Memorandum

June 9, 2023

To: All-Cause Admissions and Readmissions Standing Committee, Fall 2022

From: Battelle staff

Re: Post-comment web meeting to discuss public comments received

Background

Quality improvement has a critical goal of reducing avoidable hospital admissions and readmissions. Avoidable admissions and readmissions affect patients' daily lives and contribute to unnecessary health care spending. However, concerns about the unintended consequences of using measures of admissions and readmissions in accountability programs have prompted important study and discussion to meet quality goals while protecting access to necessary and appropriate care. The All-Cause Admissions and Readmissions (ACR) standing committee oversees a portfolio of quality measures that continues to address inefficiencies in readmissions and improve transitions and care coordination between care settings. For the Fall 2022 cycle of the ACR project, the standing committee evaluated two measures undergoing maintenance review against standard measure evaluation criteria.[1] The standing committee recommended one measure for endorsement and did not reach consensus on the second.

The standing committee recommended the following measure:

- CBE #3490 Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (Centers for Medicare & Medicaid Services [CMS]/Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation [Yale CORE])

The standing committee did not reach consensus on the following measure:

- CBE #3474 Hospital-Level, Risk-Standardized Payment Associated With a 90-Day Episode of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty (CMS/Yale CORE)

Standing Committee Actions in Advance of the Meeting

1. Review this briefing memo and meeting summary.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses, and discuss and revote on consensus not reached measure.

Comments Received

[1] National Quality Forum. Measure Evaluation Criteria and Guidance. 2021.

Following the standing committee's measure evaluation meeting on February 22 and 28, 2023, the committee endorsement recommendations were posted on the Partnership for Quality Measurement (PQM)™ website for public comment. The commenting period opened on March 28, 2023 and closed on May 5, 2023. The committee received four comments from four organizations and/or individuals pertaining to the measures under review and the committee endorsement recommendations. This memo focuses on comments received after the standing committee's evaluation. One comment was from the measure developer to support the discussions for the consensus not reached measure, CBE #3474, and the other three comments summarized in this memo raise concern with the measures under review.

All comments that have been received are posted on the respective committee post-comment webpage.

Battelle staff have included all post-evaluation comments that were received in the Post-comment Response Excel file. Measure stewards/developers were asked to respond to comments where appropriate, which have also been included in the Excel file. Please review this memo, agenda, and the Post-comment Response Excel file in advance of the meeting and consider whether you have any concerns with comments received and the responses for each comment.

Consensus Not Reached

CBE #3474 Hospital-Level, Risk-Standardized Payment Associated With a 90-Day Episode of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty (CMS/Yale CORE)

Description: This measure estimates hospital-level, risk-standardized payments for an elective primary total THA/TKA episode of care, starting with an inpatient admission to a short-term acute care facility and extending 90 days post admission for Medicare fee-for-service (FFS) patients who are 65 years of age or older; **Measure Type:** Cost and Resource Use; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Claims

Consensus was not reached on validity. During the discussion of the validity criterion, a public comment submitted prior to the meeting noted concerns of whether lower cost is better, whether the submission should have included an analysis of costs compared to the quality of care delivered, and whether the absence of social determinants of health (SDOH) variables in the risk adjustment model is appropriate. NQF staff clarified during the meeting that NQF criteria do not require cost measures to be correlated to a quality indicator; instead, NQF requires the measure score to correctly reflect the cost of care or resources provided. Additionally, some of the Standing Committee members requested clarification on whether most of the cost variation occurred between the 30- and 90-day period, how facilities participating in both accountable care organizations' (ACOs) arrangements and fee-for-service (FFS) arrangements are accounted for in the measure, and whether the developer included dual eligibility (DE) in the risk adjustment model. One Standing Committee member noted that the SDOH variables did have a large effect on the relative ranking of the measure scores, which they stated is unusual and may warrant adjustment.

The developer responded that DE was removed from the risk adjustment model to align the risk adjustment model with a different NQF measure, which does not adjust for DE. The developer further noted that this is a CMS priority: to facilitate "apples-to-apples" comparisons, analyses,

and reporting for hospitals on Care Compare. The developer clarified that if a hospital is receiving FFS payments, it is included in the measure. Lastly, the developer stated that no specific analysis of the relationship between costs within the first 30 days and the cost between 30 and 90 days was conducted. While the developer did address the Standing Committee's questions, the Standing Committee still had outstanding concerns with the risk adjustment analysis, which showed a strong effect of the SDOH variables on the model. This resulted in the Standing Committee not reaching consensus on validity.

During the public comment period, the developer also submitted a comment, which provides more rationale and for not adjusting for DE in the risk model.

Action Item:

Re-vote on validity. If validity passes, the committee will vote on overall recommendation for endorsement. There is no consensus not reached zone for post-comment votes.

Comments and Their Disposition

Measure-Specific Comments

CBE# 3474 Hospital-Level, Risk-Standardized Payment Associated With a 90-Day Episode of Care for Elective Primary Total Hip and/or Total Knee Arthroplasty

1. This measure is important though does not seem timely or up to date and or should have an accompanying joint replacement ambulatory measure. Also DQMs and EQMs are a CMS priority as well as meaningful measures. The state of full caregiving/ aftercare / full SNFs, LTAC (complex transitions) is such that patients too often languish in hospitals (not as mobile post surgery as they should be) where muscle strength decreases and this needs to be addressed (PT virtual?) Follow up is important to readmissions and having telehealth options for many of the follow up visits is an important option.

Measure Steward/Developer Response:
Thank you for your comment. We have responded to each of your concerns separately. Measure currency/need for an ambulatory measure: We are interpreting the commenter's statement that the measure "does not seem timely or up to date" to mean that it does not reflect the shift in volume of procedures to the outpatient space. Outpatient procedures are captured by measures in the Hospital Outpatient Quality Reporting Program (HOQR); this measure is in the Inpatient Quality Reporting (IQR) Program and is therefore limited to inpatient procedures. Digital/electronic: This measure is claims-based, so it is already in an electronic/digital format. Addressing aftercare: this is a payment measure that is reported with a quality measure to account for value. For example, a low-value care hospital with high post-surgery utilization and a high complication rate could be identified using the measure as intended. Readmission: While this measure does capture utilization (payments) related to readmission, CORE (under contract with CMS) has developed a separate THA/TKA readmission measure (CBE 1551). To capture functional outcomes, CORE (under contract with CMS) has also developed a THA/TKA patient-reported outcome performance measure (PRO-PM) (CBE# 3559).

Proposed Standing Committee Response:
Thank you for your comment. The standing committee acknowledges the importance of

ensuring quality of care is not jeopardized due to reductions in cost. Since CBE #3474 is a cost measure, we recognize that there are companion quality measures, CBE #3559 and CBE #1551 that capture readmissions for THA/TKA and functional outcomes from patients. No further action is needed.

Action Item:
Discuss and finalize standing committee response.

2. Having the ability to possibly expect or predict and document somewhere when it might be more likely that someone might be readmitted to a hospital setting after major joint surgery is important. Individuals with multiple issues that might interfere with a successful 'easy' recovery after surgery might be noted in EHRs. Also today there are many who are doing ambulatory major joint surgeries where do not fit into this measure. Might be reconsidered for validity considering the landscape today

Measure Steward/Developer Response:
Thank you for supporting the validity of the THA/TKA payment measure under consideration (CBE 3474). Under contract with CMS, CORE has developed a separate measure that captures the outcome of readmission after an eligible inpatient THA/TKA procedure (CBE 1551), in addition to a THA/TKA patient-reported outcome measure (PRO-PM) (CBE 3559). All of these measures, including the payment measure, use risk models that capture patient-level characteristics that influence the outcome. Outpatient procedures fall under the Hospital Outpatient Quality Reporting (HOQR) program; this THA/TKA Payment measure captures inpatient procedures only because it is in the Inpatient Quality Reporting (IQR) program.

Proposed Standing Committee Response:
Thank you for your comment. The standing committee will take this into consideration when re-voting on validity.

Action Item:
Discuss and finalize standing committee response.

3. The American Medication Association (AMA) agrees with the Standing Committee's concerns around the validity of the measure as specified. We support the current recommendation to not maintain endorsement of this measure.

Measure Steward/Developer Response:
Thank you for your comment. We have addressed each of your concerns separately in our response below. Reliability: The facility-level reliability (signal-to-noise reliability) for the 30-day CABG mortality measure (CBE 2558) is sufficiently high for a publicly reported measure and meets CBE requirements for reliability. The mean signal-to-noise reliability, as presented in the measure maintenance submission, is 0.86; the minimum reliability is 0.57. Variation in performance: The range of performance on the measure score is also substantial; as described in section 2b.06, updated analyses of Medicare FFS data show substantial variation in measure scores among hospitals. Using data from July 2016-June 2019 (Fall 2022 Endorsement Maintenance Dataset), the median hospital risk-standardized mortality rate (RSMR) was 2.9%, with a range of 1.4% to 6.8%. The interquartile range was 2.6%-3.4%. Social risk factor testing: CORE provided substantial social risk factor testing, summarized as follows. (1) In a multivariate model that includes all of the measure's risk variables, only the low AHRQ SES variable (and

not the Black or dual eligible variable) is statistically significantly associated with the outcome, suggesting that the clinical risk variables are attenuating the impact of the dual eligible and race (Black) variables. (2) Measure scores calculated with and without the social risk factors are highly correlated, with very small absolute differences. (3) None of the social risk variables show a significant relationship between the proportion of patients with that variable and measure scores across all facilities with the highest proportion of patients with social risk factors, including the low AHRQ SES variable. (4) As shown by a decomposition analysis, the impact of the low AHRQ SES variable is mainly at the hospital level rather than the patient level. (5) As shown by calibration curves, the risk model performs well separately for patients with each social risk factor.

Proposed Standing Committee Response:
Thank you for your comment. The standing committee will take this into consideration when re-voting on validity.

Action Item:
Discuss and finalize standing committee response.