withdrawn from consideration*	3	0	3
Number of measures reviewed by the committee	2	1	3
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	1**	0	1
Number of measures not endorsed/endorsement removed	1	1	2

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting. Table 4 provides a summary of withdrawn measures.*

***Based on the committee vote for CBE #4190, the measure was Endorsed with Conditions. However, during the endorsement meeting, the committee was asked what conditions they would want to apply, and none were mentioned. Some recommendations were provided to the measure developer, but as no conditions were specified, Battelle as the CBE logged this measure as "Endorsed" in the measure database.*

Table 4. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/Steward	New/Maintenance	Reason for Withdrawal*
2393	Pediatric All-Condition Readmission Measure	Center of Excellence for Pediatric Quality Measurement	Maintenance	Retired by measure steward due to challenges with accessing data to support performance gap assessment and updated testing
2414	Pediatric Lower Respiratory Infection Readmission Measure	Center of Excellence for Pediatric Quality Measurement	Maintenance	Retired by measure steward due to challenges with accessing data to support performance gap assessment and updated testing
3474	Hospital-level, risk-standardized payment associated with a 90-day episode of care for elective primary total hip and/or total knee arthroplasty (THA/TKA)	Centers for Medicare & Medicaid Services	Maintenance	Steward no longer seeks to maintain endorsement

**Endorsement was removed for maintenance measures that were retired by the measure steward.*

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures under endorsement review through the PQM website. For this evaluation cycle, the pre-evaluation commenting period opened on December 1, 2023, and closed on January 2, 2024. Four pre-evaluation comments were submitted and shared with the committee prior to the measure evaluation meeting on January 31, 2024. A summary of comments received is provided under the measure's evaluation summary below.

Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, a potential high-priority measurement gap area emerged. This gap area is summarized below for future development and endorsement considerations.

Behavioral Health Care Gaps

Behavioral health conditions, including mental health and substance use disorders, are a leading cause of disease burden in the U.S.[5] Americans with a behavioral health condition experience higher morbidity and often poorer outcomes, which can lead to increased health care costs and low quality of life.[5] To mitigate these concerns, the health care industry has been increasingly looking to alternative payment models and approaches to integrate better, more equitable behavioral health care to improve outcomes and manage costs. One such approach is with the use of quality measures to identify and close care gaps.

For this E&M cycle, the Cost and Efficiency committee reviewed a behavioral health care resource use measure, CBE #4190 - 30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge. The committee discussed the importance of having measures that capture high-cost health care resources for patients with behavioral health conditions, particularly as behavioral health care is a community-wide effort and is often fragmented and inequitable. However, during the committee's review of CBE #4190, the committee expressed concern about the "all-cause" nature of the measure and whether it accurately captures behavioral health-related visits to emergency departments (EDs) and inpatient psychiatric facilities (IPFs). The committee considered whether the measure results were valid, due to the potential for unrelated ED visits being captured in the measure, and due to the challenge of appropriately coding diagnoses that may not directly reflect underlying behavioral health issues. To mitigate this concern, the committee recommended to review and present the top diagnoses associated with the ED visit. Overall, the committee's concern centered on ensuring the measure effectively identifies and addresses the full spectrum of behavioral health issues encountered in ED and in IPF settings, despite the complexities of coding and categorizing such visits.

Summary of Major Concerns or Methodological Issues

The committee did not raise any major concerns or methodological issues.

Measure Evaluation Summaries

CBE #4190 – 30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge [Mathematica/CMS] – *New*

Specifications | Committee Independent Review Summary

Description: The 30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility (IPF) Discharge (IPF ED Visit) measure assesses the proportion of patients ages 18 and older with an emergency department (ED) visit, including observation stays, for any cause, within 30 days of discharge from an IPF, without subsequent admission. The IPF ED Visit measure is an outcome-based measure.

Committee Final Vote: Not Endorsed due to No Consensus

Conditions: None

Vote Count: Endorse (12 votes; 36.36%), Endorse with Conditions (8 votes; 24.24%), Not Endorse (13 votes; 39.39%); recusals (1)

Summary of Public Comments: Three comments were received for this measure. One public comment requested that endorsement be removed due to problems with the numerator, denominator, and risk adjustment methodology. The second public comment recommended the measure be endorsed prior to being used and mentioned that the measure assesses an important outcome. The last comment suggested the measure be endorsed, citing it will support better follow-up care with the target population and improved cooperation among caregivers.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Measure Importance/Relevance	• The committee noted that lack of access to primary care is a known issue. The developer added that while it is a known issue, it is not quantified. • The committee recognized that this measure may help identify gaps in behavioral health care, which could lead to addressing community-wide issues and action plans. The developer said their technical expert panel (TEP) agreed with this.
Measure Specifications and Scientific Acceptability (i.e., Reliability and Validity)	• The committee acknowledged the stable accountable entity-level reliability results, which the developer reported were between 0.6 and 0.7. • Several committee members and two Battelle-invited subject matter experts (SMEs) expressed concern over the “all-cause” nature of the measure. One SME noted that “noise” may affect the metric as some patients may come in for unrelated ED visits. • The developer stated that the all-cause nature was incorporated to harmonize with readmission measures. • One committee member said all-cause measures are common for CMS. • Another committee member asked if it would be easier to exclude comorbidities rather than adjust for them; the developer did not have a response. • Several committee members and SMEs expressed concern that the IPF would be held accountable for a community health issue that is affected by social, political, and cultural factors as well as access to resources. • The developer noted that the social determinants of health had been added to the risk model and did not impact the measure score. The developer also shared that patients have to be insured for a certain amount of time to be included in the measure.

Discussion Theme	Recommendations Group Discussion
	• The committee questioned whether this measure may be more appropriate at a different level due to the unintended consequences it may have on inpatient facilities (IPFs) and EDs.

Additional Recommendations for the Developer/Steward and Future Directions

The committee considered whether the measure results were valid, due to the potential for unrelated ED visits being captured in the measure and due to the challenge of appropriately coding diagnoses that may not directly reflect underlying behavioral health issues. To mitigate this concern, the committee recommended to review and present the top diagnoses associated with the ED visit.

CBE #2687 – Hospital Visits after Hospital Outpatient Surgery [Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation/CMS] – *Maintenance*

Specifications | Committee Independent Review Summary

Description: Hospital Visits after Hospital Outpatient Surgery measure reports the facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a procedure performed at a hospital outpatient department (HOPD) among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Committee Final Vote: Endorsed with Conditions

Conditions: None*

Vote Count: Endorse (24 votes; 72.72%), Endorse with Conditions (6 votes; 18.18%), Remove Endorsement (3 votes; 9.1%), recusals (0)

***Note:** Based on the committee vote the measure was Endorsed with Conditions. However, during the endorsement meeting, the committee was asked what conditions they would want to apply, and none were mentioned. Some recommendations were provided to the measure developer, but as no conditions were specified, Battelle as the CBE is logging this measure as Endorsed in the measure database.

Summary of Public Comments: One public comment was received prior to the endorsement meeting. The comment stated that endorsement for the measure should be removed due to issues with the numerator, denominator, and the risk adjustment methodology.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Measure Importance/Relevance	• The committee asked about how the measure would fit with patient-reported outcome measures (PROMs), to which the developer responded that the measure would work in parallel with PROMs.
Measure Specifications and Scientific Acceptability (i.e., Reliability and Validity)	• The developer clarified that ambulatory surgical centers (ASCs) are not included in the measure. • The committee asked about how this measure compares to models used in ASC measures. • The developer noted that model performance is reviewed annually, and they can add a procedure-specific view of model performance and address any issues as more procedures move to the outpatient space. • With respect to the impact of social risk factors on the measure results, the committee questioned if the developer looked at changes in hospital rankings. • The developer said they conducted a Pearson correlation with the Hospital-wide Readmission (HWR) measure, which assesses overall correlation rather than ranking. The developer reported a very weak positive correlation, as expected. • The developer further commented that it did not find a noticeable difference due to identified social risk factors.
Equity	• The committee considered the developer's analysis of social risk factors, acknowledging that stratification is the real advantage of this measure, since hospitals will receive reports on outcomes for patients with social risk factors.
Use and Usability	• The committee acknowledged that facilities receive individual reports for each patient and whether their procedure is included in the denominator. This gives the hospital information about risk factors and trends within their facility. • The committee considered the usability of the measure and if facilities are using the measure data. The developer stated it believed facilities are engaging with the measure information. • The committee recommended a survey of measured entities to clarify whether those who have access to the data are using it. • The committee also supported having the measure information for patients, since there is limited choice on where to have outpatient procedures.

Additional Recommendations for the Developer/Steward and Future Directions

The committee did not have additional recommendations.

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CBE #0695 – Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI) [American College of Cardiology (ACC)] – *Maintenance*

Specifications | Committee Independent Review Summary

Description: This measure estimates a hospital-level risk-standardized readmission rate (RSRR) following PCI for Medicare Fee-for-Service (FFS) patients who are 65 years of age or older. The outcome is defined as an unplanned readmission for any cause within 30 days following a hospital stay. The measure includes both patients who are admitted to the hospital (inpatient) for their PCI and patients who undergo PCI without being admitted (outpatient or observation stay). A specified set of planned readmissions do not count as readmissions. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment and Medicare claims to identify readmissions. Additionally, the measure uses direct patient identifiers including Social Security Number (SSN) and date of birth to link the datasets.

Committee Final Vote: Endorsement Removed due to No Consensus. The committee did not reach consensus due to the lack of recent data to establish whether a performance gap remains; to determine reliability and validity of the measure, namely at the accountable entity-level; and to establish whether the measure has improved over time. In addition, the measure is not currently being used.

Conditions: None

Vote Count: Endorse (1 vote; 3.12%), Endorse with Conditions (19 votes; 59.37%), Remove Endorsement (12 votes; 37.5%), recusals (0)

Summary of Public Comments: None received.

Appeals: None

Discussion Theme	Recommendations Group Discussion
Measure Importance/Relevance	• The committee acknowledged the importance of the measure focus, noting that hospital readmissions remain an important area to address. • Several committee members had concerns due to the lack of recent data to establish whether a performance gap remains and due to limited literature justifying the casual relationship between low quality of care and readmissions. • The developer acknowledged that a limitation of this measure is lack of the claims data necessary to assess performance gap and to test the measure cannot currently be accessed by ACC. ACC worked with other medical societies seeking legislative action to remove barriers to access claims data; however, Congress did not act.

Discussion Theme	Recommendations Group Discussion
Measure Specifications and Scientific Acceptability (i.e., Reliability and Validity)	• The committee expressed the same concern with the lack of recent data to support updated testing for this measure. The developer clarified that all data, except those related to 30-day outcomes, originates from the CathPCI Registry. The 30-day outcome data needs to come from claims data. • The committee considered whether the performing physician should be the accountable entity. The developer emphasized that the facility is the appropriate accountable entity, as facilities can take actions to improve readmission rates. • Some committee members considered whether conditions could be placed on this measure, such that in three years, if the developer obtained the necessary claims data, they would update the testing and performance data, have a plan for use and implementation, and share any trend data in measure performance over time. • Other committee members expressed that conditions may not be reasonable because it would take an act of Congress to be able to access the appropriate data.
Use and Usability	• The developer highlighted that the measure is not currently in use because ACC cannot access the necessary claims data.

Additional Recommendations for the Developer/Steward and Future Directions

The committee did not have additional recommendations.

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Appendix A: Cost and Efficiency Committee Roster

Fall 2023 Cycle

Member	Affiliation/Organization	Advisory or Recommendation Group
Mary Schramke *(Patient Representative Co-chair)*	-	Recommendation
Amy Chin *(Non-Patient Representative Co-chair)*	HSS Center for the Advancement of Value in Musculoskeletal Care & Value Management Office at HSS	Recommendation
Alice Bell	American Physical Therapy Association	Advisory
Benjamin Schleich	Hackensack Meridian Health; Hackensack Meridian School of Medicine	Recommendation
Beth Godsey	Vizient, Inc.	Advisory
Bijan Borah	Mayo Clinic College of Medicine and Science	Advisory
Christopher M. Dezii	Healthcare Quality Advocacy & Strategy Consultants, LLP	Recommendation
Daniel Halevy	Healthfirst	Advisory
Danny Van Leeuwen	Health Hats	Recommendation
David Schultz	Evansville Primary Care	Recommendation
Dmitriy Poznyak	Mathematica	Recommendation
Emma Hoo	Purchaser Business Group on Health	Advisory
Hal McCard	Spencer Fane, LLP	Recommendation
Harold D. Miller	Center for Healthcare Quality and Payment Reform	Advisory
Henish Bhansali	Duly Health and Care	Advisory
Jack Needleman	University of California, Los Angeles, Fielding School of Public Health	Advisory
Joan Gleason Scott	New Jersey Hospital Association	Advisory
John Martin	Premier, Inc.	Advisory
Kim Tyree	Evergreen Family Medicine	Advisory
Kimberly Geoffrey	-	Recommendation
Lauren Campbell	NORC at the University of Chicago	Advisory

Member	Affiliation/Organization	Advisory or Recommendation Group
Louise Y. Probst	St. Louis Area Business Health Coalition	Advisory
Lynn Ferguson	Patient and Family Advisory Council, Vanderbilt University	Advisory
Mahil Senathirajah	Merative	Recommendation
Margaret Woeppel	Nebraska Hospital Association	Advisory
Marisa Elliott	Ascension Medical Group	Advisory
Megan Guinn	BJC Healthcare ACO and BJC Medical Group	Advisory
Michelle Hammer	Elevance Health	Advisory
Pamela Roberts	Cedars-Sinai Medical Center & Physical Medicine and Rehabilitation, Cedars Sinai Medical Center	Advisory
Paul Kallaur	Center for the Study of Services	Recommendation
Pranavi Sreeramoju	Thomas Jefferson University Hospital, Inc., Jefferson Health	Recommendation
Rosa Plasencia	National Core Indicators, Aging and Disabilities (NCI-AD); ADvancing State	Advisory
Sandeep Das	University of Texas Southwestern Medical Center	Advisory
Seth Morrison	Patient Centered Outcomes Research Institute	Advisory
Shawn Ruder	-	Advisory
Sopida Andronaco	Hoag Orthopedic Institute	Advisory
Sunny Jhamnani	TriCity Cardiology	Recommendation
Tad Mabry	Mayo Clinic	Advisory
Tera Heidtbrink	Bryan Health Connect	Recommendation
William Golden	University of AR for Medical Sciences, Arkansas Medicaid	Advisory

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Yale Center for Outcomes Research and Evaluation

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