[SLIDE 1]

HOLST: Good afternoon, and welcome to our June Information Session, "Get a Clue About Measure Reviews: PRMR, MSR and E&M." My name is Haley von Holst, and I am the information session lead for the CMS Measures Management System (MMS) contract, supported by Battelle. Our presenters this afternoon, we have Mel Gross and Kim Rawlings with CMS, and then Anna Michie with Battelle today to dive into this topic.

[SLIDE 2]

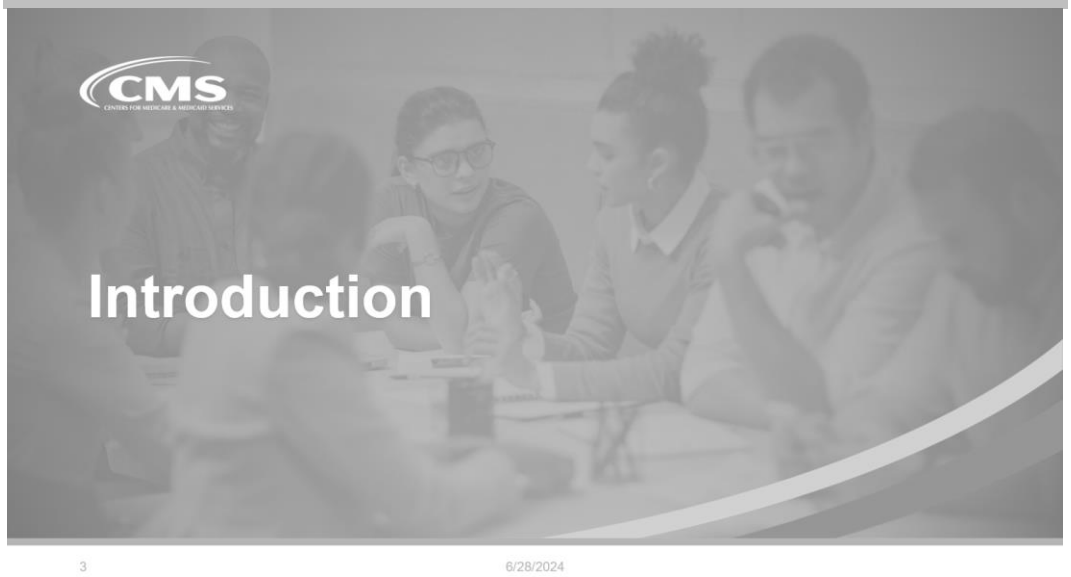
HOLST: So the purpose of today's webinar is to explain the similarities and differences in the goals and evaluation criteria for three distinct measure review processes, managed by the Centers for Medicare & Medicaid Services CBE. So we're going to describe the goals and evaluation criteria for Pre-Rulemaking Measure Review (PRMR), Measure Set Review (MSR) and Endorsement and Maintenance (E&M), and then we'll discuss the unique perspectives of PRMR/MSR, and E&M committees and what they apply during their review.

So if you'd like to download today's slides, they'll be available on the MMS Hub after the presentation. We will also post a recording of today's session on the MMS Hub in a few weeks.

So as part of the Measures Management System's outreach task, we produce these Information Sessions throughout the year to educate about quality

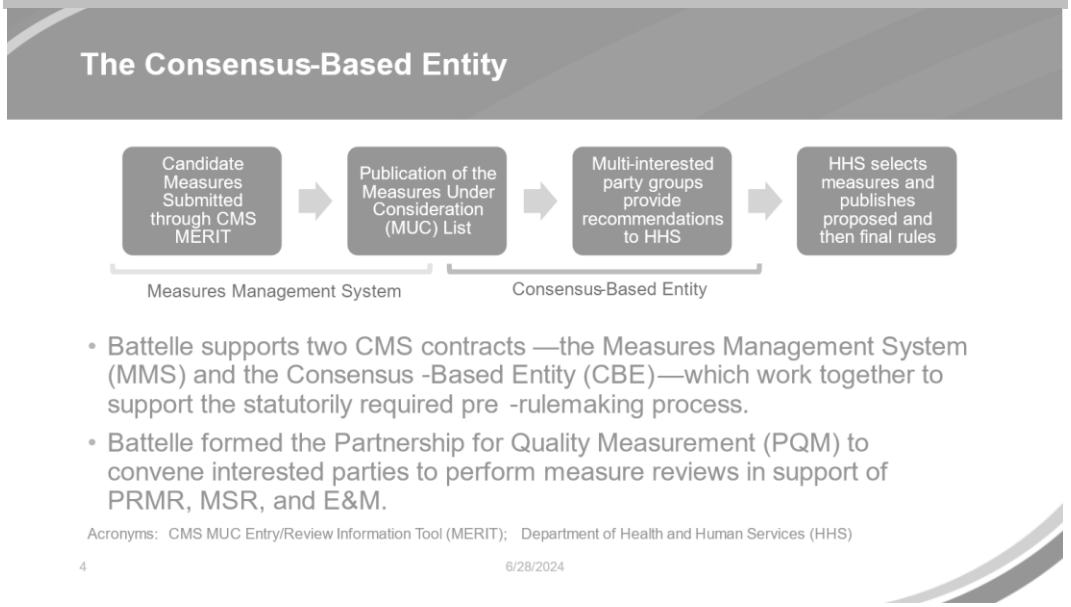
measurement topics and engage those interested in measure development and maintenance. I highly encourage you to submit questions throughout today's presentation using the Q&A feature near the bottom of your screen, and then we'll try to address as many as we can at the end of the presentation today. And with that, I will turn it over to our first presenter here, Anna, to further introduce our topic.

[SLIDE 3]



MICHIE: Thank you, Haley. So hello, everyone. My name is Anna Michie from Battelle. I'm the deputy task lead for the Endorsement and Maintenance (E&M) task. So I'll kick us off with a couple of introductory slides, and then I'll pass it off to Kim to talk about PRMR.

[SLIDE 4]

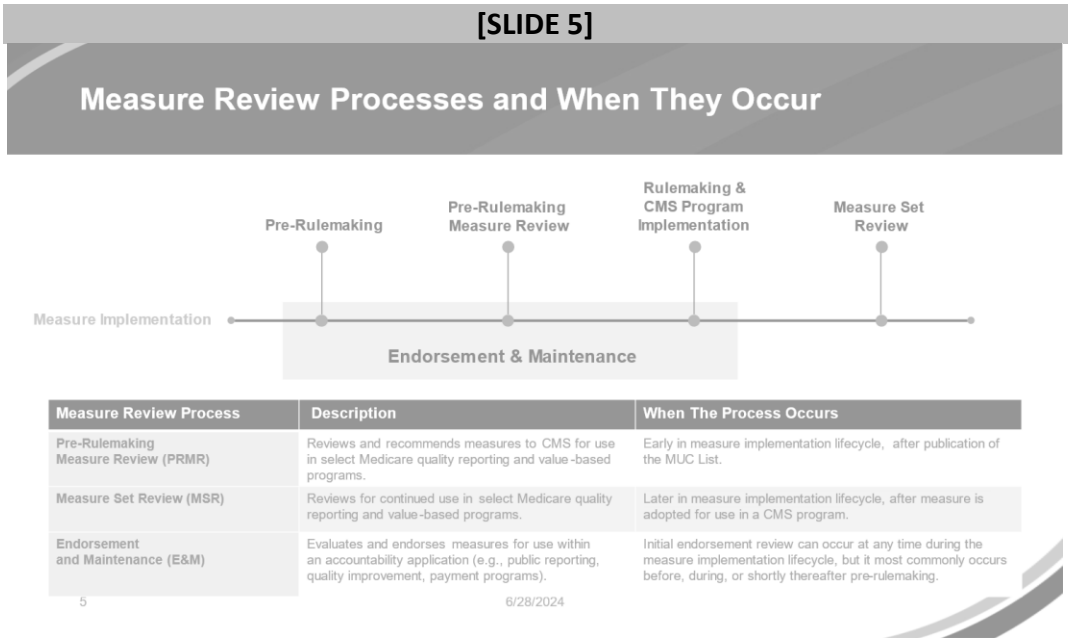


MICHIE: So Battelle supports two CMS contracts. First, since 2014 Battelle has served as the Measures Management contractor, overseeing the Measures Management System or MMS, which is a trusted source for quality measures and quality measure development and maintenance information. Since 2023, Battelle has served as a CMS-recognized consensus-based entity (CBE), bringing together members from across the healthcare and quality landscape who are interested in promoting meaningful quality measurement. The MMS and CBE teams worked together to support the statutorily required pre-rulemaking process shown on the graphic in this slide.

And to facilitate the execution of CBE tasks, Battelle formed the Partnership for Quality Measurement (PQM), which is comprised of all interested parties, including healthcare providers, patients and caregivers, measure experts, and health information technology specialists. As the CBE, Battelle manages the Pre-

Rulemaking Measure Review (PRMR) process, the Measure Set Review (MSR) process, and the Endorsement and Maintenance (E&M) measure review processes, sponsored by the Centers for Medicare & Medicaid Services (CMS).

[SLIDE 5]



MICHIE: The three measure review processes in today's presentation occur during the measure implementation phase when a measure progresses from the development state into an "active in-use" state. The review of quality and efficiency measures for use by the Department of Health and Human Services (HHS) in select Medicare quality reporting and value-based programs (VBPs) begins with pre-rulemaking, shown by the first milestone on this timeline.

A measure may then proceed to a Pre-Rulemaking Measure Review (PRMR) process. If selected for implementation, the measure will be proposed through federal rulemaking, and if finalized, implemented into the applicable CMS Medicare quality reporting or value-based program.

Measures implemented into these CMS programs are reviewed annually for continued use in the program as part of the Measure Set Review (MSR). The Endorsement and Maintenance (E&M) process evaluates and endorses measures for use within an accountability application, such as public reporting or payment programs. Accountability applications are not limited to CMS programs only. Measures can be submitted for initial endorsement review at any point in time, but submission occurs most commonly before, during, or shortly thereafter pre-rulemaking. Endorsed measures are reviewed every five years for maintenance.

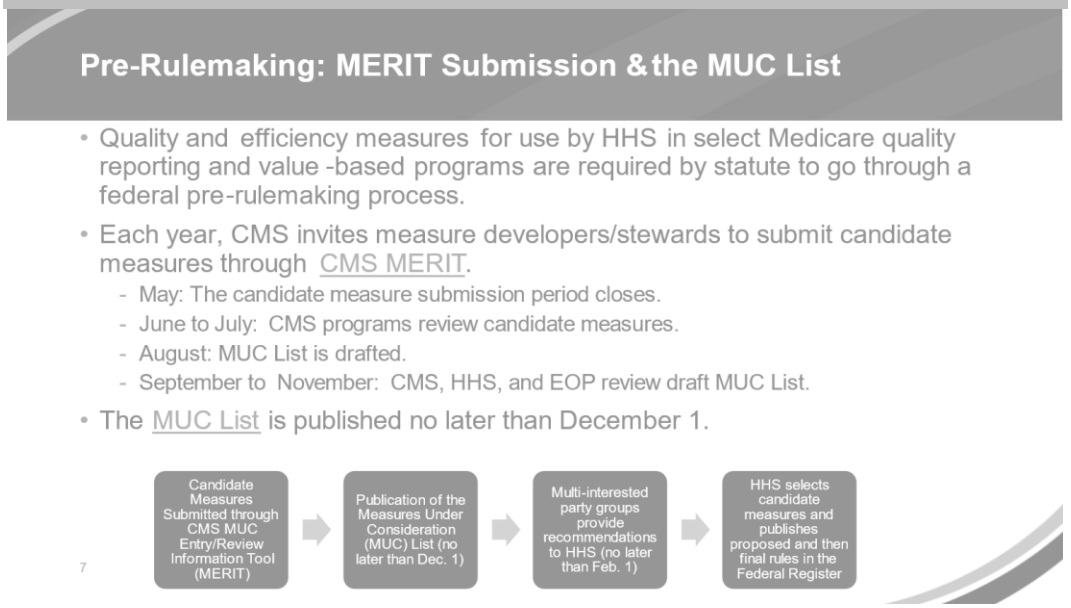
So then during today's webinar we'll review the PRMR, MSR, and E&M measure reviewed processes. I will now pass it off to Kim Rawlings from CMS to discuss PRMR.

[SLIDE 6]

RAWLINGS: Thank you, Anna. So yes, my name is Kim Rawlings and I work in the quality measures and value-based incentives group within the Center for Clinical Standards and Quality (CCSQ) at CMS. I am the lead of PRMR, the Pre-

Rulemaking Measure Review, as well as the lead of the CMS National Quality Strategy (NQS). So it's nice to kind of get in the weeds with measures here through this process, but then also have a little bit of a global outlook on things as well.

[SLIDE 7]



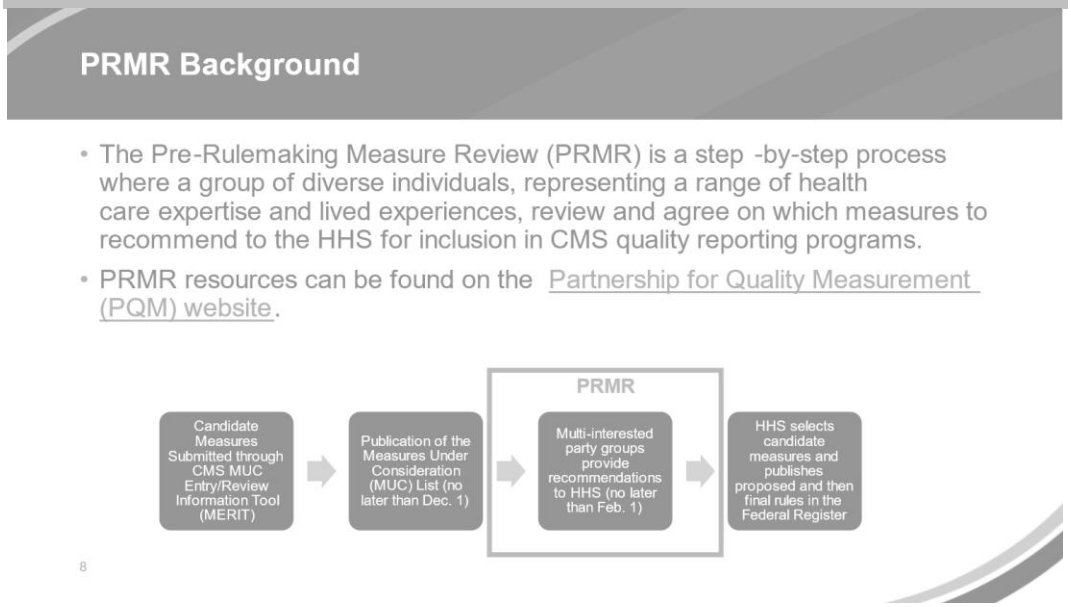
RAWLINGS: Before we jump into specifically talking about PRMR, I just want to like take a step back a little bit and set the stage, because there's a lot of work that comes before the measures get to PRMR. So first off, here with PRMR we are specifically talking about pre-rulemaking. It's a part of the pre-rulemaking process, and as such, only measures that are being proposed for Medicare quality reporting and value-based programs are required to go through the federal pre-rulemaking process, and so programs like the marketplace Quality Rating System (QRS), all of the various Medicaid Core Sets, et cetera, they do not need to go through this pre-rulemaking process and subsequently do not need to go through PRMR either.

As many of you probably know, each year CMS invites measure stewards to submit measures through our system, CMS MERIT, for consideration to go onto the MUC List. The period for that submission closes sometime in the May timeframe, and then our program and measure leads spend all of June and July really considering and looking at each of the candidate measures individually to see if it could be a good fit for the program, if it fills a gap, et cetera.

Then come time for August we have that list together of measures that we are considering putting into our program. It's drafted and then from September until November it goes through a review by, not only CMS and all of the various components of CMS, but also HHS as well as EOP, the Office of the Executive of the President. So they will all review the list. And then once it's gone through all of those reviews, it's published no later than December 1st. So you see that represented in that kind of second bucket there.

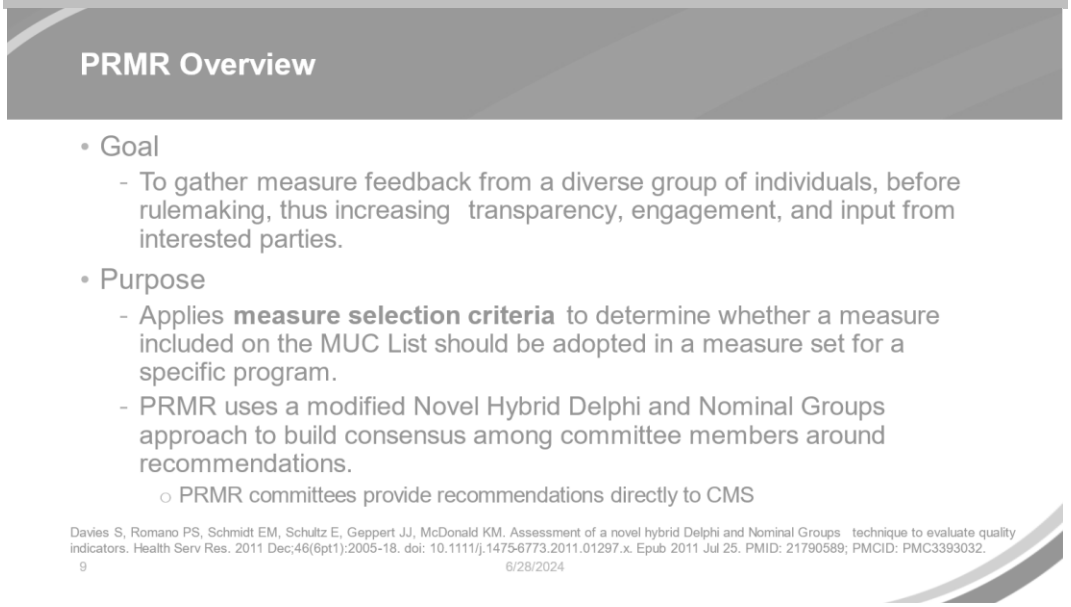
And then from there it goes per the statute, a multi-interested party group provides recommendations to HHS no later than February 1st. And then we take those candidate measures and propose the ones that we would like to propose in the rules.

[SLIDE 8]



RAWLINGS: So with this process PRMR is that third bucket. PRMR is the process by which the multi-interested party groups provide those recommendations to us. So it's really important, as with any sort of commenting and any sort of committee meeting, et cetera, that we really are getting feedback from a diverse group of individuals — not just individuals that receive care and give care and provide care, but also thinking about all of the national associations. Sometimes the health plans and sometimes EHR vendors can be on these committees, et cetera. So really just a whole host of folks to make sure that we get a lot of various interested parties represented at the table to be able to give that feedback. There are some resources that can be found specific to PRMR on the Partnership for Quality Measurement (PQM) website there.

[SLIDE 9]

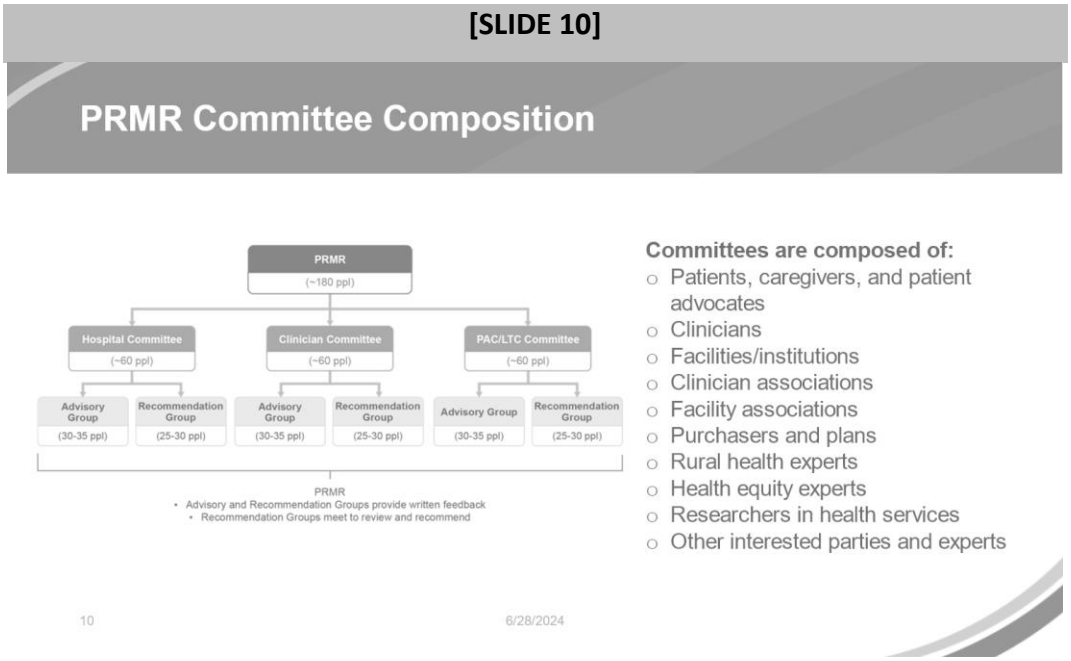


RAWLINGS: So the goal of pre-rulemaking is to get that added feedback before a measure goes into rulemaking. So then given that PRMR is a "piece" of the pre-rulemaking process, those goals align. So the goal for PRMR is really to gather that feedback, like I said, from a diverse group of individuals, organizations, et cetera. That way we just have an extra layer of feedback before rulemaking, which helps to increase transparency and engagement and helps us on the CMS end. It gives us more feedback and input as we're considering which measures to propose into the program.

So their purpose and their kind of direction is to apply the measure selection criteria that's been outlined, that everyone has had a chance to weigh in to apply that to each measure included on the MUC List, and make a recommendation on whether or not it should be adopted. As you can imagine, it can be challenging to hear all of those voices and have all of those voices kind of come to consensus. So the team has developed a modified process for the Novel Hybrid

Delphi and Nominal Groups — well, that's a mouthful! But in short, I'll go over it a little bit. It's a process that helps engage around 60 folks to help them weigh in on each of these measures, in addition to public comment more broadly.

[SLIDE 10]



RAWLINGS: So, as you can see here, this is the committee composition. As I mentioned, it's really important that this is a diverse group, and so we have patients, caregivers, advocates, other individuals receiving care, clinicians of all sorts, facilities, clinician associations and facility associations.

We do have a few purchasers and plans on it, but then it's also important that in addition to representing these different parties and their perspectives, that we also have "experts" in the room as well. So really looking to try and bring in experts that have the perspective of overall health and how the measures can impact those communities, as well as health equity and looking at health disparities. Is a particular measure going to advance health equity, or is it going

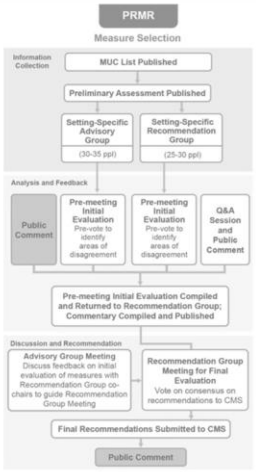
to increase the prevalence of disparities? And then different, you know, researchers and health services, et cetera.

So PRMR as a whole has around 180 individuals. They are split up between three committees — a hospital committee, a clinician committee, and then the post-acute care (PAC)/long-term care (LTC) committee as well, each having about 60 individuals. So again, a lot of feedback for each of these measures.

And then, furthermore, within each committee we have an advisory group, and we have a recommendation group. The advisory group, their purpose is to really work on providing written feedback and really guiding the discussion that the recommendation group is going to have. Then as we get closer to that February timeframe, the recommendation group will discuss the measures, and they will be the ones that will vote.

[SLIDE 11]

PRMR Process and Timelines



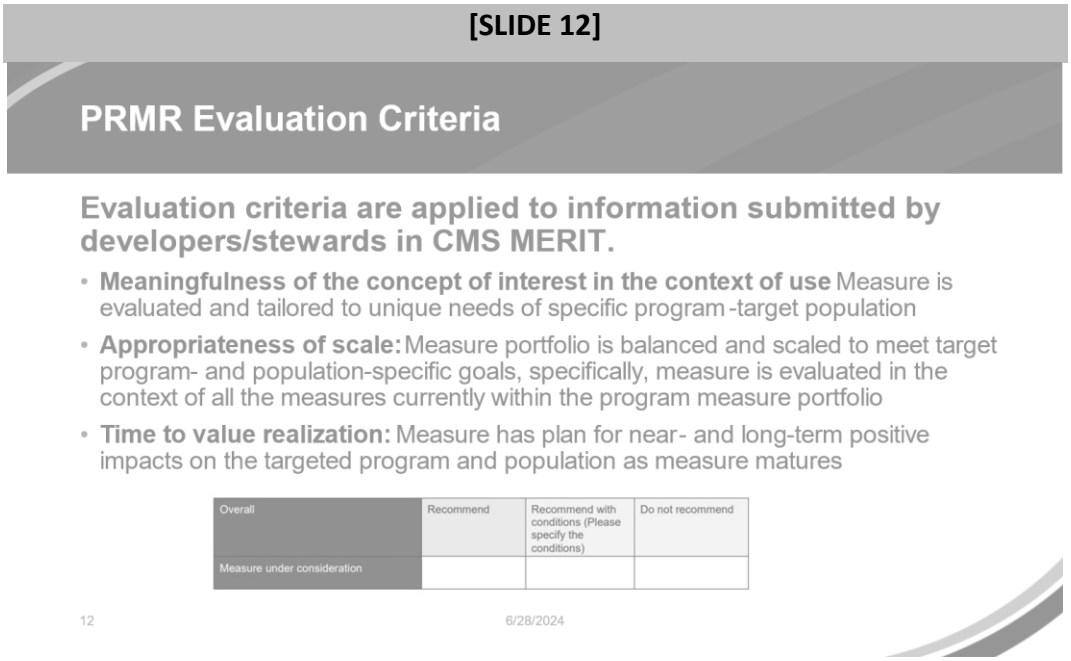
Month	Dec	Dec	Dec	Dec	Jan	Jan	Jan	Jan	Feb
Weeks	1	2	3	4	1	2	3	4	1
CMS releases MUC List; the public comments on MUC List	X	X	X						
PRMR committees provide written feedback (PIE)	X	X	X						
CMS and Battelle host listening sessions to facilitate Q&A and public comment		X							
Battelle synthesizes feedback from public comment and PIE			X	X	X				
Advisory Group meetings					X				
Recommendation Group meetings						X	X		
Battelle publishes PRMR recommendations spreadsheet								X	

Note: The process and timeline graphics above represent proposed changes from the 2023 process that may shift before the finalization of the 2024 PRMR/MSR Guidebook in July.

6/28/2024

RAWLINGS: So here you can see some of the specifics. I won't go into a bunch of detail here, but essentially, it's an overview of the process as well as the timeline. There's a lot that happens between December 1st and February 1st when the recommendations to HHS are statutorily mandated, but the important thing to note here is that we have two opportunities for public comment, the first of which is approximately three weeks long. And then we're getting feedback from 180 people, around 60 people for each measure. So it's a ton of feedback both in writing, as well as in the discussion to really help make great recommendations to us as we consider whether to move forward with some of these measures.

[SLIDE 12]



RAWLINGS: And just to have a kind of quick peek here, PRMR is unique in the sense that the evaluation criteria is really around "is this measure appropriate for the program that the measure steward proposed it for?" So we're not necessarily looking at the specifics with the science, or "is this a good measure overall?" It's really about "is this measure a good fit for this program?" So really

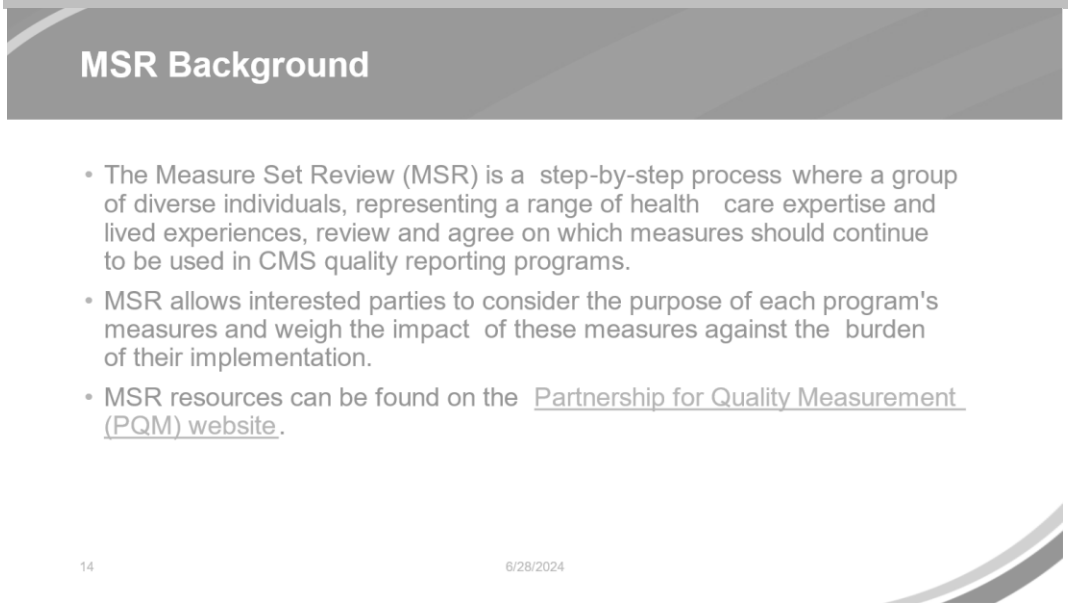
looking at the concept and the context in which that program will be used, and is it tailored to fit the needs of a specific population that that program is targeting.

Also, looking at the appropriateness of scale. So kind of looking overall at the measure portfolio of that program that it's being suggested to, and then how is that measure going to fit within that portfolio? And then also time to value realization, and so really looking at the short and long-term positive impacts on the targeted program and population that the measure is measuring, as the measure continues to mature and making sure that there are no unintended consequences there. And I think with that, I'm going to turn it over to Mel to talk about the Measure Set Review (MSR).

[SLIDE 13]

GROSS: Thank you, Kim. Hi, everyone. Thank you for joining today. I also work in the same area as Kim, so I'm in QMVIG and in CCSQ as well. So I usually go by "Mel," but you'll usually see my email as "Melissa," but you can call me "Mel." I am the new task lead for the Measure Set Review (MSR) process.

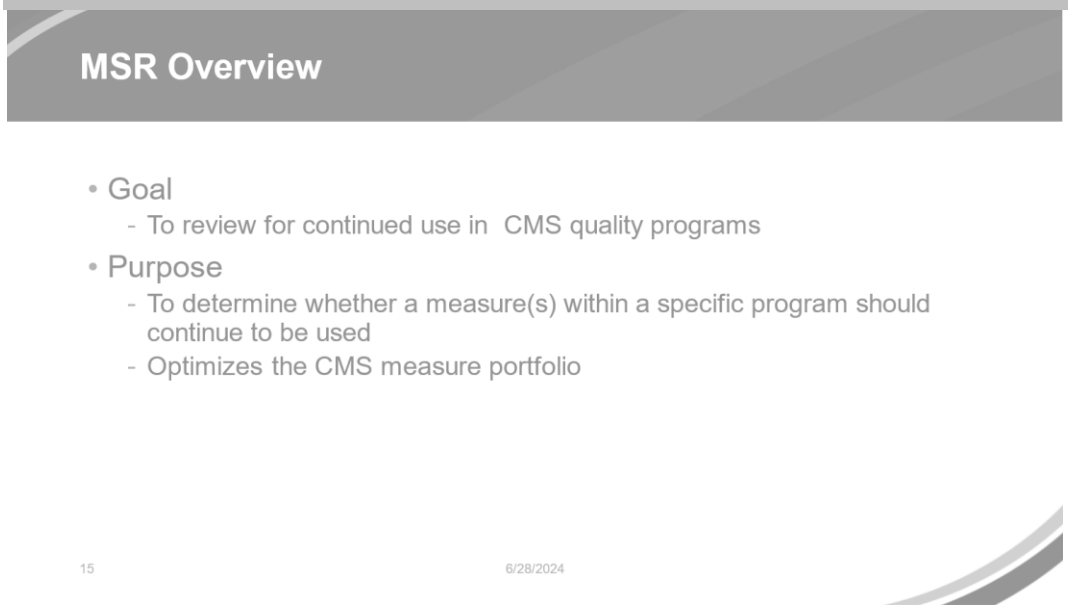
[SLIDE 14]



GROSS: Okay, so the Measure Set Review (MSR) background. It's a step-by-step process where a group of diverse individuals representing a range of healthcare expertise and lived experiences review and agree on which measure should continue to be used in CMS quality reporting programs (QRPs). So it's also a part of the entire review process that the CBE does as a whole. So it continues on that process of reviewing the measures within CMS quality reporting programs (QRPs).

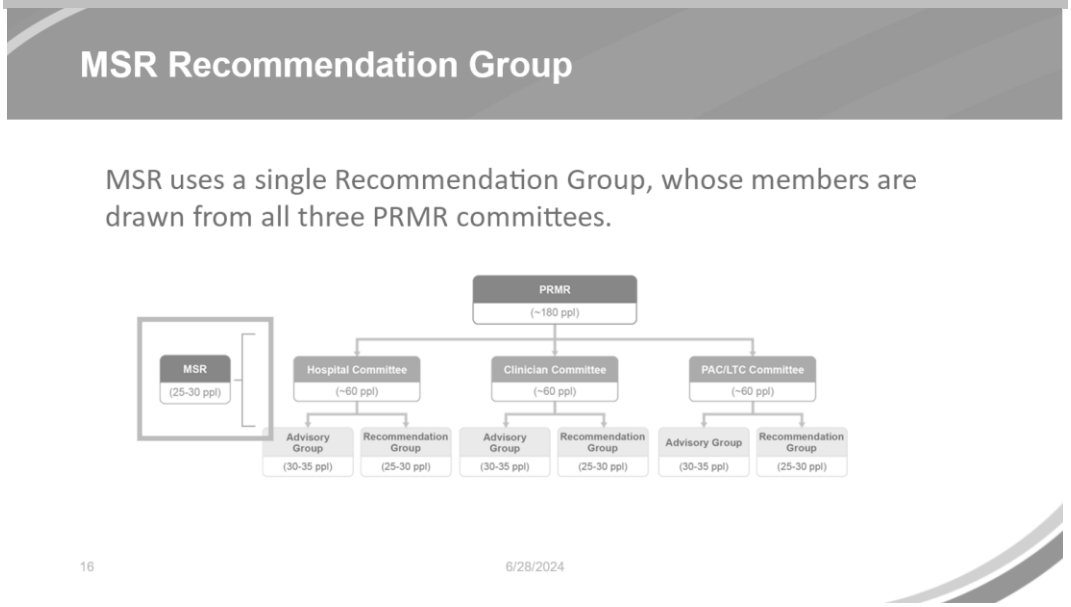
MSR allows interested parties to consider the purpose of each program's measures and weigh the impact of these measures against the burden of their implementation. So making sure that they're in a good place in the program, and that they're appropriate. I'm sure we already shared this, but you can always find more information on the Measure Set Review (MSR) resources on the Partnership for Quality Measurement or PQM website.

[SLIDE 15]



GROSS: So the goal of the MSR or Measure Set Review process is to review the CMS quality program measures for continued use. So ultimately, it helps us to optimize our CMS measure portfolio, and it just helps us to determine whether a measure in a specific program should continue to be used and if it still makes sense for that program.

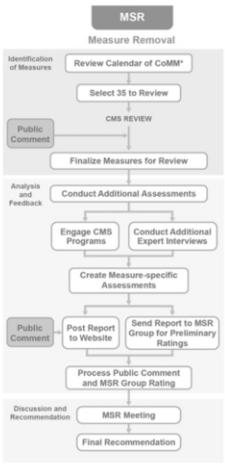
[SLIDE 16]



GROSS: So we already discussed the recommendation groups for the PRMR committees. The MSR recommendation group is a little bit different in that it takes the people that are in these other committees. It takes a subset of those, and there is a 25-30 recommendation group total for this process. It's not as large as PRMR, but it's a subset of those same groups.

[SLIDE 17]

MSR Process and Timelines



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Battelle conducts internal review of the Cascade priorities and consults committee members to identify measures for MSR	X	X	X	X				
Public comments on measures initially identified for MSR review; Battelle and CMS finalize list of measures				X	X			
Battelle conducts measure evaluation (specific outreach with CMS program/measure leads, internal analyses, ad hoc expert interviews)				X	X			
Battelle develops PAs					X	X		
Public comment on PAs						X	X	
Measure Set Review: Recommendation Group meeting							X	X
Battelle submits final recommendations on MSR to CMS								X

Note: The process and timeline graphics above represent proposed changes from the 2023 process that may shift before the finalization of the 2024 PRMR/MSR Guidebook in July.

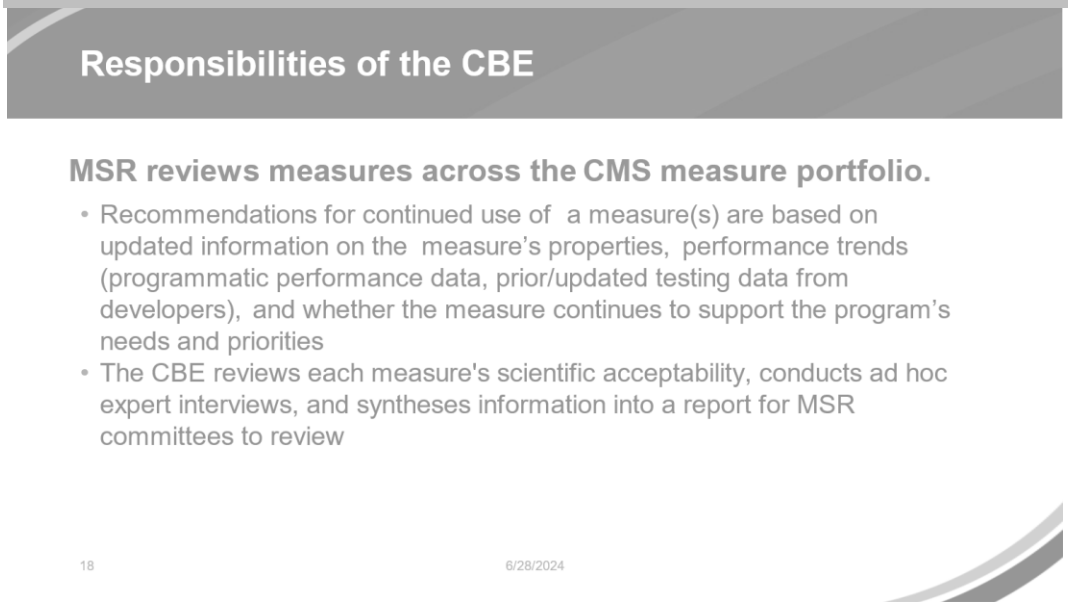
6/28/2024

GROSS: You also saw a similar timeline for PRMR. So for MSR we're actually in the process right now. So I'll go through a little bit of this, but the Measure Set Review (MSR) looks at the Cascade of Meaningful Measures as a start to identify the measures that are going to be in the 35 measures to be reviewed. That goes through a public comment period. CMS is given a chance to review and look at those measures as well. And then we move into a process, once we've finalized which measures are going to be on the list. We then move into an analysis phase, and there are assessments that are created and an analysis of those measures are shared. That also goes through a public comment period as well.

So, aside from that, we're kind of in this middle section, this orange section of "analysis and feedback." So, if you look to the right, we've already established the measures that are going to be on the list. So right now, if you look down on this right graphic, we've already received public comment and now are doing a development of the preliminary assessment. So we're in this June-July

timeframe, and those preliminary assessments will go through public comment again in July. And then we'll have the MSR meeting in the fall.

[SLIDE 18]



GROSS: So the recommendations for continued use of a measure are based on updated information on the measures' properties, performance trends, programmatic performance data, prior or updated testing data from developers, and whether the measure continues to support the program's needs and priorities. The CBE reviews each measure's scientific acceptability, conducts ad hoc expert interviews and synthetizes the information into a report for the MSR committees to review.

[SLIDE 19]

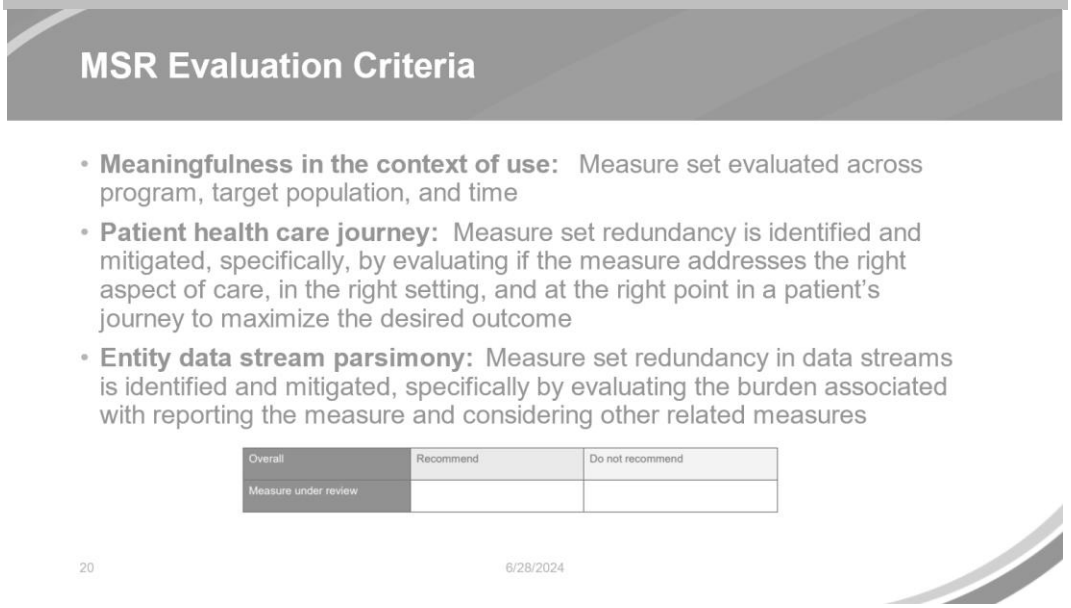
GROSS: So going back to what we were discussing for the selection of measures, what the CBE uses is the Cascade of Meaningful Measures, which it helps to prioritize the measures. So they've kind of organized it by three cycles, but Battelle ultimately aims to strategically consider all measures used in CMS quality programs for MSR over the course of a five-year period. They want to make the MSR process more manageable, and the portfolio has been divided into three different cycles using that Cascade as a guide.

And for those of you who are not familiar, the Cascade of Meaningful Measures is a tool to help prioritize existing healthcare quality measures, to help align or reduce the number of measures, to identify where there are gaps, or where there is a need for measures to be developed. Every MSR cycle Battelle proposes a set of measures across programs and populations within a select Cascade priority for review. The selection of a Cascade priority may be informed by conversation with key interested parties, such as the PRMR committee

members, CMS, and other national policymakers, and through environmental scans from conferences and other national healthcare priority activities.

So this approach manages the volume of measures under review for each cycle, and you can see in this house graphic here, person-centered care, safety, chronic conditions, seamless care coordination, equity, affordability and efficiency, wellness and prevention, and behavioral health. Right now we are using Cycle C and are in the "affordability and efficiency" for this year's measure review.

[SLIDE 20]



GROSS: So the evaluation criteria for MSR. "Meaningfulness in the context of use." So measure sets are evaluated across programs, target populations and time. When measures are initially added to the programs, the decisions to add them are supported by evidence that the measure is meaningful and necessary to yield a positive benefit.

"Patient healthcare journey." The patient journey through the healthcare system can be defined in various ways; for example, patient experience of care, patient outcomes and patient wellness. Some of the measures may impact the patient at the population level, while others might be more impactful on vulnerable populations. So the purpose of this criteria is to determine if the measure set is implemented across the patient journey in a manner consistent overall.

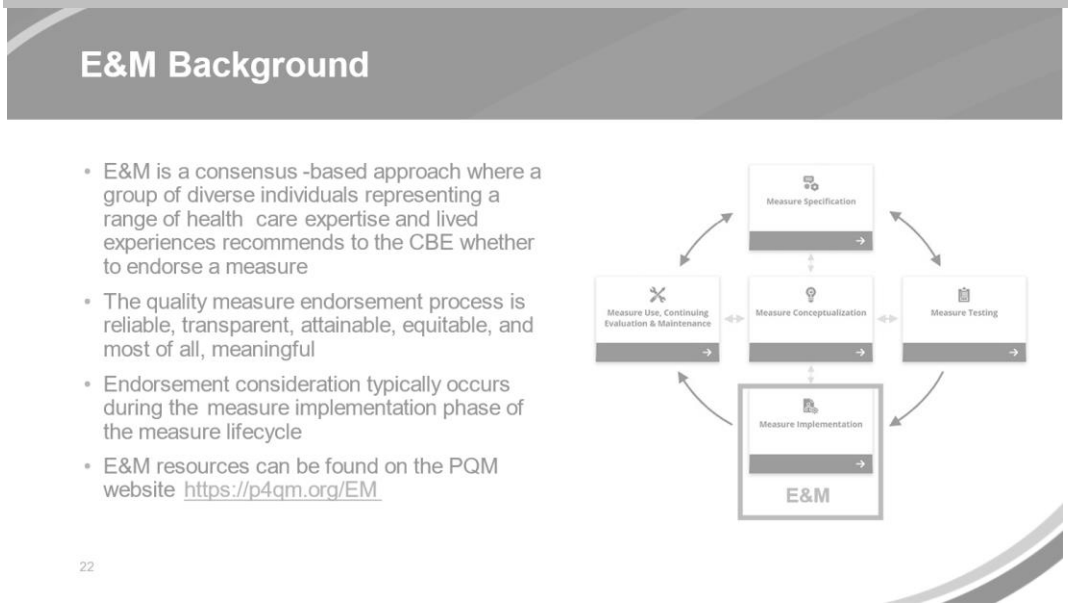
Then there's "entity data stream parsimony." Measures individually may be determined to be feasible to collect and report quality data, and the benefit of such data collection and reporting may exceed the burden. However, if a set of measures within a program do not align well — such as a slight difference in age ranges, differences in the target population, the data source or the reporting mechanism — this can contribute additional burden to the reporting entity. So the purpose of this criteria is to identify and mitigate measure set redundancies and burden.

So unlike the PRMR process, MSR requires a simple majority of greater than 50% to arrive at a voting outcome, and that's either to recommend or do not recommend the measure to be retained. The higher consensus standard for PRMR is applied, because decisions to include measures in quality programs have the potential to add burden to persons and entities. So this is not the case for MSR. All right, I think that is all for MSR that we have today. I will be passing it to Anna.

[SLIDE 21]

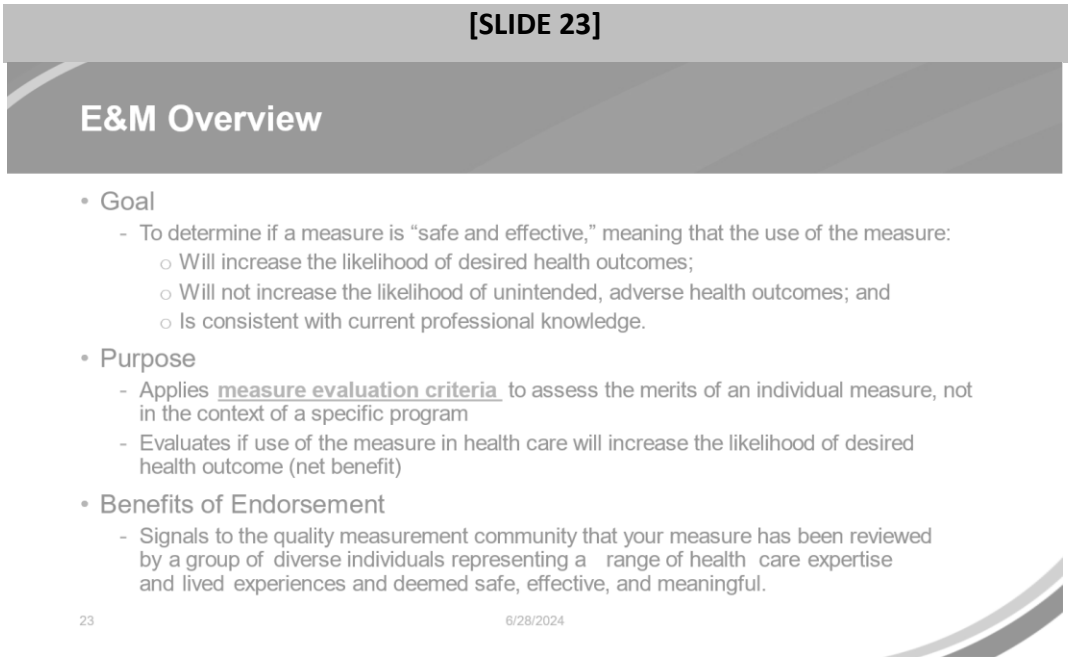
MICHIE: Thanks, Mel. Hello, everyone. Okay, so let's review the Endorsement and Maintenance (E&M) process.

[SLIDE 22]



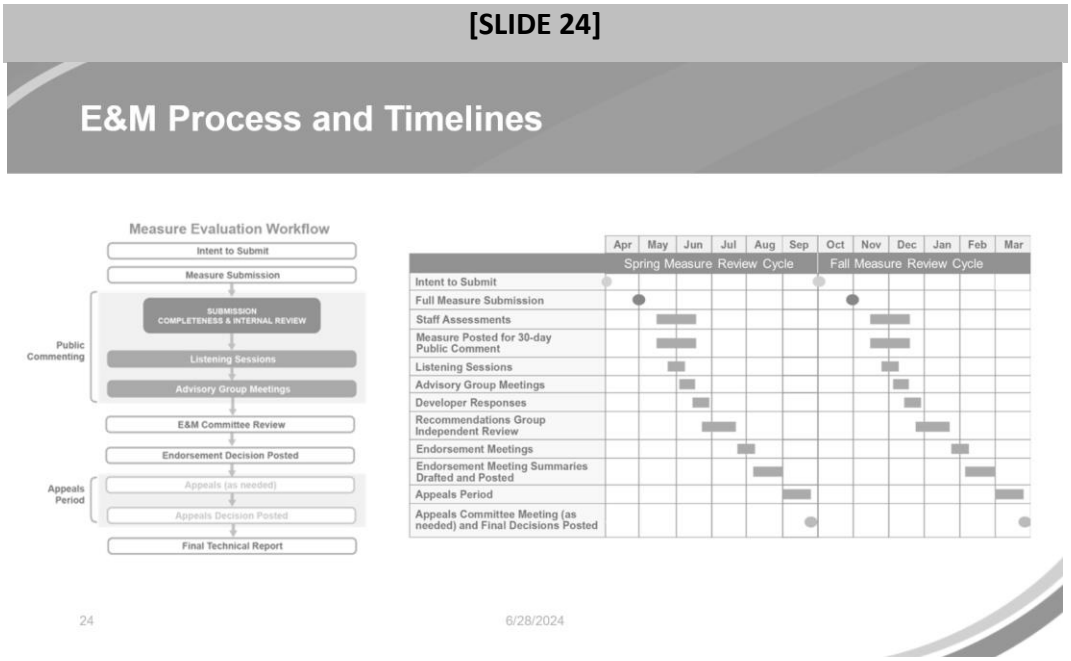
MICHIE: So the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requires the Department of Health and Human Services (HHS) to contract with the CBE regarding performance measurement. The CBE reviews and endorses quality measures through a transparent, consensus-based process, incorporating feedback from interested parties to foster healthcare quality improvement. So the Endorsement and Maintenance (E&M) process typically occurs during the measure implementation phase of the lifecycle and gathers measure feedback, again from a group of diverse individuals representing a range of healthcare expertise and lived outcomes. E&M uses a consensus-based approach designed to be reliable, transparent, equitable, attainable and meaningful. Again, a variety of endorsement maintenance resources including the E&M guidebook and the measure evaluation criteria can be found on this link on this slide for the PQM website.

[SLIDE 23]



MICHIE: So the ultimate goal of E&M is to determine if a measure is safe and effective, meaning that the use of the measure will increase the likelihood of a desired health outcome, will not increase the likelihood of unintended adverse health outcomes, and is consistent with current professional knowledge. So the E&M process applies measure evaluation criteria to assess the merits of an individual measure, not in the context of a specific CMS program. E&M evaluates if the use of a measure in healthcare will increase the likelihood of desired health outcomes. One of the key benefits of measure endorsement is that it signals to the quality measurement community that your measure has been deemed safe, effective, and meaningful after being reviewed by a diverse group of individuals.

[SLIDE 24]

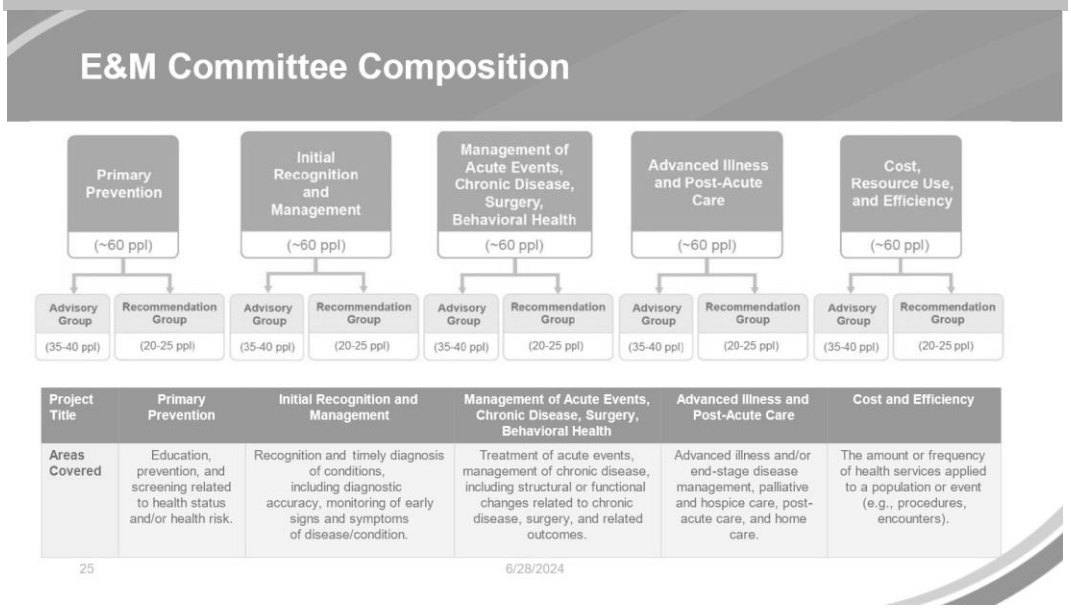


MICHIE: The E&M cycles are designed to be six months each without overlap. So we hold one cycle in the spring which spans from April to September, and another in the fall which spans from October through March. There are six major steps in the E&M process.

So each cycle begins with “intent to submit” where measure developers will provide some basic information about their measure, such as their measure specifications and the level of analysis. And then about a month later, measure developers will then provide the full “measure submission” which includes information about measure importance and evidence, testing, and the intended use of the measure. From there the Battelle team will conduct completeness checks which is a process we use to ensure that the application is complete, that the attachments were submitted correctly, and all of the applicable information is showing in the application.

Shortly thereafter there will be a public comment period which consists of an opportunity to provide both written feedback, as well as verbal feedback, during a public comment “listening session.” We then hold meetings to collect feedback directly from advisory group members, and this feedback along with public comments is summarized and provided to the recommendation group, who then provide written measure feedback and vote on an endorsement decision during the recommendation group meetings later in the cycle. There is an opportunity for appeals toward the end of the cycle, and it concludes with a “final technical report.”

[SLIDE 25]



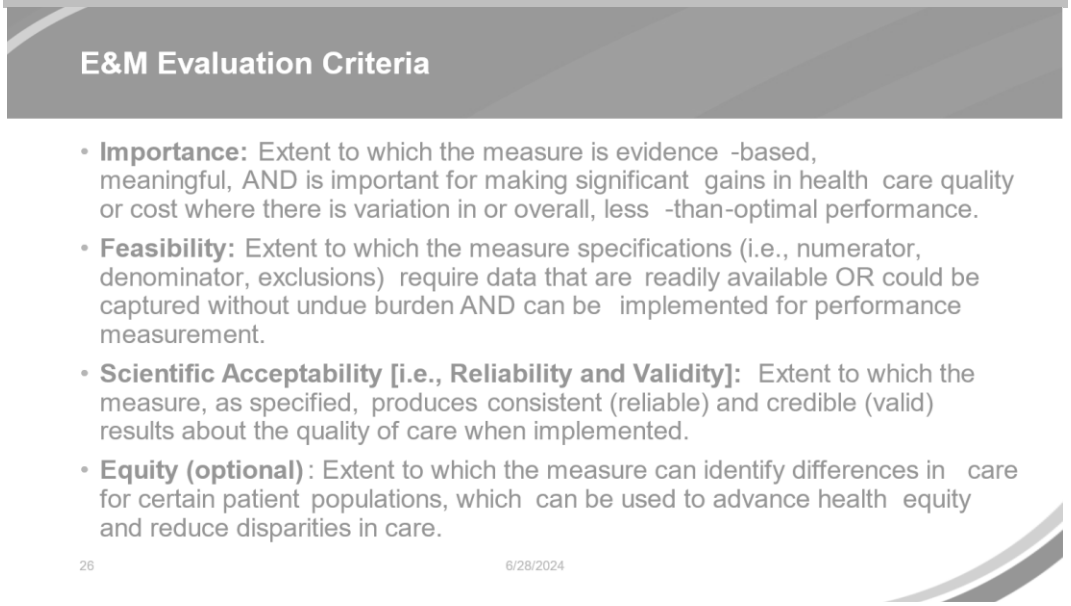
MICHIE: So similar to PRMR and MSR, E&M committees are composed again of a diverse group of individuals representing all facets of the healthcare system, including patients and caregivers and clinicians, facilities, purchasers, rural health and health equity experts, other interested stakeholders, policymakers and health services researchers. Measures for E&M are organized into five project topical areas shown here on the screen, and so primary prevention, initial recognition and management, management of acute events in chronic conditions, advanced illness and post-acute care (PAC), and cost and efficiency.

Measures are assigned to these projects based on similar topics and where the measure has the most relevance in a patient's journey throughout the healthcare. Each E&M project has a committee that's further divided into an advisory group and into a recommendation group, and that really helps to maximize member engagement and produce consistent application of the evaluation criteria. So the advisory group reviews measures and provides

feedback to ensure a larger number of voices that contribute to the consensus-building process, and the recommendation group is the endorsement voting body of the committee.

So prior to the endorsement meetings, the recommendation group again reviews and provides ratings and written comments on measures, taking into account feedback and questions from the advisory group, public comments, and responses from measure developers and stewards. During the endorsement meeting the recommendation group discusses the measure and then votes on an endorsement decision.

[SLIDE 26]



MICHIE: So the evaluation criteria that's used for E&M consists of five domains. That's importance, feasibility, scientific acceptability, equity, and use and usability. The first domain is "importance," and that looks at the evidence base for a measure. It evaluates if there's a business case, meaning that the existence

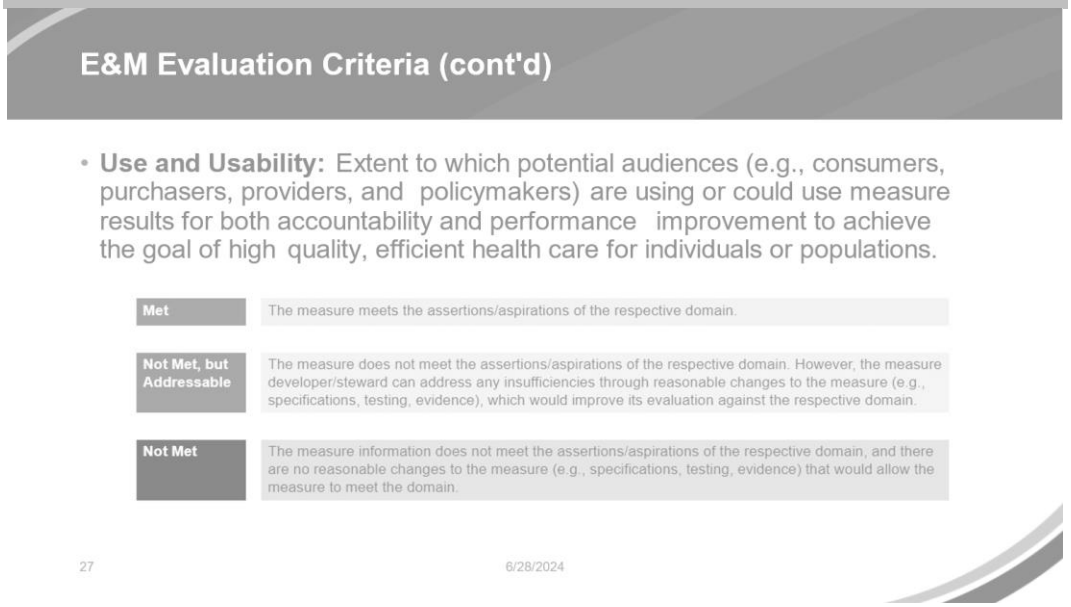
and the use of the measure leads to a beneficial outcome and is supported by evidence. The importance domain also looks at variation and less than optimal performance of the accountable entity, indicating a need for the measure. Finally, the importance domain considers whether the patient population finds the measure meaningful.

The second domain is "feasibility." Feasibility is looking at the extent to which the measure specifications can be used and implemented without undue burden and for performance measurement. So this domain reviews whether the data used to calculate the measure are readily available, and if collecting the data is not too far outside of the process of care.

The third domain is "scientific acceptability," which consists of reliability and validity. So reliability is looking at the extent to which the measure as specified produces consistent results, and validity is looking at the extent to which the measure as specified is credible, and the score is a true reflection of the quality of care when implemented.

The fourth domain is "equity," and that looks at the extent to which a measure can identify differences in care for certain patient populations, and can be used to reduce disparities in care and advance health equity, and so this is currently an optional domain.

[SLIDE 27]



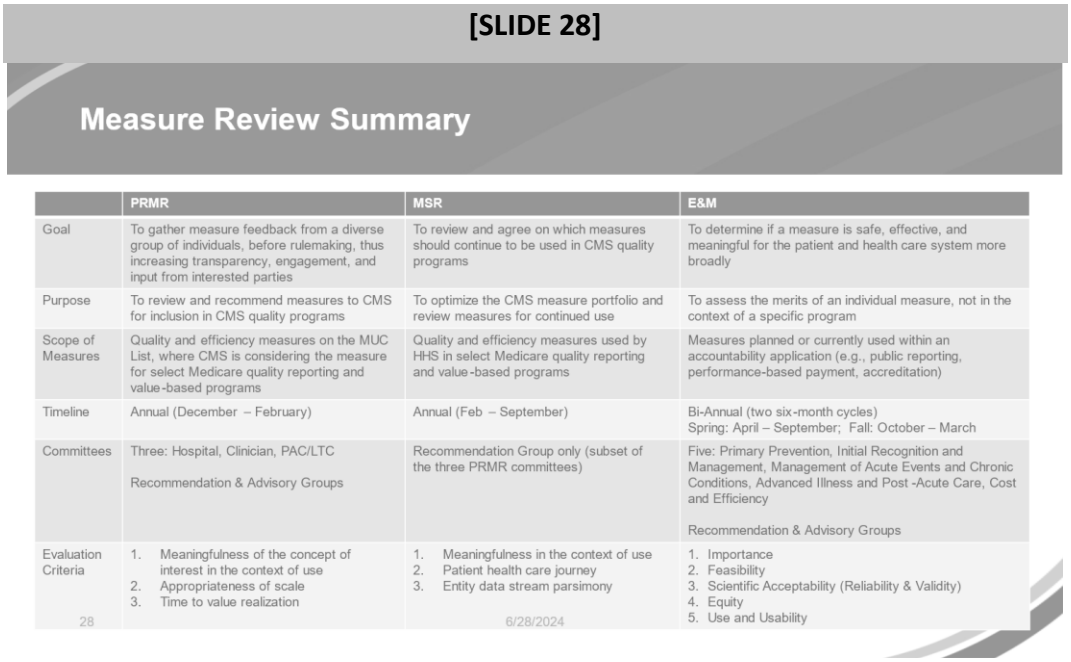
MICHIE: So the final and fifth domain is "use and usability," which looks at the extent to which audiences such as consumers and providers and policymakers can use the measure results for accountability and performance improvement. So accountability applications use measure performance results to make judgments and decisions based on performance. So this can be confidential reporting for reward or recognition, payment or selection. So it's accountability applications such as public reporting or for accreditation or performance-based payment, or for network inclusion or exclusion. If a measure is new and submitted for initial endorsement, the use and usability domain is looking to see that there's a plan for using the measure in the near future. If the measure is used, are there improvements that are happening over time, or are there any unintended consequences?

The five domains are scored individually as "met," meaning that the measure meets the assertions of the respective domain; "not met but addressable,"

meaning the measure does not meet the assertions of the domain, but that the developer can address insufficiencies through reasonable changes to improve the evaluation against the criteria, and then "not met," which means that the measure does not meet the domain assertions and there are no reasonable changes that would allow for the measure to meet the domain.

So Battelle staff and E&M committees apply the measure evaluation criteria to evaluate these five measure properties, and ultimately the recommendations group discuss and recommend to CBE whether to endorse the measure.

[SLIDE 28]



Measure Review Summary

	PRMR	MSR	E&M
Goal	To gather measure feedback from a diverse group of individuals, before rulemaking, thus increasing transparency, engagement, and input from interested parties	To review and agree on which measures should continue to be used in CMS quality programs	To determine if a measure is safe, effective, and meaningful for the patient and health care system more broadly
Purpose	To review and recommend measures to CMS for inclusion in CMS quality programs	To optimize the CMS measure portfolio and review measures for continued use	To assess the merits of an individual measure, not in the context of a specific program
Scope of Measures	Quality and efficiency measures on the MUC List, where CMS is considering the measure for select Medicare quality reporting and value-based programs	Quality and efficiency measures used by HHS in select Medicare quality reporting and value-based programs	Measures planned or currently used within an accountability application (e.g., public reporting, performance-based payment, accreditation)
Timeline	Annual (December – February)	Annual (Feb – September)	Bi-Annual (two six-month cycles) Spring: April – September; Fall: October – March
Committees	Three: Hospital, Clinician, PAC/LTC Recommendation & Advisory Groups	Recommendation Group only (subset of the three PRMR committees)	Five: Primary Prevention, Initial Recognition and Management, Management of Acute Events and Chronic Conditions, Advanced Illness and Post-Acute Care, Cost and Efficiency Recommendation & Advisory Groups
Evaluation Criteria	1. Meaningfulness of the concept of interest in the context of use 2. Appropriateness of scale 3. Time to value realization	1. Meaningfulness in the context of use 2. Patient health care journey 3. Entity data stream parsimony	1. Importance 2. Feasibility 3. Scientific Acceptability (Reliability & Validity) 4. Equity 5. Use and Usability

MICHIE: So we have covered a lot of content for PRMR, MSR, and E&M. So the purpose of this slide is just a quick reference to highlight the key differences in each of the three measure review processes and to summarize the key points. So, in summary, PRMR is the annual process used to evaluate, or used to review measures on the MUC List and to recommend measures to CMS for inclusion in

CMS quality and value-based programs. PRMR is statutorily required under Section 3014 of the Patient Protection and Affordable Care Act (PPACA).

MSR is statutorily enabled by the Consolidated Appropriations Act and reviews measures again annually to optimize the CMS measure portfolio, and to agree on which measures should continue to be used in CMS quality and value-based programs (VBPs). Finally, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 statutorily required HHS to contract with CBE regarding measure performance, and so Battelle as the CBE facilitates the Endorsement and Maintenance (E&M) process, which again offers two cycles per year where developers and stewards can submit measures for assessment to determine if they are safe, effective and meaningful, for the patient population and healthcare system more broadly. So again, E&M reviews measures planned or currently used within an accountability application and is not limited to CMS programs. Okay, and so with that I will pass it off to Haley to walk us through any questions that we've received.

[SLIDE 29]

Q: "Can developers repurpose or leverage documentation submitted for the MUC List reviewed during PRMR for E&M?"

MICHIE: Absolutely, there are some instances where there's similar content across applications that measure developers can leverage for both the MUC List and for E&M submission; for example, information about measure evidence like clinical practice guidelines and peer-reviewed literature that support the measure's importance and testing information, so performance scores, reliability and validity. So I'll just note to remember to tailor your content within each application appropriately. So keeping in mind again that the focus for PRMR is when a measure is used within a specific Medicare quality or value-based program (VBP), and that E&M is accessing the measure more broadly to determine if they are safe, effective, and meaningful for the patient population and healthcare system more broadly.

Q: "Can a measure be reviewed by PRMR if it is not endorsed?"

RAWLINGS: The short answer is yes, but there is a *but*. So oftentimes the measures on the measures under consideration (MUC) list that have been reviewed by PRMR and previous processes, they have not gone through the endorsement process. When that happens, typically it causes or has kind of the ripple effect of the committee members really focusing on looking at the measure fundamentally and thinking about the measure science and "is this measure reliable?" Is it valid, et cetera?" Really focusing on those aspects of it.

When really with PRMR, in our ideal kind of conversation we would really be focusing on "does the measure meet the unique needs of the program?" So when a measure is not endorsed, it tends to again be a slightly different conversation, and it tends to be a lot more nuanced, more technical, et cetera. Our hope is that given the new Endorsement and Maintenance (E&M) process and the fact that it's only six months to get a measure endorsed — and there's an Endorsement and Maintenance (E&M) cycle that nicely aligns with PRMR, and the MUC List submission and everything — our hope is that we will see an increase in the number of measures that are endorsed and have gone through the endorsement process prior to being discussed by PRMR committees.

Q: "So is there any overlap in the individuals who serve on the PRMR, MSR, and E&M committees?"

MICHIE: So Battelle conducts a formal nomination process each year to select individuals to serve on those committees for PRMR, MSR, and for E&M. So when submitting their nominations individuals can indicate a preference to sit on PRMR, MSR, E&M, or on both, but we really strive to ensure a diversity of

individuals across committees. So we try to avoid instances where one individual is serving on PRMR, MSR, and E&M at the same time, but overlap is not prohibited and sometimes it occurs.

Q: "So could you explain the relationship or level of alignment between criteria used for PRMR vs. CBE review and how that relates to the CMS Quality Measure Index (QMI)?"

RAWLINGS: As we're taking the measures through all of these different processes and getting feedback on them, we do want to first and foremost be transparent about what the criteria are, but then also be aligned. That way it's very clear as to the threshold that the measure steward needs to meet in order to do well, and then to create a good quality measure.

So if we're thinking about the processes, again they're looking at different things, and as such they have criteria that overlap and are in sync with one another, but I wouldn't necessarily say that it's the exact same criteria because they're looking at different things. So if we're thinking about PRMR, then we're talking about the appropriateness of that measure for a particular program. "Does the measure meet the unique needs of that population?" Really evaluating it in the context of the measures, the other measures in the program, and then looking at the impact that that measure could have in the short and long-term.

E&M and QMI I think are very much aligned both in goal and subsequently their evaluation criteria. Both of these processes are looking at the measure in and of itself and asking the question of "is this a good quality measure and is it aligned?" I'm sorry, not aligned. "Is it scientifically acceptable? Is it going to fill a gap? Is there that importance, that need to have the measure, et cetera?"

I think where the QMI tends to differ a little bit is that QMI is specific for CMS measures, and so we do have some evaluation criteria around agency priorities and whether or not they meet our agency priorities.

And then lastly, MSR. MSR is for measures that have actively been used in CMS programs, and so we go back then to it being program-specific and looking at performance of the measure and evaluating it on that front. E&M, as Anna mentioned, is ongoing in the sense that there is the opportunity to kind of renew that endorsement status. So it's not this once and done. It can be like a cyclical process in the sense of some of these reviews. I hope that answers your question, but please feel free to elaborate if you wanted more specifics.

Q: "Regarding the optional nature of the equity E&M criteria, can CMS MMS provide more information around why it's optional vs. required given the national push for equity across HHS, and who determines whether equity will be evaluated? The submitting entity or the E&M committee/CMS?"

MICHIE: So I think this question and the next question regarding the equity criteria and the feasibility of the data capture are related, and so I'll answer them both. Yes, one of the reasons why the equity criteria is currently optional is around the feasibility aspect. So we are in the information-gathering stages where we are looking at what's feasible to collect and expect to collect in terms of data elements and methods and approaches for equity; however, understanding the national push and the importance of equity, looking ahead we are looking for this to be a required domain in 2025. So currently we're in the information-gathering stages for E&M, and we're looking to put together some

guidance for measure developers for when the equity domain will eventually become required, but it's a process.

Q: "Is there an eCQM feasibility assessment required to be completed again for maintenance measures, if no significant changes have been made to the measure?"

MICHIE: So when we're looking at maintenance measures, when we're looking at the eCQM feasibility assessment for maintenance measures, we're focused less on the feasibility of the individual data element and focused more on whether there have been any feasibility challenges during implementation. So it's just kind of framing it a little bit differently. So we're not looking for a feasibility assessment of each individual data element that you've already done during the initial review, but we're looking for any feasibility challenges that you've had during implementation.

HOLST: Thank you, Anna. Let me scan our questions here. There are a few responses that were answered via a written answer, so please pay attention to those if you had a question. I don't see any other questions in the chat, and so I might just turn it back to our presenters to see if there was anything else they had before we wrap up our presentation today?

[SLIDE 30]

HOLST: Okay, it sounds like that will cover it. Just a reminder that the slides will be posted on the MMS Hub after our call today, and then we'll follow up later posting the recording and some of our great questions that we covered this afternoon. So thank you for your attendance and have a good rest of your day.

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