National Consensus Development and Strategic Planning for Health Care Quality Measurement

Fall 2023 Cost and Efficiency Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Cost and Efficiency Committee on January 31, 2024, for discussion and voting on measures submitted to the committee for endorsement consideration for the Fall 2023 cycle.

Meeting participants joined virtually through the Zoom meeting platform. Both the Recommendations and Advisory Group committee members joined the call. The Recommendations Group was responsible for discussing the measures and both groups voted during the meeting using a virtual voting platform. Measure stewards/developers and members of the public were also in attendance.

The objectives of the meeting were to:

- Review and discuss candidate measures submitted to the committee for the Fall 2023 cycle;
- Review public comments received for the submitted candidate measures; and
- Render endorsement decisions for the submitted candidate measures.

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

After the committee's endorsement meeting, measures and the committee's endorsement decisions enter an appeals period for three weeks, from February 26 to March 18, 2024. Any interested party may submit an appeal, which Battelle will review for eligibility according to the criteria within the endorsement and maintenance (E&M) Guidebook. If eligible, the Appeals Committee, consisting of all co-chairs from the five E&M project committees, will convene to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.

Welcome, Roll Call, and Disclosures of Interest

Nicole Brennan, PQM Executive Director, welcomed the attendees to the meeting and introduced her co-facilitator, Matt Pickering, E&M Technical Lead of the PQM. Dr. Brennan also introduced the committee co-chairs, Mary Schramke and Amy Chin, who each provided welcoming remarks.

Dr. Pickering then conducted roll call and members disclosed any perceived conflicts of interest regarding the measures under review. One member was recused from voting based on Battelle's conflict of interest policy. For CBE #4190, Dimitriy Poznyak was recused due to his role as testing lead for that measure.

After roll call, Battelle facilitators established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum required the attendance of at least 60% of the active Recommendations Group members (at least 9 out of 14) during roll call. Voting quorum required at least 80% of active Recommendations and Advisory Group members (at least 32 out of 40) who had not recused themselves from the vote. Discussion quorum and voting quorum were established and maintained for all measure discussions except for CBE #0695, in which an Advisory Group member had stepped away from the meeting shortly before voting, resulting in a loss of voting quorum. However, after the call, the member attested to hearing the committee's discussion of the measure and confirmed their vote of "Endorsed with Conditions."

Evaluation of Candidate Measures

Dr. Pickering provided an overview of the three measures under review. For the Fall 2023 cycle, the Cost and Efficiency committee received one new measure and two measures undergoing maintenance endorsement review (Figure 1). The measures focused on hospital visits within 30 days of an inpatient psychiatric facility discharge, readmission rates following outpatient procedures, and readmission rates following a cardiac procedure.

Figure 1. Fall 2023 Measures for Committee Review

At least three weeks prior to an E&M committee endorsement meeting, the Recommendations Group and the Advisory Group received the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the public comments received for the measures under review, and the E&M team preliminary assessments.

Members of both groups were asked to review each measure, independently, against the PQM Measure Evaluation Rubric. Committee members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, committee members provided associated rationales for each domain rating, which were based on the rating criteria listed for each domain. Battelle staff aggregated and summarized the results and distributed them back to the committee, and to the respective measure developers and/or stewards, for review at least one week prior to the endorsement meeting. Battelle facilitators compiled these independent committee member ratings, and the facilitators and committee co-chairs used them to guide committee discussions.

During the endorsement meeting, the committee voted to endorse one measure with conditions, but did not reach consensus on two measures, which resulted in one measure not being

endorsed (new measure) and one measure having its endorsement removed (maintenance measure) (Table 1). Summaries of the committee's deliberations for each measure along with any conditions for endorsement are noted below.

Table 1. Fall 2023 Cost and Efficiency Measure Endorsement Decisions

CBE ID	Measure Title	New / Maintenance	Endorsement Decision	Endorse | N (%)	Endorse with Conditions | N (%)	Not Endorse/Remove Endorsement | N (%)	Recusals
4190	30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge	**New**	Not Endorse due to No Consensus	12 (36.36)	8 (24.24)	13 (39.39)	1
2687	Hospital Visits after Outpatient Surgery	**Maintenance**	Endorse with Conditions *	24 (72.72)	6 (18.18)	3 (9.1)	0
0695	Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)	**Maintenance**	Remove Endorsement due to No Consensus	1 (3.12)	19 (59.37)	12 (37.5)	0

**Note: Based on the committee vote the measure was Endorsed with Conditions. However, during the endorsement meeting, the committee was asked what conditions they would want to apply, and none were mentioned. Some recommendations were provided to the measure developer, but as no conditions were specified, Battelle as the CBE is logging this measure as Endorsed in the measure database.*

CBE #4190 – 30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge [Mathematica/CMS]

Specifications | Committee Independent Review Summary

Description: The 30-Day Risk Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility (IPF) Discharge (IPF ED Visit) measure assesses the proportion of patients ages 18 and older with an emergency department (ED) visit, including observation stays, for any cause, within 30 days of discharge from an IPF, without subsequent admission. The IPF ED Visit measure is an outcome-based measure.

Committee Final Vote: Not Endorse due to No Consensus

Conditions: None

Vote Count: Endorse (12 votes; 36.36%), Endorse with Conditions (8 votes; 24.24%), Not Endorse (13 votes; 39.39%); recusals (1)

Measure Discussion:

Dr. Brennan presented an overview of the measure and then reviewed the public comments received for the measure, noting that there were three comments received prior to the meeting. One public comment for this measure requested that endorsement be removed due to problems relating to the numerator, denominator, and risk adjustment methodology. The second public comment recommended that the measure be endorsed prior to being used and mentioned that the measure assesses an important outcome. The last comment suggested that the measure be endorsed, citing that the measure will support better follow-up care with the target population and improved cooperation among caregivers.

Dr. Brennan noted that CBE #4190 recently went through Battelle's Pre-Rulemaking Measure Review (PRMR) process and was recommended by PRMR with the condition that it attain CBE endorsement. She then gave an opportunity for the developer to give a brief introduction to the measure.

Dr. Brennan opened the discussion to public comment and no public comments were received. She then opened the floor to the committee for general comments and clarifying questions on the measure. One committee member asked if the purpose of the measure is to evaluate the quality of psychiatric care delivered by the IPF (inpatient facility) and reimburse the facility based on that quality score. The developer stated that this measure would be a "pay for reporting" measure whose purpose is to evaluate an IPF's ability to facilitate positive community-based outcomes. Another committee member asked for clarification on whether this measure evaluates a physician's performance or a facility's performance. The developer answered that this measure evaluates a facility's performance. Another committee member asked the developer if there were any resource availability concerns, given the data comes from various IPFs across the U.S., and resources for keeping patients out of emergency departments (EDs) are not always present. The member also asked if patients losing insurance impacted the measure. With respect to community resources, the developer noted that social determinants of health (SDOH) were added to the risk model and did not impact the measure score. Regarding insurance, the developer noted that patients need to have been insured for a certain period of time, since the assessment is based on admission information within the 30 days after discharge from an IPF.

Several committee members brought up the “all-cause" nature of the measure as a concern and most of the measure discussion focused on this issue. Two subject matter experts (SMEs), who were invited by Battelle to provide input for the committee’s consideration, had concerns about the all-cause approach. One of the SME’s noted that there may be “noise” that affects the metric, since some patients may come in for unrelated ED visits, and the SME asked how that could be avoided. The developer noted that for other ED visit measures, patients that are readmitted are excluded. The developer added that the all-cause nature was incorporated to harmonize with readmission measures for the benefit of IPFs and gave the example of a patient who arrives at an ED presenting with chest pain and shortness of breath, but the primary diagnosis was not related to mental health even though these symptoms may be related to a panic attack. A committee member asked if there was literature on the inclusion and exclusion of these symptoms and how frequently these kinds of misdiagnoses happen, to which the developer replied that no research was found. When asked how the measure will deal with the inclusion of surgical or medical procedures that are not behavioral health related, the developer repeated her previous point that the goal is to harmonize with other readmission measures to address issues with how diagnoses are coded.

Another prominent concern from committee members was that accountability is with the IPF facility, when the issue being addressed can be considered a community health issue. One committee member noted that there are many social, political, and cultural factors that may affect the measure and mentioned in his time evaluating follow-up visits (non-ED), he saw improvements in coordination of care when community services (e.g., law enforcement) were integrated. The developer agreed; however, they noted that IPF facilities can increase re-integration through actions such as patient-centered care and capitalizing on the patient’s social network prior to discharge. Another committee member suggested this measure be applied in some way to health systems, since the lack of resources within a system can lead to undesirable effects in IPFs and EDs. The developers further noted that although the accountability is with the IPF, they view this measure as a way to encourage a discussion on how additional community resources can be made available. The developer noted that this measure seeks to meet patients where they are in terms of community integration. One SME reiterated the concern that the IPF will be measured for a community-wide issue and gave the example that behavioral health may be monopolized by one single entity in a given area and therefore does not allow for other facilities to achieve the standard established by this measure. However, the committee patient co-chair mentioned that having information on gaps in behavioral health care is a good thing, and this measure may help identify silos for addressing community-wide issues and making action plans to address those.

Regarding importance, the developer mentioned that the technical expert panel (TEP) recognized issues with the all-cause nature of the measure and had similar concerns about the ability of the IPF to effect change. However, the developer emphasized the patient co-chair’s point about collecting information on gaps in care through this measure could be a catalyst for change. One committee member noted that the all-cause nature is a real trend for other CMS measures. Another committee member agreed and added that this measure should be applied to the EDs in order to truly be effective. Dr. Brennan reminded the committee that since this is a new measure, the committee can decide that it go down a path of being endorsed but re-evaluated once it is up for maintenance against these considerations (i.e., all-cause, availability of community resources) if the measure is considered important.

Regarding scientific acceptability, one committee member noted that in their experience working for an organization that has an IPF, the lack of access to primary care is a known issue. The developer responded that this may be a known issue; however, the lack of access to primary

care is not quantified. The developer asked if any committee members had questions about the reliability or if the method used was appropriate. The developer noted that this measure uses a risk adjustment methodology and after resampling, there was a reliability coefficient between 0.6 and 0.7, showing that the results were stable. One committee member asked, regarding the all-cause concern, whether it would be easier to exclude comorbidities rather than to adjust for them in the model used. The developer did not have a response to this question.

Regarding equity, one committee member asked if any committee established guidance on how to incorporate SDOH. The developer noted that this came up in the TEP discussion and reiterated that when these variables were added to the risk model, there was no impact to either the fit of the model or the measure score, and so it was decided not to include these factors, to reduce unnecessary complexity.

Dr. Brennan summarized the prominent discussion points, and then gave an opportunity for the developer to give any final remarks. The developer noted that although there were concerns regarding comorbidities that may cloud the measure data, this measure would be useful in providing a starting point for addressing gaps and thanked the committee for its input.

Additional Recommendations: None.

CBE #2687 – Hospital Visits after Hospital Outpatient Surgery [Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation/CMS]

Specifications | Committee Independent Review Summary

Description: Hospital Visits after Hospital Outpatient Surgery measure reports the facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a procedure performed at a hospital outpatient department (HOPD) among Medicare Fee-For-Service (FFS) patients aged 65 years and older. An unplanned hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Committee Final Vote: Endorse with Conditions

Conditions: None.

Vote Count: Endorse (24 votes; 72.72%), Endorse with Conditions (6 votes; 18.18%), Remove Endorsement (3 votes; 9.1%), recusals (0)

Note: Based on the committee vote the measure was Endorsed with Conditions. However, during the endorsement meeting, the committee was asked what conditions they would want to apply, and none were mentioned. Some recommendations were provided to the measure developer, but as no conditions were specified, Battelle as the CBE is logging this measure as Endorsed in the measure database.

Measure Discussion:

Dr. Brennan gave an overview of the measure, then noted that one public comment was received prior to the endorsement meeting. The comment stated that endorsement for the measure should be removed due to issues with the numerator, denominator, and the risk adjustment methodology. Dr. Brennan then opened up the floor for anyone on the call to verbalize a public comment, and none were received. The developer then gave an overview of the measure.

Moving to committee discussion, the committee had several questions, including on how this measure fits with patient-reported outcome measures (PROMs) particularly those on joint replacement procedures that happen more commonly in outpatient settings, how hospitals use reports generated for this measure, and how the measure considers non-ED follow-ups for procedures. The developer responded that this measure would work in parallel with PROMs that assess patient outcomes and gave an example of an inpatient hip/knee measure, which will soon be moved to the outpatient setting, and which could be complementary to this measure. In response to how hospitals use the reports, the developer said that hospitals receive individual reports for each patient and whether their procedure is included in the denominator, which can give the hospital information about risk factors and trends within their facility. The developer spoke to non-ED follow-ups, mentioning that the ideal process of care coordination is to have a physician follow-up after an outpatient procedure rather than an ED visit.

The committee had no specific questions about the importance or feasibility of the measure. One of the committee co-chairs noted one question that came through the meeting chat, asking if hospital-owned surgical centers will be counted in this measure. The developer clarified that ambulatory surgical centers (ASCs) are not included in this measure, because there are separate ASC measures. The developer added that all outpatient surgical centers have to be owned by hospitals.

Regarding scientific acceptability, committee members asked (1) about the difference in the model used in this measure compared to the models used in ASC measures; (2) if the developer could comment on how fast outpatient procedures are moving to ASCs; and (3) if this necessitates an earlier review of the measure. The developer responded that their process involves reviewing model performance annually and they can add a procedure-specific view of model performance and address any issues as more procedures move to the outpatient space.

Dr. Brennan presented the slide showing the measure strengths and limitations related to equity and gave the developer an opportunity to speak to these. The developer noted that they have done substantial analysis that includes SDOH. However, they can make further progress as more variables become available. The developer emphasized that stratification is the real advantage of this measure, since hospitals will receive reports on outcomes for patients with social risk factors. One committee member asked if this measure is publicly reported, and the developer responded that it is not. The same committee member asked if the developer looked at changes in hospital rankings when considering SDOH. The developer responded that they conducted a Pearson correlation, which looks at overall correlation rather than rankings. The measure scores were highly correlated, and they did not see a notable difference.

Regarding use and usability, one committee member asked if the developer reviewed literature documenting that the measure is being used. The developer noted that facilities are asking questions about individual cases and whether such cases are included in the measure, and that is a good sign that they are engaging with the information. The committee member suggested that a survey of measured entities to clarify whether those who have access to the data are using it would be a good thing to consider. Finally, the patient committee co-chair noted that the information would be useful to have from a patient perspective, since there is limited choice on where to have outpatient procedures. Since the non-stratified measure is publicly reported, this gives an opportunity to look at performance across facilities.

Additional Recommendations: None.

CBE #0695 – Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI) [American College of Cardiology (ACC)]

Specifications | Committee Independent Review Summary

Description: This measure estimates a hospital-level risk-standardized readmission rate (RSRR) following PCI for Medicare Fee-for-Service (FFS) patients who are 65 years of age or older. The outcome is defined as an unplanned readmission for any cause within 30 days following a hospital stay. The measure includes both patients who are admitted to the hospital (inpatient) for their PCI and patients who undergo PCI without being admitted (outpatient or observation stay). A specified set of planned readmissions do not count as readmissions. The measure uses clinical data available in the National Cardiovascular Disease Registry (NCDR) CathPCI Registry for risk adjustment and Medicare claims to identify readmissions. Additionally, the measure uses direct patient identifiers including Social Security Number (SSN) and date of birth to link the datasets.

Committee Final Vote: Endorsement Removed due to no consensus. The committee did not reach consensus due to the lack of recent data to establish whether a performance gap remains; to determine reliability and validity of the measure, namely at the accountable entity-level; and to establish whether the measure has improved over time. In addition, the measure is not currently being used.

Conditions:

- None

Vote Count: Endorse (1 vote; 3.12%), Endorse with Conditions (19 votes; 59.37%), Remove Endorsement (12 votes; 37.5%), recusals (0)

Measure Discussion:

Dr. Pickering introduced the measure, noting that there were no public comments received for the measure. He then opened the floor for members of the public to voice a comment for this measure before the committee discussion. No comments were received. He then gave the developer an opportunity to give an overview of the measure. The developer highlighted that this measure is currently not in use and stressed that unlike other ACC measures that are submitted with updated gap and testing data, a limitation of this measure is that the claims data necessary to implement and continue to test the measure cannot currently be accessed by ACC. ACC worked with other medical societies seeking legislative action to remove barriers to access claims data; however, Congress did not act. Despite this, and based on the literature review conducted, ACC feels that the readmission issue is still important to address; as soon as data can be accessed, this measure would start to be implemented.

Dr. Pickering noted that ACC also submitted a measure (CBE #0694, Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator (ICD) to the E&M Management of Acute Events and Chronic Conditions committee for the Fall 2023 cycle. He noted that this measure (CBE #0694) had similar data availability challenges. He further stated that the Management of Acute Events and Chronic Conditions committee considered several conditions for the measure (CBE #0694), including having the measure come back for maintenance in three years. At that time, if the developer obtained the necessary data, then the developer would update the testing and performance data, and it would have a plan for use and implementation and share any trend data in measure performance over time. He noted that this committee also has the option to place similar conditions on this PCI measure

if they choose to do so after the discussion. He opened the floor to general questions from the committee on this measure. One committee member asked what portion of the data comes from the CathPCI Registry, to which the developer replied that all data except for those related to the 30-day outcome originates from the registry. The 30-day outcome data are difficult for facilities to obtain and therefore would need to come from claims data.

Regarding importance, Dr. Pickering noted the limitations identified in the committee reviews before the meeting, including the previously mentioned concerns about outdated data, limited literature justifying the causal relationship between low quality of care and readmissions, lack of patient involvement, and a suggestion that the performing physician—and not the acute-care facility—should be the accountable entity. The developer spoke to two of these concerns, noting that two patient representatives were involved when the measure was developed and the same would be true once the measure is able to be implemented again. The developer also noted that facilities can take actions to improve readmission rates and therefore accountability is at the appropriate level. The committee asked questions regarding reporting, including how the measure data are reported to the public, and if there may be self-selection bias for the facilities that are currently reporting. The developer responded that facilities currently reporting include those that are not performing well, which leads them to believe that the bias would be limited. They added that, if able to implement this measure, they would consider pointing out facilities that are not reporting, which could serve as additional useful information.

The data access concerns continued to be voiced throughout the committee discussion. Two committee members asked about the logistics of an “Endorsed with Conditions” decision, specifically about the difference between requirements for new versus maintenance measures. Dr. Pickering explained that new measures are required to provide a business case and a plan for use, noting that CBE #0695 is a maintenance measures and is not currently being used. Maintenance measures are required to show that there is a change in measure score over time. Dr. Pickering presented the option of endorsing the measure with conditions similar to the other ACC measure reviewed by the Management of Acute Events and Chronic Conditions committee. The committee patient co-chair added that it may not be reasonable to place conditions on the measure that are dependent on an act of Congress enabling the developer to access the necessary data. One committee member noted that the measure's reliability is low and reiterated a limitation identified by the committee reviews regarding validity not being proven. Regarding reliability, the developer responded that the mean difference between the two samples in testing was approximately a 700-patient difference and it believes that performance between the two samples was similar overall.

Moving to equity, use, and usability, Dr. Pickering gave the developer an opportunity to speak to both the limitations identified by the committee, which related to the lack of information as well as the limitation of the measure not currently being used. The developer did have anything further to share, since these limitations centered around the data access concern.

Additional Recommendations: None

Opportunity for Public Comment

No public comments were received during the call.

Next Steps

Dr. Pickering noted that Battelle will post the meeting summary to the E&M committee project page by February 26, 2024. The summary will include any conditions placed on any of the measures. He noted that the appeals period for this cycle will begin on February 26, 2024, and end on March 18, 2024. He explained that any endorsement decision rendered by the committee can be appealed by any interested party based on the eligibility criteria, which can be found in the E&M Guidebook. The standing Appeals Committee meeting date is March 27, 2024. The Appeals Committee consists of all co-chairs from all project committees. Dr. Pickering and the Cost and Efficiency co-chairs then thanked the committee, developers, and members of the public before adjourning the call.