Partnership for Quality Measurement
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Fall 2022 Cycle

Geriatrics and Palliative Care Final Technical Report

October, 2023

This report is funded by the Centers for Medicare & Medicaid Services under contract number 75FCMC23C0010.

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Executive Summary

Palliative care is designed to improve quality of life and outcomes for seriously ill patients. Alongside the medical benefits for patients and their families, it can also reduce health care costs.[1] Millions of people across the United States could benefit from palliative care services and its expansion. In the past decade, more than 1000 new hospital-based palliative care teams have been created.[1] Paired with America's growing elderly and severely ill populations, reducing barriers and improving provision of palliative care services is a timely and important effort.

Quality measures are necessary tools for assessing improvements in geriatric and palliative care, as well as the extent to which health care stakeholders are using evidence-based strategies to advance the quality of care. To support this effort, Battelle endorses and maintains performance measures related to geriatrics and palliative care through a standardized, consensus-based process.

For this project's measure review cycle, seven measures were submitted for endorsement consideration (Table 1a). One measure (CBE #3654) was withdrawn from consideration by the developer as it did not pass the Scientific Methods Panel (SMP) review. Therefore, it was not reviewed by the committee. One measure, up for maintenance endorsement review, was not submitted, as the measure was retired by the measure steward (Table 1b). Of the six remaining measures reviewed by the Geriatrics and Palliative Care committee, three were recommended for endorsement and three were not recommended for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the committee's endorsement recommendations.

Effective March 27, 2023, the National Quality Forum (NQF) is no longer the 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. Battelle has been selected to oversee the endorsement & maintenance (E&M) of clinical quality and cost/resource use measures. Since the Fall 2022 cycle launched at NQF, measures submitted for Fall 2022 E&M cycle continued along the prior E&M protocols that were in place at time of the Fall 2022 "Intent to Submit." In addition, the Scientific Methods Panel review and the committee's measure evaluation meeting for the Fall 2022 cycle were conducted under NQF. Battelle took over the E&M work beginning with the public comment period to close out the Fall 2022 cycle. This included launching the Fall 2022 post-comment period, convening the E&M committees for the post-comment meeting, convening the CSAC to render a final endorsement decision, and executing the Appeals period.

Table 1a. Measures Submitted for Endorsement Consideration

Measure Number	Measure Title	New/ Maintenance	Developer/Steward	Final Endorsement Decision
0091	COPD: Spirometry Evaluation	Maintenance	Northfield Associates LLC/ American Thoracic Society	Endorsed
2651	CAHPS® Hospice Survey, Version 9.0	Maintenance	Centers for Medicare & Medicaid Services	Endorsed
3654	Hospice Care Index	New	Abt Associates/Centers for Medicare & Medicaid Services	Withdrawn
3672	Ratio of observed over predicted rates for diagnosis of dementia	New	University of Southern California	Not Endorsed
3707	Ratio of observed over predicted rates for diagnosis of mild cognitive impairment	New	University of Southern California	Not Endorsed
3726	Serious Illness Survey for Home-Based Programs	New	RAND Corporation	Endorsed
3729	Ratio of observed over predicted rates for diagnosis of cognitive impairment of any stage	New	University of Southern California	Not Endorsed

Table 1b. Maintenance Measures Retired at the Steward's Request

Measure Number	Measure Title	Developer/Steward	Reason for Withdrawal *
1626	Patients Admitted to ICU who Have Care Preferences Documented	RAND Corporation	Retired the measure

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

Summaries of the measure evaluation meetings are linked within the body of the report. Detailed summaries of the committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

There are nearly 56 million adults aged 65 and over in the United States (U.S.),[2] and an estimated 90 million Americans with serious illness.[3] With both estimates expected to grow in the coming years, combined with the current 6 million people in the U.S. who could benefit from palliative care, this is an increasingly important area of health care. Approximately 68% of Medicare costs are related to patients who could qualify for palliative care, and an estimated $6 billion per year could be saved by better integration of palliative care into the health system.[3]

Quality measures are tools to measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health. Furthermore, quality metrics can be a powerful tool in helping identify substantial performance gaps in geriatric and palliative care, affecting patient outcomes and overall cost.

Battelle, a CBE, convenes volunteer committees to evaluate and build consensus around quality measures for endorsement based on a standardized set of criteria. For the Fall 2022 cycle, the Geriatrics and Palliative Care standing committee reviewed measures focused on dementia and cognitive impairment diagnosis, hospice and home care, and chronic obstructive pulmonary disease evaluation.

Dementia and Cognitive Impairment Diagnosis

Two out of three Americans will experience cognitive impairment at some point in their life.[4] Occurring with age, mild cognitive impairment (MCI) is the stage between the expected decline in memory and thinking and the more serious decline of dementia. Cognitive impairment and dementia affect a large and growing number of older adults in the U.S. Total expenditures for dementia care may cost up to $215 billion per year and are expected to increase.[5] Early and accurate diagnosis of cognitive impairments allows for implementation of changes that can slow the progression of disease, as well as improving access to support mechanisms and future symptom management.[4]

Hospice and Home Care

Hospice and home care are intended to support patients and their families by improving their quality of life when their condition reaches a point of continual progressive decline. Studies have shown hospice care to be associated with more positive experiences among patients and caregivers, as well as cost savings.[6,7] Although utilization of hospice and home care is increasing, there are still disparities to accessing and experiencing appropriate care, including disparities based on race and socioeconomic status.

COPD Evaluation

Chronic Obstructive Pulmonary Disease, or COPD, is a progressive lung disease currently affecting 12.5 million people in the U.S. Direct and indirect costs for COPD care near $50 billion every year.[8] Absolute counts of COPD are increasing,[9] and ensuring effective care based on

disease severity continues to be essential to addressing the burden of COPD for many in the U.S. Adequate testing for and monitoring of COPD severity can lead to appropriate treatment and improved quality of life.

Geriatrics and Palliative Care Measure Evaluation

For this measure review cycle, the Geriatrics and Palliative Care standing committee (Appendix B) evaluated four new measures and two measures undergoing maintenance review against standard measure evaluation criteria. One measure, (CBE #3654), was withdrawn from consideration, and therefore not evaluated by the committee, as it did not pass the SMP's review of scientific acceptability (i.e., reliability and validity). Additionally, one measure, up for maintenance endorsement review (CBE #1626), was not submitted, as the measure was retired by the measure steward (Table 1b).

Table 2a. Number of Fall 2022 Geriatrics and Palliative Care Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	2	5	7
Number of measures withdrawn from consideration*	0	1	1
Number of measures reviewed by the committee	2	4	6
Number of measures endorsed	2	1	3
Number of measures not endorsed	0	3	3

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the CSAC meeting. Table 2b provides a summary of withdrawn measures.*

Table 2b. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/Steward	New/Maintenance	Reason for Withdrawal*
3654	Hospice Care Index	Abt Associates / CMS	New	Withdrawn after SMP review

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

Scientific Methods Panel Measure Evaluation

Prior to the committee's review, the SMP reviewed three measures (CBE #2651, CBE #3654, and CBE #3726) in this topic area for scientific acceptability (i.e., reliability and validity). The SMP passed two measures on reliability and validity (CBE #2651 and CBE #3726) during its

measure evaluation meeting. It did not pass the last measure (CBE #3654) on both reliability and validity due to inappropriate methodology used to demonstrate reliability and/or validity.

Comments Received Prior to Standing Committee Evaluation

For this evaluation cycle, pre-evaluation public commenting was conducted under NQF. No pre-evaluation comments were submitted prior to the measure evaluation meeting on February 23, 2023.

Comments Received After Standing Committee Evaluation

Following the standing committee's measure evaluation meeting, the committee's endorsement recommendations were posted on the PQM website for public comment. The commenting period opened on March 28, 2023, and closed on May 5, 2023. The committee received seven comments from two commenters pertaining to the measures under review and the committee endorsement recommendations. Both commenters were supportive of CBE #3726, and one commenters was supportive of CBE #0091 and CBE #2651. Additionally, one commenter expressed non-support of CBE #3707, CBE #3672, and CBE #3729. Battelle convened the committee for the Fall 2022 post-comment web meeting on June 12, 2023, to review and respond to the full text of comments received. A summary of comments for each measure reviewed is provided in Appendix A.

Summary of Potential High-Priority Gaps

Cognitive Impairment and Dementia Diagnosis

During the standing committee's evaluation of the measures, the committee considered three new measures that focused on the rates of observed over predicted rates for diagnosis of mild cognitive impairment (CBE #3707), dementia (CBE #3672), and cognitive impairment of any stage (CBE #3729). Although the committee did not pass these measures due to a lack of evidence supporting the measure concept, it did recognize that cognitive impairment and dementia remain underdiagnosed, and that more measurement is needed in this area.

Summary of Major Concerns or Methodological Issues

Lack of Evidence Demonstrating Improved Outcomes

During the standing committee's evaluation of the measures, three measures (CBE #3672, CBE #3707, and CBE #3729) did not receive endorsement due to lack of strong empirical evidence that the measures lead to improved outcomes. The committee recognized the importance of timely and accurate diagnosis of cognitive impairment and dementia. The committee further acknowledged the importance of informing providers of the proportion of their patients that have cognitive impairment and/or dementia based on what would be expected, which is what these measures intended to capture. However, the committee expressed the need for more evidence to support these concepts and recognized the unintended consequences and challenges of diagnostic accuracy and of providing appropriate treatment to patients. Details of the standing committee's discussion for each measure are included in Appendix A.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Under the NQF process, quorum is 66% of active standing committee members minus any recused standing committee members. Due to the exclusion of recused standing committee members from the quorum calculation, the required quorum for live voting may vary among measures. Quorum (13 out of 19 standing committee members for all measures) was reached and maintained throughout the full measure evaluation meeting on February 23, 2023. Vote totals may differ between measure criteria and between measures because standing committee members may have joined the meeting late, stepped away for a portion of the meeting, or had to leave the meeting before voting was complete. The vote totals listed below reflect the committee members present and eligible to vote at the time of the vote.

A measure is recommended for endorsement by the standing committee when greater than 60% of voting members select a passing vote option (i.e., Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40% of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

A.1 Measures Endorsed

CBE #3726 Serious Illness Survey for Home-Based Programs

Staff Assessment | Specifications

Numerator Statement: Measure scores are “top-box” scores that reflect the percent of respondents who select the most positive response category(ies) in response to the survey item(s) within the measure. Therefore, the numerator is the number of respondents who select the most positive response category(ies) in response to the survey items within the measure.

Denominator Statement: Survey respondents are patients receiving care from home-based serious illness programs. Survey eligibility criteria and exclusions are detailed below in sections sp.16 – sp.18. Screener questions and tailored non-applicable response options (e.g., I did not want help for my pain) are used to identify respondents who are and are not eligible to respond to survey items included in evaluative measures. Therefore, denominators vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item.

Exclusions: The Serious Illness Survey for Home-Based Programs is designed for administration to adult patients who are currently enrolled in home-based serious illness programs. Patients are excluded from the survey sample if they:

• Are under age 18

• Receive care from a serious illness program in a setting OTHER than home or an assisted living facility (e.g., in a nursing home or other long-term care facility)

• Are known to have been discharged to hospice

• Are known to have died

• Have been enrolled in the serious illness program for less than six weeks as of the date of survey sampling

In keeping with the Medicare CAHPS Survey https://www.cms.gov/files/document/ma-pdp-cahps-qapts-v11-complete-manual.pdf, a survey is considered partially completed if there are responses to at least one measure and for less than 50% of survey items that are applicable to all. A survey is considered completed if there are responses to at least one measure and for 50% or more of the survey items that are applicable to all. Final analytic datasets include all completed and partially completed surveys.

There are no explicit exclusions based on language; the survey is available in English and Spanish.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Other

Setting of Care: Home Care

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: RAND Corporation

STANDING COMMITTEE EVALUATION

Table A.1-1.1 Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-16; Pass-15; No Pass-1 (15/16 – 93.7%, Pass)	• The standing committee recognized that this new measure has a logic model postulating that home-based serious illness programs, providing key processes of care, will achieve positive patient-reported outcomes for the five multi-item measures. • The developer assessed the meaningfulness of the measure via qualitative interviews with patients, family caregivers, and health care professionals from home-based programs across the United States. The developer also cited research from 2008 to 2018 supporting the association between home-based serious illness care and a range of positive patient outcomes. • During the discussion on evidence, the standing committee noted that while many measures document institutional care, this measure fills an important gap in palliative care by targeting home-based programs. • The standing committee passed the measure on evidence with no major concerns.

1b. Performance Gap	• Total Votes-16; H-11; M-4; L-0; I-1 (15/16 – 93.7%, Pass)	• The committee recognized that the developer calculated top-box scores for 28 programs that received at least 10 completed surveys during the field test conducted from October 2019 through January 2020. The total number of respondents for the 28 programs was not included in the developer's submission.
		  • The Communication measure had the highest top box score (mean = 78.5; IQR = 9.9).
		  • The Planning for Care measure had the lowest top-box score (mean = 55.5; IQR = 8.6).
		• The developer postulated that there is considerable opportunity for improvement across all measures.
		• The developer also identified disparities with this measure based on sex, race, ethnicity, age, and Medicare/Medicaid status.
		• The standing committee expressed that the measure demonstrates a gap in care and that disparities exist among survey respondents.
		• The standing committee passed the measure on performance gap with no major concerns.

Table A.1-1.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale

2a. Reliability	• Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
	
	• SMP Total Votes-11; H-4; M-4; L-2; I-1
		• The standing committee recognized that the testing data were from 32 serious illness programs with a total of 2,263 respondents. Eligible patients were randomly assigned one of two modes of administration: mail-only or telephone-only.
		• The standing committee noted that reliability testing was conducted at the patient/encounter-level
		  • Cronbach's alpha was used to assess the internal consistency of multi-item measures. Cronbach's alpha was greater than or equal to 0.70 for four of five multi-item measures. For the fifth measure, it was 0.69. Cronbach's alpha with item deletion was lower.
		  • The developer calculated a Pearson item-total correlation, which ranged from 0.44 to 0.69.
		• The standing committee also noted that reliability testing was also conducted at the accountable entity level.
		  • Program-level reliability was calculated using intraclass coefficients (ICCs) of case-mix and survey-mode adjusted top-box scores for programs with 10 or more respondents (28 of 32 programs).
		  • Predicted program-level reliability was calculated using the Spearman–Brown formula at 100 respondents. Program-level reliability at 100 measure respondents ranged from 0.67 to 0.80. Values were greater than 0.70 for all but one measure (single-item global measure of Rating of Program).
		• The standing committee noted that the SMP reviewed the measure prior to the measure evaluation meeting and that some SMP members expressed that the accountable entity-level reliability testing results reported were low. One SMP member expressed concern that it is unclear if the measure should be used when there are fewer than 10 respondents.
		  • The developer provided responses to the SMP concerns, stating that the only item, Overall Rating, is less than 0.67, which nears the threshold of 0.70 at reliability of 0.67 at 100 respondents. Therefore, the devleoper recommends a sample size of 100 completed surveys for making comparisons between home-based serious illness programs. The devleoper further noted that although there is no national registry of home-based serious illness programs, more than half of the programs that participated in the field test of the survey had 100 or more patients in care at a given time.
		  • The SMP passed the measure on reliability.
		• The standing committee accepted the SMP's ratings for reliability without further discussion.

Criterion	Total Votes	Rationale

2b. Validity	• Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)
	
	• SMP Total Votes-11; H-3; M-6; L-2; I-0
		• The standing committee recognized that validity testing was conducted at the patient/encounter level and at the accountable entity level.
		  • At the patient/encounter level, the confirmatory factor analyses of 18 survey items were identified by a devleoper-convened technical expert panel (TEP). The assessed overall model fit for the five-factor model using comparative fit index was 0.992. The root mean square error of approximation was 0.023. The weighted root mean square residual was 1.463. The factor loadings were above 0.70. The overall fit chi-square was 269.45, for a model with 125 degrees of freedom.
		  • At the accountable entity level, the construct validity was assessed by examining the associations between each multi-item measure top-box score with two single-item global measures top-box scores. The developer estimated multivariate linear regression models with the global measures as dependent variables. Models were adjusted for case-mix and survey mode and estimated with weighted least square mean and variance adjustment. Standardized regression coefficients ranged from 0.44 to 0.57 across the measures.
		• The standing committee recognized that the measure was risk-adjusted for eight risk factors (age, education, primary diagnosis, proxy response, self-reported functional status, self-reported physical health, self-reported mental health, and response percentile).
		• The standing committee noted the SMP's review of the validity testing. Some SMP members noted concerns that in the risk adjustment assessment, it is not clear how much scores changed rankings and whether adjustment is needed. One member noted concerns that variance explained by case-mix adjustment is less than 12%. Another member noted that the model cannot adequately explain the variation in responses and entity scores since the result is similar with and without risk adjustment. One SMP member suggested that Spanish language be considered for inclusion in the adjustment method.
		  • The developer provided responses to the SMP concerns, noting that Spanish language was statistically insignificant with respect to the association with respondent evaluations and with the impact on one or more outcome measures. In addition, the developer noted that between 18 and 29% of programs participating in the field test scored either significantly above or below the field test program average. Among these programs, the mean absolute differences between the programs' scores and the average program score for a given measure ranged from 11.0 for Communication to 17.9 for Care Planning, indicating large differences from the program average.
		  • The SMP passed the measure on validity.
		• The standing committee accepted the SMP's ratings for validity without further discussion.

Table A.1-1.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• Total Votes-16; H-2; M-13; L-1; I-0 (15/16 – 93.7%, Pass)	• The standing committee acknowledged that the survey instrument is available to all at no cost. • The standing committee also recognized that patient-reported data are collected via a survey instrument, and while the field-tested survey was administered via mail and telephone, the developer noted that the survey could also be administered electronically via email. • The developer did not note any difficulties regarding data collection and states that the overall survey response rate of 36.4% is on par with those of other national care experience surveys. • The standing committee passed the measure on feasibility with no major concerns.

Table A.1-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)	• The standing committee recognized that this newly developed measure is not yet in widespread use. • The developer stated that there are ongoing discussions with various stakeholders regarding survey implementation, and it will administer an adapted version of the survey in 2023 to inform quality improvement and to compare care experiences between select seriously ill patients who are Medicare Advantage members of Blue Cross Blue Shield of Massachusetts. • The standing committee noted that the field test of the Serious Illness Survey for Home-Based Programs was conducted from October 2019 through January 2020 among patients of 32 geographically diverse serious illness programs that provide home-based care. Each of the 32 participating programs was provided a summary report via secure file transfer at the conclusion of the field test. • The developer noted that the data collected by Blue Cross Blue Shield of Massachusetts would not be publicly reported, but the results would be included in a peer-reviewed journal publication. • The standing committee requested clarification on how home-based serious illness programs are identified and how they are distinguished from other types of palliative care programs. The developer stated that there is no comprehensive list or accreditation of home-based serious illness programs and elaborated that RAND sourced its list of programs for field testing from previous publications and the Center to Advance Palliative Care's registry, in which organizations self-identify as having home-based serious illness programs. • The developer distinguished home-based serious illness programs as providing interdisciplinary medical care with discussions and planning for daily living, whereas home health provides direct assistance with daily living. The programs were broadly defined by the services they provide rather than by their respective eligibility criteria. • The standing committee acknowledged the distinction between home-based serious illness programs and home health, hospice, and home-based primary care. • The standing committee passed the measure on use.
4b. Usability	• Total Votes-15; H-2; M-13; L-0; I-0 (15/15 – 100%, Pass	• The standing committee acknowledged that due to the measure's limited use, performance improvement data were not available. • However, the developer described how programs and payers might find the measure useful to assess quality of care in ongoing or future initiatives. • The standing committee noted that the developer listed no unexpected findings or potential harms. • Raising no concerns, the standing committee passed the measure on usability.

Table A.1-1.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• CBE #2651 CAHPS Hospice Survey®, Version 9.0 • CBE #3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood • CBE #3666 Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain	• The committee recognized that this measure is related to the following measures: CBE #2651 - *CAHPS Hospice Survey®, Version 9.0*, CBE #3665 - *Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood*, and CBE #3666 - *Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain*. • CBE #2651 measures the care experiences of patients who died while receiving hospice care through survey responses from their primary caregivers. In contrast, CBE #3726 respondents are patients who receive care from a home-based serious illness program. • CBE #3665 and CBE #3666 measure the patient-reported communication and pain palliation of patients who have received specialty palliative care in an outpatient setting. In contrast, CBE #3726 respondents receive care in their homes. • Some standing committee members acknowledged that some patients may fall under multiple measure denominators, particularly those newly enrolled in home-based serious illness programs who may also be seen by a palliative care physician at a clinic. Yet, the standing committee noted that the potential overlap was small and that each measure addresses unique programs. • The standing committee determined these measures to be harmonized to the extent possible.

Table A.1-1.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	• Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass)	• The Standing Committee passed the measure on overall suitability for endorsement. • One member expressed that the measure is a step forward for patient-reported outcome measures in palliative care.

Table A.1-1.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• Two	Pre-evaluation comments • None Post-evaluation comments *Clarification for distinguishing between programs* • One comment was supportive of the committee's recommendation to endorse the measure, but requested clarification on how the measure will distinguish between home-based serious illness programs and home-based primary care programs and emphasized the importance of incorporating patient and family input into this and similar measures. The developer responded by noting the definition of how home-based care was specified and key features of home-based programs as defined. • The standing committee shared potential points of overlap between home-based serious illness and home-based primary care programs and that serious illness versus primary care program differentiation is determined by the characteristic of focus, the population, or the care delivery model. *General support for endorsement* • The second comment expressed support for the endorsement of the measure.
Non-supportive comments	• None	• N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-1.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	• Total Votes-13; Yes-13; No-0	• Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-1.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	• N/A	• N/A

CBE #0091 COPD: Spirometry Evaluation

Staff Assessment | Specifications

Numerator Statement: Patients with documented spirometry results in the medical record (FEV1 and FEV1/FVC)

Denominator Statement: All patients aged 18 years and older with a diagnosis of COPD

Exclusions: Documentation of medical reason(s) for not documenting and reviewing spirometry results. Documentation of patient reason(s) for not documenting and reviewing spirometry results. Documentation of system reason(s) for not documenting and reviewing spirometry results

Adjustment/Stratification: None

Level of Analysis: Clinician: Group/Practice

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: American Thoracic Society

STANDING COMMITTEE EVALUATION

Table A.1-2.1 Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-16; H-2; M-14; L-0; I-0)16/16 – 100%, Pass)	• The standing committee considered the logic model for this measure, which posits that the use of spirometry is important to confirm the correct diagnosis of COPD. The correct diagnosis leads to appropriate treatment choices, which improves patient outcomes, decreases symptoms, reduces exacerbation, and improves health-related quality-of-life. • The developer submitted new evidence and summarized a few studies that found continued underuse of spirometry for confirmation of COPD and highlighted the continued patterns of both under and over-diagnosis of COPD. The developer noted that the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines were updated in 2022 to include a requirement for the use of spirometry in making a confident diagnosis of COPD. • The standing committee agreed that the updated evidence provided supports the use of spirometry to confirm the diagnosis of COPD. • The standing committee voted to pass the measure on evidence without additional discussion.

Criterion	Total Votes	Rationale
1b. Performance Gap	Total Votes-16; H-3; M-13; L-0; I-0 (16/16 – 100%, Pass)	• The standing committee acknowledged that performance data were not provided for this measure. However, data from literature can be considered if performance data are not available. • The developer provided performance data for CBE #0577, including aggregate rates by health plan type for adults 40 years of age and older who have a new COPD, or newly active COPD, and received spirometry testing to confirm the diagnosis. The data showed a decrease in performance in 2020 data compared 2018 for all plan types reported. In both 2018 and 2020, the Medicaid Health Maintenance Organizations (HMOs) had the lowest average spirometry testing rates with 31% and 26.8%, respectfully. In 2018 and 2020, Commercial HMO plans had the highest rates reported with average rates of 41.7% and 37.3%, respectively. • The standing committee also noted that the developer provided a summary of literature indicating that gender and race disparities exist in the diagnosis of COPD, which may be linked to a disparity in performing spirometry on at-risk populations. • The standing committee also highlighted data from the measure submission, which showed that less than 50% of individuals diagnosed with COPD underwent a spirometry test to confirm the diagnosis. Additionally, rates of spirometry declined during the COVID-19 pandemic because COVID-19 testing results were required prior to the administration of spirometry. • The standing committee agreed that gender and race disparities exist in the diagnosis of COPD, which may be linked to a disparity in performing spirometry on at-risk populations. The developer suggested increasing access to spirometry in primary care clinics with a higher percentage of underserved populations as one solution. • The standing committee passed the measure on performance gap.

Table A.1-2.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	• Total Votes-16; H-0; M-15; L-1; I-0 (15/16 – 93.7%, Pass)	• The standing committee noted that the developer did not submit updated reliability testing. • The developer stated that a former measure developer created and tested the measure and that it only had access to the information provided in prior submissions for review. • The committee acknowledged that updated reliability testing is not required at maintenance if the measure specifications have not changed. • Therefore, the standing committee passed the measure on reliability based on prior reliability testing, since no changes were made to the measure specifications.

Criterion	Total Votes	Rationale
2b. Validity	• Total Votes-16; H-2; M-8; L-4; I-2 (10/16 – 62.5%, Pass)	• The standing committee recognized that the developer did not submit updated validity testing. • The committee acknowledged that updated validity testing is not required at maintenance if the measure specifications have not changed. • The standing committee noted concerns regarding the potential lack of using Current Procedural Terminology (CPT) codes related to the review of prior spirometry testing during the visit. The standing committee discussed that while practices are likely to include the CPT codes for the actual administration of a spirometry test, potential barriers to coding the review of an older spirometry test may lead to missing data or under-reporting. • One standing committee member stated that some practices will have processes such as pop-ups in the coding system to ensure that the code is added appropriately. • The standing committee passed the measure on validity with no further discussion.

Table A.1-2.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• Total Votes-16; H-3; M-12; L-1; I-0 (15/16 – 93.7%, Pass)	• The standing committee recognized that this measure is claims-based and that all data elements are in defined electronic fields. The data are collected by and used by health care personnel during the provision of care. • The standing committee noted the measure is free to use, it is reported using International Classification of Diseases (ICD) codes for diagnosis and CPT codes for spirometry, and both clinical and billing systems can include decision support to assist practices in reporting all data required for the measure. • The standing committee passed the measure on feasibility.

Table A.1-2.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• Total Votes-16; Pass-15; No Pass-1 (15/16 – 93.7%, Pass)	• The standing committee recognized that the measure was used in the CMS Merit-based Incentive Payment System (MIPS) though performance year 2019. CMS removed the measure from MIPS in performance year 2020 as documentation of spirometry is a required component of another measure, CBE #0102, *Appropriate Use of Long-Acting Bronchodilators*. • The developer stated that the measure CMS retained in MIPS only captures patients who underwent a spirometry test and received treatment compared with CBE #0091, which uses the measure for the appropriate diagnosis of COPD. • The developer is working with CMS regarding future potential use of the measure in the CMS MIPS Value Pathways related to COPD, asthma, sleep, and general pulmonary. • The standing committee passed the measure on use based on the developer rationale, noting that the measure was used in an accountability program and publicly reported during the time frame required for measures undergoing maintenance of endorsement review.
4b. Usability	• Total Votes-16; H-2; M-5; L-3; I-6 (7/16 – 43.7%, Consensus Not Reached)	• The standing committee acknowledged that data to support progress on improvement or trends in performance results were not provided. • The standing committee also recognized that the developer attested to not knowing of any unintended consequences related to the use of this measure. • The standing committee did not reach consensus on usability, which is not a must-pass criterion.

Table A.1-2.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• CBE #0577 Use of Spirometry Testing in the Assessment and Diagnosis of COPD	• This measure was identified as related to the following measure CBE #0577, *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.* • The committee suggested that the developers consider harmonizing the age and lookback time frame of the spirometry testing used in the two measures.

Table A.1-2.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	• Total Votes-16; Yes-15; No-1 (15/16 – 93.7%, Pass)	• The standing committee voted to recommend the measure for endorsement without further discussion.

Table A.1-2.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• One	Pre-evaluation comments • None Post-evaluation comment *Concern about individuals with established COPD for year* • One commenter noted support for the measure but expressed concern about individuals who have established COPD for years. It may be burdensome for the patient to get a spirometry evaluation or any pulmonary function test that would not lead to a change in COPD management. This may occur if they are clinically and if they have imaging consistent with COPD, respond well to COPD treatment, are frail, and are sick. The commenter noted that the benefit of documentation does not outweigh the burden these patients would face.
Non-supportive comments	• None	• N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-2.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	• Total Votes-13; Yes-13; No-0	• Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-2.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	• N/A	• N/A

CBE #2651 CAHPS® Hospice Survey, Version 9.0

Staff Assessment | Specifications

Numerator Statement: CMS calculates CAHPS Hospice Survey measure scores using top-, middle- and bottom- box scoring. The top-box score refers to the percentage of caregiver respondents that give the most positive response(s). The bottom box score refers to the percentage of caregiver respondents that give the least positive response(s). The middle box is the proportion remaining after the top and bottom boxes have been calculated; see below for details. Details regarding the definition of most and least positive response(s) are noted in Section SP.14 below.

Denominator Statement: In national implementation and public reporting, CAHPS® Hospice Survey measure scores are calculated only for hospices that had at least 30 completed questionnaires over the most recent eight quarters of data collection.

The target population for the survey are the adult primary caregivers of hospice decedents. Respondent eligibility and exclusions are defined in detail in the sections that follow. A survey is defined as completed when at least 50 percent of the questions applicable to all decedents/caregivers are answered. The survey uses screener questions to identify respondents eligible to respond to subsequent items. Therefore, denominators vary by survey item (and corresponding multi-item measures, if applicable) according to the eligibility of respondents for each item. In addition, for the Getting Hospice Care Training measure, scores are calculated only among those respondents who indicate that their family member received hospice care at home or in an assisted living facility.

Exclusions: The exclusions noted here are those who are ineligible to participate in the survey. The one exception is caregivers who report on the survey that they "never" oversaw or took part in the decedent's care; these respondents are instructed to complete the "About You" and "About Your Family Member" sections of the survey only.

Cases are excluded from the survey target population if:

• The hospice patient is still alive

• The decedent's age at death was less than 18

• The decedent died within 48 hours of his/her last admission to hospice care

• The decedent had no caregiver of record

• The decedent had a caregiver of record, but the caregiver does not have a U.S. or U.S. Territory home address

• The decedent had no caregiver other than a nonfamilial legal guardian

• The decedent or caregiver requested that they not be contacted (i.e., by signing a no publicity request while under the care of hospice or otherwise directly requesting not to be contacted)

• The caregiver is institutionalized, has mental/physical incapacity, has a language barrier, or is deceased

• The caregiver reports on the survey that he or she "never" oversaw or took part in decedent's hospice care

Adjustment/Stratification: Statistical risk model

Level of Analysis: Facility

Setting of Care: Home care, Inpatient/Hospital, Other

Type of Measure: Outcome: PRO-PM

Data Source: Instrument-Based Data

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE EVALUATION

Table A.1-3.1 Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)	• The standing committee considered the logic model for this measure, which included minor updates since the 2019 submission. The updates reflect the important role that hospice has in explaining care options, formulating goals of care that reflect patient and family preferences, and then creating a plan of care that aims to achieve those goals. The key process of hospice care is assessed by the new CAHPS Hospice Survey Care Preferences measure. • The standing committee noted that there have been no changes in the evidence since the measure was last evaluated and agreed that the evidence basis for the measure has not changed and repeated discussion was not needed. • The standing committee passed the measure on evidence.

1b. Performance Gap	• Total Votes-16; H-2; M-13; L-1; I-0 (15/16 – 93.7%, Pass)	• The standing committee considered the summary of analyses from the 2021 CAHPS Hospice Survey mode experiment data, including 4,749 caregiver respondents from 56 hospices noting potential disparities in the experience of care measures.
		  • Caregivers of decedents who are Black reported better experiences than caregivers of White decedents on Hospice Team Communication (4.1 percentage points higher; $p<0.05$), but similar or worse experiences for all other measures.
		  • Caregivers of decedents who are Hispanic reported worse experiences than caregivers of White decedents with regard to Emotional and Religious Support (3.4 percentage points lower; $p<0.05$), but similar care experiences for other measures.
		• One standing committee member asked whether there is a way to look at the disparities based on geographical location or neighborhood-level data along with disparities based on race. The developer replied that although differences in care by race and ethnicity have been analyzed, considering geography in future analyses could be an option.
		• Another standing committee member questioned how religious support is qualified or quantified into being measured as excellent, very good, good, fair, etc. The developer clarified that the survey asks the caregiver respondent to describe their own experiences and whether that family caregiver felt they received the right amount of support. Like all questions on the survey, the caregiver's perspective on what happened defines what is "right" for them in the context of those questions.
		• Raising no further questions and having no further discussion, the standing committee passed the measure on performance gap.

Table A.1-3.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	• Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass) • SMP Total Votes-11; H-6; M-3; L-2; I-0	• The committee considered the updated testing at the person/encounter- and accountable entity-levels, which reflected the revisions made to the instrument, including shortening and simplifying the instrument and adding a new two-item Care Preferences measure. • The standing committee recognized that the SMP did not note any concerns with the reliability of this measure. • The standing committee accepted the SMP's passing rating for reliability and agreed that a discussion and separate vote were not needed.
2b. Validity	• Total Votes-16; Yes-16; No-0 (16/16 – 100%, Pass) • SMP Total Votes-10; H-1; M-5; L-2; I-2	• The committee considered the updated testing at the person/encounter- and accountable entity-level and acknowledged that the risk-adjustment model has not been updated or retested. • The standing committee recognized that the SMP raised some concern around the lack of retesting of the risk adjustment model and the large nonresponse rates. The developer provided responses to these concerns. With respect to the risk adjustment model, the developer posited that there was no compelling reason to believe that the best set of case-mix adjustors should be any different for the revised measures and the mode experiment data provide less precise estimates of case-mix coefficients than data from national implementation. Regarding the nonresponse rates, the developer posited that case-mix adjustment addresses nonresponse bias with greater statistical efficiency than nonresponse weighting. • With no concerns or discussion, the standing committee accepted the SMP's passing rating for validity and concluded that a discussion and separate vote were not needed.

Table A.1-3.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	• Total Votes-15; H-1; M-14; L-0; I-0 (15/15 – 100%, Pass)	• The standing committee recognized that the data for this measure are collected via a survey that can be administered via mail, telephone, or web. The standing committee noted that the Hospice CAHPS survey is fielded to the caregiver following the death of the hospice patient, and thus the data elements are not routinely generated and used during care delivery and that the response rate for the survey is fairly low, although it is comparable to other CAHPS surveys. • Some standing committee members noted that the CAHPS Hospice Survey process has been in place since 2015 and that although it relies on family caregiver versus patient experience, it appears to be the best method available to obtain data on the patient's hospice experience. • The standing committee passed the measure on feasibility.

Table A.1-3.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	• Total Votes-16; Pass-16; No Pass-0 (16/16 – 100%, Pass)	• The standing committee acknowledged that this measure is used for public reporting in the CMS Hospice Quality Reporting Program and in the 2023 Hospice Payment Rate Update proposed rule, and also that CMS requested comments on potential updates to CAHPS Hospice Survey content and modes of administration. Hospices expressed support for a shorter survey instrument and web-based mode of survey administration, which resulted in a shortened survey by eight questions that was tested and is now available via web-mail. • The standing committee passed the measure on use.
4b. Usability	• Total Votes-15; H-0; M-15; L-0; I-0 (15/15 – 100%, Pass)	• The standing committee recognized that performance data submitted by the developer included evidence of small improvements in CAHPS Hospice Survey measures, with greatest improvement during the short period corresponding to care provided after public reporting began in February 2018. • The standing committee noted that the developer did not report any unexpected findings or potential harms and passed the measure on usability.

Table A.1-3.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• CBE #1623 Bereaved Family Survey	• This measure is related to the following measure: CBE #1623 - *Bereaved Family Survey.* • The result of CBE #1623 is a single score that indicates the family's perceptions of the quality of care that veterans received from Veterans Affairs during the last month of life; aspects of care included in the measure are communication, emotional and spiritual support, pain management, and personal care needs. • The standing committee reviewed the measure and agreed that the measures were harmonized to the extent possible.

Table A.1-3.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Recommended for Endorsement	• Total Votes-15; Yes-15; No-0 (15/15 – 100%, Pass)	• The standing committee voted to recommend the measure for endorsement without further discussion.

Table A.1-3.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• Two	Pre-evaluation comments • None Post-evaluation comments *Reconciling measure to be seamless with CBE #0679* • One comment emphasized the importance of reconciling this measure to be seamless with CBE #0679, given the challenges distinguishing between avoidable and unavoidable events around end of life. The commenter also suggested hospice or comfort care patients be excluded from the denominator or a comfort care exclusion be operationalized. • The committee did not express any concerns with the developer's response, which explained that the CAHPS® Hospice Survey assesses experiences of hospice care received across all settings in which hospice care is delivered, including the nursing home. Hospice decedents are not excluded from the sample based on their diagnoses or symptoms. Additionally, the developer noted that the measures of CBE #2651 assess distinct concepts from those assessed by measures of nursing home pressure ulcers. *General support for endorsement* • The second comment expressed support for the endorsement of the measure.
Non-supportive comments	• None	• N/A

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.1-3.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Endorsed	• Total Votes-13; Yes-13; No-0	• Unanimous approval to endorse the measure via a consent calendar.

APPEALS BOARD EVALUATION

Table A.1-3.9. Appeals

Appeal Received (Yes/No)	Appellant Organization	Summary of Appeal and Its Review
No	• N/A	• N/A

A.2 Measures Not Endorsed

CBE #3707 Ratio of observed over predicted rates for diagnosis of mild cognitive impairment

Staff Assessment | Specifications

Numerator Statement: Number of individuals aged 65 and older under the care of a clinician or practice who are diagnosed with mild cognitive impairment.

Denominator Statement: Predicted number of individuals aged 65 and older under the care of a clinician or practice with mild cognitive impairment based on the demographic profile of the respective clinician or practice. Limit reporting to clinicians and practices with at least 25 attributed patients per CMS' guidance to ensure stability of measure results.

Exclusions: The measures do not use any exclusions as they are based on the 100% samples for both Medicare fee-for-service and Medicare Advantage Plans. While we limit reporting of the measure to clinicians and practices with at least 25 attributed patients, this does not constitute an exclusion per NQF guidance, since those patients might be reported when reporting on higher levels of aggregation, such as a state. We merely follow CMS' recommendations for minimum sample size to report stable results.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care

Type of Measure: Process

Data Source: Claims

Measure Steward: University of Southern California

STANDING COMMITTEE EVALUATION

Table A.2-1.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-15; H-1; M-0; L-8; I-6 (1/15 – 6.7%, Pass)	• The standing committee recognized that this new measure has a logic model that posits that reporting on under- or over-diagnosis of mild cognitive impairment will lead providers to adjust their approach to identifying cognitive impairment, which will lead to more early-stage diagnosis and appropriate treatment. • The developer provided guidelines and a systematic review that recommend early diagnosis to allow for early intervention in mild cognitively impaired patients. The developer also provided evidence indicating that early intervention has the potential to improve outcomes for mild cognitively impaired patients. • The developer noted that the impact of social support and educational interventions has not been studied due to the ethical issues with withholding a diagnosis. Also, phase 3 clinical trials for disease modifying Alzheimer's treatment will become available soon, but this treatment is only indicated in the early disease stages. • The standing committee acknowledged the importance of the early detection of MCI to provide treatment and interventions to keep patients safe as they continue to age. • The standing committee recognized that cognitive impairment remains underdiagnosed and that the measure can help identify gaps in diagnosis. However, the standing committee noted that due to the current challenges of diagnosing cognitive impairment and therefore limited available data, there are concerns regarding whether the treatment of MCI would be effective or beneficial. Challenges have included the ethical considerations of accomplishing trials to assess interventions and medications. • Lastly, the committee agreed that the evidence did not demonstrate that the proposed process of care measure would lead to a positive patient outcome. Much of the evidence presented was also not graded or graded as moderate. • The standing committee therefore did not pass the measure on evidence.
1b. Performance Gap	Vote Note Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-1.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Criterion	Total Votes	Rationale
2b. Validity	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-1.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-1.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.
4b. Usability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-1.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• CBE #2872e Dementia: Cognitive Assessment	• Measure was not recommended for endorsement; therefore the related measures were not discussed.

Table A.2-1.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Not Recommended for Endorsement	Vote Not Taken	• The standing committee did not vote on overall endorsement because the measure did not pass on evidence—a must-pass criterion.

Table A.2-1.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• None	• N/A
Non-supportive comments	• One	Pre-evaluation comments • None Post-evaluation comment *Utility and accuracy unclear* • One commenter noted that the utility and accuracy of measuring missed diagnoses of MCI is not clear. The commenter asked if a clinic with lower rates would mean that the clinic is doing a better job of controlling risk factors thus preventing MCI or the clinic is not checking cognition thus unable to identify MCI. • The developer did not provide a response to this comment.

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.2-1.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Not Endorsed	• Total Votes-13; Accept-13; Do Not Accept-0 (13/13 – 100%, Not Endorsed)	• The CSAC had no major concerns and upheld the standing committee's decision to not endorse the measure.

APPEALS BOARD EVALUATION

9. Appeals:

- Based on the prior consensus-based entity's process, only endorsed measures are eligible for any appeal.

CBE #3672 Ratio of observed over predicted rates for diagnosis of dementia

Staff Assessment | Specifications

Numerator Statement: Number of Medicare beneficiaries aged 65 and older, who are attributed to a clinician or practice and who have been diagnosed with dementia based on claims data.

Denominator Statement: Number of expected cases with dementia among the panel of Medicare beneficiaries aged 65 and older attributed to a clinician or practice based on a predictive model. Report measure only for clinicians and practices with at least 25 attributed patients to ensure measure stability following CMS' guidance.

Exclusions: The measures do not use any exclusions as they are based on the 100% samples for both Medicare fee-for-service and Medicare Advantage Plans. While we limit reporting of the measure to clinicians and practices with at least 25 attributed patients, this does not constitute an exclusion per NQF guidance, since those patients might be reported when reporting on higher levels of aggregation, such as a state. We merely follow CMS' recommendations for minimum sample size to report stable results.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Clinician: Group/Practice, Clinician: Individual

Setting of Care: Ambulatory Care

Type of Measure: Process

Data Source: Claims

Measure Steward: University of Southern California

STANDING COMMITTEE EVALUATION

Table A.2-2.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-16; H-0; M-1; L-12; I-3 (1/16 – 6.3%, No Pass)	• The standing committee found that the logic model for this measure, which posits reporting on under- or over-diagnosis of dementia, will lead providers to adjust their approach to identifying dementia, which will lead to more early-stage diagnosis and appropriate treatment and support options for patients. • The developer provided guidelines and a systematic review recommending early diagnosis to allow for early intervention in dementia patients. The developer also provided evidence indicating that early intervention has the potential to improve outcomes for mild dementia patients. • The standing committee recognized that the evidence presented was the same evidence as CBE #3707, which was discussed prior to CBE #3672. • The standing committee acknowledged that the measure would potentially highlight gaps in diagnoses of dementia but had concerns about whether the measure's process of care would lead to improved patient outcomes.

Criterion	Total Votes	Rationale
1b. Performance Gap	Vote Note Taken	• Having the same evidence concerns as CBE #3707, the standing committee did not pass the measure on evidence—a must-pass criterion. Therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-2.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.
2b. Validity	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-2.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-2.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.
4b. Usability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-2.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• CBE #2872e Dementia: Cognitive Assessment	• Measure was not recommended for endorsement; therefore, the related measures were not discussed.

Table A.2-2.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Not Recommended for Endorsement	Vote Not Taken	• The standing committee did not vote on overall endorsement because the measure did not pass on evidence—a must-pass criterion.

Table A.2-2.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• None	• N/A

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Non-supportive comments	• One	Pre-evaluation comments • None Post-evaluation comment *Utility and accuracy unclear* • One commenter noted that the utility and accuracy of measuring missed diagnoses of dementia is not clear. The commenter noted that the measure has the potential to incentivize to increase diagnosis rates and that individuals with possible dementia are more likely to visit geriatric medicine practices and it is unclear if these practices are excluded in the measure. The commenter stated that clarification is needed on whether a clinic with lower rates is considered as doing a better job of controlling risk factors thus preventing dementia or if they are not checking cognition and therefore not identifying dementia. • The developer did not provide a response to this comment.

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.2-2.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Not Endorsed	• Total Votes-13; Accept-13; Do Not Accept-0 (13/13 – 100%, Not Endorsed)	• The CSAC had no major concerns and upheld the standing committee's decision to not endorse the measure.

APPEALS BOARD EVALUATION

9. Appeals:

- Based on the prior consensus-based entity's process, only endorsed measures are eligible for any appeal.

CBE #3729 Ratio of observed over predicted rates for diagnosis of cognitive impairment of any stage

Staff Assessment | Specifications

Numerator Statement: Number of Medicare beneficiaries aged 65 and older, who are attributed to a clinician or practice and who have been diagnosed with any stage cognitive impairment based on claims data.

Denominator Statement: Number of expected cases with dementia among the panel of Medicare beneficiaries aged 65 and older attributed to a clinician or practice based on a predictive model.

(Report only on clinicians and practices with at least 25 attributed patients to ensure measure stability.)

Exclusions: N/A

Adjustment/Stratification: Statistical risk model

Level of Analysis: Clinician: Group/Practice, Clinician: individual

Setting of Care: Ambulatory Care

Type of Measure: Process

Data Source: Claims

Measure Steward: University of Southern California

STANDING COMMITTEE EVALUATION

Table A.2-3.1. Importance to Measure and Report (MUST PASS)

Criterion	Total Votes	Rationale
1a. Evidence	• Total Votes-16; H-0; M-2; L-14; I-0 (2/16 – 12.5%, No Pass)	• The standing committee recognized that the logic model for this measure, which posits reporting on under- or over-diagnosis of cognitive impairment of any stage, will lead providers to adjust their approach to identifying cognitive impairment, which will lead to more early-stage diagnosis and appropriate treatment and support options for patients. • The standing committee noted that the developer provided guidelines and a systematic review recommending early diagnosis to allow for early intervention in cognitively impaired patients. Also, the evidence indicated that early intervention has the potential to improve outcomes for cognitively impaired patients. • The standing committee recognized the importance of identifying cognitive impairment early. However, it had similar concerns regarding the evidence, as it did for CBE #3707 and CBE #3672. The standing committee noted that the evidence is not strong enough to indicate that the differences in diagnosis of cognitive impairment at any stage would result in differences in treatment outcomes. • The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Criterion	Total Votes	Rationale
1b. Performance Gap	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-3.2. Scientific Acceptability of Measure Properties (MUST PASS)

Criterion	Total Votes	Rationale
2a. Reliability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.
2b. Validity	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-3.3. Feasibility

Criterion	Total Votes	Rationale
3. Feasibility	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-3.4. Use and Usability (USE IS MUST PASS FOR MAINTENANCE MEASURES)

Criterion	Total Votes	Rationale
4a. Use	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.
4b. Usability	Vote Not Taken	• The standing committee did not pass the measure on evidence—a must-pass criterion; therefore, the standing committee did not discuss or vote on any subsequent criteria.

Table A.2-3.5. Related and Competing Measures

Criterion	Related and/or Competing Measure(s)	Rationale
5. Related and Competing	• None	• N/A

Table A.2-3.6. Standing Committee Recommendation for Endorsement

Committee Endorsement Recommendation	Total Votes	Rationale
Not Recommended for Endorsement	Vote Not Taken	• The standing committee did not vote on overall endorsement because the measure did not pass on evidence—a must-pass criterion.

Table A.2-3.7. Public and Member Comment

Supportive/Non-supportive Comments	Number of Comments Received	Comment Summary
Supportive comments	• None	• N/A
Non-supportive comments	• One	Pre-evaluation comments • None Post-evaluation comments *Uncertainty of utility and accuracy* • One commenter stated that there is uncertainty of the measure's utility and accuracy.

CONSENSUS STANDARDS APPROVAL COMMITTEE (CSAC) EVALUATION

Table A.2-3.8. CSAC Endorsement Decision

CSAC Endorsement Decision	Total Votes	Rationale
Not Endorsed	• Total Votes-13; Accept-13; Do Not Accept-0 (13/13 – 100%, Not Endorsed)	• The CSAC had no major concerns and upheld the standing committee's decision to not endorse the measure.

APPEALS BOARD EVALUATION

9. Appeals:

- Based on the prior consensus-based entity's process, only endorsed measures are eligible for any appeal.

Appendix B: Geriatrics and Palliative Care Standing Committee and Battelle Staff

GERIATRICS AND PALLIATIVE CARE STANDING COMMITTEE

Amy J. Berman, BSN, LHD, FAAN (Co-Chair)
Senior Program Officer, John A. Hartford Foundation

R. Sean Morrison, MD (Co-Chair)
Co-Director, Patty and Jay Baker National Palliative Care Center; Director, National Palliative Care Research Center; Director, Hertzberg Palliative Care Institute, Icahn School of Medicine at Mount Sinai

Samira Beckwith, LCSW, FACHE, LHD
President and CEO, Hope HealthCare Services

Cleanne Cass, DO, FAAHPM, FAAFP
Director of Community Care and Education, Hospice of Dayton

Jeff Garland, DMin, EdS, BCC – PCHAC
Chaplain, VNA Health Group Barnabas Health Home and Hospice & Palliative Care Center

Marian Grant, DNP, ACNP-BC, ACHPN
Senior Regulatory Advisor, Coalition to Transform Advanced Care (C-TAC)

George Handzo, BCC, CSSBB
Director, Health Services Research and Quality, HealthCare Chaplaincy

Arif H. Kamal, MD, MBA, MHS, FACP, FAAHPM
Physician Quality and Outcomes Officer, Duke Cancer Institute

Christopher Laxton, CAE
Executive Director, AMDA - The Society for Post-Acute and Long-Term Care Medicine

Katherine Lichtenberg, DO, MPH, FAAFP
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Douglas Nee, Pharm D, MS (*Inactive*)
Clinical Pharmacist, Self

Tracy Schroepfer, PhD, MSW (*Inactive*)
Professor of Social Work, University of Wisconsin, Madison, School of Social Work

Linda Schwimmer, JD
Attorney, President and CEO, New Jersey Health Care Quality Institute

Christine Seel Ritchie, MD, MSPH
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Karl Steinberg, MD, CMD, HMDC, HEC-C
Chief Medical Officer, Mariner Health Central; Chief Medical Officer, Beecan Health; Medical Director, Hospice by the Sea, Life Care Center of Vista, Carlsbad by the Sea Care Center

Paul E. Tatum, MD, MSPH, CMD, FAAHPM, AGSF
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Sarah Thirlwell, MSc, MSc(A), RN, AOCNS, CHPN, CHPCA, CPHQ
Clinical Administrator, LifePath Hospice, a Chapters Health System Affiliate

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