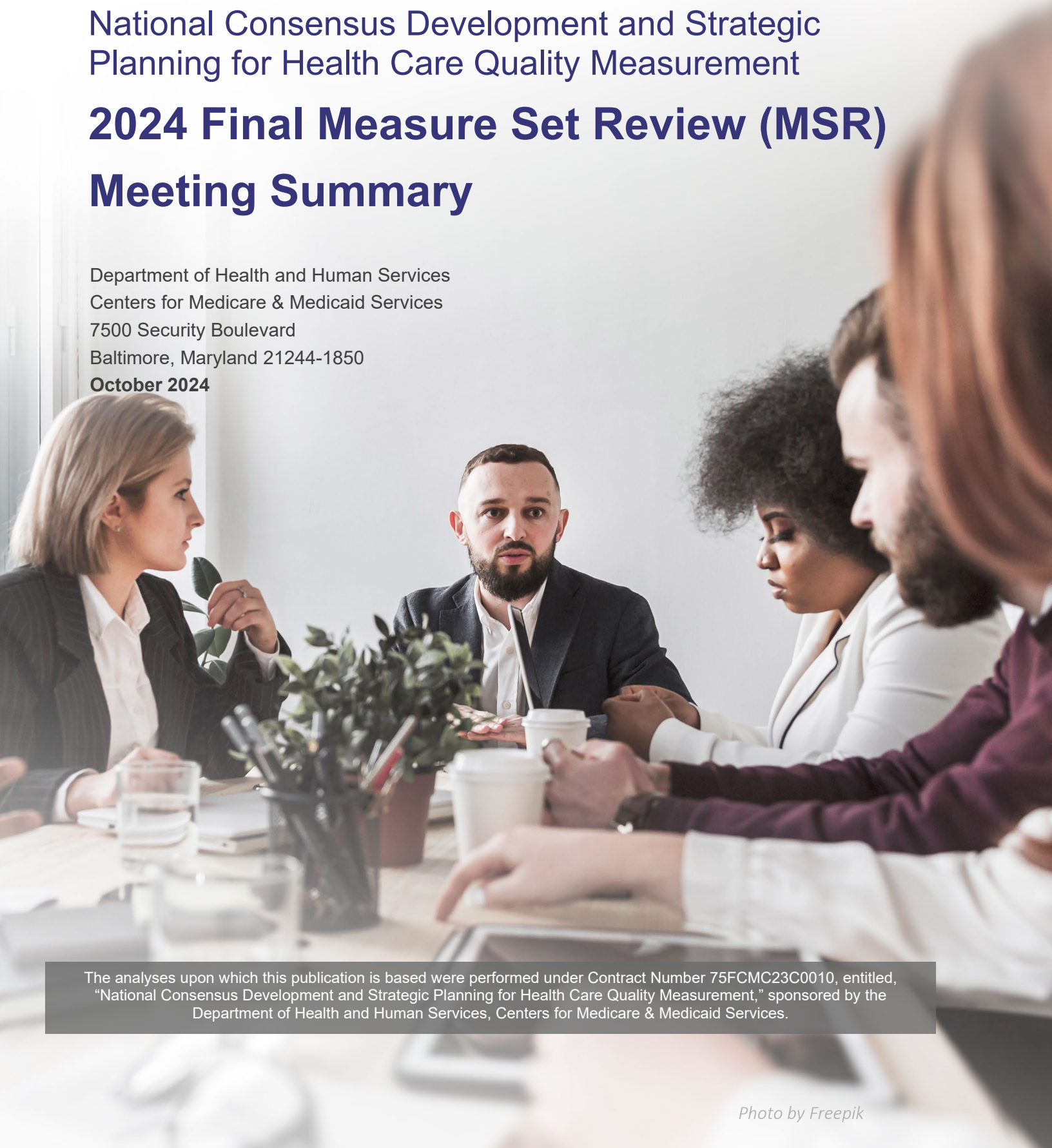
Partnership for Quality Measurement
Powered by Battelle

National Consensus Development and Strategic Planning for Health Care Quality Measurement

2024 Final Measure Set Review (MSR) Meeting Summary

Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850
October 2024



The analyses upon which this publication is based were performed under Contract Number 75FCMC23C0010, entitled, "National Consensus Development and Strategic Planning for Health Care Quality Measurement," sponsored by the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Photo by Freepik

Table of Contents

List of Tables

Page

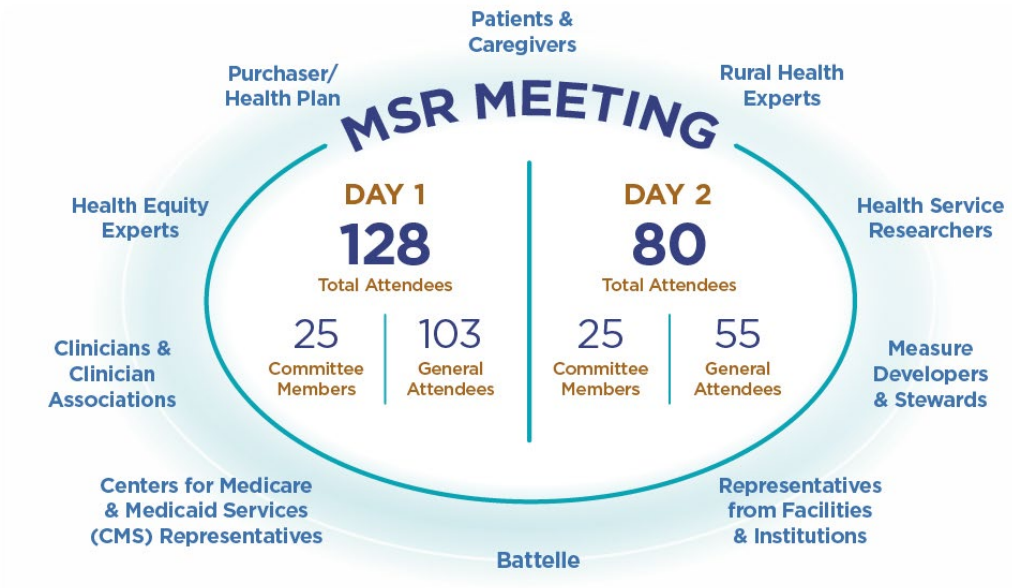
List of Figures

2024 Measure Set Review (MSR) Summary

Battelle staff virtually convened the Measure Set Review (MSR) Recommendation Group for the 2024 MSR Meeting on September 30 and October 1, 2024, to review 35 measures across the Centers for Medicare & Medicaid Services (CMS) measure portfolio.

The goal of this meeting was to discuss the measures in the Cascade of Meaningful Measures Affordability and Efficiency domain and make recommendations to CMS for continued use of measures from the perspective of interested parties impacted by the program. This meeting summary provides an overview of the meeting and outcomes and will be followed by a comprehensive MSR Meeting Recommendations Report and Recommendations Spreadsheet.

Figure 1. Measure Set Review Meeting Attendance



Meeting participants joined virtually through the Zoom meeting platform. Figure 1 outlines overall meeting attendance. The MSR Recommendation Group, tasked with discussing and voting on measures, consists of 25 members, all of whom were in attendance. These members represented the interested parties shown in Figure 1, which also highlights the inclusion of representatives from CMS, Battelle, and measure developers/stewards.

Overview and Purpose

Brenna Rabel, MPH, technical director of the Partnership for Quality Measurement, welcomed the attendees to the meeting and introduced her co-facilitator and the Pre-Rulemaking Measure Review (PRMR)/MSR task lead, Dr. Meridith Eastman, PhD, MSPH. Recommendation Group co-chairs Rosie Bartel and Akin Demehin, MPH, each shared their perspectives and motivation for serving in this role. After a brief overview of the day's objectives and agenda, Deputy Task Lead Kate Buchanan, MPH, conducted roll call, and Recommendation Group members

disclosed any conflicts of interest regarding the 35 measures under review. One member reported conflicts of interest for multiple measures, as noted in Table 1.

Dr. Eastman reviewed the overall MSR process, highlighting the importance of the voting procedures. Dr. Lydia Stewart-Artz, PhD, MHS gave a brief overview of the MSR evaluation criteria including meaningfulness, data stream parsimony, and patient health care journey.

Several attendees, including Traci Archibald, OTR/L, MBA, Deputy Director of the Quality Measurement & Value-Based Incentives Group (QMVIG), represented CMS on behalf of Dr. Michelle Schreiber, MD, Director of QMVIG. Traci Archibald shared gratitude for the day's attendees and expressed support for the importance of the MSR process in optimizing the CMS measure portfolio.

Affordability and Efficiency Measure Set Review Discussion

After opening remarks, Battelle facilitators outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least 60% of the Recommendation Group members during roll call at the beginning of the meeting. The voting quorum requires at least 80% of active and non-recused Recommendation Group members. Throughout the meeting, some members stepped away temporarily, so Battelle collected voting counts for each measure to ensure quorum. The voting outcome is determined by a simple majority, which requires greater than 50% of the votes.

At the start of each measure discussion, Battelle facilitators presented an overview of the measure and shared a summary of public comments and results of the Pre-Meeting Initial Evaluation (PIE) forms that committee members completed ahead of time. CMS medical officers then provided a brief introduction and rationale for the measure from the CMS program perspective. Throughout the subsequent measure discussions, two Battelle facilitators coordinated virtual attendees' participation by voicing written comments and organizing a queue of virtual attendees who wished to contribute orally.

Table 1 shows the vote counts by measure. MSR Recommendation Group members had the option to vote to recommend the continued use or discontinuation of a measure in the relevant CMS program. Members voted in real time via the Voteer platform.

Table 1. MSR Recommendation Group Vote Counts per Measure

CMIT ID	Measure Title	Continue Use	Discontinue Use	Recusals
00033-01-C-MIPS	Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse)	**23 (100%)**	0 (0%)	0
00039-01-C-MIPS	Age Appropriate Screening Colonoscopy	7 (30%)	**16 (70%)**	0
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	8 (33%)	**16 (67%)**	0

CMIT ID	Measure Title	Continue Use	Discontinue Use	Recusals
00487-01-C-MIPS	Overuse of Imaging for the Evaluation of Primary Headache	**18 (75%)**	6 (25%)	1
00101-01-C-MIPS	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients	5 (21%)	**19 (79%)**	0
00069-01-C-MIPS	Appropriate Follow-up Imaging for Incidental Abdominal Lesions	**22 (92%)**	2 (8%)	1
00070-01-C-MIPS	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients	**23 (96%)**	1 (4%)	1
00419-01-C-MIPS	Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse)	**18 (75%)**	6 (25%)	0
00237-02-C-MIPS	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years	**23 (100%)**	0 (0%)	0
00237-01-C-MIPS	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older	**23 (100%)**	0 (0%)	0
00543-01-C-MIPS	Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score - better)	**23 (100%)**	0 (0%)	0
00737-01-C-MIPS	Unplanned Reoperation within the 30-Day Postoperative Period	**21 (95%)**	1 (5%)	0
00736-01-C-MIPS	Unplanned Hospital Readmission within 30 Days of Principal Procedure	9 (39%)	**14 (61%)**	0

CMIT ID	Measure Title	Continue Use	Discontinue Use	Recusals
00561-02-C-PARTC	Plan All-Cause Readmissions	**18 (78%)**	5 (22%)	0
00452-01-C-PARTD	MPF Price Accuracy	**23 (100%)**	0 (0%)	0
00005-01-C-HOQR	Abdomen Computed Tomography (CT) - Use of Contrast Material	**14 (64%)**	8 (36%)	1
00097-01-C-HOQR	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery	0 (0%)	**22 (100%)**	1
00453-01-C-HOQR	MRI Lumbar Spine for Low Back Pain	1 (4%)	**22 (96%)**	1
00021-02-C-HOQR	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	**16 (73%)**	6 (27%)	0
00021-01-C-PCHQR	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	**17 (77%)**	5 (23%)	0
00004-01-C-PCHQR	30-Day Unplanned Readmissions for Cancer Patients	**20 (91%)**	2 (9%)	0
00045-01-C-ASCQR	All-Cause Hospital Transfer/Admission	**22 (96%)**	1 (4%)	0
00253-01-C-HOQR	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	**20 (87%)**	3 (13%)	0
00253-01-C-ASCQR	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	**19 (86%)**	3 (14%)	0
00345-02-C-ASCQR	Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures	**22 (96%)**	1 (4%)	0
00346-02-C-	Hospital Visits After Urology	**21**	0	0

CMIT ID	Measure Title	Continue Use	Discontinue Use	Recusals
ASCQR	Ambulatory Surgical Center Procedures	**(100%)**	(0%)	
00254-01-C-ASCQR	Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers	**20 (100%)**	0 (0%)	0
00576-01-C-IRFQR	Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program	**20 (91%)**	2 (9%)	0
00210-05-C-HHQR	Discharge to Community (DTC) - Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	**21 (95%)**	1 (5%)	0
00210-03-C-LTCHQR	Discharge to Community (DTC) - Post Acute Care (PAC) Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)	**20 (100%)**	0 (0%)	0
00210-02-C-SNFQRP	Discharge to Community (DTC) - Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)	**21 (100%)**	0 (0%)	0
00575-04-C-HHQR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program	**16 (80%)**	4 (20%)	0
00575-01-C-IRFQR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program	**17 (85%)**	3 (15%)	0
00575-02-C-LTCHQR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP)	**17 (85%)**	3 (15%)	0
00575-03-C-	Potentially Preventable 30-Day Post-Discharge Readmission	**17 (85%)**	3 (15%)	0

CMIT ID	Measure Title	Continue Use	Discontinue Use	Recusals
SNFQRP	Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)			

Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) [00033-01-C-MIPS]

Measure Review Final Vote: Committee recommends continued use in the Merit-based Incentive Payment System.

Vote Count: Continue Use (23) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: CMS medical officer Ron Kline, MD, FAAP, provided a brief overview and rationale for continued inclusion of this measure in the Merit-based Incentive Payment System (MIPS) program. Dr. Kline explained that this measure addresses the high-priority area of antibiotic resistance and aligns with 2015 clinical guidelines. He discussed the measure as part of MIPS Value Pathways (MVP) and provided historical benchmark performance data for the measure. The 2025 Physician Fee Schedule (PFS) proposed rule will provide updated instructions and clarification on what constitutes an occurrence for the purpose of attributing patients to the denominator of the measure. CMS provided an overview of the rulemaking process and needed steps to implement such a change to the measure.

The committee discussed the use of this measure within the MIPS program. One member cited the limited number of MIPS measures applicable to the field of otolaryngology, expressing the concern that specialists would have limited options for MIPS participation if the measure were recommended for discontinuation. The committee discussed a suggestion to expand the measure denominator to include patients under the age of 18, with supporters suggesting that this may be a population in which the measure could have significant impact in antibiotic overuse. The measure steward conveyed that the age range and the 10-day window for the measure are based on current clinical practice guidelines. The steward expects the clinical practice guideline to be updated in the spring of 2025, which could potentially lead to updates to the measure as well.

Alternatively, other committee members expressed concern about this expansion, citing that the underlying measure science and evidence would need to support such an expansion and cautioning against making changes without this foundation. Overall, the committee considered this an appropriate measure for addressing antibiotic overuse in the target population.

Additional Considerations and Future Directions: CMS and measure developers may want to examine potential expansion of this measure to include pediatric populations in the future if supported by prescribing trends, clinical evidence, and scientific acceptability of the measure. The committee encourages continuous feedback from clinicians and patients to inform updates and improvements to the measure.

Age Appropriate Screening Colonoscopy [00039-01-C-MIPS]

Measure Review Final Vote: Committee recommends the discontinued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (7) (30%), Discontinue Use (16) (70%), No Recusals.

Measure Discussion: CMS medical officer Marsha Smith PhD, MPH, FAAP, introduced this measure to the committee. Noting that this measure is "topped out," with performance consistently at a high level across measured entities, Dr. Smith explained CMS's rationale for proposing removal of this measure in calendar year (CY) 2025: The measure has become standard of care, limiting its ability to improve clinical outcomes.

One committee member representing clinician perspectives voiced strong support for maintaining this measure in the MIPS program, citing the importance of the measure to the safety of older adults, who constitute a vulnerable population. The committee encouraged CMS to reconsider the proposed removal until a replacement measure could be identified. The committee considered the potential variability in screening colonoscopy rates among white and Black patient communities, reflecting on potential equity implications of measure removal.

The committee considered the potential of lowering the measure's age requirement to explore whether the measure would still appear to be "topped out." In response, the steward highlighted the complexity of adjusting the age range and the need for further data analysis to make an informed decision on whether such a change would affect the measure's status as topped out. The committee also reviewed the U.S. Preventative Services Task Force (USPSTF) recommendation that was cited by the measure steward as the original source of the 86 years' threshold. A patient shared their perspective, saying they agreed with measure removal due to potential complications from screening colonoscopy for those who do not have prior indication, explaining that the burden of experiencing the procedure was unnecessary for these patients.

The committee encouraged CMS to consider how it identifies measures as "topped out" from a programmatic standpoint and to consider the effects on rural areas when such measures are removed. From the rural perspective, a committee member shared that resource-constrained communities still have room for improvement on "topped-out" measures. CMS explained that measures are assessed annually to identify those that are topped out, assess their impact in specialty sets with limited measures, and identify any performance gaps or opportunities for improvement. Additionally, through such annual assessment, CMS determines if there are any scoring limitations due to measures being topped out.

Additional Considerations and Future Directions: The committee encourages CMS to consider potential scientific acceptability and use of a measure that assesses this measure focus in a younger population. Additionally, they should examine how they analyze whether a measure is "topped out" and explore stratified performance data by factors such as rurality and urbanicity to ensure they are not unduly disadvantaging rural providers when removing measures.

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]

Measure Review Final Vote: Committee recommends the discontinued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (8) (33%), Discontinue Use (16) (67%), No Recusals.

Measure Discussion: CMS medical officer Lenise Cummings-Vaughn, MD, CMD, introduced the measure to the committee. Dr. Cummings-Vaughn provided the CMS rationale for proposing removal of this measure in CY 2025, noting the high performance rate and limited potential to improve clinical outcomes, describing the measure as "topped out." The measure focus has become standard of care.

The committee requested clarification on the measure's exclusion criteria and whether they align with current guidelines, particularly regarding chronic kidney disease. CMS clarified that that end-stage renal disease is part of the exclusions, but chronic, non-dialysis kidney disease is not part of the exclusions. A committee member cited the low reporting rates for this measure and questioned whether the performance data, given lower response rates, accurately reflects the measure's performance and whether it can truly be considered "topped out." A patient representative noted that this measure essentially represents the current standard of care, suggesting that its continued use in the program is unlikely to drive further improvements in patient care. The committee considered the impact of removing this measure, particularly whether it would lead to a shortage of measures within the three specialty sets to which the measure currently belongs. However, they concluded that enough alternative measures are available for selection.

CMS reminded the committee about the flexibility of MIPS in allowing clinicians to choose which measures to report. CMS emphasized that this factor is important to consider in discussions about this and other MIPS measures, especially when evaluating high performance levels. The committee explored why a measure might achieve "topped-out" performance, including the potential for reporting bias due to clinicians' ability to choose which measures to report in MIPS. The committee revisited the concern that certain subpopulations of clinicians, such as those in rural settings, might not be fully represented in the "topped-out" assessment; the committee discussed that rural settings may still have room for improvement compared to their urban counterparts, due to limited health care access and different patient demographics.

Additional Considerations and Future Directions: CMS is encouraged to consider rural providers as a subgroup when assessing whether measures are "topped out" to ensure that removal of these measures truly reflects high performance across all reporting entities.

Overuse of Imaging for the Evaluation of Primary Headache [00487-01-C-MIPS]

Measure Review Final Vote: Committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (18) (75%), Discontinue Use (6) (25%), 1 Recusal.

Measure Discussion: Dr. Cummings-Vaughn introduced the measure to the committee. CMS recommends maintaining this inverse appropriate use patient safety measure as it is a high-priority measure and aligns with clinical recommendations to limit radiation exposure. It was proposed for inclusion in the Optimal Care for Patients with Episodic Neurological Conditions MVP. The measure is one of only two specialty-specific measures within the MVP. Continued use of this measure and inclusion in the MVP may increase reporting, which may further elucidate gaps in performance.

Committee members supported the measure's importance, validity, and specification. The committee noted that the measure reduced unnecessary testing and costs, improved access for medically necessary imaging, and is a claims-based measure with minimal redundancy. The committee considered the role of MVPs in constraining the measures clinicians select and the implications on its MVP of discontinuing this measure. They also considered the clinician's viewpoint on the circumstances and reasons for ordering CT scans to evaluate primary headaches, as well as the implications of these practices on resources in various settings. Committee members highlighted the convenience factor as a primary reason for choosing CT scans over magnetic resonance imaging (MRI), noting that the ease of access significantly influences clinical decisions. Similarly, the presence of CT scanning equipment in the same

location can greatly increase the likelihood of its use, highlighting the resource implications in outpatient settings.

Additional Considerations and Future Directions: None.

Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low-Risk Surgery Patients [00101-01-C-MIPS]

Measure Review Final Vote: The committee recommends the discontinued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (5) (21%), Discontinue Use (19) (79%), No Recusals.

Measure Discussion: CMS medical officer Stephanie Clark, MD, MPH, MSPH, introduced the measure to the committee as an inverse measure, meaning a lower score indicates better performance. While the measure is topped out, the Society of Nuclear Medicine and Molecular Imaging has requested coding updates, which would allow more clinicians to report on this measure. This change is anticipated to potentially increase the adoption of the measure and highlight gaps in performance, thereby enhancing its relevance and effectiveness. CMS introduced substantive updates in the 2025 PFS proposed rule, which is why they support the measure's continued use in the program.

Several committee members noted that the measure relies on physician judgement, which makes it difficult to capture and creates hesitancy among physicians on reporting it. Several members also noted the high performance rates and questioned whether there is room for improvement.

A committee member expressed concern about the challenges of defining "low-risk" surgery patients from claims data, highlighting that many individuals are categorized as low-risk primarily because they lack insurance and consequently do not have a documented medical history. CMS and the measure steward confirmed that risk is based on the type of surgery and vascular impacts rather than patient factors. A committee member noted that the surgeries included in the measure vary in complexity, which might impact measure performance.

A patient representative questioned the utility of this measure in the program. The patient representative expressed that shared decision-making with physicians is the most effective approach for determining the necessity of preoperative tests, highlighting the uncertainty on whether the measure supports shared decision-making.

Additional Considerations and Future Directions: Though this measure defines risk based on surgery type, the committee encouraged CMS to consider risk adjustment based on patient-level factors. Such factors should not rely solely on claims history because people without access to care may not be captured.

Appropriate Follow-up Imaging for Incidental Abdominal Lesions [00069-01-C-MIPS]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (22) (92%), Discontinue Use (2) (8%), 1 Recusal.

Measure Discussion: Dr. Kline provided the rationale for continued use of this measure in the MIPS program, noting that it is a high-priority measure that addresses concerns over unnecessary additional radiation and costly procedures. He provided the historical benchmark

performance data for the measure and noted that this measure is one of six in the diagnostic radiology specialty set. CMS recommends maintaining this measure due to its importance in avoiding unnecessary follow-up procedures, which can be costly and burdensome.

The committee discussed the usefulness and importance of the measure in the MIPS program. One member acknowledged that while the measure might be "topped out" in MIPS, a review of the literature identified a gap in performance, which necessitates the measure's retention in the program. The committee also considered the patient perspective, noting the psychological stress that can come from incidental findings and emphasizing the importance of providers communicating why additional imaging may not be necessary. Overall, the committee provided positive feedback on the retention of the measure while recognizing areas for improvement. The committee agreed that the importance of the measure outweighed any potential negative impacts.

Additional Considerations and Future Directions: None.

Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients [00070-01-C-MIPS]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (23) (96%), Discontinue Use (1) (4%), 1 Recusal.

Measure Discussion: Dr. Clark provided the rationale for continued use in the MIPS program. She noted it is an appropriate use inverse measure that aligns with clinical best practices and decreases overuse, including unnecessary follow-up imaging and procedures, which can be costly and burdensome to patients. She added that the measure is in the sixth year of the topped-out lifecycle.

The committee discussed the use of this measure in the MIPS program, echoing similar sentiments from measure 00069-01-C-MIPS. Many committee members recognized the value and importance of this measure as there are gaps in performance, which is supported by the literature despite MIPS data showing high performance. The committee discussed the discrepancy between the performance data reported through MIPS and the findings in the literature. This discrepancy led to concerns about potential selection bias in reporting. It was suggested that those who choose to report on this measure might be the ones performing better, thus skewing the data to appear more favorable than the general practice. Some committee members raised questions surrounding the usefulness of the measure, considering the difficulty in capturing data. CMS acknowledged the potential for bias and the challenges with voluntary reporting and encouraged the committee to discuss any potential replacements for the measure if it were recommended for removal. While the committee noted their concerns around the ability of the measure to drive improvements in care, they agreed that the measure should remain in the MIPS program.

Additional Considerations and Future Directions: None.

Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse) [00419-01-C-MIPS]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (18) (75%), Discontinue Use (6) (25%), No Recusals.

Measure Discussion: Dr. Smith introduced the measure to the committee. The measure is included in the finalized Women's Health MVP and is included in two MIPS specialty sets. In a 2022 rule, CMS required a new benchmark to be established, but to date there is insufficient data to do so due to a lack of reporting. Dr. Smith explained that the rationale behind this measure is to reduce risks associated with early elective delivery, such as prematurity, increased neonatal intensive care unit admissions, and higher rates of cesarean sections. The measure aims to improve maternal and neonatal outcomes by discouraging unnecessary early deliveries. It is considered a high-priority measure and addresses a CMS priority clinical area, aligning with clinical recommendations to discourage non-indicated, elective delivery before 39 weeks gestation. CMS hopes that the inclusion of the measure in the Women's Health MVP may increase its adoption. The measure is also similar to measures in the Core Quality Measures Collaborative (CQMC) and Medicaid Adult Core Set, which facilitates alignment.

A committee member asked if removing the measure would leave a gap in women's health care. They noted that in rural areas there is a maternal health crisis, and it is difficult to safely provide care with the increasing challenges. This measure could help women in rural areas deliver safely. A patient representative expressed concern that if the measure were to be discontinued, it might lead to an increase in elective deliveries before 39 weeks.

A committee member highlighted a public comment that sought clarification on the similarities and differences between this measure, 00419-01-C-MIPS, and the PC-01 Elective Delivery measure. A representative of The Joint Commission clarified that the PC-01 Elective Delivery measure is slightly different from this measure. The PC-01 Elective Delivery measure is a "topped-out" measure that assesses the rate of elected C-sections between 37-39 weeks, which captures a different aspect of care than the MIPS measure under discussion. Several committee members noted that the MIPS measure is not as frequently reported on as the PC-01 hospital-based measure. This could be because the hospital prioritizes reporting on its C-section measure and clinicians have difficulty obtaining the hospital data they need to report on the MIPS measure.

A member noted that The Joint Commission no longer includes Maternity Care: Elective Delivery (Without Medical Indication) at less than 39 Weeks (Overuse) in its hospital accreditation program, as it prioritizes the PC-01 Elective Delivery, PC-02 Cesarean Section, and PC-07 Severe Obstetric Complications measures.

Additional Considerations and Future Directions: Given the maternal health crisis in the country, CMS is encouraged to consider alignment of C-section and elective delivery measures across MIPS and hospital programs.

Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years [00237-02-C-MIPS] and Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older [00237-01-C-MIPS]

Measure Review Final Vote: Committee recommends the continued use of the measures in the Merit-based Incentive Payment System.

Vote Count:

00237-02-C-MIPS Continue Use (23) (100%), Discontinue Use (0) (0%), No Recusals.

00237-01-C-MIPS Continue Use (23) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Kline provided a brief overview and rationale for continued inclusion of these measures in the MIPS program. CMS recommends retaining these measures because they address patient safety, which is a high priority for CMS. These measures reduce costs and limit unnecessary exposure to radiation. Dr. Kline noted doctors are finding that even a small number of CT scans of the body is resulting in measurable increases in cancer risk. Both measures are included in the Emergency Medicine Specialty Set and adopt the best practice of promoting patient safety in the MVP. Measure 00237-02 has a continued gap in performance rate. Measure 00237-01-C-MIPS is entering its second year in the topped-out lifecycle; however, because it is included in the MVP, reporting of this measure may increase, which may further elucidate gaps in performance.

The committee discussed the use of these measures in the MIPS program. One member asked if there are variations in how minor blunt head trauma is documented. The measure developer noted there are set definitions for minor blunt force trauma, so while there may be some variability, generally patients are diagnosed using specific criteria. Dr. Kline noted that for pediatric patients, Pediatric Emergency Care Applied Research Network (PECARN) criteria are used to guide diagnosis, so the diagnostic approach is not especially subjective. The measure developer added that pediatric patients and adult patients have separate criteria, so keeping these measures separated is important. The measure developer also noted that because the measure has been added to the MVP and because facilities are no longer exempt from reporting as they were during COVID-19, they expect an increase in facilities reporting on this measure.

Overall, the committee provided positive remarks for this measure, noting the measure is straightforward and they had no major concerns. One member noted, as a head injury survivor, a CT at the time of their injury would have been helpful and cautioned against bypassing a CT scan for patients that may need it.

Additional Considerations and Future Directions: Given the changes in MIPS and the potential impacts of COVID-19 exemptions, the committee implied that ongoing monitoring and accurate data collection are crucial for future evaluations of these measures.

Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life (lower score - better) [00543-01-C-MIPS]

Measure Review Final Vote: Committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (23) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Kline provided a brief overview and rationale for continued inclusion of this measure in the MIPS program. CMS recommends maintaining this inverse appropriate use measure, as it addresses the CMS priority of appropriate use for health care cancer patients in the last 14 days of life. The measure is in two specialty sets and the Advancing Cancer Care MVP. The measure is also part of the CQMC Measure Set. There is a current gap in performance, and the measure is currently driving improvement. Dr. Kline noted, as a pediatric oncologist, giving chemotherapy up until the last minute is not always the best course of action. PIE forms and public comments were supportive of the measure, highlighting its impact on quality of end-of-life care and its role in promoting informed decision-making.

The committee discussed the expansion of this measure to include additional treatments for cancer other than chemotherapy. During the discussion, the committee and developer noted that the title of the measure was incorrect and required updating. The correct measure title/numerator includes systemic cancer-directed therapy, not only chemotherapy. One committee member offered support for this measure from a patient perspective, describing her experience with “comfort chemo” that was offered to her husband after a late cancer diagnosis. Her husband was not adequately informed about the side effects of chemotherapy, and she emphasized the need for better education for patients regarding the treatments they undergo. Other committee members did not express any concern about the measure.

Additional Considerations and Future Directions: CMS may want to consider expansion of this measure to include education for patients receiving chemotherapy or other forms of care used to treat cancer.

Unplanned Reoperation within the 30-Day Postoperative Period [00737-01-C-MIPS]

Measure Review Final Vote: Committee recommends the continued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (21) (95%), Discontinue Use (1) (5%), No Recusals.

Measure Discussion: Dr. Clark provided a brief overview and rationale for continued inclusion of this measure in the MIPS program**.** This is an inverse outcome measure that is included in three MIPS specialty sets aimed at capturing adverse surgical outcomes to improve surgical care quality. The measure aligns with CMS’s priority to move toward outcome-based quality measurements. CMS is continuing to collaborate with the measure steward to broaden the denominator to include coding for additional specialties, which may increase the adoption of the measure and elucidate a wider performance gap. CMS proposed standard changes to the measure updates in 2025. The measure’s performance has been high in payment year 2024, but it is not topped out. The measure was finalized for inclusion in the otolaryngology-focused MIPS Value Pathway, and it is proposed for inclusion in the Surgical Care MVP. The measure has shown year-after-year improvement based on historical benchmarks.

Committee members discussed the definition for unplanned operations and why this measure is not risk adjusted. The measure steward explained the measure uses the International Classification of Diseases (ICD) procedure codes and can be self-reported. The measure steward noted the measure was originally created and submitted with a risk-adjustment algorithm as part of the surgeon-specific registry for the MIPS program, but CMS was not able to implement it at that time.

Committee members inquired about the specific types of surgeries for which this measure is applicable. The program lead clarified that the measure is utilized across three specialty areas: general surgery, plastic surgery, and otolaryngology. The committee member subsequently asked for clarification on the specialties that use this measure within the MIPS program. The program lead provided a link to the 2024 Quality Measures: Traditional MIPS Tool. One committee member offered support from a patient perspective and shared an instance when they had to undergo a second surgery because the first one was not performed correctly.

Additional Considerations and Future Directions: None.

Unplanned Hospital Readmission within 30 Days of Principal Procedure [00736-01-C-MIPS]

Measure Review Final Vote: Committee recommends the discontinued use of the measure in the Merit-based Incentive Payment System.

Vote Count: Continue Use (9) (39%), Discontinue Use (14) (61%), No Recusals.

Measure Discussion: Dr. Clark provided a brief overview and rationale for continued inclusion of this measure in the MIPS program. This measure is similar to the previous measure (00737-01-C-MIPS). It aligns with the CMS priority to move toward outcome-based quality measurement. The measure is included in three MIPS specialty sets, facilitating alignment across programs. The purpose of the measure is to capture an important adverse surgical outcome and again improve the quality of surgical care and follow-up. This inverse measure is also high performing but not topped out. This measure may potentially be used in the surgical MVPs in the future, which may increase adoption of the measure and reveal a wider performance gap. Performance for this measure has shown gradual improvement based on historical benchmarks.

Committee members asked how the topped-out designation is assigned. The CMS program lead noted there are different designations for process measures versus non-process measures. This measure is a non-process measure, and the following definition was provided: a measure where the truncated coefficient of variation is less than 0.10 and the 75th and 90th percentiles are within two standard errors. Another committee member asked how the measure is related to other readmission measures in MIPS. CMS determined that further analysis would be needed to answer this question. A committee member asked to clarify if this measure applies to ambulatory surgical procedures or only principal procedures that were performed in the hospital. The measure steward could not confirm with certainty that this only applies to procedures performed in a hospital as the measure relies on the Current Procedural Terminology (CPT) coding of the principal procedure, which could include both hospital and ambulatory.

Committee members asked for clarification on if the measure is risk adjusted and if “unplanned” indicates that the readmission could be unrelated to the previous reason for admission. The measure steward confirmed this interpretation was correct and similar to the previous measure, this measure was originally proposed to be risk adjusted, but it was not accepted by CMS. A committee member expressed concern with the lack of risk adjustment for this measure, specifically compared to the last measure, because different social determinants of health (SDOH) factors may play a role in a patient being readmitted. Other committee members agreed with this comment. Dr. Kline noted part of the issue is the number of ICD-10 codes and the limitations on the provider from a claims standpoint. Another committee member expressed concern that this measure may penalize health systems that treat patients with low health literacy or high health needs that are not adjusted for.

Committee members also expressed concern that this may incentivize limiting readmissions even if it is what is best for the patient. The CMS program lead noted they are trying to incorporate SDOH into more of their measures, but information may not have been available for older measures; however, such measures may have the opportunity to be stratified for certain factors in the future. A committee member expressed concern that there is no risk adjustment related to co-morbidities or other factors. The measure steward noted these types of metrics in general pit clinicians against each other rather than focusing on the comprehensive evaluation

of the medical procedure or the overall episode of care. The measure steward added that CMS is looking into patient-reported outcome measures related to this topic area.

Additional Considerations and Future Directions: None.

Plan All-Cause Readmissions [00561-02-C-PARTC]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Part C Star Ratings program.

Vote Count: Continue Use (18) (78%), Discontinue Use (5) (22%), No Recusals.

Measure Discussion: CMS Division Director of Consumer Assessment and Plan Performance Elizabeth Goldstein, PhD, provided background on the measure, noting its purpose is to assess the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. She added that the measure is risk adjusted for age, gender, comorbidities, and the condition at discharge. The rationale for inclusion in the program is to prevent avoidable readmissions and for Medicare Advantage plans and Part D plans to improve care transitions, reduce readmission rates, and improve health outcomes, particularly for older adults and those with multiple chronic conditions. She also noted that confidential reports are provided to the health plans, stratified by dual eligibility, low-income subsidy status, and disability.

The committee discussed the role of health plans in managing readmissions. One member was able to clarify to the committee how the health plans use claims-based data to calculate the necessary information. Many committee members shared their concern that while the intent of the measure is clear and important, the measure could have unintended consequences, such as penalizing clinicians or hospitals instead of engaging health plans in improving patient care. The committee discussed that plans serving populations with higher social risks often experience higher readmission rates. CMS clarified that the measure is targeted at health plans for comparison, not for use on an individual clinician or hospital basis. The purpose is to hold plans accountable for increasing care coordination. One committee member mentioned the importance of distinguishing causes of readmission that are related to care coordination and causes that are less modifiable with care coordination.

Additional Considerations and Future Directions: The developer should incorporate social risk factors in the measure's risk adjustment.

MPF Price Accuracy [00452-01-C-PARTD]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Medicare Part D Star Ratings program.

Vote Count: Continue Use (23) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Goldstein introduced the measure to the committee. CMS uses the measure on its Medicare Plan Finder (MPF) tool, which allows consumers to compare their prescription prices across different Medicare Advantage plans. CMS supports the measure's continued inclusion in the program because it helps ensure plan sponsors submit accurate drug prices and supports beneficiaries' informed decision-making.

A member had a concern about the potential for "gaming" the measure and asked what controls are in place to ensure that the MPF price is an accurate representation of the price. CMS

representatives explained that countermeasures are in place, such as display measures that track if plans post higher prices on the MPF than the actual prices at the pharmacy. Additionally, inflating prices could deter beneficiaries from enrolling in the plan, serving as a natural deterrent against gaming the system.

The patient participant who uses MPF noted they use the tool in a readmission prevention program they work on with a local hospital. If patients know how much their prescriptions cost before being discharged, patients may be less likely to not collect their medications due to cost concerns. A committee member supported this comment and noted the measure is important to maintain transparency on drug pricing because information is limited at the point of care.

Additional Considerations and Future Directions: CMS may consider additional monitoring methods to identify incorrect MPF pricing practices.

Abdomen Computed Tomography (CT) - Use of Contrast Material [00005-01-C-HOQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Hospital Outpatient Quality Reporting Program.

Vote Count: Continue Use (14) (64%), Discontinue Use (8) (36%), 1 Recusal.

Measure Discussion: Dr. Clark introduced this imaging efficiency measure. The purpose is to reduce unnecessary use of tests that double radiation exposure. She explained that the measure uses electronic health records and excludes specific diagnoses for which combined imaging is appropriate. These diagnoses are adrenal mass, diseases of the urinary system, hematuria, kidney infections, jaundice, liver lesion (mass or neoplasm), malignant neoplasm of the bladder, malignant neoplasm of the pancreas, non-traumatic aortic disease, pancreatic disorders, or unspecified disorder of the kidney or ureter. She added that there is still a performance gap in the measure.

During the discussion, a committee member highlighted challenges in her facility, noting that issues often arise from external referrals lacking proper documentation, which affects their performance on this measure. This led to discussions about whether the measure unfairly penalizes facilities for actions outside their direct control. CMS reframed the issue as one of communication rather than just attribution, suggesting that improving communication between radiologists and ordering physicians could mitigate the issue, emphasizing the need for dialogue to ensure appropriate testing. Patient representatives shared that they felt the welfare of the patient should come first and health care systems should adapt accordingly. One member added that the measure may be too limited to significantly improve communication between providers and radiologists; a more effective measure would have a broader focus on improving communication regarding the appropriateness of testing and imaging procedures. A patient representative shared her personal experience with repeated CT scans due to initial orders without contrast followed by orders with contrast, highlighting the inconvenience and logistical challenges from a patient's perspective.

The committee also considered the risks of unnecessary contrast imaging, specifically on the kidneys. CMS agreed, noting that hospitals should attempt to reduce inappropriate exposure to radiation, as this measure contains outliers each year. One committee member asked how CMS evaluates the measure and how it is used within the program to incentivize performance. CMS answered that the program is pay-for-reporting. The measure developer added that the measure's ability to identify facilities with extreme scores pointed to its value in identifying low performers.

Additional Considerations and Future Directions: The committee recommends either a replacement or complementary measure more focused on communication/coordination among providers and to expand the exclusion criteria to potentially address attribution challenges.

Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery [00097-01-C-HOQR]

Measure Review Final Vote: The committee recommends the discontinued use of the measure in the Hospital Outpatient Quality Reporting Program.

Vote Count: Continue Use (0) (0%), Discontinue Use (22) (100%), No Recusals.

Measure Discussion: Dr. Clark provided a brief introduction to the measure, noting the measure's purpose is to decrease unnecessary exposure to radiation and contrast material. She added that the measure has been proposed for removal from the Hospital Outpatient Quality Reporting (HOQR) Program CY 2025 proposed rule, based on measure removal factor 2 (that is, performance or improvement on a measure does not result in better patient outcomes).

The committee discussion supported removal of the measure from the program due to lack of strong reliability, lack of variation in measure scores, and being topped out. One committee member noted that the change in the measure from a 24-hour to a 30-day pre-procedure window led to a decline in performance within her health system. However, a patient partner shared the value of cardiac imaging in her personal life, as it identified a major health issue. She noted that her significant hospital bill could have been avoided, had the imaging been performed sooner. The committee requested additional feedback from CMS on the proposal for removal. CMS shared that improvement in the measure did not result in improved patient outcomes and noted their concerns over the large number of exclusions that resulted in low case numbers.

Additional Considerations and Future Directions: Recognizing the ongoing need for effective cardiac screening measures, the committee encourages CMS to consider other measures to address cardiac screening should this measure be removed.

MRI Lumbar Spine for Low Back Pain [00453-01-C-HOQR]

Measure Review Final Vote: The committee recommends the discontinued use of the measure in the Hospital Outpatient Quality Reporting Program.

Vote Count: Continue Use (1) (4%), Discontinue Use (22) (96%), 1 Recusal.

Measure Discussion: Dr. Smith introduced the measure and added that the goal of the measure is to promote use of high-quality efficient care, reduce unnecessary exposure to radiation and contrast materials, ensure adherence to evidence-based medicine and clinical practice guidelines, and provide data to consumers and other stakeholders about imaging use at the facility, state, and national level. She added that this measure has been proposed for removal from the Hospital Outpatient Prospective Payment System (OPPS) CY 2025 proposed rule, due to limited reliability and indication that the measure may not be improving patient outcomes.

The committee expressed concerns similar to those associated with measure 00097-01-C-HOQR. One committee member highlighted struggles with managing an overwhelming number of imaging requests from doctors when only a small subset is appropriate per the guidelines reflected in this measure. The limited number of radiologists hinders effective MRI order management and communication, leading to poor performance on this measure at their facility.

The measure developer acknowledged the issue of extensive denominator exclusions, and CMS agreed that the denominator exclusions may be what is driving improvements in the measure, not true patient care improvements. The committee agreed that CMS should continue to pursue other measures that focus on MRI overuse for low back pain, as it is a patient concern and a cost issue. The committee largely agreed on the importance of reducing unnecessary MRI usage but expressed concerns that the current measure does not effectively drive improvements or reflect patient care quality because of its design and the high number of exclusions. A patient partner commended the committee and CMS for discussing alternatives to MRI use for low back pain, as other alternatives can be utilized prior to imaging. CMS agreed that this issue is nuanced, but the measure is unable to capture the nuance, and that they are committed to improving ways to measure this topic.

Additional Considerations and Future Directions: None.

Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy [00021-02-C-HOQR and 00021-01-C-PCHQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Hospital Outpatient Quality Reporting Program.

The committee recommends the continued use of the measure in the PPS-Exempt Cancer Hospital Quality Reporting Program.

Vote Count:

00021-02-C-HOQR Continue Use (16) (73%), Discontinue Use (6) (27%), No Recusals.

00021-01-C-PCHQR Continue Use (17) (77%), Discontinue Use (5) (23%), No Recusals.

Measure Discussion: Dr. Kline introduced the measure to the committee. The measure encourages supporting patients undergoing outpatient chemotherapy (i.e., fluids, pain control, and nausea/vomiting control) to avoid them coming to the hospital and being admitted. CMS recommends the continued use of the measure to address the continued gaps in performance.

Several members expressed support for the continued use of the measure, especially because it identifies gaps in care transitions, can support communication between the ED and acute care settings, encourages more communication between the patient and provider, and encourages preventative care.

A patient participant noted the measure's value for elderly patients, patients with comorbidities, and low-income/rural patients.

Several members expressed concern about the potential for the measure to disincentivize admissions for patients who have very real concerns and need to be admitted, though the facilitator clarified that the concerns about people being denied care is more applicable to the admissions rate than the ED visit rate. The committee also was concerned about the broadness of symptoms and outcomes listed and questioned what clinicians and health systems can do to prevent some of those symptoms. Additionally, committee members discussed the impact of social determinants of health and the availability of resources in different settings, which might affect the applicability and fairness of the measure across different hospital settings.

One member shared that there are nuances to this measure because of capacity challenges. Another committee member concurred, noting that in many parts of the country, particularly in rural communities and safety net hospitals serving metropolitan areas, some people do not have

the option to visit an urgent care facility for intravenous treatments; instead, they must go to the ED. Furthermore, due to workforce shortages, rural communities have fewer resources and lessened capacity to support post-hospital care so they may see higher rates of ED and admission visits. Committee members asked if there is a way to address some of the health disparities that exist in certain patient populations. The developer noted that the measure is stratified by sex, age, and dual eligibility status; they found that dually eligible individuals tend to have worse outcomes.

Additional Considerations and Future Directions: None.

30-Day Unplanned Readmissions for Cancer Patients [00004-01-C-PCHQR]

Measure Review Final Vote: Committee recommends the continued use of the measure in the PPS-Exempt Cancer Hospital Quality Reporting Program.

Vote Count: Continue Use (20) (91%), Discontinue Use (2) (9%), No Recusals.

Measure Discussion: Dr. Kline provided a brief overview and rationale for continued inclusion of this measure in the PCHQR program. The measure looks at all unplanned readmissions for all kinds of chemotherapy, not only outpatient chemotherapy. The intent of the measure is not to deny care but to determine additional sites of care that are more cost effective for the patient compared to the ED.

A committee member expressed concern that there is not enough information provided in the meeting materials about current readmissions measures across programs and settings, emphasizing the importance of understanding which measures are attributed to facilities or providers and whether there are parallels or disconnects. A representative from CMS confirmed that CMS will take this into consideration. Another committee member expressed concern with the 30-day period and commented that 7 or 14 days may be more indicative of a concern directly related to the primary visit. The committee member noted many cancer patients have multiple unrelated conditions that could lead to readmission. Other committee members agreed with this recommendation, noting this is especially true in rural settings or in hospitals that serve populations with higher comorbidities. The program lead commented that the 30-day period was put in place for payment purposes. CMS thanked the committee for the recommendation but asked for feedback specific to the measure in its current state. Committee members highlighted the importance of retaining this measure regardless of the current 30-day period with suggestions to continue exploring the impacts of changing the measurement window.

Additional Considerations and Future Directions: CMS could consider reevaluating the 30-day period for this unplanned readmission measure to better capture readmissions that are related to the initial visit rather than unrelated admissions that may occur, especially in rural settings and populations with higher comorbidities.

All-Cause Hospital Transfer/Admission [00045-01-C-ASCQR]

Measure Review Final Vote: Committee recommends the continued use of the measure in the Ambulatory Surgical Center Quality Reporting Program.

Vote Count: Continue Use (22) (96%), Discontinue Use (1) (4%), No Recusals.

Measure Discussion Dr. Smith provided a brief overview and rationale for continued inclusion of this measure in the ASCQR program. The goal of this measure is to track the percentage of patients who are transferred into the hospital from an ambulatory surgical center. Some

readmissions are warranted, but if this event happens frequently, there may be an issue with the quality of care, because unplanned readmissions come with cost and time burdens to the patient. CMS implemented the measure in 2014 and proposed its removal in 2019 due to high and unvarying performance. CMS agrees that it is important to continue to monitor and report. Reporting was suspended in 2019 but proposed to be reimplemented in 2023 with a new web-based submission method to ease reporting. Dr. Anita Bhatia from CMS provided additional background information for the measure, noting endorsement was removed because the measure steward did not seek re-endorsement. The data collection method utilized quality data codes, but the facility was unable to correct errors. This caused the measure to be suspended, but the ASCQR Program and the facilities themselves find this information valuable, which led to CMS's continued support.

Overall, committee members expressed support for this measure. One committee member offered a hospital perspective, explaining that giving organizations outside the hospital feedback is important because it helps to ensure quality care from start to finish. Several committee members expressed support for the measure, emphasizing its role in improving patient safety, providing feedback to ambulatory surgical centers, and ensuring appropriate patient selection. Committee members also raised concerns about the potential for ambulatory surgery centers to become overly selective, possibly denying care to high-risk patients.

Committee members sought clarification on the type of data this measure captures, specifically if there is patient-level data. CMS confirmed the measure is used for all payers and is submitted in aggregate.

Additional Considerations and Future Directions: In the future, CMS could consider adding a claims-based measure to complement this measure to obtain additional patient-level data.

Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy [00253-01-C-HOQR and 00253-01-C-ASCQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Hospital Outpatient Quality Reporting Program.

The committee recommends the continued use of the measure in the Ambulatory Surgical Center Quality Reporting Program.

Vote Count:

00253-01-C-HOQR Continue Use (20) (87%), Discontinue Use (3) (13%), No Recusals.

00253-01-C-ASCQR Continue Use (19) (86%), Discontinue Use (3) (14%), No Recusals.

Measure Discussion: Dr. Smith introduced both 00253-01-C-HOQR and 00253-01-C-ASCQR. She noted that these measures have been endorsed and encourage quality improvement at hospital outpatient departments and ambulatory surgical centers by tracking unplanned hospital visits within 7 days after a colonoscopy procedure. The measures also aim to increase transparency for beneficiaries and providers. Dr. Smith added that the measures are stratified by dual eligibility in facility-specific reports to encourage providers to improve equitable care for vulnerable groups. CMS recommends the continued use of both measures in the HOQR and ASCQR programs.

The committee discussed both measures together. One member noted the issue of patients meeting the inclusion criteria for the measure with a hospital visit that is unrelated to the outpatient colonoscopy. Another member agreed and added that the dual eligibility stratification

does not represent the population in her area. She advocated for stratifying by risk rather than by eligibility. CMS acknowledged the issue with dual eligibility because Medicare coverage differs across the country and added this information is for the benefit of the facility and is not shared with the public. The measure developer provided the rates per 1,000 patients for hospital outpatient departments that ranged from 9-18% and for ambulatory surgical centers with a range of 6-14%.

The committee considered the potential for high-risk patients and patients with comorbidities to be denied care in an effort for a facility to maintain a better score for the measure. The committee also discussed the impact on rural communities and facilities if patients are admitted to hospitals that are separate from the facility in which the colonoscopy was performed. CMS clarified that the hospital visit is attributed to the facility where the colonoscopy is performed, not the hospital the patient is admitted to.

Additional Considerations and Future Directions: None.

Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures [00345-02-C-ASCQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Ambulatory Surgical Center Quality Reporting Program.

Vote Count: Continue Use (22) (96%), Discontinue Use (1) (4%), No Recusals.

Measure Discussion: Dr. Smith provided an overview and rationale for continued use of the measure in the ASCQR. Due to the increasing number of complex orthopedic procedures in ambulatory surgical centers, the measure promotes quality improvement by providing ambulatory surgical centers with information on patients who have an unplanned hospital visit. The measure is endorsed and has strong face and concurrent validity and moderate reliability. While the performance data suggests very little change in the measure over time, it is not topped out.

The committee briefly discussed the importance of this measure, noting the increasing number of orthopedic procedures in ambulatory surgical centers. CMS corroborated this, highlighting that the procedures are also increasingly complex. Committee members expressed interest in having CMS consider a composite measure to cover hospital visits after ambulatory surgical center procedures. However, CMS responded by noting that many ambulatory surgical centers specialize in specific types of procedures, which might render a composite measure less effective or applicable across different centers due to their varying specializations. The committee discussed the conditions indicated during the endorsement process of the measure, which were to evaluate improvement over time and to consider additional approaches for the reliability assessment that inform the reliability-validity and reliability-usability tradeoffs. Overall, the committee had generally positive feedback on the continued use of the measure in the program.

Additional Considerations and Future Directions: None.

Hospital Visits After Urology Ambulatory Surgical Center Procedures [00346-02-C-ASCQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Ambulatory Surgical Center Quality Reporting Program.

Vote Count: Continue Use (21) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Smith provided a brief overview and rationale of the measure for continued inclusion in ASCQR. Similar to the measure on Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures, urologic procedures are also rising in ambulatory surgery centers. Dr. Smith said that the measure indicated improvement over time, noting the value in providing ambulatory surgery centers with information about patients with unplanned hospital visits.

The committee discussed the conditions presented during the endorsement process, which were to evaluate improvement over time and to consider additional approaches for the reliability assessment that inform the reliability-validity and reliability-usability tradeoffs. There was little discussion on this measure due to the similarities between it and the previous measure.

Additional Considerations and Future Directions: None.

Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers [00254-01-C-ASCQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Ambulatory Surgical Center Quality Reporting program.

Vote Count: Continue Use (20) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Smith provided an overview of the measure: It is a facility-level ratio of risk-standardized, all-cause, unplanned hospital visits and supports quality improvement by providing ambulatory surgery centers with detailed information about patients who have an unplanned hospital visit.

The committee considered the importance and usefulness of this measure in the program. Patient partners emphasized the importance of the measure from a patient care perspective, particularly noting the significance of tracking hospital visits within 7 days post-surgery. The committee discussed the potential overlap of the surgical procedure population with other ASC measures and how actionable this measure is compared to others. CMS clarified that general surgery patients are not included in the measure's population for the orthopedic and colonoscopy measures. Facilities can access reports with the measure specifications to see which procedures are counted under general surgery. The committee also noted the importance of consistency across the outpatient colonoscopy, orthopedic procedure, and urology procedure measures. As these measures are very similar, there is potential for a composite measure to reduce burden. A committee member highlighted that many rural areas lack specialists and are more likely to have general surgeons. Therefore, a composite measure could be particularly beneficial in these regions. The measure developer provided the measure score range (0.59-1.84) and the interquartile range (0.97-1.01), noting that a ratio of less than 1 indicates better quality and more than 1 indicates lower quality.

Additional Considerations and Future Directions: None.

Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facility Quality Reporting Program [00576-01-C-IRFQR]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Inpatient Rehabilitation Facility Quality Reporting Program.

Vote Count: Continue Use (20) (91%), Discontinue Use (2) (9%), No Recusals.

Measure Discussion: Dr. Cummings-Vaughn introduced the measure to the committee. The measure is part of potentially preventable readmissions group and is modeled after the hospital-wide readmission measure. The measure is in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), although it is not specifically mandated by the act. CMS's rationale for the continued inclusion of this measure is that it can address poor outcomes regarding readmission rates for unplanned and potentially preventable diagnosis due to suboptimal care or shortcomings with care coordination.

A committee member said that from the patient journey perspective the measure might unintentionally promote normalization of decline to avoid admitting people. Providers might attribute decline to age or other chronic conditions rather than evaluating for need to be readmitted or to have a more acute level of care.

Other members shared their experience, noting that measures like this encourage facilities to build up capacity to treat residents in place. Providers and facilities can make improvements on this measure and patient care because they are able to expand the services they provide.

A committee member argued that the measure incentivizes better immediate care and quicker diagnoses, dismissing concerns about unintended consequences as theoretical rather than real. CMS confirmed that inpatient rehabilitation facilities (IRFs) report on this measure every 2 years to help alleviate low-volume concerns.

Additional Considerations and Future Directions: None.

Discharge to Community (DTC) - Post Acute Care (PAC) [00210-05-C-HHQR and 00210-03-C-LTCHQR and 00210-02-C-SNFQRP]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Home Health Quality Reporting Program.

The committee recommends the continued use of the measure in the Long-Term Care Hospital Quality Reporting Program.

The committee recommends the continued use of the measure in the Skilled Nursing Facility Quality Reporting Program.

Vote Counts:

00210-05-C-HHQR Continue Use (21) (95%), Discontinue Use (1) (5%), No Recusals.

00210-03-C-LTCHQR Continue Use (20) (100%), Discontinue Use (0) (0%), No Recusals.

00210-02-C-SNFQRP Continue Use (21) (100%), Discontinue Use (0) (0%), No Recusals.

Measure Discussion: Dr. Cummings-Vaughn introduced the measures to the committee. The committee discussed the measures as a group but conducted a separate vote for the measures' continued use in their respective programs. Dr. Cummings-Vaughn provided a historical overview of these measures and discussed how they fulfil an area of measurement statutorily required by the IMPACT Act. She provided the CMS rationale for the importance of discharge to the community both from a cost-effectiveness perspective and for alignment with patients rating the ability to receive at-home care highly on quality-of-life assessments. CMS also reviewed measure performance and reliability data for this measure across programs.

The committee began discussion of these measures with the continued use of this measure within the Home Health Quality Reporting Program. The committee reviewed measure performance and reliability metrics with CMS program representatives, noting overall high reliability of the measure in HHQRP. One committee member reflected on the historical challenge of the measure to correctly capture discharge codes with potential variation in real-world discharge claims in these settings. A CMS representative shared that they are confident the measure is correctly identifying codes in current use. The committee expressed strong support for exploring options for a complementary Patient-Reported Outcome Performance Measure (PRO-PM) on this topic and inclusion of functional improvement measures within the HHQRP and other programs. A PRO-PM could provide greater representation of patient voice and identify gaps or barriers from the patient perspective. The committee asked CMS to review their ongoing monitoring of implemented measures in the HHQRP program and to discuss how updates are made.

The committee then considered use of the measure within the Long-Term Care Hospital Quality Reporting Program. For this program, the committee strongly supported CMS exploring options for a complementary PRO-PM on this topic and including functional improvement measures in the program. The committee considered the current hospice exclusion in the measure denominator and supported this exclusion to align with the measure's intent. The committee discussed the differences in patient populations being served by long-term care compared with home health or skilled nursing facilities and reviewed the risk-adjustment model. As evidence on the drivers for readmission among more medically complex patients in long-term care settings grows, the committee encouraged CMS to continue review of measure performance to ensure appropriate fit to this patient population. The committee then explored the implications of this measure for rural settings given the decreasing number of long-term care settings in rural communities.

The committee concluded the discussion with consideration of the measure's use in the Skilled Nursing Facility (SNF) Quality Reporting Program. The committee considered the challenge of variation in SNF availability across the country, noting that rural settings may face restrictions in available SNF beds for patients. They discussed the throughput of patients from hospital-based care to appropriate SNF. They said the limited availability of SNF beds is a reason for delays in discharge and increased cost during hospitalization. A committee member shared the managed care perspective on community discharge for SNF patients, explaining that this adds complexity to discharge due to individuals being cut too early from the SNF and unable to find appropriate community care despite discharge planning. The committee said that the 2-year window for the measure is a limitation for clinicians who may want to see their progress update more readily while participating in the program. The committee also considered whether this measure may encourage already at-capacity SNFs to "cherry pick" or preferentially admit patients who have less complex or resource-intensive medical needs so that ratings on this measure may stay artificially inflated. Finally, one committee member suggested developing metrics that evaluate the extent to which the patients and their families participate in discharge planning and shared decision-making.

Additional Considerations and Future Directions: Overall, the committee had several recommendations for future directions of this measure and the programs. First, they strongly supported a patient-reported outcome performance measure and a functional improvement measure to be added to all reviewed programs as a complement to these measures. Next, the committee encourages CMS to consider specific implications for rural settings or resource-limited communities when looking at measure performance and implementation monitoring over time to ensure the measure still performs as intended. Finally, as part of potential PRO-PM

additions to these programs, CMS should explore the level of patient and family involvement in discharge planning as a potential measure target.

Potentially Preventable 30-Day Post-Discharge Readmission Measure [00575-04-C-HHQR and 00575-01-C-IRFQR and 00575-02-C-LTCHQR and 00575-03-C-SNFQRP]

Measure Review Final Vote: The committee recommends the continued use of the measure in the Home Health Quality Reporting Program.

The committee recommends the continued use of the measure in the Inpatient Rehabilitation Facility Quality Reporting program.

The committee recommends the continued use of the measure in the Long-Term Care Hospital Quality Reporting Program.

The committee recommends the continued use of the measure in the Skilled Nursing Facility Quality Reporting Program.

Vote Count:

00575-04-C-HHQR Continue Use (16) (80%), Discontinue Use (4) (20%), No Recusals.

00575-01-C-IRFQR Continue Use (17) (85%), Discontinue Use (3) (15%), No Recusals.

00575-02-C-LTCHQR Continue Use (17) (85%), Discontinue Use (3) (15%), No Recusals.

00575-03-C-SNFQRP Continue Use (17) (85%), Discontinue Use (3) (15%), No Recusals.

Measure Discussion: Dr. Cummings-Vaughn introduced the cross-setting measure to the committee. The committee discussed the setting-specific versions of the measure as a group but voted separately for their continued use in the four programs. Dr. Cummings-Vaughn provided a historical overview of the measure and discussed how it fulfils an area of measurement statutorily required by the IMPACT Act. CMS also reviewed measure performance and reliability data across programs.

The committee began the discussion with continued use within the Home Health Quality Reporting Program. The committee considered alignment with other readmission measures across CMS program and discussed areas of overlap and difference. The committee discussed the difference between the post-discharge readmission measure and similar within-stay measures as well as the rationale for the 30-day window to better understand discharge patterns. They encouraged CMS to consider if a within-stay measure might also address the statutorily required category for this measure topic. The committee discussed the unique challenges of rural providers, including less access to home health services and how for some patients, readmission may be the most appropriate course of care. The committee explored risk adjustment to mitigate potential performance differences across high-need populations and resource-limited settings as well as to prevent “cherry picking” of less medically complex patients by home health agencies.

The committee then discussed use in the Inpatient Rehabilitation Facility Quality Reporting Program (IRFQRP). CMS shared their commitment to age-friendly measures and the 4M framework for care of older adults. There was limited discussion of this measure in the IRFQRP and there were no additional concerns for continued use in this program.

The committee then considered use within the Long-Term Care Hospital Quality Reporting Program. They considered how the measure may perform differently in the LTCH program due

to differences in medical complexity and needs of patients in long-term care. The committee discussed how rates of readmission may be expected to be higher for a long-term care population with more comorbidities and frailty than SNF or HH patients. The committee reviewed the hospice exclusion in the measure's denominator and found it appropriate to the measure's intent within this program. The committee also voiced support for analyzing this and other post-acute care/long-term care (PAC/LTC) measures alongside SDOH metrics to assess stratified performance and ensure there are no gaps in measure appropriateness.

The committee concluded the discussion with consideration of use in the Skilled Nursing Facility (SNF) Quality Reporting Program. The committee considered how the SNF patient population may vary from that of LTCH and HH settings but had no additional concerns or clarifications to discuss related to measure use in the SNFQRP.

Additional Considerations and Future Directions: The committee encouraged CMS to consider alignment of this cross-setting measure with other readmission measures across programs and the potential use of within-stay measures for these programs. Additionally, the potential for LTCH patients to be more medically complex and thus more likely to require readmission should be considered in how the measure is implemented and assessed within the LTCHQRP. Finally, the committee encouraged CMS to further develop methods of collecting SDOH data so the measures can be better analyzed across subgroups or adjusted for confounders beyond the control of the measured entity.

Closing Remarks and Next Steps

Brenna Rabel expressed gratitude to all attendees for their active and enthusiastic participation. She informed meeting attendants that they would be notified once the final 2024 MSR Recommendation Report is published for public comment. Ms. Rabel noted that Battelle is open to feedback, including recommendations for future meetings. Battelle and CMS indicated that they would reflect on this meeting's discussions, lessons learned, and recommendations to make decisions for future meeting timelines and schedules, with dates being sent out to members far in advance.