National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Initial Recognition and Management Endorsement Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Initial Recognition and Management committee on July 29, 2024, for discussion and voting on measures under endorsement consideration for the Spring 2024 cycle. Meeting participants joined virtually through a Zoom meeting platform. Measure stewards/developers and members of the public were also in attendance.

The objectives of the meeting were to:

- Review and discuss measures submitted to the committee for the Spring 2024 cycle;
- Review staff preliminary assessments, Advisory and Recommendation Group feedback, public comments, and developer responses regarding the measures under endorsement review; and
- Render endorsement decisions using a virtual voting platform.

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

After the endorsement meeting, measures and endorsement decisions enter an appeals period for 3 weeks, from August 30-September 20, 2024. Any interested party may submit an appeal, which will be reviewed for eligibility according to the criteria within the Endorsement and Maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will convene to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Welcome, Roll Call, and Disclosures of Interest

Matt Pickering, PharmD, Battelle's E&M task lead, welcomed the attendees to the meeting and introduced his co-presenters Anna Michie, E&M deputy task lead, Isaac Sakyi, and his co-facilitator, Nicole Brennan, executive director of PQM. Dr. Pickering also introduced the committee co-chairs, Matt Austin, PhD, and Patricia Merryweather-Arges, MA, who each provided welcoming remarks.

Mr. Sakyi then conducted roll call, and members disclosed any perceived conflicts of interest regarding the measures under review. One member was recused from voting based on Battelle's conflict of interest policy. Tamaire Ojeda was recused from voting on CBE #3592e because she works for the measure developer.

After roll call, Battelle staff established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least 60% of the active Recommendation Group members (n=12). Voting quorum requires at least 80% of active Recommendation Group members who have not recused themselves from the vote (n=16). Both discussion quorum and voting quorum were established and maintained throughout the meeting.

Evaluation of Candidate Measures

Ms. Michie provided an overview of the four measures under review. For Spring 2024, the Initial Recognition and Management committee received two new measures and two measures undergoing maintenance review (Figure 1). The measures focused on malnutrition care during hospitalization, cardiovascular disease (CVD) risk assessment for pregnant/postpartum patients, kidney health evaluation for diabetes patients, and pharmacotherapy for opioid use disorder.

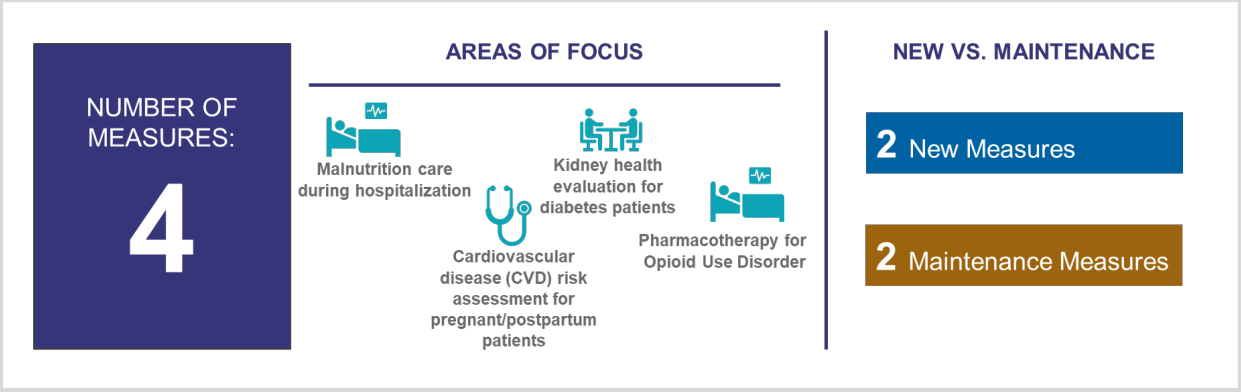

Figure 1. Initial Recognition and Management measures for Spring 2024

Battelle convened a public Advisory Group meeting on June 4, 2024 to gather initial feedback and questions about the measures under endorsement review. Battelle summarized the Advisory Group's feedback and questions and shared them with developers/stewards for review and written response. Battelle then shared the Advisory Group feedback and questions, along with the developer/steward responses, with the Recommendation Group a week prior to the endorsement meeting.

On June 17, 2024, Battelle provided Recommendation Group members 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 staff preliminary assessments.

Recommendation Group members were asked to independently review each measure against the PQM Measure Evaluation Rubric. Recommendation Group members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. Recommendation Group members also provided 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 Recommendation Group, and to the respective measure developers/stewards, for review within 1 week of the endorsement meeting.

Battelle staff compiled these independent Recommendation Group member ratings, and Battelle facilitators and committee co-chairs used them to guide committee discussions.

During the endorsement meeting, the Recommendation Group voted to endorse two measures with conditions and did not endorse two measures due to not reaching consensus (Table 1). Summaries of the Recommendation Group's deliberations for each measure along with any conditions for endorsement are noted below.

Table 1. Spring 2024 Initial Recognition and Management Measure Endorsement Decisions

CBE ID	Measure Title	New/ Maintenance	Endorsement Decision	Endorse | N (%)	Endorse with Conditions | N (%)	Not Endorse/Remove Endorsement | N (%)	Recusals
3592e	Global Malnutrition Composite Score	Maintenance	Endorsed with Conditions	6 (33.33%)	10 (55.56%)	2 (11.11%)	1
4360	CVD Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients Who Receive a CVD Risk Assessment with a Standardized Tool	New	Not Endorsed due to No Consensus	2 (11.11%)	6 (33.33%)	10 (55.56%)	0
4315e	Kidney Health Evaluation	New	Not Endorsed due to No Consensus	7 (38.89%)	6 (33.33%)	5 (27.78%)	0
3400	Use of Pharmacotherapy for Opioid Use Disorder	Maintenance	Endorsed with Conditions	8 (44.44%)	8 (44.44%)	2 (11.11%)	0

CBE #3592e – Global Malnutrition Composite Score [Commission on Dietetic Registration]

Specifications | Discussion Guide

Description: This composite measure assesses the percentage of hospitalizations for adults aged 18 years and older at the start of the inpatient encounter during the measurement period with a length of stay equal to or greater than 24 hours who received optimal malnutrition care during the current inpatient hospitalization where care performed was appropriate to the patient's level of malnutrition risk and severity. A version of this measure, assessing performance only for adults aged 65 years and older, is currently endorsed and active in the Hospital Inpatient Quality Reporting Program (IQR) program; this submission describes a substantive change in the measure, as the population is changed to all adults aged 18 and older.

Committee Final Vote: Endorsed With Conditions

Conditions:

- When this measure comes back for maintenance, the committee would like to see:
    - Implementation data (to include patients 18 years and older) that examines whether the measure is associated with improved nutritional status or related clinical endpoint.

Vote Count: Endorse (6 votes; 33.33%), Endorse with Conditions (10 votes; 55.55%), Remove Endorsement (2 votes; 11.11%); recusals (1).

Public Comments: The measure received one public comment prior to the meeting. The comment was supportive of the measure and recent changes made to the measure.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Variability and Resources	• Recommendation Group members asked if all locations, such as rural hospitals and safety net hospitals, would have the resources (such as dietitian and nutritionist staff) to support this measure. • The developer responded by saying they had not seen a difference in timing in the assessments of large vs. small hospitals (which included rural and critical access hospitals). Over time, the clinical workflows evened out, and they believed that rural hospitals offering remote services may help contribute to the lack of difference.
Business Case	• Several Recommendation Group members asked for clarification on the measure's intent. Some felt that the measure did not adequately demonstrate how it improves outcomes after a hospital stay and asked why the measure focused so narrowly on the hospital stay. • The developer said the focus is on the completion of the steps within the measure. The measure is intended to be a starting place to highlight malnutrition as an important issue and, while a malnutrition assessment is supposed to be standard of care, sometimes the assessment still is not completed. The developer added that they do have evidence that patients who have these steps implemented during their stay have better outcomes, such as

Discussion Topic/Theme	Recommendation Group Discussion
Business Case	decreases in readmission, decrease in length of stay, improvement in wound healing, and reduction in cost. • Other Recommendation Group members agreed with the developer's response that this measure is a good starting point and reminded the committee that this is not an outcome measure. Several Recommendation Group members noted the measure's importance, particularly because nutrition is closely related to social determinants of health (SDOH). One Recommendation Group member commented that they liked the measure because it aligned with The Joint Commission's standard. • The Recommendation Group placed a condition on the measure, which is to show implementation data (to include patients 18 years and older) that examines where the measure is associated with improved nutritional status or related clinical endpoint by measure maintenance in 5 years.
Reassessment	• Recommendation Group members asked whether it would be beneficial for patients to potentially be assessed more than once during a hospital stay to observe whether they developed malnutrition during their stay or to have a plan of care made closer to discharge. • The developer said this was a valid point and added that there are no timing clauses on the assessments and they can be done at any time.
Other At-Risk Populations	• A Recommendation Group member asked if the developer had considered adding a pediatric component, while another member asked if the measure would be used in behavioral health, where they would encounter unhoused individuals. • The developer said they know that pediatric populations are uniquely impacted by SDOHs and that behavioral health populations have unique circumstances for nutrition and long-term treatment. They would like to include these groups in future iterations but are focusing on adult inpatient populations for now.
Information Collection	• A Recommendation Group member asked for more information on what patients are being asked and how they are being assessed. • The developer said they recommend using a standard and reliable tool for the assessment. In general, they said a dietitian would look at changes in weight status and dietary intake as well as perform a comprehensive physical assessment.
Feasibility and Workflow	• Recommendation Group members asked questions about how difficult it is to collect data that are not in structured fields. One member added that while the measure has limited risk associated with it, providers would have to dedicate time and resources to any data collection. • The developer responded, saying that the expected burden of backend work of mapping is small and that it is not unique to this measure. They added that they have found the measure is easily built into the actual workflow.

Additional Recommendations: None were discussed.

CBE #4360 – CVD Risk Assessment Measure – Proportion of Pregnant/Postpartum Patients Who Receive CVD Risk Assessment with a Standardized Tool [University of California, Irvine]

Specifications | Discussion Guide

Description: This measure determines the percentage of pregnant or postpartum patients at a given clinic who were assessed for cardiovascular disease (CVD) risk with a standardized tool, such as the CVD risk assessment algorithm developed by the California Maternal Quality Care Collaborative (CMQCC). The aim is to perform CVD risk assessment using a standardized tool on all (100%) eligible pregnant/postpartum patients.

Committee Final Vote: Not Endorsed due to No Consensus

Vote Count: Endorse (2 votes; 11.11%), Endorse with Conditions (6 votes; 33.33%), Not Endorse (10 votes; 55.55%); recusals (0).

Public Comments: The measure received 61 public comments prior to the meeting. Fifty-nine of the comments were supportive, highlighting the potential to significantly reduce maternal mortality and improve health care quality by identifying high-risk cardiovascular conditions in pregnant and postpartum patients; that the integration of the tool into electronic health record (EHR) systems can streamline screening processes; and that early detection and management of CVD risk factors is important and can lead to timely and effective interventions. Dr. Pickering added that most of these comments were from individuals affiliated with the developer organization. One commenter asked if the measure was based on clinical guidelines that outlined how frequently an assessment should occur; they also said they were unable to determine a performance gap and if the level of testing performed aligns with the level of analysis. The last comment said those using the measure should be allowed to modify the CMQCC risk assessment tool with additional data or use a different tool, as the CQMCC tool includes African American race as a variable, which is a proxy for implicit bias rather than a biological variable.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance	• Several Recommendation Group members highlighted how important of an issue maternal mortality is, particularly in the United States.
Equity	• Recommendation Group members said that while they understood that equity is still an optional domain, equity seems to be implicit in this measure given its topic. They expressed wanting to see information on how the measure performed in rural vs. urban settings and safety net hospitals, saying that the measure currently seems “university based.” • The developer said that although they are a university, they have rural sites. They added that having a CVD risk assessment helps rural providers decide how to triage patients and conduct follow-up.
Cost and Burden vs. Benefits	• The Recommendation Group applauded the developer for providing testing that supports the logic model for the measure. • However, in reviewing the testing for the measure, several committee members expressed concern that a significant amount of follow-up testing occurred due to the CVD risk assessment, resulting in only a marginal increase in people being diagnosed with

Discussion Topic/Theme	Recommendation Group Discussion
Cost and Burden vs. Benefits	CVD. In addition, many of those being diagnosed would likely have been captured by another method. This would be a burden for both providers and patients and that burden significantly outweighs the marginal increase in confirmed CVD diagnosis. • The developer said that implementing standardized screening would help better inform who should be tested and how to use resources wisely. Prior to implementation of standardized screening, they found that testing was done at the provider's discretion, resulting in a lower yield of diagnoses for the same test. • Recommendation Group members also asked if the developer had analyzed the impact of false positives. • The developer said that when a patient is screened positive, they receive counseling and education. The developer stated that they conducted qualitative interviews with patients, and even false-positive patients said they were fine with having additional follow-up and that they appreciated having more awareness of what they could do to prevent CVD and on how to recognize symptoms if they arose later. In addition, providers have better awareness to pay attention to those patients. The developer added that patients appreciated that someone was paying attention to them. • Several Recommendation Group members said they have not seen evidence that education leads to better outcomes, improvements in people's experience of care, or changes in clinicians' methods of providing care. Those committee members also remained concerned about the potential burden and the impact on false-positive patients, including having to take off work, emotional burden, and higher co-pays.
Feasibility	• Recommendation Group members had questions about which screening tools could be used to conduct the CVD assessment. • The developer said that, to date, their tool is the only one that has been tested and validated. In the future, it would perhaps be possible to use others. Their tool is integrated into Epic and Cerner, and a paper version is available. • A Recommendation Group member expressed concern that all the current evidence and messaging relates to the developer's tool. The committee member asked if a provider found the developer's tool to be inappropriate for their patient population, would they be measured as failing to perform the assessment? • The developer said if that were to happen, they would like to hear from those individuals so they can work with them.
Race	• A Recommendation Group member asked how race was considered by the CVD risk assessment. • The developer said that if a person identifies themselves as African American, that goes into the assessment and a point is added in the risk screening.

Additional Recommendations: Recommendation Group members expressed wanting to see information on how the measure performed in rural vs. urban settings. In addition, the Recommendation Group wanted to see evidence demonstrating clinical benefit of the measure beyond CVD diagnosis to justify additional follow-up testing burden.

CBE #4315e – Kidney Health Evaluation [National Kidney Foundation]

Specifications | Discussion Guide

Description: Percentage of patients aged 18-85 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period.

Committee Final Vote: Not Endorsed due to No Consensus

Vote Count: Endorse (7 votes; 38.89%), Endorse with Conditions (6 votes; 33.33%), Not Endorse (5 votes; 27.78%); recusals (0).

Public Comments: The measure received four public comments prior to the meeting. One comment was supportive. Two comments recommended the measure be modified by 1) aligning with the National Committee for Quality Assurance (NCQA) Kidney Health Evaluation for Patients with Diabetes (KED) Healthcare Effectiveness Data and Information Set (HEDIS) measure, stating this will reduce provider burden and that the NCQA measures kidney health evaluation more precisely; and 2) lowering the age limit to 75. One comment questioned whether the measure produces scores that are sufficiently reliable as the minimum reliability was 0.42, which is below 0.7.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Hypertension as Part of Denominator	• A few Recommendation Group members asked why patients with hypertension were not included as part of the denominator. • The developer said when they began to create this measure, hypertension guidelines did not recommend uACR. More recently, the developer has had discussions with NCQA regarding the inclusion of hypertension and is awaiting for new hypertension guidelines from the American College of Cardiology and American Heart Association. Once this new evidence exists, the developer noted that they will likely expand the denominator.
Reliability and Minimum Sample Size	• The Recommendation Group acknowledged that the reliability testing data included providers with only one patient, which skewed the results. A committee member asked if the developer had considered running analyses with a minimum sample size. • A methodologist from the developer said they did some testing by excluding clinicians with a sample size of one and the results did not change significantly. They said they would be open to exploring more testing. • Several Recommendation Group members were still concerned with the small sample sizes.
Exclusions	• A Recommendation Group member asked if the developer analyzed how often discharge to palliative care or hospice occurred as an exclusion in the measure population. • The developer said that were unable to test these exclusions because their testing sites did not provide palliative services. The developer added that they kept this in the measure specifications to align with the NCQA HEDIS measure and feel comfortable that if a practice does provide palliative care, they will be able to capture this information.

Discussion Topic/Theme	Recommendation Group Discussion
Age Range	• A Recommendation Group member asked how the selected age range aligns with clinical guidelines, expressing that that there shouldn't be an upper age limit. • The developer responded, stating the age range was one of the most-contested issues on their technical expert panel (TEP). They said they started with an upper age range of 75 years based on randomized controlled trials available at the time. The age range was then expanded to 85 to align with the NCQA HEDIS measure. The developer said interventions for kidney disease have fewer benefits for those over the age of 85. They added that kidney function is a patient safety issue that is key to medication management. In addition, exclusions for frailty and hospice will help limit those who would not benefit. • The same Recommendation Group member said they still felt there should be no upper age limit.
Equity and Race	• A Recommendation Group member asked if racial profiling was relevant in eGFR. • The developer responded by saying the measure should drive equity in testing, and that the recent recommendation is to use only race-free eGFR. • Several Recommendation Group members felt that it may be beneficial to collect race and ethnicity data to be able to measure the impact the measure is having on subpopulations, as kidney disease disproportionately affects some minority groups.
Validity and Feasibility	• A few Recommendation Group members expressed concern that the validity testing was not strong in the two testing sites. Specifically, there was poor agreement for eGFR and uACR given small sample sizes. • The developer said that was one of the reasons why they changed how the test was verified as being completed was to capture urine concentration rather than uACR. The developer anticipates that validity can and should improve with retesting. • Several Recommendation Group members still expressed concern, stating this is a feasibility issue in addition to validity.

Additional Recommendations: Recommendation Group members expressed wanting the developer to explore reliability results for clinicians with small case counts and consider implementing a minimum case count (n>1). In addition, the Recommendation Group wanted the developer to conduct additional testing to assess numerator validity (given the poor agreement for eGFR and uACR) and feasibility.

CBE #3400 – Use of Pharmacotherapy for Opioid Use Disorder [The Lewin Group/Centers for Medicare & Medicaid Services (CMS)]

Specifications | Discussion Guide

Description: The Use of Pharmacotherapy for Opioid Use Disorder measure evaluates the percentage of Medicaid or Medicare-Medicaid participants, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage OUD during the measurement year.

Committee Final Vote: Endorsed with Conditions

Conditions: When the measure comes back for maintenance the developer should have:

- Explored the impact of patients in remission or who are on other forms of treatment on the performance results; and
- Assessed potential unintended consequences (e.g., discouraging use of other, non-pharmacological therapies) during implementation.

Vote Count: Endorse (8 votes; 44.44%), Endorse with Conditions (8 votes; 44.44%), Remove Endorsement (2 votes; 11.11%); recusals (0).

Public Comments: The measure received one supportive public comment prior to the meeting. The commenter also asked if the developer had looked at Medicare Advantage, as older populations have a higher incidence of overdose. The developer noted that results from older adults dual-enrolled in Medicaid and Medicare Advantage are presented within the Full Measure Submission form. Specifically, the over 65 age group and dual-eligible beneficiaries had much lower performance than their respective cohorts within the age and dual-eligibility status categories. Dual-eligible beneficiaries had a treatment rate of 8.3 percent versus a rate of 59.0 percent for non-dual eligible beneficiaries, while those over age 64 had a treatment rate of only 3.8 percent versus rates ranging from 36.6 percent to 65.9 percent for younger age groups.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Unintended Consequences	• Some Recommendation Group members expressed concern that the measure would diminish the patient-provider relationship and provider judgement, particularly if providers are overeager to perform well on the measure. • Others expressed concern around how this measure would account for patients who are in remission or are successfully using non-pharmacological approaches. • The developer emphasized that this measure is designed to evaluate one component of OUD, and that other measures exist to look at continuity of care as well as other components of managing OUD. They acknowledged that while medication-assisted therapy (MAT) is the gold standard of treatment, it will not be right for every patient, so the goal is not 100% compliance with the measure. Rather, the measure is intended be a starting point, giving states data on their performance for improvement and how they compare with other states across the country. The developer added that the measure, until now, has been optional for use and they anticipate receiving feedback from the Medicaid offices and clinicians on use

Discussion Topic/Theme	Recommendation Group Discussion
Unintended Consequences	and unintended consequences. The developer acknowledged the patient-physician relationship concern, adding that since this is a claims-based measure, they are only able to obtain data on items that are billable. Thus, it is not possible to assess the impact of this measure on patient-physician decision-making with these data alone. • A Recommendation Group member suggested a secondary or balancing measure that could potentially look at how the patients perceive their quality of care or counseling. • The developer said they would take this recommendation back to CMS and the Substance Abuse and Mental Health Services Administration (SAMSHA). • The Recommendation Group placed two conditions on the measure, which were to: 1) explore the impact of patients in remission or who are on other forms of treatment on performance results; and 2) assess potential unintended consequences (e.g., discourage use of other, non-pharmacological therapies) during implementation by measure maintenance in 5 years.
Harmonization	• One Recommendation Group member asked how the measure relates to the NCQA Initiation and Engagement of Substance Use Disorder Treatment (IET) measure. The developer said this state-level measure is complementary to the NCQA measure, which is a health plan-level measure.

Additional Recommendations: None were discussed.

Next Steps

Battelle staff shared that a meeting summary would be published by August 30, 2024. The appeals period will run from August 30 – September 20, 2024. If an eligible appeal is received, the appeals committee will meet on September 30, 2024 to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.