Partnership for Quality Measurement

Measure Set Review (MSR) Recommendation Group Measure Review Meeting

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Housekeeping Reminders

We are pleased to have you join us and want to create a meaningful exchange. We encourage you to keep your video on throughout the event.

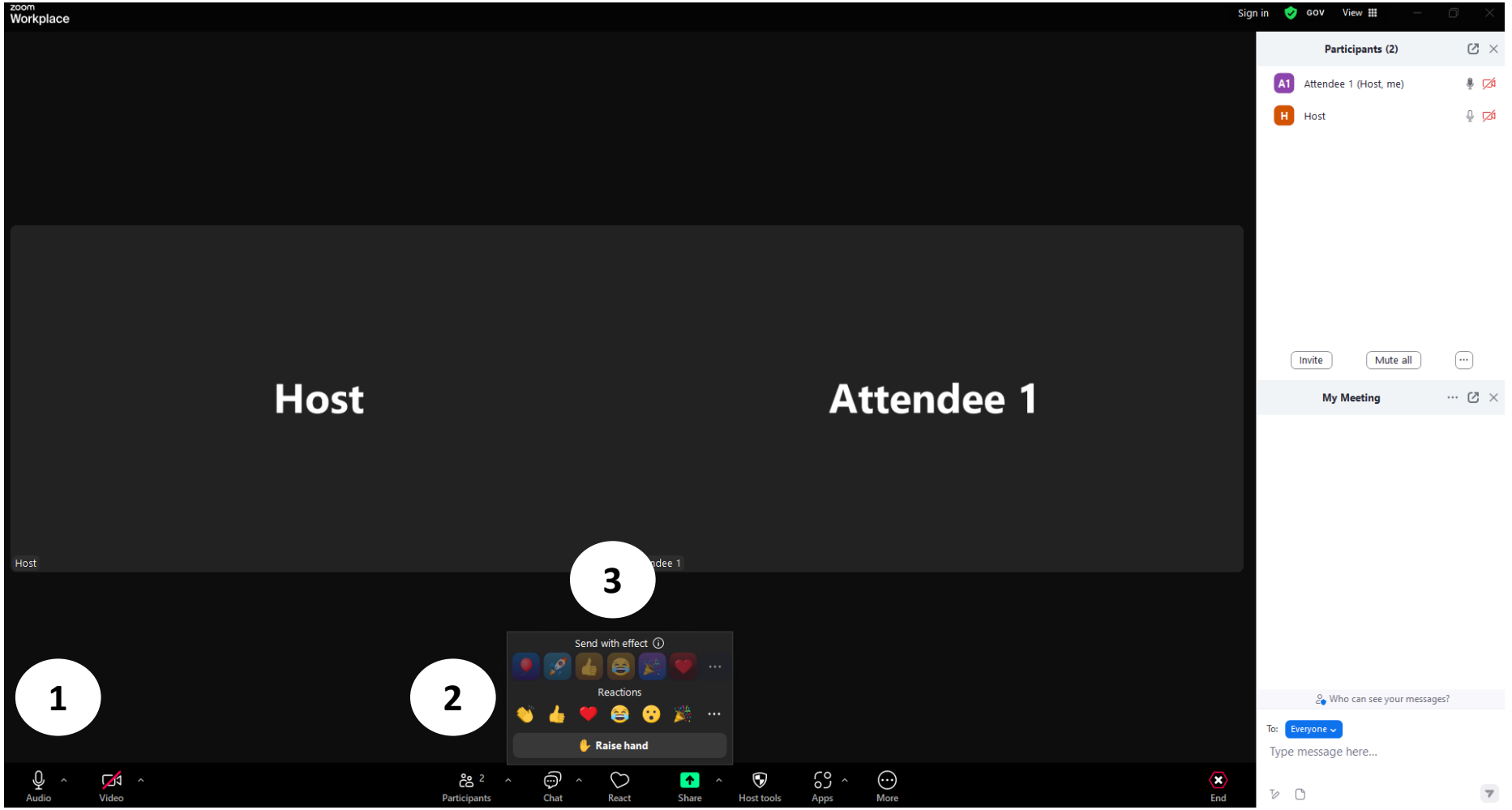
To participate in the discourse, type in the chat or raise your hand. Battelle staff will serve as virtual moderators.

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

Community Guidance

- Respect all voices.
- Remain engaged and actively participate.
- Keep your comments concise and focused.
- Be respectful and allow others to contribute.
- Share your experiences.
- Learn from others.

Using the Zoom Platform



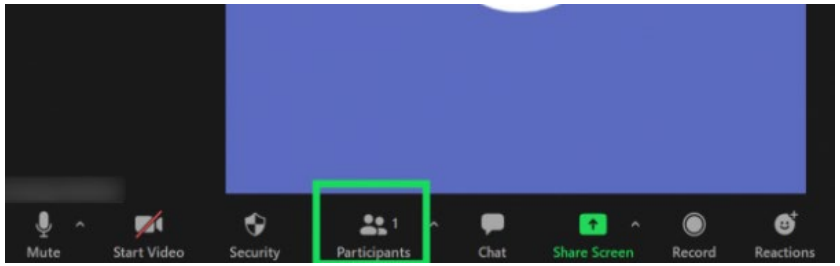
1. Click the lower part of your screen to mute/unmute, start, or pause video.

2. Click on the participant or chat button to access the full participant list or the chat box.

3. To raise your hand, select the raise hand button under the react tab.

Using the Zoom Platform (Renaming)

1



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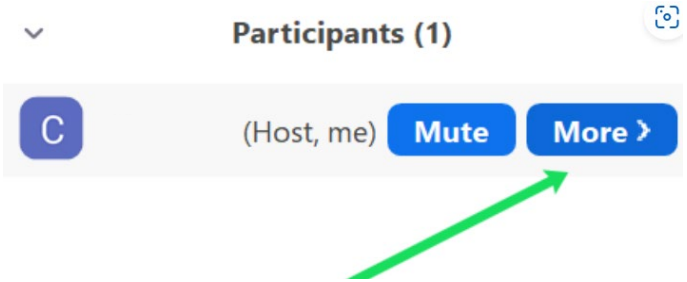

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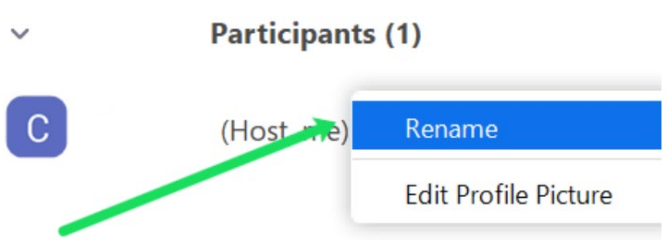

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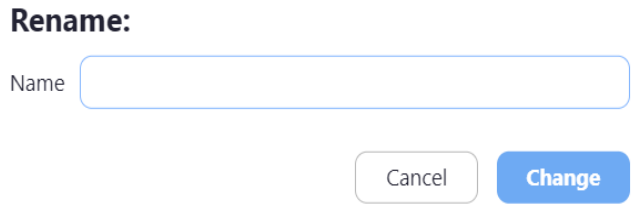
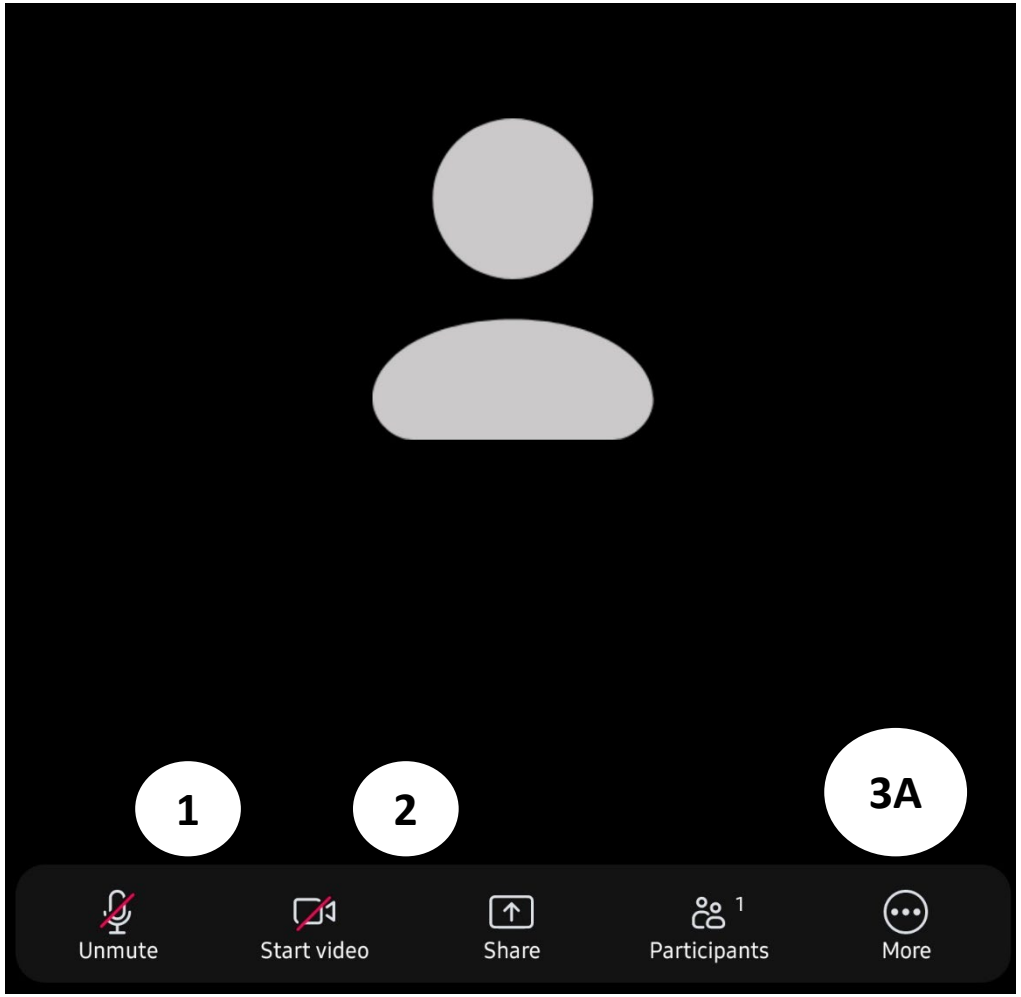


1 Click on the participant button to access the full participant list.

2 Hover your mouse over your name, click **More** (2A) and click **Rename** (2B)

3 In the pop-up box, enter your display name and click **Change.**

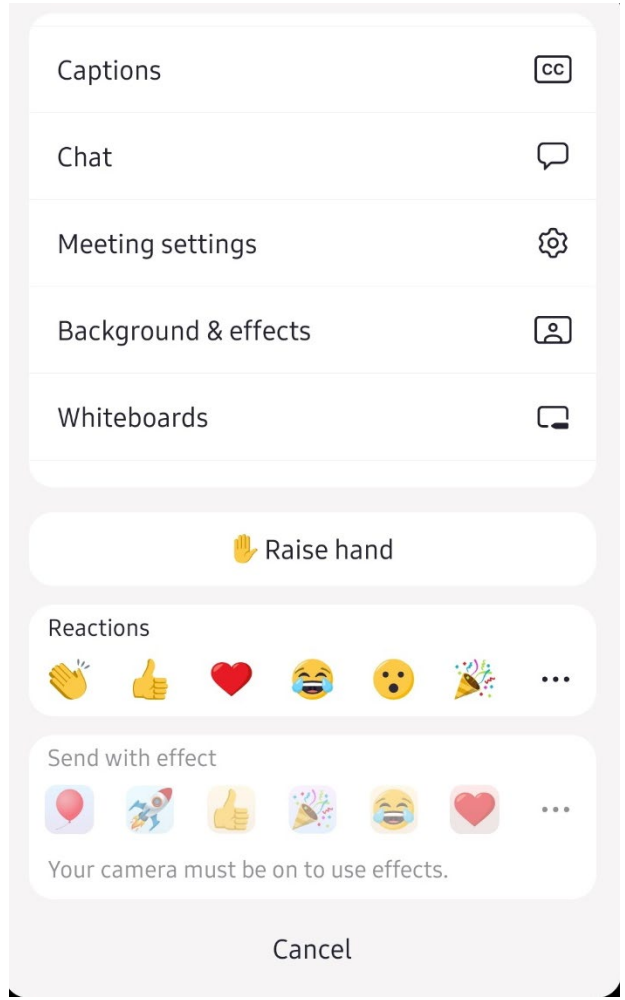
Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start, or pause video.

2. Click on the participant button to view the full participant list.

3. Click on (3A) “More” button to view the chat box, (3B) show closed captions, or (3C) to raise your hand. To raise your hand, select the raised hand function under the reactions tab.



Acronyms

- AG: Advisory Group
- CBE: Consensus-Based Entity
- CMS: Centers for Medicare & Medicaid Services
- CoMM: Cascade of Meaningful Measures
- E&M: Endorsement and Maintenance
- MSR: Measure Set Review
- MUC: Measures Under Consideration
- MUD: Measure Under Development
- NHDNG: Novel Hybrid Delphi and Nominal Groups
- PA: Preliminary Assessment
- PAC/LTC: Post-Acute Care/Long-Term Care Workgroup
- PRMR: Pre-Rulemaking Measure Review
- PQM: Partnership for Quality Measurement
- RG: Recommendation Group
- STAR: Submission Tool and Repository

Welcome and Introductions

Introductions

Battelle Staff

- Brenna Rabel, MPH – Technical Director
- Meridith Eastman, PhD, MSPH – Pre-Rulemaking Measure Review (PRMR)/MSR Task Lead
- Jeff Geppert, JD, EdM – Scientific Methods Lead
- Kate Buchanan, MPH – Deputy Task Lead
- Lydia Stewart-Artz, PhD, MHS – Measure Evaluation Lead
- Isaac Sakyi, MSGH – Social Scientist

Centers for Medicare & Medicaid Services (CMS) Staff

- Dr. Michelle Schreiber, MD, Deputy Director of Quality, Center for Clinical Standards and Quality (CCSQ)
- Helen Dollar-Maples, RN, Director, Division of Program and Measurement Support (DPMS), CCSQ
- Nidhi Singh Shah, MPH, Deputy Director, DPMS, CCSQ
- Melissa Gross, BSN, CMS MSR Lead
- Charlayne Van, JD, CMS Contracting Officer's Representative
- CMS Medical Officers
- CMS Leads

Meeting Agenda Day 1

10:00 am	Welcome and Process Overview
10:45 am	Measure Review
12:15 pm	Lunch
12:45 pm	Measure Review
5:20 pm	Adjourn

* All times listed in ET

Roll Call and Disclosures of Interest

Kate Buchanan | Battelle

Disclosures of Interest (DOIs)

- Prior to the meeting, committee members were asked to complete a “measure-specific DOI” form for each measure, or batch of measures, assigned to the committee.
- During the Recommendation Group (RG) meeting, committee members verbally disclose relevant interests.
- If there is a perceived or actual conflict of interest (COI), Battelle requires affected members to recuse themselves from discussing and voting regarding the applicable measure(s)

Roll Call and Disclosures of Interest

Co-chairs: Rosie Bartel and Akinluwa Demehin

- Erica Alexander
- Nishant Anand
- Anita Bemis-Dougherty
- Rachel Blair
- Laura Conner
- Scott Cowan
- Michelle Dardis
- Kristina Davis
- Thomas Frederickson
- Shawn Griffin
- Joanna Horst
- Stefanie Ledbetter
- David Levine
- Jennifer Lundblad
- Sai Ma
- Amy Minnich
- Devika Nair
- Ethan Novikoff
- Mark Paris
- Koryn Rubin
- Jessica Schumacher
- David Seidenwurm
- Kiran Sreenivas
- Christine Von Raesfeld
- Mamata Yanamadala
- Isis Zambrana

MSR Co-Chair Introductions

Rosie Bartel

Akinluwa Demehin

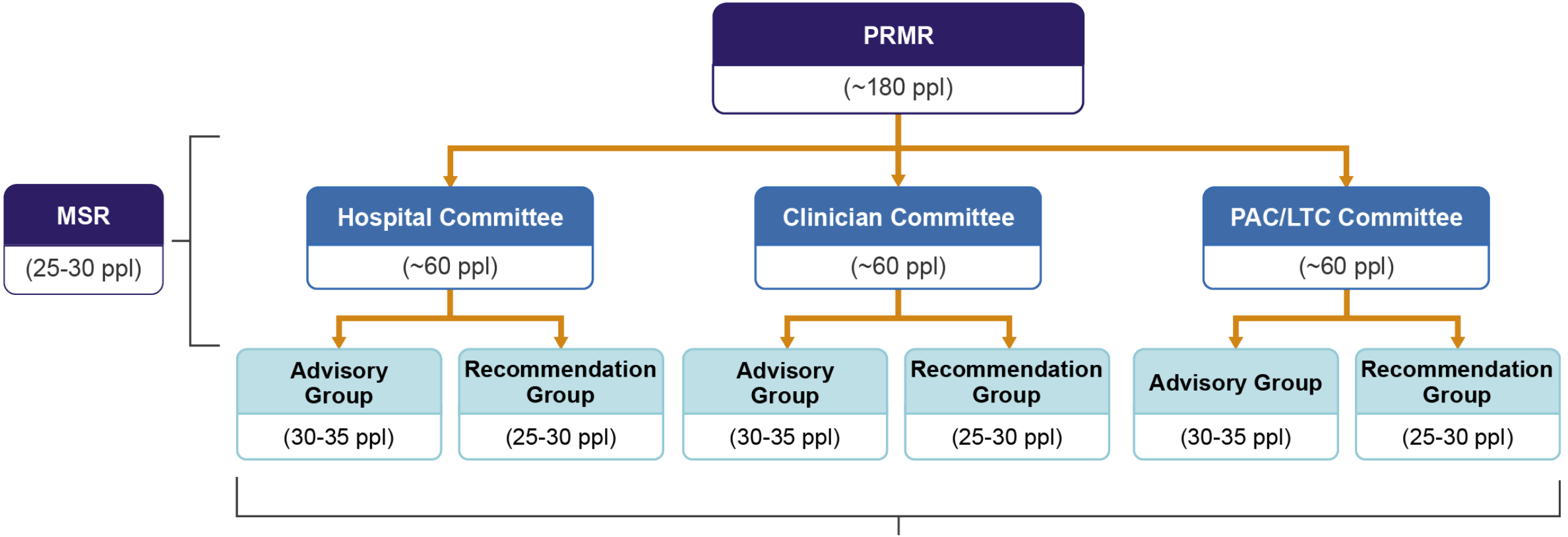
CMS Opening Remarks

Dr. Michelle Schreiber | Centers for Medicare & Medicaid Services (CMS)

MSR Process

Meridith Eastman | Battelle

Committee Organization



PRMR

- Advisory and Recommendation Groups provide written feedback
  - Recommendation Groups meet to review and recommend

PRMR and MSR

A select group of **PRMR committee members** are identified based on representation criteria for ensuring a range of voices within the group and are invited to serve on the MSR Recommendation Group.

The **MSR Recommendation Group** has 25 to 30 members and is inclusive of representatives across the three different settings (Hospital, Clinician, and PAC/LTC) in the PRMR process.

MSR and the Cascade of Meaningful Measures

We aim to **strategically** consider all measures used in CMS quality programs for MSR over the course of a **5-year period**.

The portfolio has been divided into **three cycles** using the **Cascade of Meaningful Measures** as a guide.

The **Cascade of Meaningful Measures**, based on the eight health care priorities of Meaningful Measures 2.0, is a tool to help prioritize existing health care quality measures, align or reduce measures where there are too many, and identify gaps where new measures may need to be developed. More information about the Cascade is available at www.cms.gov/cascade-measures.

Anticipated MSR Review Schedule

Year	Cycle	Cycle Description	Cascade of Meaningful Measures Priorities (Number of Measures)
Year 1 – Pilot Year	N/A	To pilot the MSR process, the year 1 cycle focused on measures in the End-Stage Renal Disease (ESRD) Quality Improvement Program (QIP).	• N/A (15)
Year 2	**Cycle C:** Cost-Effectiveness and Efficiency in Health Care Utilization	This group of measures addresses the financial and operational aspects of health care delivery.	• Affordability and Efficiency (107)
Year 3	**Cycle A:** Patient-Centered and Outcome-Focused Care	This group of measures focuses on the individualized needs of patients, emphasizing personalized care plans, preventive measures, and chronic disease management.	• Person-Centered Care (131) • Wellness and Prevention (88)
Year 4	**Cycle A:** Patient-Centered and Outcome-Focused Care (Continued)	See above.	• Chronic Conditions (116) • Behavioral Health (80)
Year 5	**Cycle B:** Safety, Quality, and Equity in Health Care Delivery	This group of measures focuses on creating a safe, equitable, and coordinated health care environment.	• Safety (132) • Seamless Care Coordination (31) • Equity (5)

2024 MSR Cycle

For the 2024 MSR process, Battelle will focus on a priority area from the Cascade of Meaningful Measures.

The 2024 MSR cycle will review measures included in Cycle C: Cost-Effectiveness and Efficiency in Health Care Utilization.

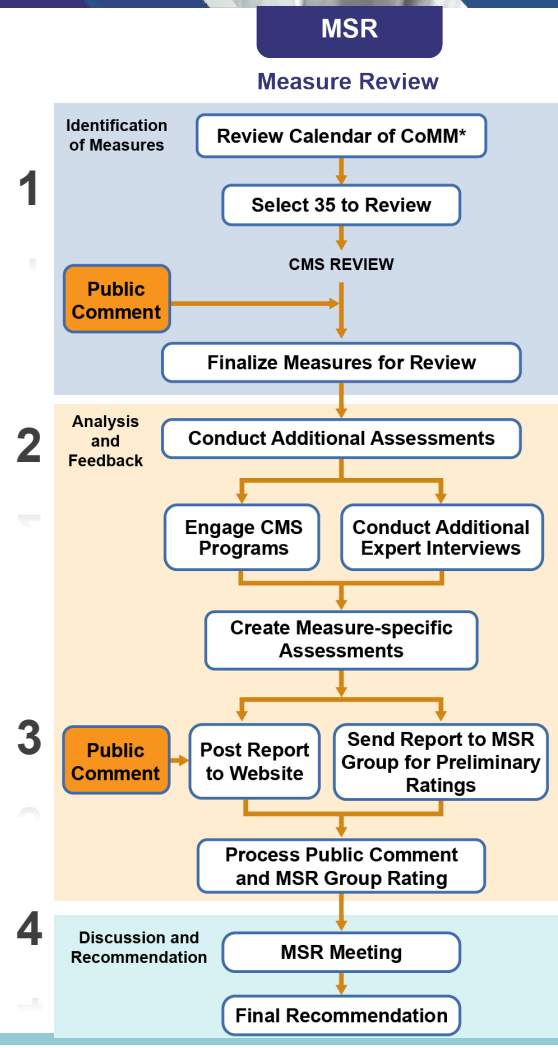
This group of measures addresses appropriate use and the operational and financial aspects of health care delivery.

MSR Process

The purpose of the MSR process is to optimize the CMS measure portfolio via review of measures for continued use of measures in programs.

Four Major Steps:

1. Identification of cycle focus
2. Information collection and synthesis
3. Recommendation Group feedback
4. Discussion and recommendations



MSR Evaluation

Lydia Stewart-Artz | Battelle

MSR Assertions

Meaningfulness in the Context of Use

- When evaluating meaningfulness in the context of use, committees should consider if the measure provides importance, validity, reliability, and usability.
  - ✓ Does data show us that using the measure in a quality program will provide benefits that outweigh the costs? (Importance)
  - ✓ Is it clear that a clinician or entity can make changes to improve the desired outcome? (Validity)
  - ✓ Does data show us that differences in measure performance across clinicians/entities truly reflects differences in care quality? (Reliability)
  - ✓ Is it clear that this measure can be effectively implemented and used, and is it clear that any barriers to doing so are known and addressable? (Usability)

MSR Assertions (cont.)

Data Stream Parsimony

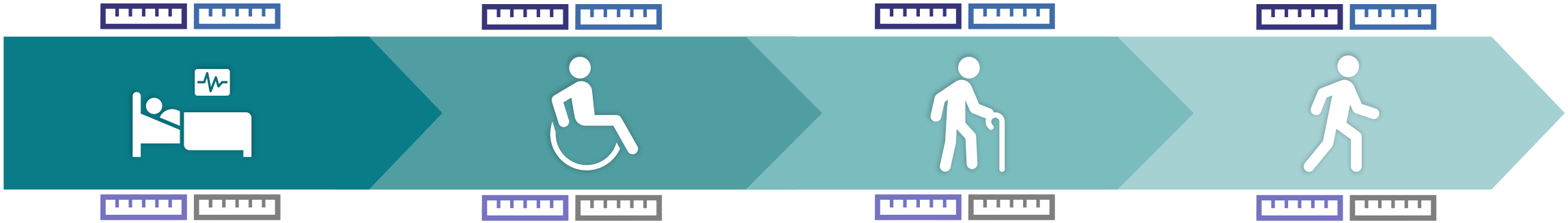
When evaluating entity data stream parsimony, committee members should evaluate whether:

- The clinical data flow required for the measure promotes **non-burdensome** data collection and reporting.
- **Measure set redundancy** in data streams is identified and mitigated.

MSR Assertions (cont.)

Patient Health Care Journey

- When evaluating the patient journey, committee members should evaluate whether:
  - ✓ The measure addresses the appropriate aspects of care to align with the patient health care journey.
  - ✓ Measure set is implemented across the patient health care journey in a manner consistent with the measure set impact model.



Preliminary Assessments

- Battelle provided committee members with measure-specific preliminary assessments (PAs).
- PAs include:
- Descriptive information about measure specification, endorsement, and use
  - CMS-provided rationale for measure inclusion in the CMS program
  - Considerations for statutorily required measure areas and upcoming rulemaking
  - Analysis of most recent past 3-year performance data in CMS program

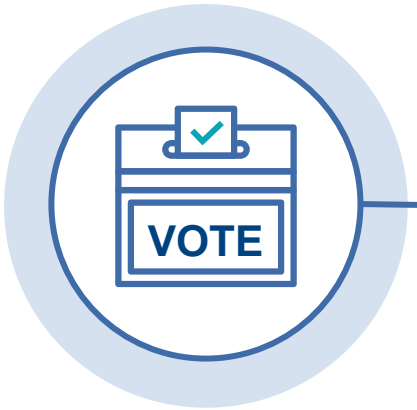
Pre-Meeting Initial Evaluation (PIE) Forms

- Committee members were assigned a selection of MSR measures to review ahead of the measure review meeting.
- PIE forms included detailed instructions and plain-language version of criteria.
- Based on the PAs and personal experience, committee members answered if the measure meets each criteria.
  - Yes/No and free-text response options
- The PIE forms were administered via Microsoft Forms format with ability to download completed form.
- Committee responses informed development of discussion questions for this meeting.

MSR Voting Procedures

Meridith Eastman | Battelle

Voting Procedure – Consensus



Battelle staff will work with co-chairs to establish meeting ground rules and goals, keep discussion on track, prevent discussions from being dominated by a small number of participants, and ensure decisions are reached.

Battelle will utilize an online voting system to capture votes by committee members.

Consensus is a simple majority: greater than 50%.

Online Voting

Online voting via Voteer

Link provided via email to voting members

Vote at time indicated by facilitator for each measure

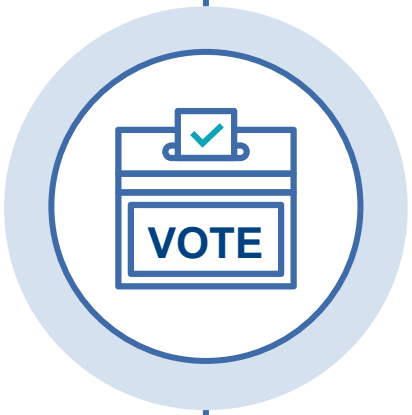
If you need voting assistance, please contact the project team via chat on the virtual platform or at PQMsupport@battelle.org.

MSR Recommendation

Committee votes on overall recommendation of the measure

- Recommend that the measure should be **continued** in the designated CMS quality program
- Recommend that the measure should **not be continued** in the designated CMS quality program

Voting Procedure – Quorum



Discussion quorum: The discussion quorum requires the attendance of at least 60% of the Recommendation Group members at roll call at the beginning of the meeting.

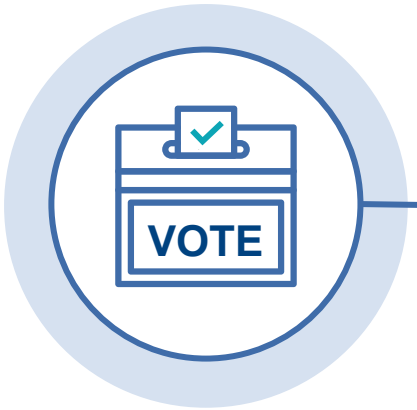
Voting quorum: The voting quorum requires at least 80% of active Recommendation Group members who have not been recused.

Voting Procedure – Quorum (cont.)

It is extremely important to the process to have voting quorum, and we kindly request you stay for the entirety of discussion and voting.

- If the voting quorum is not met, we will collect the votes for those present and follow up with absent participants until a voting quorum is reached.

Quorum Requirements



Discussion Quorum

- 28 MSR committee members
- 17 needed to have discussion

Voting Quorum

- 23 MSR committee members

Consensus: A simple majority, 50% or greater, for a recommendation

Voting Test

Isaac Sakyi | Battelle

Partnership for Quality Measurement

MSR Recommendation Group Measure Review

Measure Review Steps

- For each measure:
  - Battelle will summarize measure information.
  - CMS medical officer will provide brief measure overview and/or contextual background.
  - Battelle will review public comment summary and PIE results.
  - Committee will discuss.
  - Committee will vote.

Health Equity Assessment

- The Institute for Healthcare Improvement (IHI) conducted assessments of potential impacts to health equity associated with measure continuation/discontinuation.
- Equity is not an MSR criterion; however, the health equity assessments support the committee's efforts to provide meaningful feedback to CMS and measure developers on this important topic.
- For all measures, IHI identified stratified reporting (e.g., by race, ethnicity, ancestry, language, sexual orientation, gender identity, social determinants of health, and other relevant demographics) as a strategy to enhance healthy equity.
  - This is a recommendation for CMS consideration but should not factor into committee decisions.

Public Comment Overview

- Number of comments: 29 in total
  - 27 comments on the list of measures
  - 2 comments on the MSR PAs
- Overall themes
  - Prioritizing patient safety while balancing cost efficiency
  - Retaining evidence-based measures that prevent overuse and unnecessary procedures
  - Administrative burden and better alignment across programs
  - Call for actionable, patient-specific data to drive care improvements
  - Lack of meaningful performance improvements

Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)

00033-01-C-MIPS

Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
Measure Overview

- **Brief Description of Measure:** Percentage of patients, aged 18 years and older, with a diagnosis of acute viral sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms.
- **Measure Steward:** American Academy of Otolaryngology Head and Neck Surgery Foundation
- **Program Use**: Merit-based Incentive Payment System (MIPS)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 1 not met)
  - Support: Measure importance established in literature and measure fills a gap
  - Concerns: Implementation challenges related to provider behavior; workflows; and wait time for respiratory panel
  - Further consideration: Encourage clarification of exclusion criteria and consider inclusion of patients <18
- **Patient Journey** (3 met, 1 not met)
  - Support: Aligns with patient journey in outpatient setting; valuable to patients
  - Concerns: May not align with patient expectations for prescriptions and adds wait time during viral confirmation
- **Data Stream Parsimony** (3 met, 1 not met)
  - Support: Type and amount of data are parsimonious; available in electronic health record (EHR)
  - Concerns: None

Public Comment

- Received two public comments
  - 2 support and 0 concerns
- Support summary:
  - Crucial for promoting appropriate antibiotic use and preventing antibiotic resistance
  - Shown effectiveness over time, with a significant decrease in inappropriate antibiotic prescriptions for viral sinusitis †
  - Measure is neither topped out nor meets the criteria for the 7-point cap †

† Comment from the measure developer

Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)
Discussion Topics

- The preliminary assessment for this measure shows little to no opportunity for improvement for the top 60% of reporting entities. Can this measure be used to improve quality specifically for the lower performers?
- Is there value to extending the denominator population to include individuals under 18 years of age?

Age Appropriate Screening Colonoscopy

00039-01-C-MIPS

Age Appropriate Screening Colonoscopy
Measure Overview

- **Brief Description of Measure:** This is an overuse measure that captures the percentage of screening colonoscopies performed in patients greater or equal to 86 years of age from January 1 to December 31.
- **Measure Steward:** American Gastroenterological Association
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Age Appropriate Screening Colonoscopy
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 2 not met)
  - Support: Measure prevents potential harms to older patients (dehydration, bleeding, infection due to procedure).
  - Concerns: May not be as necessary and meaningful as in prior years; potentially "topping out."
  - Further consideration: One member suggested revision of specification to include patients aged 83 and older instead of 86 and older.
- **Patient Journey** (3 met, 1 not met)
  - Support: Limits patient exposure to a potentially harmful procedure; appropriate outpatient measure; reduces cost and negative outcomes for patients
  - Concerns: Risks for older patients (dehydration, bleeding, infection) may not outweigh benefits; alignment with standard of care
- **Data Stream Parsimony** (4 met, 0 not met)
  - Support: Uses data elements routinely collected and defined in EHR
  - Concerns: None

Public Comment

- Received four public comments
  - 3 support and 1 concern
- Support summary:
  - Aligns with clinical guidelines and contributes to quality improvement in gastroenterology. It is considered crucial for clinician reporting within the MIPS framework and is seen as a key component in combating colorectal cancer. Premature retirement of the measure is based on limited data.
  - In the context of the MIPS Value Pathway, removing this measure would leave only two reportable measures specifically addressing colorectal cancer prevention in the 2025 GI Care MVP.
- Concern summary:
  - Relevance of the measure for patients over 85 years old: the proportion of these patients receiving colonoscopies is very small.

Age Appropriate Screening Colonoscopy
Discussion Topics

- How impactful is this measure, given the small proportion of patients 86 and older receiving colonoscopies?
- The preliminary assessment shows that the median has been a perfect score over the past 3 years, with 98.9% of the entities having a perfect score in the latest year of data reported. Is there value in continuing this measure?
- Is there reason to believe that hospitals serving certain communities struggle with this measure?

Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

00076-02-E-MIPS

Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
Measure Overview

- **Brief Description of Measure:** The percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.
- **Measure Steward:** CMS
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Endorsed; Endorsed 2019	Yes	No

Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 2 not met)
  - Support: Importance (prevent unnecessary radiation exposure, psychological stress, and health care costs) and usability in setting
  - Concerns: Performance data suggest “topped-out” measure; minimal impact or value added to care; potentially easy to circumvent measure.
- **Patient Journey** (4 met, 0 not met)
  - Support: Appropriate for care setting/patient journey and of value to patients
  - Concerns: None
- **Data Stream Parsimony** (2 met, 2 not met)
  - Support: Data elements routinely collected and defined in EHR
  - Concerns: Measure does not reduce redundancy.

Public Comment

- Received one public comment
  - 0 support and 1 concern
- Concern summary:
  - Harms of overuse from dual-energy X-ray absorptiometry (DXA) scans being relatively low.
  - The measure does not fill a significant performance gap.
  - Denominator exclusion criterion do not follow current guidelines.

Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

Discussion Topic

- Referencing the preliminary assessment, does the committee agree that performance on this measure is high and unvarying, suggesting that this measure is topped out?
- Are risks associated with DXA greater for certain subpopulations (e.g., non-white patients, patients with co-occuring conditions?

Overuse of Imaging for the Evaluation of Primary Headache

00487-01-C-MIPS

Overuse of Imaging for the Evaluation of Primary Headache
Measure Overview

- **Brief Description of Measure:** Percentage of patients for whom imaging of the head (CT or MRI) is obtained for the evaluation of primary headache when clinical indications are not present.
- **Measure Steward:** American Academy of Neurology
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Overuse of Imaging for the Evaluation of Primary Headache
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Measure importance supported in literature, acceptable validity, appropriately specified
  - Concerns: None
- **Patient Journey** (2 met, 0 not met, 1 no response)
  - Support: Reduces unnecessary testing and costs, improves access for patients with medical need for imaging
  - Concerns: None
- **Data Stream Parsimony** (2 met, 0 not met)
  - Support: Claims based with minimal redundancy in data stream
  - Concerns: None

Public Comment

- No public comments received.

Overuse of Imaging for the Evaluation of Primary Headache
Discussion Topics

- The preliminary assessment for this measure shows little to no opportunity for improvement for the top 60% of reporting entities. Can this measure be used to improve quality specifically for the lower performers?
- Is continued use of this measure warranted given that CT and MRI for evaluation of primary headache is not the standard of care for patients without specific risk factors for structural disease?
- Are there certain subpopulations more likely to be impacted by the discontinuation of this measure?

Lunch Break

Please return by 12:45 PM

The PRMR and MSR Guidebook introduces processes and incorporates changes as suggested by interested parties through a public comment period.

The Measures Management System (MMS) Hub is a great plain-language general resource on quality measures.

Become a PQM member – it's free!

Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients

00101-01-C-MIPS

Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients

Measure Overview

- **Brief Description of Measure:** Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low-risk surgery patients 18 years or older for preoperative evaluation during the 12-month submission period.
- **Measure Steward:** American College of Cardiology Foundation
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients

PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 1 not met)
  - Support: Measure "generally meets criteria" for meaningfulness.
  - Concerns: Measure reliability and ability for providers to continue to improve; potential to increase in excess testing.
  - Further Consideration: Adding FDG PET in future years.
- **Patient Journey** (2 met, 1 not met)
  - Support: Prevents unnecessary testing and health care costs which is of benefit to patients; promotes efficient and expeditious access to care.
  - Concerns: None
- **Data Stream Parsimony** (1 met, 1 not met, 1 no response)
  - Support: Aligned with clinical data flow.
  - Concerns: None

Public Comment

- No public comments received

Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients

Discussion Topics

- PIE feedback for this measure was largely positive; do any committee members have concerns about this measure?
- Are there any patient groups/subpopulations more likely to be impacted by this measure (in terms of benefits or harms) than others?

Appropriate Follow-up Imaging for Incidental Abdominal Lesions

00069-01-C-MIPS

Appropriate Follow-up Imaging for Incidental Abdominal Lesions
Measure Overview

- **Brief Description of Measure:** Percentage of final reports for imaging studies for patients aged 18 years and older with one or more of the following noted incidentally with a specific recommendation for no follow-up imaging recommended based on radiological findings: cystic renal lesion that is simple appearing (Bosniak I or II), adrenal lesion less than or equal to 1.0 cm, adrenal lesion greater than 1.0 cm but less than or equal to 4.0 cm classified as likely benign or diagnostic benign by unenhanced computed tomography (CT), or washout protocol CT or magnetic resonance imaging (MRI) with in- and opposed-phase sequences or other equivalent institutional imaging protocols.
- **Measure Steward:** American College of Radiology
- **Program Use**: MIPS

Appropriate Follow-up Imaging for Incidental Abdominal Lesions
Measure Overview (cont.)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Appropriate Follow-up Imaging for Incidental Abdominal Lesions
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Reduces inappropriate use of radiologic studies and health care costs
  - Concerns: None
- **Patient Journey** (3 met, 0 not met)
  - Support: Prevents unnecessary testing and psychological stress
  - Concerns: Potential for limited shared-decision making with patients when lesions are found
- **Data Stream Parsimony** (2 met, 0 not met, 1 no response)
  - Support: Use of data is non-burdensome and does not add to redundancy
  - Concerns: None

Public Comment

- No public comments received

Appropriate Follow-up Imaging for Incidental Abdominal Lesions
Discussion Topics

- Does this measure continue to meet a need in the MIPS program and/or advance the goals of MIPS?
- To what extent do the advantages of the measure (reducing inappropriate use, preventing unnecessary testing and psychological stress on patients, low reporting burden) outweigh the perceived impact on shared decision-making with patients?

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients

00070-01-C-MIPS

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
Measure Overview

- **Brief Description of Measure:** Percentage of final reports for computed tomography (CT), CT angiography (CTA), or magnetic resonance imaging (MRI) or magnetic resonance angiogram (MRA) studies of the chest or neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule < 1.0 cm noted incidentally with follow-up imaging recommended.
- **Measure Steward:** American College of Radiology
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Measure importance supported; reduces overuse of imaging, reduces costs
  - Concerns: None
- **Patient Journey** (3 met, 0 not met)
  - Support: Reduces burden, costs, and psychological stress for patients
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low burden for data collection
  - Concerns: None

Public Comment

- No public comments received

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
Discussion Topics

- Does this measure continue to meet a need in the MIPS program and/or advance the goals of MIPS?
- To what extent do the advantages of the measure (reducing inappropriate use, preventing unnecessary testing and psychological stress on patients, low reporting burden) outweigh the perceived impact on shared decision-making with patients?

Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)

00419-01-C-MIPS

Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)
Measure Overview

- **Brief Description of Measure:** Percentage of patients, regardless of age, who gave birth during a 12-month period, delivered a live singleton at < 39 weeks of gestation, and had elective deliveries (without medical indication) by cesarean birth or induction of labor.
- **Measure Steward:** CMS
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Clinician	Not endorsed; None	Yes	No

Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 0 not met)
  - Support: Measure importance supported; prevents increased cost for patients
  - Concerns: Lack of performance data available limited ability to assess
- **Patient Journey** (1 met, 0 not met)
  - Support: Committee member representing the patient perspective expressed support for measure specification and timing in the care journey.
  - Concerns: None
- **Data Stream Parsimony** (0 met, 1 not met)
  - Support: None
  - Concerns: None

Public Comment

- Received one public comment
  - 0 support and 1 concern
- Concern summary:
  - The measure is topped-out, thus diminishing its utility as a tool for distinguishing between levels of care or driving improvement.
  - Was recently retired in the IQR program by CMS.

Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)
Discussion Topics

- This measure is topped out overall; are there any patient subgroups for whom performance on this measure continues to lag?
- If this measure is not retained, does it leave a gap in the program related to maternity care?

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

00237-02-C-MIPS

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

00237-01-C-MIPS

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years/18 Years and Older
Measures Overview

- **Brief Description of Measure:** Percentage of emergency department visits for patients (aged 2 through 17 years, or 18 years and older) who presented with a minor blunt head trauma who had a head CT for trauma ordered by an emergency care provider who are classified as low risk according to the Pediatric Emergency Care Applied Research Network prediction rules for traumatic brain injury.
- **Measure Steward:** American College of Emergency Physicians
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Not endorsed; None	Yes	No

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years

PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Reduces overuse of imaging and exposure to radiation in pediatric populations. Performance data support continued use.
  - Concerns: Benefits of imaging outweigh added radiological risk.
- **Patient Journey** (3 met, 0 not met)
  - Support: Aligns with patient perspective that appropriate use of scans is important as well as concerns such as reducing ED overcrowding and radiation exposure.
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low burden for data collection and reporting
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concern
- Support summary:
  - Both measures (Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years/18 Years and Older) are widely used among MIPS participants.
  - The child measure is not topped out.
  - These measures are in the Emergency Medicine MVP suggesting these are valuable to CMS.

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older

PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Addresses overuse of imaging in the ED, promotes patient safety
  - Concerns: None
- **Patient Journey** (3 met, 0 not met)
  - Support: Reduces ED crowding and patient perceptions of injury, which are valuable from patient perspective
  - Concerns: May limit patient perspective and shared decision-making
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low burden for data collection and reporting
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concern
- Support summary:
  - Both measures (Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years/18 Years and Older) are widely used among MIPS participants.
  - These measures are in the Emergency Medicine MVP suggesting these are valuable to CMS.

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years/18 Years and Older

Discussion Topics

- The adult measure (ages 18+) is topped out; would this measure leave a gap in MIPS if not retained?
- Are there any unique considerations for the pediatric measure (2-17 years) as compared to the adult measure(18+)?

Break

Please return by 3:05 PM

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)

00543-01-C-MIPS

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)
Measure Overview

- **Brief Description of Measure:** Percentage of patients who died from cancer receiving systemic cancer-directed therapy in the last 14 days of life.
- **Measure Steward:** American Society of Clinical Oncology
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Clinician	Endorsed; August 2009 (initial), Spring 2022 (most recent)	Yes	No

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 0 not met)
  - Support: None
  - Concerns: None
- **Patient Journey** (2 met, 0 not met)
  - Support: Caregiver perspective values this measure for improving quality of end-of-life care and promoting patient voice in decision-making
  - Concerns: None
- **Data Stream Parsimony** (2 met, 0 not met)
  - Support: None
  - Concerns: None

Public Comment

- Received two public comments
  - 2 support and 0 concern
- Support summary:
  - Support the retention of this measure because patients undergoing chemotherapy are underserved in terms of symptom management and end-of-life care.
  - The measure is actionable, impactful, and not duplicative within the MIPS program.†
  - Measure helps to ensure patients and their families are making informed decisions about end-of-life care.†
  - Can help identify providers that are pushing overly aggressive chemotherapy at the end-of-life.†

† Comment From the measure developer

Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score better)
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- Are there any patient groups/subpopulations more likely to be impacted by this measure (in terms of benefits or harms) than others?

Unplanned Reoperation within the 30-Day Postoperative Period

00737-01-C-MIPS

Unplanned Reoperation within the 30-Day Postoperative Period
Measure Overview

- **Brief Description of Measure:** Percentage of patients aged 18 years and older who had any unplanned reoperation within the 30-day postoperative period.
- **Measure Steward:** American College of Surgeons
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Clinician	Not endorsed; None	Yes	No

Unplanned Reoperation within the 30-Day Postoperative Period
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 0 not met)
  - Support: Measure importance relates to patient safety
  - Concerns: None
- **Patient Journey** (2 met, 0 not met)
  - Support: Aligns with patient journey within the 30 days' postsurgical procedure. Provided patient perspectives indicate measure is valued and should continue in program.
  - Concerns: None
- **Data Stream Parsimony** (2 met, 0 not met)
  - Support: Low data collection and reporting burden due to EHR and registry data
  - Concerns: None

Public Comment

- No public comments received

Unplanned Reoperation within the 30-Day Postoperative Period
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- How does this measure align with the patient journey and/or reflect patient perspectives?

Unplanned Hospital Readmission within 30 Days of Principal Procedure

00736-01-C-MIPS

Unplanned Hospital Readmission within 30 Days of Principal Procedure
Measure Overview

- **Brief Description of Measure:** Percentage of patients aged 18 years and older who had an unplanned hospital readmission within 30 days of principal procedure.
- **Measure Steward:** American College of Surgeons
- **Program Use**: MIPS

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Clinician	Not endorsed; None	Yes	No

Unplanned Hospital Readmission within 30 Days of Principal Procedure
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Importance to patient safety and reducing health care costs. Measure is feasible for care settings selected.
  - Concerns: None
- **Patient Journey** (3 met, 0 not met)
  - Support: Focus on patient safety during the 30-day period aligns with patient perspective and journey. Measure is of value to patient respondents.
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low data collection and reporting burden, use of EHR data elements
  - Concerns: None

Public Comment

- No public comments received

Unplanned Hospital Readmission within 30 Days of Principal Procedure
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- What are potential unintended consequences for continuation of this (or other) readmissions measures?

Plan All-Cause Readmissions

00561-02-C-PARTC

Plan All-Cause Readmissions
Measure Overview

- **Brief Description of Measure:** The percentage of plan members aged 18 and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same conditions as their recent hospital stay or for a different reason. (Patients may have been readmitted back to the same hospital or to a different one. Rates of readmission take into account how sick patients were when they went into the hospital the first time. This "risk-adjustment" helps make the comparisons between plans fair and meaningful.)
- **Measure Steward:** National Committee for Quality Assurance (NCQA)
- **Program Use**: Medicare Part C Star Ratings

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Health plan	Not endorsed; None	Yes	No

Plan All-Cause Readmissions
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 1 not met)
  - Support: Improves transparency for patients; 70% of entities have reliability 60% or higher
  - Concerns: Lack of performance data prior to 2022 limited review; range of reliability across measured entities and potential “plateau” of measure performance; lack of risk adjustment for socio-economic status factors.
  - Further consideration: Several members requested further clarification on how measure score is calculated
- **Patient Journey** (4 met, 0 not met)
  - Support: Improves transparency for patients and aligns with desire to avoid readmission
  - Concerns: None
- **Data Stream Parsimony** (4 met, 0 not met)
  - Support: Non-burdensome data collection and reporting; unique measure focus among readmission measures in similar program measure sets
  - Concerns: None

Public Comment

- No public comments received

Plan All-Cause Readmissions
Discussion Topics

- PIE inputs were overwhelmingly positive, and we did not receive public comments on this measure; do any committee members have any concerns about the All-Cause Readmissions measure to discuss?

MPF Price Accuracy

00452-01-C-PARTD

MPF Price Accuracy
Measure Overview

- **Brief Description of Measure:** The MPF Price Accuracy measure is a score comparing the drug's total cost at the pharmacy (reflected in Prescription Drug Event [PDE] data) to the drug prices the plan provided for the MPF website. Higher scores indicate better performance by plans because they mean the plans provided more accurate prices. The measure is a composite score that factors in both how much (magnitude of difference) and how often (frequency of difference) PDE prices exceeded the prices reflected on the MPF tool. A plan's MPF Price Accuracy Score is the average of the Accuracy Index (the "Price Accuracy Score"), which measures the amount that the PDE price is higher than the MPF price, and the Claim Percentage Index (the "Claim Percentage Score"), which measures how often the PDE price is higher than the MPF price. The Price Accuracy Score and the Claim Percentage Score consider both ingredient cost and dispensing fee when comparing MPF and PDE prices. Prices only count against the plan's score if the PDE price is higher than the MPF price; instances where the PDE price is lower than the MPF price do not count against the plan's score. The measurement period is January to September in the calendar year.

MPF Price Accuracy
Measure Overview (cont.)

- **Measure Steward:** CMS
- **Program Use**: Medicare Part d Star Ratings

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Medicare Part D plans	Not endorsed; None	Yes	No

MPF Price Accuracy
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 1 not met)
  - Support: High performance in years assessed; some members found adequate importance and usability
  - Concerns: Potential to "game" measure; limited measure importance; concern that it does not address overall plan affordability; barriers to usability
- **Patient Journey** (3 met, 1 not met)
  - Support: Improves transparency for patients
  - Concerns: None
- **Data Stream Parsimony** (3 met, 1 not met)
  - Support: Minimal overlap with other measures; low data collection and reporting burden
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concern
- Support summary:
  - It is important for patients to know accurate drug costs.*

* Comment from committee member

MPF Price Accuracy
Discussion Topics

- The goal of this measure is to increase transparency about drug pricing and to incentivize plans to share accurate drug pricing information on the MPF website, which members agree is important. Is the measure achieving that goal?
  - Consider PIE comments about barriers to usability and “gameability”
- How does this measure benefit patients in a meaningful way?

Next Steps

Meridith Eastman | Battelle


Partnership for
Quality Measurement
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Partnership for
Quality Measurement

Day 2

Meeting Agenda Day 2

10:00 am	Welcome and Process Overview
10:15 am	Measure Review
12:30 pm	Lunch
1:00 pm	Measure Review
5:45 pm	Adjourn

* All times listed in ET

Welcome and Roll Call

Roll Call and Disclosures of Interest

Co-chairs: Rosie Bartel and Akinluwa Demehin

- Erica Alexander
- Nishant Anand
- Anita Bemis-Dougherty
- Rachel Blair
- Laura Conner
- Scott Cowan
- Michelle Dardis
- Kristina Davis
- Thomas Frederickson
- Shawn Griffin
- Joanna Horst
- Stefanie Ledbetter
- David Levine
- Jennifer Lundblad
- Sai Ma
- Amy Minnich
- Devika Nair
- Ethan Novikoff
- Mark Paris
- Koryn Rubin
- Jessica Schumacher
- David Seidenwurm
- Kiran Sreenivas
- Christine Von Raesfeld
- Mamata Yanamadala
- Isis Zambrana

Voting Test

Isaac Sakyi | Battelle

Abdomen Computed Tomography (CT) - Use of Contrast Material

00005-01-C-HOQR

Abdomen Computed Tomography (CT) - Use of Contrast Material
Measure Overview

- **Brief Description of Measure:** This measure calculates the percentage of abdomen and abdominopelvic computed tomography (CT) studies that are performed without and with contrast out of all abdomen and abdominopelvic CT studies performed (those without contrast, those with contrast, and those without then with contrast) at each facility. The measure is calculated based on a 1-year window of Medicare claims data.
- **Measure Steward:** CMS
- **Program Use**: Hospital Outpatient Quality Reporting Program (HOQR)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Facility/Hospital/ Agency	Not endorsed; None	Yes	No

Abdomen Computed Tomography (CT) - Use of Contrast Material
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 2 not met)
  - Support: Measure importance and usability
  - Concerns: Lack of endorsement; measure performance over last 3 years; lack of reliability analysis
  - Further considerations: Given lack of risk adjustment, encourage consideration of exclusion criteria to include more “acutely ill” patients
- **Patient Journey** (4 met, 0 not met)
  - Support: Increases transparency for patients and reduces unnecessary imaging and associated cost, which aligns with patient interests
  - Concerns: None
- **Data Stream Parsimony** (3 met, 1 not met)
  - Support: Low burden of data collection and reporting
  - Concerns: None

Public Comment

- No public comments received

Abdomen Computed Tomography (CT) - Use of Contrast Material
Discussion Topics

- PIE inputs suggest this measure is feasible, important, and meaningful, but lacks data needed to assess its scientific properties.
- Does this measure fill a gap in the HOQR program (or would it create a gap, should the committee recommend against retention)?

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery

00097-01-C-HOQR

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
Measure Overview

- **Brief Description of Measure:** This measure calculates the percentage of stress echocardiography, single photon emission computed tomography myocardial perfusion imaging (SPECT MPI), stress magnetic resonance imaging (MRI), or coronary computed tomography angiography (CCTA) studies performed at a hospital outpatient facility in the 30 days prior to an ambulatory, noncardiac, low-risk surgery performed at any location (e.g., within the same facility as the cardiac imaging, at another hospital unaffiliated with the site of the index cardiac imaging, or within a physician's office).
- **Measure Steward:** CMS
- **Program Use**: HOQR

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
Measure Overview (cont.)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Facility/Hospital/ Agency	Endorsement removed; April 2011 (initial), March 2021 (removed)	Yes	No

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (0 met, 4 not met)
  - Support: None
  - Concerns: Low reliability; lack of variation and "topped-out" performance; meets CMS removal criteria Factors 1 and 2; proposed for removal
- **Patient Journey** (1 met, 3 not met)
  - Support: Aligns with patient interest in safety
  - Concerns: Not serving patient interests due to performance
- **Data Stream Parsimony** (2 met, 1 not met, 1 no response)
  - Support: None
  - Concern: Overlap with similar measure in use; benefits do not outweigh burden of measure

Public Comment

- No public comments received

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
Discussion Topics

- PIE inputs show little support for the measure to be retained. Would this measure leave a gap in the HOQR program if the committee recommends against retention?
- Do any committee members strongly support retention of this cardiac imagine measure?

MRI Lumbar Spine for Low Back Pain

00453-01-C-HOQR

MRI Lumbar Spine for Low Back Pain
Measure Overview

- **Brief Description of Measure:** This measure calculates the percentage of MRI studies of the lumbar spine for Medicare fee-for-service (FFS) beneficiaries with a diagnosis of low back pain on the imaging claim for which the patient did not have claims-based evidence of antecedent conservative therapy prior to undergoing the index imaging. Antecedent conservative therapy may include: 1. Claim(s) for physical therapy in the 60 days preceding the lumbar spine MRI. 2. Claim(s) for chiropractic evaluation and manipulative treatment in the 60 days preceding the lumbar spine MRI. 3. Claim(s) for evaluation and management (E&M) (e.g., office visits) in the period >28 days and <60 days preceding the lumbar spine MRI.
- **Measure Steward:** CMS
- **Program Use**: HOQR

MRI Lumbar Spine for Low Back Pain
Measure Overview (cont.)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Process	Facility/Hospital/ Agency	Endorsement removed; August 2008 (initial), April 2017 (removed)	Yes	No

MRI Lumbar Spine for Low Back Pain
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (0 met, 4 not met)
  - Support: None
  - Concerns: Proposed for removal; low reliability; limited ability to improve on measure; endorsement removed
- **Patient Journey** (2 met, 2 not met)
  - Support: Addresses issue of interest to patients
  - Concerns: Limited capacity for improvement; not best value for patients
  - Further considerations: Interest in seeing measure set impact model
- **Data Stream Parsimony** (0 met, 3 not met, 1 no response)
  - Support: None
  - Concerns: Overlap with similar measure in use, benefits do not outweigh burden of measure

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - The measure has potential in guiding appropriate use of MRI diagnostics, thus reducing unnecessary drug treatments and delayed recovery.*

* Comment from committee member

MRI Lumbar Spine for Low Back Pain
Discussion Topics

- Will retention (or non-retention) of this measure impact certain patient groups more than others? For example, are certain patients more likely to receive more aggressive diagnostics/therapy than others?
- Patient inputs were mixed for this measure; does this measure align with patient needs and values?

Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

00021-02-C-HOQR
00021-01-C-PCHQR

Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
Measure Overview

- **Brief Description of Measure:** This measure estimates rates of inpatient admissions or ED visits for at least one of the following 10 diagnoses (Dx) within 30 days of hospital-based outpatient chemo: anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis. Rates of admission and ED visits are calculated and reported separately.
- **Measure Steward:** CMS
- **Program Use**: HOQR and PCHQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsed; June 2016 (initial), July 2023 (most recent)	Yes	No

Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (HOQR)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (HOQR/PCHQR: 2/3 met, 1/0 not met)
  - Support: Met criteria for importance for reducing ED visits and associated costs; had acceptable reliability and validity
  - Concerns: Observation stays not included in numerator; variation in reliability across entities; higher-risk patients may be triaged to care settings not included in measure
- **Patient Journey** (HOQR/PCHQR: 3/3 met, 0/0 not met)
  - Support: Aligns well with the patient journey by focusing on early detection, validated improvement methods, and reliable care quality
  - Concerns: None
- **Data Stream Parsimony** (HOQR/PCHQR: 3/3 met, 0/0 not met)
  - Support: Minimal collection and reporting burden; claims measure
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - High rates of admissions and ED visits can indicate complications or adverse effects from chemotherapy that might be preventable with improved outpatient care and monitoring. As such, this measure can drive better management of chemotherapy side effects, leading to more effective and patient-centered care.†
  - Monitoring admissions and ED visits can highlight issues with care coordination.†
  - Frequent admissions and ED visits are costly and disruptive.†

† Comment from the measure developer

Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (HOQR) *Discussion Topics*

- Does this measure fill an important gap within the HOQR program? What about the PCHQR program?
- What impact would a recommendation against retention have on patients and hospitals?
- Are there patient subgroups for whom this measure is especially important?

30-Day Unplanned Readmissions for Cancer Patients

00004-01-C-PCHQR

30-Day Unplanned Readmissions for Cancer Patients
Measure Overview

- **Brief Description of Measure:** 30-Day Unplanned Readmissions for Cancer Patients measure is a cancer-specific measure. It provides the rate at which all adult cancer patients covered as fee-for-service Medicare beneficiaries have an unplanned readmission within 30 days of discharge from an acute care hospital. The unplanned readmission is defined as a subsequent inpatient admission to a short-term acute care hospital, which occurs within 30 days of the discharge date of an eligible index admission and has an admission type of emergency or urgent.
- **Measure Steward:** Seattle Cancer Care Alliance
- **Program Use**: PCHQR

30-Day Unplanned Readmissions for Cancer Patients
Measure Overview (cont.)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Endorsed; 2017 (initial)	Yes	No

30-Day Unplanned Readmissions for Cancer Patients
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 1 not met)
  - Support: Met criteria for importance for reducing unplanned readmissions and associated cost; had acceptable validity and reliability
  - Concerns: Lack of clarity on how target population is defined
- **Patient Journey** (3 met, 0 not met)
  - Support: Addresses wider patient experience, aligns with patient interests and journey
  - Concerns: Lower rates of participating hospitals may limit utility of measure for patients.
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low burden for data collection and reporting
  - Concerns: Potential for regulatory burden

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - High readmission rates may indicate quality-of-care issues; this measure can help identify gaps in patient safety and care coordination.
  - Unplanned readmissions are costly; this measure can help address the causes of these readmissions.
  - Reducing unplanned readmissions can directly improve patient outcomes, especially for cancer patients.

30-Day Unplanned Readmissions for Cancer Patients
Discussion Topics

- Comments from PIEs and the public were overwhelmingly positive. Do any committee members have concerns about this measure?
- Does this measure fill a gap within the PCHQR program?

Lunch Break

Please return by 1:00 PM

The PRMR and MSR Guidebook introduces processes and incorporates changes as suggested by interested parties through a public comment period.

The Measures Management System (MMS) Hub is a great plain-language general resource on quality measures.

Become a PQM member – it's free!

All-Cause Hospital Transfer/Admission

00045-01-C-ASCQR

All-Cause Hospital Transfer/Admission
Measure Overview

- **Brief Description of Measure:** The percentage of ambulatory surgical center (ASC) admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC.
- **Measure Steward:** ASC Quality Collaboration
- **Program Use**: ASCQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsement removed; November 2007 (initial), February 2016 (endorsement removed)	Yes	No

All-Cause Hospital Transfer/Admission
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 2 not met)
  - Support: Strong evidence for readmission reduction. Reduces unnecessary transfers, provides usable data, and ensures quality of care.
  - Concerns: One member suggested that measure is potentially more of a descriptive statistic than quality measure. Lack of reliability analysis limited ability to review. Concerns related to usability in program.
- **Patient Journey** (2 met, 1 not met)
  - Support: Aligns with patient interest and journey
  - Concerns: May not be a sufficient indicator of quality to be of benefit to patients
- **Data Stream Parsimony** (1 met, 1 not met, 1 no response)
  - Support: Low burden for reporting
  - Concerns: Data collection via medical record review could be burdensome

Public Comment

- No public comments received

All-Cause Hospital Transfer/Admission
Discussion Topics

- What concerns does the committee have regarding the usability of this measure within the ASCQR program? What about feasibility/parsimony?
- How does this measure benefit patients?

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

00253-01-C-HOQR
00253-01-C-ASCQR

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
Measure Overview

- **Brief Description of Measure:** Rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy among Medicare fee-for-service (FFS) patients aged 65 years and older.
- **Measure Steward:** CMS
- **Program Use**: HOQR and ASCQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsed; December 2014 (initial), 2024 (endorsed with conditions)	Yes	No

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (HOQR/ASCQR: 4/2 met, 0/0 not met)
  - Support: Met criteria for importance and usability with acceptable levels of validity and reliability
  - Further consideration: Clarification needed on how frequent event occurs in target population
- **Patient Journey** (HOQR/ASCQR: 4/2 met, 0/ not met)
  - Support: Improves quality of care and patient safety; reduces potential stress and disruptions for patients experiencing complications. Promotes effective and safe colonoscopy techniques
  - Concerns: None
- **Data Stream Parsimony** (HOQR/ASCQR: 4 met, 0 not met)
  - Support: Low burden for data collection and reporting; claims measure
  - Concerns: None

Public Comment

- No public comments received

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- Are there any patient groups/subpopulations more likely to be impacted by this measure (in terms of benefits or harms) than others?
- Does this measure fill a gap in the HOQR and ASCQR programs (or would it create a gap, should the committee recommend against continuation)?

Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures

00345-02-C-ASCQR

Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures *Measure Overview*

- **Brief Description of Measure:** The population included in the measure is Medicare fee-for-service (FFS) patients aged 65 years and older undergoing outpatient orthopedic procedures at ASCs. The measure's outcome is any unplanned hospital visit (emergency department [ED] visit, observation stay, or unplanned admission) by a patient occurring within 7 days of an index procedure (a patient's initial procedure).
- **Measure Steward:** CMS
- **Program Use**: ASCQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsed; June 2019 (initial), Spring 2024 (endorsed with conditions)	Yes	No

Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Measure importance supported by evidence. Important for improving quality of care by incentivizing reductions in avoidable hospital visits.
  - Concerns: None
  - Further considerations: Encourage exploration of composite measure on this topic
- **Patient Journey** (3 met, 0 not met)
  - Support: Aligns with patient interests and promotes improved outcomes
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low data collection and reporting burden; claims measure
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - The measure provides actionable data for patient experience and is not duplicative.

Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- Would it be useful for CMS to consider a composite measure to cover hospital visits after orthopedic ambulatory surgical center procedures?

Hospital Visits After Urology Ambulatory Surgical Center Procedures

00346-02-C-ASCQR

Hospital Visits After Urology Ambulatory Surgical Center Procedures *Measure Overview*

- **Brief Description of Measure:** The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a urology surgery at an ASC among Medicare fee-for-service (FFS) patients aged 65 years and older.
- **Measure Steward:** CMS
- **Program Use**: ASCQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsed; June 2019 (initial), Spring 2024 (endorsed with conditions)	Yes	No

Hospital Visits After Urology Ambulatory Surgical Center Procedures
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Measure importance supported by evidence. Important for improving quality of care by incentivizing reductions in avoidable hospital visits. Performance data indicate that measured entities can continue to improve.
  - Concerns: None
  - Further consideration: Clarification requested on if measure is limited to ASCs.
- **Patient Journey** (3 met, 0 not met)
  - Support: Aligns with patient interests and promotes improved outcomes
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low data collection and reporting burden; claims measure
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concern
- Support summary:
  - The measure provides actionable data for patient experience and is not duplicative.

Hospital Visits After Urology Ambulatory Surgical Center Procedures
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?

Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers

00254-01-C-ASCQR

Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers
Measure Overview

- **Brief Description of Measure:** The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within 7 days of a general surgery at an ASC among Medicare fee-for service (FFS) patients aged 65 years and older.
- **Measure Steward:** CMS
- **Program Use**: ASCQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/ Agency	Endorsed; June 2018 (initial), Spring 2024 (under E&M review)	Yes	No

Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 0 not met)
  - Support: Met criteria for importance, validity, and usability. Considered meaningful for patient safety.
  - Concerns: Lack of reliability data limited review
- **Patient Journey** (3 met, 0 not met)
  - Support: A patient provided their perspective that the measure is “crucial” for identifying and addressing issues after surgical care.
  - Concerns: None
- **Data Stream Parsimony** (3 met, 0 not met)
  - Support: Low burden for data collection and reporting
  - Concerns: None

Public Comment

- No public comments received

Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers
Discussion Topics

- Initial committee feedback in PIE forms was largely supportive; do any committee members have concerns about this measure?
- How does this measure align with the patient care journey and patient perspectives in the post-surgical period? (i.e., Do ASC patients believe it is important to track whether they end up in a hospital for any reason within 7 days of a procedure?)

Break

Please return by 3:20 PM

Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

00576-01-C-IRFQR

Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

Measure Overview

- **Brief Description of Measure:** This set of potentially preventable readmission (PPR) measures for post-acute care (PAC) estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and LTCHs. This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation.
- **Measure Steward:** CMS
- **Program Use**: Inpatient Rehabilitation Facility Quality Reporting Program

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	No

Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 3 not met)
  - Support: Measure addresses important area of care and could prevent readmissions
  - Concerns: Low reliability, potential for unintended consequences such as changes in admission practices for patients who are medically complex, low volume of entities in performance data
  - Further consideration: Encourage consideration of measure's use across settings with high barriers to accessing care or where care may be routinely sought at hospitals due to lack of alternatives.
- **Patient Journey** (3 met, 1 not met)
  - Support: Aligns with patient interest in avoiding readmissions, and measurement period is appropriate for the patient journey
  - Concerns: Measure could result in changes in admission practices, which may compromise patient safety
- **Data Stream Parsimony** (4 met, 0 not met)
  - Support: Low data collection and reporting burden, claims measure
  - Concerns: Overlap with other active measure

Public Comment

- Received two public comments
  - 1 support and 1 concern
- Support summary:
  - It is an important measure in the post-acute care continuum and is important for consumer decision-making and provider quality improvement.
- Concern summary:
  - It is burdensome and has potential unintended consequences from public reporting beyond patient harm.

Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
Discussion Topics

- Does this measure fill a gap in the IRFQR program? Would a recommendation against continued use create a gap in the program?
- PIE input raised concerns about unintended consequences due to changes in readmissions practices. Is there evidence to suggest that patient safety is at risk?
  - Are certain patient populations (e.g., those who are medically complex) at greater risk of unintended consequences due to changes in readmissions policies?
- Is low volume a particular concern for this measure?

Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)

00210-05-C-HHQR

Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
Measure Overview

- **Brief Description of Measure:** Percentage of home health stays in which patients were discharged to the community and do not have an unplanned admission to an acute care hospital or long-term care hospital (LTCH) in the 31 days and remain alive in the 31 days following discharge to community. The term community, for this measure, is defined as home/self-care, without home health services, based on Patient Discharge Status Codes 01 and 81 on the Medicare fee-for-service (FFS) claim.
- **Measure Steward:** CMS
- **Program Use**: Home Health Quality Reporting Program (HHQR)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility	Endorsed; 2019 (initial)	Yes	Yes (IMPACT Act)

Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (2 met, 1 not met)
  - Support: Measure importance supported by evidence. Important for reduction in readmission rates following community discharge and improving quality and safety of discharge. Reliable and valid metric.
  - Concerns: None
  - Further consideration: Clarification requested on how patient population is defined. Consider reduction in 2-year observation window.
- **Patient Journey** (3 met, 0 not met)
  - Support: Discharge to community is of value and important from patient perspective in home health settings
  - Concerns: None
- **Data Stream Parsimony** (2 met, 1 not met)
  - Support: Claims data used has low collection burden
  - Concerns: Patient surveys/assessments could increase burden on patients and caregivers as well as facilities. Response rates may vary by factors beyond provider control such as region.

Public Comment

- Received two public comments
  - 2 support and 0 concerns
- Support summary:
  - The measure is important for consumer decision-making and provider quality improvement.

Discharge to Community - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
Discussion Topics

- Feedback from PIEs and public comment were largely supportive, though reviewers questioned the completeness of the data used to calculate the measure. Does that impact committee perception of the measure?
- Note: This measure meets a statutory requirement for the HH QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it

Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

00210-03-C-LTCHQR

Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) *Measure Overview*

- **Brief Description of Measure:** This measure reports an LTCH's risk-standardized rate of Medicare fee-for-service (FFS) patients who are discharged to the community following an LTCH stay, and do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home/selfcare, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.
- **Measure Steward:** CMS
- **Program Use**: Long-Term Care Hospital Quality Reporting Program (LTCHQR)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Institution	Endorsed; 2019 (initial)	Yes	Yes (IMPACT Act)

Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 3 not met)
  - Support: Measure importance is supported by evidence
  - Concerns: Low reliability; risk adjustment may not be needed; usability and feasibility may be limited by external factors
  - Further consideration: Consider variation on this metric for rural settings where readmission may be limited due barriers to accessing timely care. Consider if readmission alone is valuable metric.
- **Patient Journey** (3 met, 1 not met)
  - Support: Discharge to community is of value and important from patient perspective.
  - Concerns: Potential unintended consequences such as changes in admission procedures
- **Data Stream Parsimony** (3 met, 1 not met)
  - Support: Low burden data collection and reporting
  - Concerns: Additional data may be needed to ensure measure is equitable across measured entities and patient populations

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - The measure is important for consumer decision-making and provider quality improvement.

Discharge to Community-Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) *Discussion Topics*

- Note: This measure meets a statutory requirement for the LTCH QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- Should CMS consider a complementary measure for use in rural settings, where readmissions may be less feasible for patients?

Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

00210-02-C-SNFQRP

Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Measure Overview

- **Brief Description of Measure:** This measure assesses successful discharge to the community from a PAC setting, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge. Specifically, this measure reports a SNF's risk-standardized rate of Medicare fee-for-service (FFS) residents who are discharged to the community following a SNF stay, and do not have an unplanned readmission to an acute care hospital or long-term care hospital (LTCH) in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community. Community, for this measure, is defined as home or self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.
- **Measure Steward:** CMS
- **Program Use**: Skilled Nursing Facility Quality Reporting Program (SNFQRP)

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	Yes (IMPACT Act)

Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 2 not met)
  - Support: Measure importance supported in evidence and covers statutorily required topic area for the program. There is opportunity for improvement and reliable performance across measured entities.
  - Concerns: Limited evidence this will improve long-term outcomes. Measure performance could be limited by external factors that would serve as confounders. Limited evidence provided for 31-day window.
- **Patient Journey** (4 met, 1 not met)
  - Support: Discharge to community is of value and important from patient perspective
  - Concerns: Some patients and caregivers may prefer institutionalization, and measure should reflect patient choice
- **Data Stream Parsimony** (4 met, 1 not met)
  - Support: Low data collection and reporting burden
  - Concerns: If confounders are considered, they would require data not in health record

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - It is important for consumer decision-making and provider quality improvement.

Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Discussion Topics

- Note: This measure meets a statutory requirement for the SNF QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- To what extent does this measure reflect patient choice regarding where they receive care?

Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program

00575-04-C-HHQR

Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program
Measure Overview

- **Brief Description of Measure:** Percentage of home health (HH) stays in which patients who had an acute inpatient discharge within the 30 days before the start of their home health stay and were admitted to an acute care hospital or long-term care hospital (LTCH) for unplanned, potentially preventable readmissions in the 30-day window beginning 2 days after home health discharge.
- **Measure Steward:** CMS
- **Program Use**: HHQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	Yes (IMPACT Act)

Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 3 not met)
  - Support: Clinically meaningful
  - Concerns: Low reliability, and limited evidence that interventions at home health level can impact readmissions post discharge
  - Further consideration: Measure may not be appropriate for rural settings where access to care is limited
- **Patient Journey** (2 met, 2 not met)
  - Support: Transition from home health facility to discharge is part of care journey of importance to patients
  - Concerns: 30-day window may not align with patient journey, potential for unintended consequences such as “cherry picking” of patients for home health facilities
- **Data Stream Parsimony** (4 met, 0 not met)
  - Support: Low data collection and reporting burden, claims measure
  - Concerns: Some overlap with similar measures

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - The measure is important for consumer decision-making and provider quality improvement.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program *Discussion Topics*

- Note: This measure meets a statutory requirement for the HH QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- Committee reviewers raised concerns about cherry-picking of patients by HH agencies. Is this an addressable concern?
- Is this measure appropriate for use in rural settings?
- Is it within HH agencies' control to drive improvements on this measure? Is there evidence linking home health interventions with post-discharge readmissions?

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

00575-01-C-IRFQR

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program

Measure Overview

- **Brief Description of Measure:** This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation. These outcome measures reflect readmission rates for patients who are readmitted to a short-stay acute-care hospital or an LTCH with a principal diagnosis considered to be unplanned and potentially preventable.
- **Measure Steward:** CMS
- **Program Use**: IRFQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	Yes (IMPACT Act)

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (1 met, 3 not met)
  - Support: Measure addresses important area of care and could prevent readmissions
  - Concerns: Low reliability, potential for unintended consequences such as changes in admission practices for patients who are medically complex, low volume of entities in performance data
  - Further consideration: Admission to facilities outside of normal region may be difficult to track
- **Patient Journey** (3 met, 1 not met)
  - Support: Aligns with patient interest in avoiding readmissions, & measurement period is appropriate for the patient journey
  - Concerns: Measure could result in changes in admission practices, which may compromise patient safety
- **Data Stream Parsimony** (4 met, 0 not met)
  - Support: Low data collection and reporting burden, claims measure
  - Concerns: Overlap with other active measure

Public Comment

- Received two public comments
  - 1 support and 1 concern
- Support summary:
  - It is an important measure in the post-care continuum and is important for consumer decision-making and provider quality improvement.
- Concern summary:
  - The measure is burdensome and has potential unintended consequences from public reporting beyond patient harm.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program
Discussion Topics

- Note: This measure meets a statutory requirement for the IRF QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- To what extent is the committee concerned about the potential for unintended consequences raised during initial review?

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)

00575-02-C-LTCHQR

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
Measure Overview

- **Brief Description of Measure:** This measure is one of a set of potentially preventable readmission (PPR) measures for post-acute care (PAC) that estimates the risk-standardized rate of unplanned, potentially preventable readmissions for patients (Medicare fee-for-service [FFS] beneficiaries) who receive services in one of the following post-acute care provider types: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCH). This measure is conceptualized uniformly across the PAC settings, in terms of the definition of the PPR outcome, the approach to risk adjustment, and the measure calculation.
- **Measure Steward:** CMS
- **Program Use**: LTCHQR

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	Yes (IMPACT Act)

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (4 met, 1 not met)
  - Support: Measure importance supported by evidence, acceptable reliability in program. Beneficial from cost perspective.
  - Concerns: May be difficult for entities to understand risk adjustment
  - Further considerations: Measure may not be appropriate for rural settings where access to care is limited. Developers may consider alternate targets for preventing readmission in future using early identification and intervention for conditions that place patients at greater risk for readmission.
- **Patient Journey** (4 met, 1 not met)
  - Support: Transition from long-term care hospital to discharge is part of care journey of importance to patients
  - Concerns: Potential for unintended consequences such as “cherry picking” of patients and changes to admission practices
- **Data Stream Parsimony** (5 met, 0 not met)
  - Support: Low data collection and reporting burden, claims measure
  - Concerns: None

Public Comment

- Received one public comment
  - 1 support and 0 concerns
- Support summary:
  - It is an important measure in the post-care continuum and is important for consumer decision-making and provider quality improvement.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)
Discussion Topics

- Note: This measure meets a statutory requirement for the LTCH QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- To what extent is “cherry-picking” a concern for this measure?

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

00575-03-C-SNFQRP

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Measure Overview

- **Brief Description of Measure:** The risk-standardized rate of unplanned, potentially preventable readmissions for SNF Medicare fee-for-service (FFS) beneficiaries within 30 days of discharge from the SNF.
- **Measure Steward:** CMS
- **Program Use**: SNFQRP

Measure Type	Level of Analysis	CBE Endorsement Status; Endorsement History	Are all required data collected as part of clinical workflow?	Statutorily required category?
Outcome	Facility/Hospital/Agency	Not endorsed; None	Yes	Yes (IMPACT Act)

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
PIE and Public Comment Summary

PIE Form Feedback

- **Meaningfulness** (3 met, 1 not met)
  - Support: Measure is important and valid because of its focus on cost control, quality of care, and access to needed care. Beneficial from cost perspective.
  - Concerns: Potential for confounding from external and patient level factors, low reliability
- **Patient Journey** (4 met, 0 not met)
  - Support: Avoiding potentially preventable readmission and ensuring quality SNF care is important in patient journey
  - Concerns: 30-day window lacks evidence base
- **Data Stream Parsimony** (3 met, 1 not met)
  - Support: Low data collection and reporting burden, claims measure
  - Concern: Additional burden could come from gathering data to appropriately adjust for confounders

Public Comment

- Received two public comments
  - 1 support and 1 concern
- Support summary:
  - It is an important measure in the post-care continuum and is important for consumer decision-making and provider quality improvement.
- Concern summary:
  - Lack of evidence for the measure's effectiveness.

Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
Discussion Topics

- Note: This measure meets a statutory requirement for the SNF QRP. If recommending against continued use, consider suggesting:
  - Potential replacement measures, or
  - Improvements to the existing measure that would improve confidence in it
- To what extent does this measure reflect circumstances that are outside the control of a SNF? Can a SNF make reasonable changes to their practices/policies to improve on this measure? (e.g., is this measure actionable?)

Feedback on MSR Process

Meridith Eastman | Battelle

Committee Reflections

Open discussion considering:

- What went well this cycle?
- What could have gone better?

Next Steps

Kate Buchanan | Battelle

Recommendation Report

Following the MSR Recommendation Group review, Battelle synthesizes the results into a report for CMS.

The report includes:

- Committee recommendations and rationale
- Committee and interested parties' concerns or areas of dissent

The report is submitted to CMS and posted on the PQM website on 11/12.

2024 MSR Timeline

Event	Dates
MSR Recommendation Group measure review meeting	9/30/2024-10/1/2024 (10 AM-6 PM ET)
MSR Recommendation Group backup measure review meeting	10/2/2024 (10 AM-2 PM ET)
Final MSR Recommendation Spreadsheet and Report published	11/12/2024
Public comment period for MSR Recommendation Spreadsheet	11/12/2024-11/27/2024

MSR Activity Timeline

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
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 & PIE forms.							X			
Measure Set Review: Recommendation Group meeting								X	X	
Battelle submits final recommendations on MSR to CMS.									X	
Public comment on final recommendations.										X

Questions or Comments?

Contact us at p4qm.org/contact
or by emailing pqmsupport@battelle.org


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