National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Cost and Efficiency Endorsement Meeting Summary

Overview

Battelle, the consensus-based entity (CBE) for the Centers for Medicare & Medicaid Services (CMS), convened the Recommendation Group of the Cost and Efficiency committee on August 1, 2024, for discussion and voting on measures under endorsement consideration for the Spring 2024 cycle. Meeting participants joined virtually through a Zoom meeting platform. Measure stewards/developers and members of the public were also in attendance.

The objectives of the meeting were to:

- Review and discuss measures submitted to the committee for the Spring 2024 cycle;
- Review staff preliminary assessments, Advisory and Recommendation Group feedback, public comments, and developer responses regarding the measures under endorsement review; and
- Render endorsement decisions using a virtual voting platform.

This summary provides an overview of the meeting, the Recommendation Group deliberations, and the endorsement decision outcomes. Full measure information, including all public comments, staff preliminary assessments, Advisory Group feedback, and committee independent reviews can be found on the project committee's webpage 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 3 weeks, from August 30-September 20, 2024. Any interested party may submit an appeal, which will be reviewed 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

Matt Pickering, PharmD, E&M task lead of PQM, welcomed the attendees to the meeting and introduced his co-presenters, Anna Michie, E&M deputy task lead, and Isaac Sakyi, social scientist, and his co-facilitator Meridith Eastman, Pre-Rulemaking Measure Review (PRMR) task lead. Dr. Pickering also introduced the committee co-chairs, Amy Chin, DrPHc, MS, and Danny van Leeuwen, OPA, RN, MPH, who each provided welcoming remarks.

Mr. Sakyi then conducted roll call, and members disclosed any perceived conflicts of interest regarding the measures under review. No members were recused from voting.

After roll call, Battelle staff established whether quorum was met and outlined the procedures for discussing and voting on measures. The discussion quorum requires the attendance of at least

60% of the active Recommendation Group members (n=13). Voting quorum requires at least 80% of active Recommendation Group members who have not recused themselves from the vote (n=17). Voting quorum was not established during the committee roll call; however, discussion quorum was achieved. Consequently, endorsement decisions were not finalized during the meeting. The Recommendation Group members in attendance discussed the measures and submitted their endorsement votes. After the endorsement meeting, the E&M team shared the meeting recording with Recommendation Group members who were not present during the meeting and requested they submit their endorsement vote via an offline voting tool within 2 business days.

Evaluation of Candidate Measures

Ms. Michie provided an overview of the six measures under review. For the Spring 2024 cycle, the Cost and Efficiency committee received one new measure and five measures undergoing maintenance endorsement review (Figure 1). The measures focused on hospital visits after ambulatory surgical center (ASC) procedures, hospitalizations for ambulatory care-sensitive conditions, and readmission rate for Merit-Based Incentive Payment System (MIPS)-eligible clinician groups.

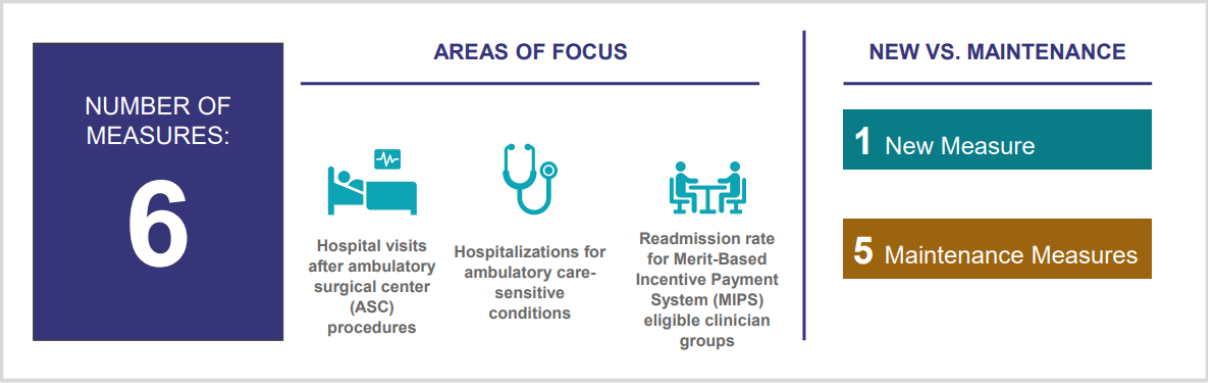

Figure 1. Cost and Efficiency measures for Spring 2024.

Battelle convened a public Advisory Group meeting on June 6, 2024, to gather initial feedback and questions about the measures under endorsement review. Battelle summarized the Advisory Group's feedback and questions and shared them with developers/stewards for review and written response. Battelle then shared the Advisory Group feedback and questions, along with the developer/steward responses, with the Recommendation Group a week prior to the endorsement meeting.

On June 17, 2024, the Recommendation 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 staff preliminary assessments.

Recommendation Group members were asked to independently review each measure against the PQM Measure Evaluation Rubric. Recommendation Group members assigned a rating of "Met," "Not Met but Addressable," or "Not Met" for each domain of the PQM Measure Evaluation Rubric. In addition, Recommendation Group 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 Recommendation Group, and to the respective measure developers/stewards, for review within 1 week of the

endorsement meeting. Battelle staff compiled these independent Recommendation Group member ratings, and Battelle facilitators and committee co-chairs used them to guide committee discussions.

During the endorsement meeting, the Recommendation Group voted to endorse 6 measures with conditions (Table 1). Summaries of the Recommendation Group's deliberations for each measure along with any conditions for endorsement are noted below.

Table 1. Spring 2024 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
3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers	Maintenance	Endorsed with Conditions	10 (52.63)	9 (47.37)	0 (0.00)	0
3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures	Maintenance	Endorsed with Conditions	9 (47.40)	10 (52.60)	0 (0.00)	0
3470	Hospital Visits after Orthopedic Ambulatory Surgical Procedures	Maintenance	Endorsed with Conditions	5 (26.23)	14 (73.68)	0 (0.00)	0
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Maintenance	Endorsed with Conditions	7 (36.84)	12 (63.16)	0 (0.00)	0
3495	Hospital-Wide 30-Day, All-Cause, Unplanned Readmission Rate (HWR) for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups	Maintenance	Endorsed with Conditions	6 (31.58)	13 (68.42)	0 (0.00)	0
4490	Hospitalizations for Ambulatory Care Sensitive Conditions among Home and Community Based Service (HCBS) Participants	New	Endorsed with Conditions	3 (16.67)	14 (77.78)	1 (5.56)	0

CBE #3357 – Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers [Yale CORE/CMS]

Specifications | Discussion Guide

Description: Facility-level risk-standardized ratio of acute, unplanned hospital visits within 7 days of a general surgery procedure performed at an ambulatory surgical center (ASC) 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: When this measure returns for maintenance, the developer should:

- Explore methods to enable the evaluation of improvement over time; and
- Consider additional approaches for the reliability assessment that inform the reliability-validity (e.g. shrinkage) and reliability-usability (e.g. stability) tradeoffs.

Vote Count: Endorse (10 votes; 52.63%), Endorse with Conditions (9 votes; 47.37%), Remove Endorsement (0 votes; 0%); recusals (0).

Public Comments: This measure received five public comments prior to the meeting. Two supportive comments emphasized the importance of the measure and shared personal experiences. Two comments opposed endorsement of this measure, criticizing its risk-adjustment model, reliability, and lack of business case. One comment questioned the rationale behind setting the age limit at 65 and older and proposed expanding the age range to include younger patients, potentially in their 50s.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Under 65 population	• Recommendation Group members discussed the inclusion of patients under the age of 65 in the measure population. • One member noted that 14% of Medicare patients are under the age of 65 and questioned why those patients are excluded. • Several Recommendation Group members explained that Medicare patients under 65 have different health statuses than those over 65 and would significantly change the measure population. • Another member noted that a significant number of patients over 65 have complex conditions and disabilities and suggested exploring whether there are enough patients to adjust for differences. • One Recommendation Group member recommended developing a separate measure for those under 65 so as not to sacrifice the scientific acceptability of this measure. • Another Recommendation Group member suggested exploring dual eligibility in the risk-adjustment model to equalize the population. • Several Recommendation Group members highlighted that ASC patients are a lower-risk population and those in Medicare who are under 65 and disabled may not go to ASCs for these types of procedures. Further exploration of the ASC patient population may be appropriate.

Discussion Topic/Theme	Recommendation Group Discussion
	• The developer explained that the under 65 and over 65 Medicare populations have widely different outcome rates. They do not include those under 65 because they have a higher burden of disability, and it would make risk adjustment more difficult. They agreed that the proportion of under 65 Medicare patients receiving procedures in ASCs is lower and adding the population may be more relevant in the inpatient and hospital outpatient department (HOPD) settings.
Medicare Advantage	• Several Recommendation Group members noted their disappointment that the population did not include Medicare Advantage patients, which is more than half of Medicare patients. However, Recommendation Group members acknowledged the technical difficulties with data availability. • The developer noted that they would love to add the Medicare Advantage population and highlighted it is currently a work in progress for inpatient measures. They explained that they have not included Medicare Advantage patients to date because of data availability and that it is up to CMS to make the decision to expand the measure's population to include Medicare Advantage.
Reliability and sample size	• The Recommendation Group discussed reliability and sample size, noting that the lower reliability in the first three deciles could be attributed to low-procedural volume facilities. • One Recommendation Group member suggested expanding the measure to 3 years to increase the sample size. • The developer noted that this is already a 2-year measure, but they could look at adding a third year. However, they have received previous pushback that data over a 3-year period are untimely and too wide of a net. • The developer explained that the minimum sample size is 25 procedures for public reporting. If they raise the minimum procedural volume to increase reliability, they limit what information is available to consumers for public reporting. • Recommendation Group members discussed reliability methodologies and thresholds, noting the scientific consensus around the 0.6 threshold but acknowledging that reliability depends on a lot of factors. • One Recommendation Group member noted that signal-to-noise is not an ideal approach to capture reliability because it masks the true performance of facilities with small volumes. • The developer explained that the preferred methodology for reliability has changed over time, shifting from test-retest (split-half) to signal-to-noise. The developer noted the reliability thresholds are now tougher to meet, as they were previously a median reliability of 0.7 and are now a minimum reliability of 0.6. • One Recommendation Group member said that they are satisfied with the reliability progress for this measure, noting that every maintenance cycle brings good discussion about addressing reliability limitations and advantages and that the developer does a nice job addressing feedback. • The Recommendation Group placed a condition for the developer to consider additional approaches to reliability assessment that inform

Discussion Topic/Theme	Recommendation Group Discussion
	the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs.
Importance and usability	• Several Recommendation Group members noted that this set of measures (CBE #3357, 3366, 3470, and 2539) were important. • The developer, a few Recommendation Group members, and an invited subject matter expert (SME), David May, MD, MBA, FACS, CPHQ, explained that ASCs receive detailed reports and find them incredibly useful, as they can review the electronic health record and understand how to improve their facility. However, benchmarking and comparison to other facilities is difficult because improvements over time is not assessed and ASCs perform different procedures. • The developer explained that the list of procedures at the ASCs changes frequently, making it difficult to evaluate improvement over time. They've been discussing options (e.g., creating coherent procedure groupings) with their experts but that requires additional resources and time. The developer noted that other stakeholders (e.g., Leapfrog, health plans) use this data and find it helpful, as no other measures are available for the ASC setting. • Recommendation Group members discussed public reporting. One member noted that patients are not looking at the CMS website to assess ACS outcomes as they predominately trust their providers to tell them where to go to have a good outcome. • The developer highlighted that public reporting began in January 2024 and improvement will take several reporting cycles. The developer also shared evidence from the colonoscopy measure (CBE #2539) that shows improvements over several years, and these measures have similar limitations. • The Recommendation Group placed a condition for the developer to explore methods to enable the evaluation of improvement over time.
Volume-outcome validity testing	• Several Recommendation Group members had concerns about potential bias if facilities with different volumes were compared. For example, higher-volume facilities may attract different types of patients than lower-volume facilities. One committee member recommended including volume as a risk factor in the risk-adjustment model. • Several members were opposed to including volume in the risk model, explaining that if higher volume has been shown to equal better quality, they don't want to "adjust that way." • The SME noted that surgeon volume may be a better indicator of quality than facility volume, noting that the literature shows that volume may equate to quality due to a repetition effect and expertise developed by the surgeon. • One Recommendation Group member noted that volume is being used as a proxy for a more distinct element connected to quality (e.g., surgeon experience, favorable payer mix). • The developer described their rationale for evaluating a volume-outcome relationship. Typically, when providing validity evidence, they would identify other quality measures in the same causal pathway and analyze measure results to assess association. However, they were unable to find another ASC measure for comparison and evaluated volume as a proxy. The developer also

Discussion Topic/Theme	Recommendation Group Discussion
	noted that recent literature supports a volume-outcome relationship for ASC procedures. The developer also clarified they do not adjust for facility-level variables (e.g., volume) but rather for procedure-level variables (e.g., type, complexity).
All-cause outcome and risk adjustment	• One Recommendation Group member asked the SME if he was comfortable with capturing the all-cause outcome (e.g., instances where the patient may return to the hospital for reasons unrelated to the ASC procedure). • The SME agreed with the all-cause outcome because of the short (7-day) time window, noting that any visit in the first 7 days is significant. • Several Recommendation Group members noted that they were satisfied with the all-cause approach and the responses received.

Additional Recommendations: Recommendation Group members suggested further exploration of the ASC population to determine if Medicare patients under the age of 65 frequently use ASCs for these procedures. Additionally, the developer should consider expanding the measure to include the Medicare Advantage population.

CBE #3366 – Hospital Visits After Urology Ambulatory Surgical Center Procedure [Yale CORE/CMS]

Specifications | Discussion Guide

Description: Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a urology procedure performed at an ambulatory surgical center (ASC) 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: When this measure comes back for maintenance, the developer should:

- Explore methods to enable the evaluation of improvement over time;
- Consider additional approaches for the reliability assessment that inform the reliability-validity (e.g. shrinkage) and reliability-usability (e.g. stability) tradeoffs.

Vote Count: Endorse (9 votes; 47.4%), Endorse with Conditions (10 votes; 52.6%), Remove Endorsement (0 votes; 0%); recusals (0).

Public Comments: This measure received four public comments prior to the meeting. One comment supported the measure, emphasized its importance, and shared a personal experience. Two comments opposed endorsement of this measure, criticizing its risk-adjustment model, low reliability, and a lack of business case. One comment questioned the rationale behind setting the age limit at 65 and older and proposed expanding the age range to include younger patients, potentially in their 50s.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Similar feedback to CBE #3357 (under 65 population, Medicare Advantage, reliability and sample size, importance and usability, and volume-outcome validity testing)	• Recommendation Group committee members expressed the same feedback surrounding the inclusion of the under 65 and Medicare Advantage populations, reliability and sample size considerations, importance and usability, and volume-outcome empirical validity testing as noted in the measure discussion for CBE #3357. • The Recommendation Group placed a condition for the developer to consider additional approaches to reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs. • The Recommendation Group placed a condition for the developer to explore methods to enable the evaluation of improvement over time.
Improvements	• The developer shared that when they looked at the distribution of the measure from 2014 to now, they saw small improvements over time across the entire distribution (with the caveat that the procedures are slightly different). • The SME, Tarik Yuce, MD, MS, noted that the procedures performed at ASCs are becoming more complex over time and it is good that the complication rate is staying stable in some of those metrics.
Patient ASC experience	• One Recommendation Group member shared their personal experience across two different ASCs, noting that the practice with better customer service decreased their anxiety and may have contributed to their better outcomes.
Measures standardized against the national average vs. a multiplier	• One Recommendation Group member asked how the ASC measures are reported, as some are rates and others are standardized against a national average. • The developer explained that the urology measure (CBE #3366) and the orthopedic measure (CBE #3470) are reported as a rate. The general surgery measure (CBE #3357) is expressed as a ratio because facilities are performing a different mix of procedures. They have received feedback that the ratio measure is difficult to interpret. The colonoscopy measure (CBE #2539) is expressed at the rate times 1,000 because the outcome rate is low (a decimal) and is easier to understand as a whole number.
Measure overlap	• A Recommendation Group member asked if the urological, orthopedic, and colonoscopy procedures feed into the general surgery measure. • The developer stated that they are mutually exclusive and do not overlap.

Additional Recommendations: Recommendation Group members suggested further exploration of the ASC population to determine if Medicare patients under the age of 65 frequently use ASCs for these procedures. Additionally, the developer should consider expanding the measure to include the Medicare Advantage population.

CBE #3470 – Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures [Yale CORE/CMS]

Specifications | Discussion Guide

Description: Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of an orthopedic procedure performed at an ambulatory surgical center (ASC) 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: When this measure comes back for maintenance, the developer should:

- Explore methods to enable the evaluation of improvement over time;
- Consider additional approaches for the reliability assessment that inform the reliability-validity (e.g. shrinkage) and reliability-usability (e.g. stability) tradeoffs.

Vote Count: Endorse (5 votes; 26.32%), Endorse with Conditions (14 votes; 73.68%), Remove Endorsement (0 votes; 0%); recusals (0).

Public Comments: The measure received five public comments prior to the meeting. Two comments expressed personal experiences and enthusiasm for the measure's potential to lead to better outcomes for patients undergoing similar procedures. Two comments opposed endorsement of this measure, criticizing its risk-adjustment model, low reliability, and a lack of business case. One comment questioned the rationale behind setting the age limit at 65 and older and proposed expanding the age range to include younger patients, potentially in their 50s.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Similar feedback to CBE #3357 (under 65 population, Medicare Advantage, reliability and sample size, importance and usability, and volume-outcome validity testing)	• Recommendation Group committee members expressed the same feedback surrounding the inclusion of the under 65 and Medicare Advantage populations, reliability and sample size considerations, importance and usability, and volume-outcome empirical validity testing as noted in the measure discussion for CBE #3357. • The Recommendation Group placed a condition for the developer to consider additional approaches to reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs. • The Recommendation Group placed a condition for the developer to explore methods to enable the evaluation of improvement over time.
Top conditions prior to total hip and knee replacement additions	• One Recommendation Group member asked what the top three conditions were prior to the addition of the knee and hip surgeries. • The developer noted that the top five conditions are incise finger tendon sheath, arthroscopic rotator cuff repair, knee arthroscopy surgery, another knee arthroscopy surgery, and repair of hammer toe.
Comparison across facilities	• One Recommendations Group member asked about any efforts to identify ASCs that are equivalent in terms of procedure complexity.

Discussion Topic/Theme	Recommendation Group Discussion
	• The developer stated that they use an indicator to look at the complexity. Because facilities will still have a mix of procedures, they have grouped the measures by specialty type. The developer also addressed how well the measure is risk-adjusted across the cohort of patients. Figure 4 in the "All Tables and Figures" attachment of their submission shows the predicted and observed outcomes are highly correlated, which indicates the risk-adjustment model is working to balance differences in patient mix. • One Recommendations Group member inquired about practices that might specialize (e.g., in hands/feet). • The developer noted that this measure is beneficial to specialists and specialist facilities, because their procedures are still being captured. Additionally, subspecialty providers sometimes organize into an ASC.

Additional Recommendations: Recommendation Group members suggested further exploration of the ASC population to determine if Medicare patients under the age of 65 frequently use ASCs for these procedures. Additionally, the developer should consider expanding the measure to include the Medicare Advantage population.

CBE #2539 – Facility 7-Day Risk-Standardized Hospital Visit Rate after Patient Colonoscopy [Yale CORE/CMS]

Specifications | Discussion Guide

Description: Facility-level risk-standardized rate of acute, unplanned hospital visits within 7 days of a colonoscopy procedure performed at a hospital outpatient department (HOPD) or ambulatory surgical center (ASC) 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. The measure is calculated separately for ASCs and HOPDs.

Committee Final Vote: Endorse with Conditions

Conditions: When this measure comes back for maintenance, the developer should:

- Consider additional approaches for the reliability assessment that inform the reliability-validity (e.g. shrinkage) and reliability-usability (e.g. stability) tradeoffs.

Vote Count: Endorse (7 votes; 36.84%), Endorse with Conditions (12 votes; 63.16%), Remove Endorsement (0 votes; 0%); recusals (0).

Public Comments: The measure received five public comments prior to the meeting. One comment shared a personal experience in this focus area and emphasized the importance of this measure. Three commenters opposed endorsement of this measure, criticizing its risk-adjustment model, reliability, and inclusion criteria. One comment questioned the rationale behind setting the age limit at 65 and older and proposed expanding the age range to include younger patients, potentially in their 50s.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Similar feedback to CBE #3357 (under 65 population, Medicare Advantage, reliability and sample size, and volume-outcome validity testing)	• Recommendation Group committee members expressed the same feedback surrounding the inclusion of the under 65 and Medicare Advantage populations, reliability and sample size considerations, and volume-outcome empirical validity testing as noted in the measure discussion for CBE #3357. • The Recommendation Group placed a condition for the developer to consider additional approaches to reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs.
Patient experience	• One Recommendation Group member noted their personal experience with colonoscopies. Though they received both verbal and written instructions, they never received post-procedure follow-up and never had their wife included in any of the discussions (even though she was the person who would take him home).
Unintended consequences	• One Recommendation Group member asked if the developer was aware of any unintended consequences. • The developer explained that from the literature, the biggest barrier to obtaining a colonoscopy is the concerns from the patient about discomfort and pain. Additionally, CMS releases a report about unintended consequences, and the developer does not believe this measure has any identified unintended consequences within that report.

Discussion Topic/Theme	Recommendation Group Discussion
Outliers	• The SME asked the developer about any outliers. • The developer noted that the method to identify statistical outliers is extremely conservative and stringent and a wide range of performance is clinically meaningful within this measure. The developer mentioned the median's odd ratios (about 1.25).
Measure rates and risk adjustment	• The SME asked if the developer adjusted for ASC vs. HOPD because both are in the measure. The SME gave the example that if they had a patient with many comorbidities, they probably wouldn't send them to an ASC. • The developer clarified that they run measure rates for ASC and HOPD separately. • A Recommendation Group member asked if the risk-adjustment variables are the same for HOPD and ASC and how often they recalibrate the model. • The developer stated that the risk models for ASC and HOPD are the same, but the odds ratios for the variables are different. They re-establish the odds ratios every year, in addition to small code changes.

Additional Recommendations: Recommendation Group members suggested further exploration of the ASC population to determine if Medicare patients under the age of 65 frequently use ASCs for these procedures. Additionally, the developer should consider expanding the measure to include the Medicare Advantage population.

CBE #3495 – Hospital-Wide 30-Day, All-Cause, Unplanned Readmission Rate (HWR) for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups [Yale CORE/CMS]

Specifications | Discussion Guide

Description: This measure is a re-specified version of the hospital-level measure, "Hospital-Wide All-Cause, Unplanned Readmission Measure" (NQF #1789), which was developed for patients who are 65 years or older, are enrolled in Fee-for-Service (FFS) Medicare and are hospitalized in non-federal hospitals. This re-specified measure attributes hospital-wide index admissions to up to three participating MIPS Eligible Clinician Groups ("providers"), rather than to hospitals. It assesses each provider's rate of 30-day readmission, which is defined as unplanned, all-cause readmission within 30 days of hospital discharge for any eligible condition. The measure reports a single-summary risk-adjusted readmission rate (RARR), derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology; general medicine; cardiorespiratory; cardiovascular; and neurology.

Committee Final Vote: Endorse with Conditions

Conditions: When this measure comes back for maintenance, the developer should:

- Explore systemic differences in ED admission/readmission rates and the potential impact on the clinician-group's ability to improve.

Vote Count: Endorse (6 votes; 31.58%), Endorse with Conditions (13 votes; 68.42%), Remove Endorsement (0 votes; 0%); recusals (0).

Public Comments: The measure received five public comments prior to the meeting. Two comments shared personal experiences with respect to the measure focus and emphasized the importance of this measure. Two comments opposed endorsement of this measure, criticizing its risk-adjustment model and low reliability. One comment asked why the measure did not provide evidence, performance gap analysis, and reliability and validity testing for accountable care organizations (ACOs) that are part of MIPS.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Attribution methodology	• The Recommendation Group asked questions about the methodology for attributing a hospital readmission to a clinician group. • The developer discussed their attribution approach, noting that the methodology was designed in consultation with their technical expert panel. A hospital readmission can be attributed to: 1) the clinician group that includes the physician who discharges the patient at the end of the hospital stay, 2) the clinician group that includes the provider caring for the patient during the hospital stay (which may or may not be the discharging physician), and 3) the clinician group that includes the outpatient provider who is responsible for following up with the patient after the hospital stay. The developer noted that clinician groups are not attributed twice for the same patient and attribution is rolled up to the taxpayer identification number (TIN) level (i.e., group level).

Discussion Topic/Theme	Recommendation Group Discussion
	• The developer clarified that any eligible patient-facing clinician could be attributed to a readmission (e.g., physical therapists or a registered nurse).
Risk adjustment	• One Recommendation Group member asked whether oncology, end-stage renal disease (ESRD), or other comorbidities that may impact patient outcomes are included in the risk model. • The developer clarified that cancer, end-stage liver disease, psychiatric disorders, and renal failure are included.
Readmission rates and access	• The Recommendation Group discussed that readmission rates are sometimes out of a physician groups' control. One member shared that patients that they serve in their primary care clinic still visit the emergency department, which is often out of the primary care physician's control. • The Recommendation Group discussed how readmissions could be impacted by access issues. For example, in rural areas, patients may have a more difficult time quickly accessing a specialist (e.g., cardiologist), potentially resulting in higher readmissions. • The Recommendation Group placed a condition on this measure: They would like the developer to explore systemic differences in ER admission versus readmission rates and the potential impact on clinician group's ability to improve by measure maintenance.

Additional Recommendations: None.

CBE #4490 – Hospitalizations for Ambulatory Care Sensitive Conditions among Home and Community Based Service (HCBS) Participants [The Lewin Group/CMS]

Specifications | Discussion Guide

Description: For Medicaid HCBS participants aged 18 years and older, this measure calculates the state-level observed and risk-adjusted rates of hospital admissions for ambulatory care-sensitive conditions, including select behavioral health conditions, per 1,000 participants for chronic and acute ambulatory care-sensitive conditions. This measure has three rates reported for potentially avoidable acute inpatient hospital admissions: chronic conditions composite; acute conditions composite; and chronic and acute conditions composite.

Committee Final Vote: Endorse with Conditions

Conditions: When this measure returns for maintenance, the developer should:

- Recalculate reliability on observed/expected rates,
- Evaluate face validity (specifically addressing whether the measure distinguishes quality), and
- Provide a robust logic model at the HCBS plan level to illustrate areas of improvement.

Vote Count: Endorse (3 votes; 16.67%), Endorse with Conditions (14 votes; 77.78%), Not Endorse (1 vote; 5.56%); recusals (0).

Public Comments: The measure received three public comments prior to the meeting. One comment expressed confusion on the title of the measure. The commenter asked for clarification on the term “Hospitalizations for ambulatory care-sensitive conditions.” Two comments expressed support for the measure, highlighting the importance of this measure in addressing gaps in HCBS quality reporting, identifying areas for improvement, and enhancing overall health outcomes.

Measure Discussion:

Discussion Topic/Theme	Recommendation Group Discussion
Importance and usability	• The Recommendation Group and two invited SMEs (Morris Hamilton, PhD, and Margherita Labson, BSN, MSHSA, CCM, CPHQ) discussed the measure’s importance. They noted this measure is a step in the right direction to address a large problem and a tremendous opportunity for states to learn from each other and target true gaps. • The Recommendation Group discussed the intended audience for the data and the accountable entity that would drive improvement. • The developer explained that a state-level measure is beneficial as it specifically targets Medicaid offices, administrators, and staff working with HCBS, as well as those more broadly involved in Medicaid. This measure equips them with crucial information, highlighting that the populations eligible for HCBS are disproportionately more vulnerable than other Medicaid recipients. • A SME (Morris Hamilton) asked if HCBS administrators for state plans can implement initiatives to improve quality and performance. • The developer explained that states can implement requirements (e.g., mandating certain training for direct care workers) to encourage providers to improve quality.

Discussion Topic/Theme	Recommendation Group Discussion
	• The Recommendation Group placed two conditions on the measure: to evaluate face validity (specifically addressing whether the measure distinguishes quality) and provide a robust logic model at the HCBS plan level to illustrate areas of improvement by measure maintenance.
Reliability and validity	• A SME (Morris Hamilton) recommended using a split-half approach for calculating reliability and mentioned that the developer might be losing a lot of their sample with a look-back period of 18 months. • The developer explained that they could explore additional sensitivity analysis and various imputation techniques but found that to get accurate data about the history of admissions they needed to use 18 months. The developer also tested the risk model at 10, 12, and 18 months and found that when they used the shorter period, the model was less stable. • The Battelle facilitator clarified that during the staff assessments, the developer conducted reliability on the observed rate only (not the observed over the expected) and Battelle also recommended using a split-half reliability approach. • The Recommendation Group placed another condition on the measure: to recalculate reliability on observed/expected rates by measure maintenance. • A Recommendation Group member asked if the developer used a beta binomial or broader signal-to-noise approach for this measure. • The developer confirmed that it was a beta binomial approach.
Variation of HCBS	• One SME (Margherita Labson) noted that this is an extraordinarily vulnerable population of older adults who typically reside in a group home or similar setting, such as bed and board. Non-compliance with home rules can lead to transfers to other facilities, which may result in equipment transfer and medication issues. Building trust with this group is time-intensive. The number of hours dedicated to a specific program or service can vary from state to state. • The Recommendation Group discussed the high variability of HCBS services and patient conditions. One Recommendation Group member discussed their past work in Massachusetts, noting neighborhoods had considerable variation based on where the group homes were located. Another member explained that the eligibility requirements for Medicaid and HCBS vary widely by state. • The developer recognized that this is a fundamental issue with Medicaid that is outside of their control. However, they do employ a risk-adjustment method to manage some of the variability. • A Recommendation Group member asked if the data will allow states to deconstruct the services that are offered and identify whether certain conditions are effectively/ineffectively managed. • The developer noted that the measure is new and is expected to be on Medicaid.gov in August or September. The measure groups acute versus chronic conditions in alignment with other existing measures. They could consider parsing the data for more granular information in the future.
Quality and completeness of Transformed Medicaid	• A Recommendation Group member asked about the quality and completeness of the T-MSIS data. • The developer explained that T-MSIS is an evolving data source, and the quality has improved over time. They use Atlas as a data

Discussion Topic/Theme	Recommendation Group Discussion
Statistical Information System (T-MSIS) data	quality tool to determine whether the variables used in the measure meet the necessary quality standards for inclusion in the analysis. The developer identified one state where the data quality was insufficient for reporting and two territories where there weren't enough data.

Additional Recommendations: None.

Next Steps

Battelle staff shared that a meeting summary would be published by August 30, 2024. The appeals period will run from August 30-September 20, 2024. If an eligible appeal is received, the appeals committee will meet on September 30, 2024, to evaluate the appeal and determine whether to maintain or overturn an endorsement decision.