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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2024 Cycle Endorsement and Maintenance (E&M) Technical Report

COST AND EFFICIENCY

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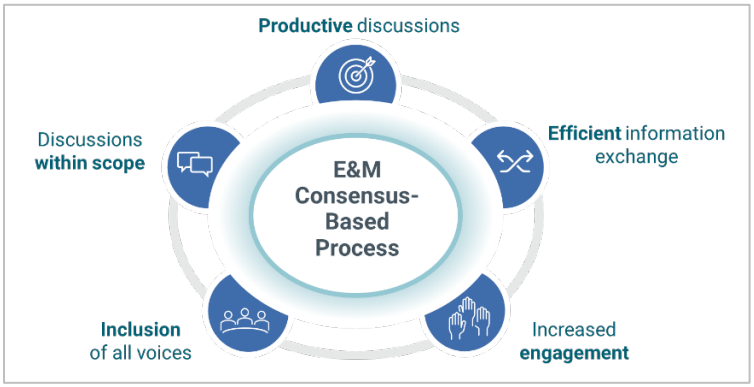
Executive Summary

For over 2 decades, the United States (U.S.) has focused on improving health care quality for Americans. One of the ways this has been done is by developing and implementing clinical quality measures to quantify the quality of care provided by health care providers and organizations. These clinical quality measures are based on standards related to the effectiveness, safety, efficiency, person-centeredness, equity, and timeliness of care.[1]

At Battelle, we have a strong collective interest in ensuring that the health care system works as well as it can. Quality measures are used to support health care improvement, benchmarking, and accountability of health care services and to identify weaknesses, opportunities, and disparities in care delivery and outcomes.[1,2]

Figure 1. E&M Consensus-Based Process



Battelle is a certified consensus-based entity (CBE) funded through the Centers for Medicare & Medicaid Services (CMS) National Consensus Development and Strategic Planning for Health Care Quality Measurement Contract. As a CMS-certified CBE, we facilitate the review of quality measures for endorsement. To support our consensus-based process, we formed the Partnership for Quality Measurement™ (PQM), which ensures informed and thoughtful endorsement reviews of quality measures across a range of focus areas that align with a person's journey through the health care system. Battelle engages PQM members to carry out the consensus-based E&M process, which relies on robust and focused discourse, efficient information exchange, effective engagement, inclusion of diverse voices (Figure 1).

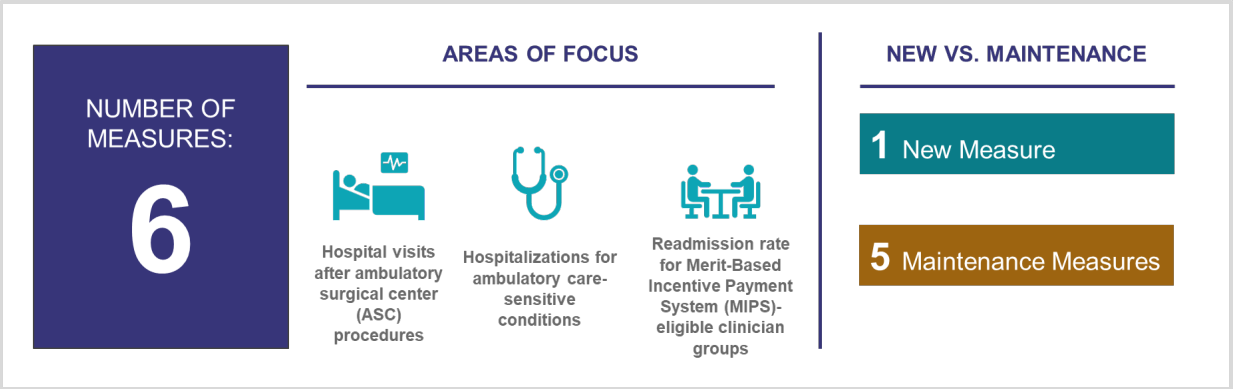
One of those focus areas is cost and efficiency, which includes measures that focus on health care resource use, such as hospital visits after ambulatory surgical center (ASC) and hospital outpatient department (HOPD) procedures, hospitalizations for ambulatory care-sensitive conditions, and readmission rates for Merit-Based Incentive Payment System (MIPS)-eligible clinician groups. Unplanned hospital visits after outpatient procedures, such as surgery or a colonoscopy, are associated with procedure-related adverse events and complications (e.g., infection, postoperative bleeding, urinary retention, uncontrolled pain, nausea, vomiting), which can negatively impact patient health outcomes and satisfaction.[3,4] By addressing modifiable risk factors, implementing evidence-based interventions, and fostering a culture of continuous learning and improvement, health care providers can mitigate the occurrence of adverse events and enhance the overall quality of outpatient procedure care.[5] In addition, hospitalizations, including readmissions, for any reason, are disruptive to patients and caregivers, costly to the health care system, and put patients at risk of hospital-acquired infections and complications. As a result, there continues to be a nationwide focus on reducing hospitalizations, including post-discharge readmissions.[5]

For this measure review cycle, developers submitted seven measures to the Cost and Efficiency committee for endorsement consideration. One of the measure stewards withdrew a measure up for maintenance review; the measure was deferred to a future endorsement review cycle (Table 5). Of the six remaining measures reviewed by the Cost and Efficiency committee (Figure 2), the committee endorsed all six measures with conditions based on the PQM Measure Evaluation Rubric of version 1.2 of the E&M Guidebook (Table 1).

Table 1. Measures Reviewed by Cost and Efficiency Committee

CBE Number	Measure Title	New/Maintenance	Developer/Steward	Final Endorsement Decision
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Maintenance	Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (Yale CORE)/Centers for Medicare & Medicaid Services (CMS)	Endorsed with Conditions
3357	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers	Maintenance	Yale CORE/CMS	Endorsed with Conditions
3366	Hospital Visits after Urology Ambulatory Surgical Center Procedures	Maintenance	Yale CORE/CMS	Endorsed with Conditions
3470	Hospital Visits after Orthopedic Ambulatory Surgical Procedures	Maintenance	Yale CORE/CMS	Endorsed with Conditions
3495	Hospital-Wide 30-Day, All-Cause, Unplanned Readmission Rate (HWR) for the Merit-Based Incentive Payment System (MIPS) Eligible Clinician Groups	Maintenance	Yale CORE/CMS	Endorsed with Conditions
4490	Hospitalizations for Ambulatory Care Sensitive Conditions among Home and Community Based Service (HCBS) Participants	New	The Lewin Group/CMS	Endorsed with Conditions

Figure 2. Spring 2024 Measures for Committee Review

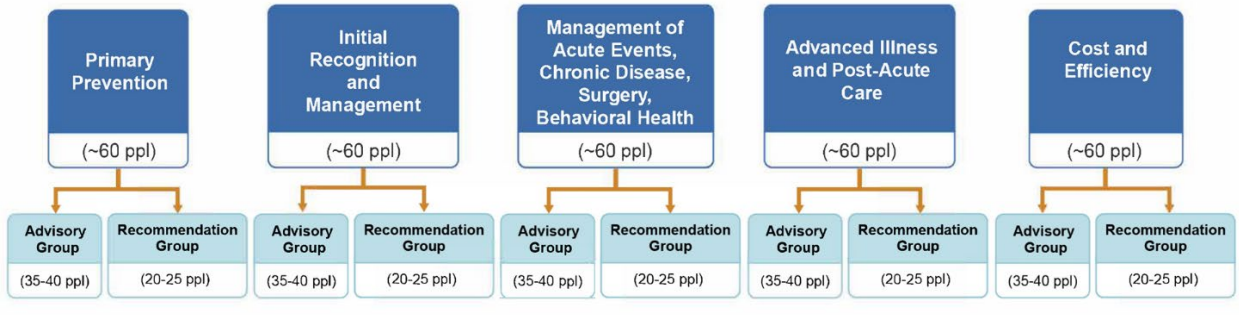


Endorsement and Maintenance (E&M) Overview

Battelle's E&M process ensures measures submitted for endorsement are evidence based, scientifically sound, and both safe and effective, meaning use of the measure will increase the likelihood of desired health outcomes; will not increase the likelihood of unintended, adverse health outcomes; and is consistent with current professional knowledge.

We organize measures for E&M by five project areas. Each project topical area has a committee that evaluates, discusses, and assigns endorsement decisions for measures under endorsement review. These E&M committees are composed of diverse PQM members, representing all facets of the health care system. Each E&M committee is divided into an Advisory Group and a Recommendation Group (Figure 3).

Figure 3. E&M Committee Structure



The goal is to create inclusive committees that balance experience, expertise, and perspectives. The E&M process convenes and engages interested parties throughout the cycle. The interested parties include those who are impacted or affected by quality and cost/resource use who come from a variety of places and represent a diverse group of people and perspectives (Figure 4).

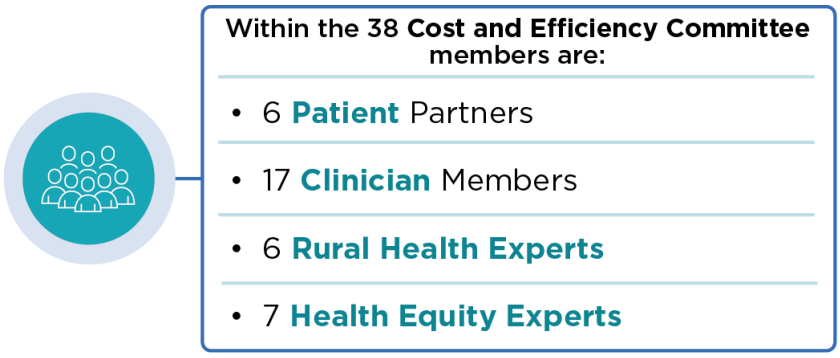
Figure 4. E&M Interested Parties

For the Cost and Efficiency committee, membership for the Spring 2024 cycle consisted of six patient partners (i.e., patients, caregivers, advocates) and 17 clinicians, with specialties in community health, nursing, ambulatory care management, and others (Figure 5). The committee also included six experts in rural health and seven in health equity.

While a list of committee members is provided in Appendix A, full committee rosters and bios are posted on the respective project pages on the PQM website.

At the beginning of each E&M cycle, committee members complete a measure-specific disclosure of interest (MS-DOI) form identifying potential conflicts with the measures under endorsement review for the respective E&M cycle. Members are recused from voting on measures potentially affected by a perceived conflict of interest (COI) based on Battelle's COI policy.

Figure 5. Cost and Efficiency Committee Members



Each E&M cycle (i.e., Fall or Spring) has a designated Intent to Submit deadline, when measure developers/stewards must submit key information (e.g., measure title, type, description, specifications) about the measure. One month after the Intent to Submit deadline (Table 2), measure developers/stewards submit the full measure information by the respective Full Measure Submission deadline.

Table 2. Intent to Submit and Full Measure Submission Deadlines by Cycle

E&M Cycle	Intent to Submit*	Full Measure Submission*
Fall	October 1	November 1
Spring	April 1	May 1

**Deadlines are set at 11:59 PM (ET) of the day indicated. If the deadline falls on a weekend or holiday, the deadline will be the next immediate business day.*

We then publish measures to the PQM website for a 30-day public comment period, which occurs prior to the endorsement meeting and concurrently with the development of the E&M staff preliminary assessments. The intent of this 30-day comment period is to solicit both supportive and non-supportive comments with respect to the measures under endorsement review. Any interested party may submit a comment on any of the measures up for endorsement review for a given cycle (i.e., Fall or Spring). Prior to the close of the public comment period, we host Public Comment Listening Sessions to gather additional public comments on the measures under endorsement review. These virtual sessions are organized by project with measures grouped by topic/condition. Any interested party may attend to give a brief verbal statement on one or more of the measures under endorsement review for that cycle.

All public comments received during this 30-day period, including those shared during the Public Comment Listening Sessions, are posted to the respective measure page on the PQM website for full transparency. A summary of the comments received for the measures submitted to the Cost and Efficiency committee for the Spring 2024 cycle is provided below.

Following the Public Comment Listening Sessions, we convene the Advisory Group of each E&M project during a public virtual meeting. The purpose of these meetings is to gather initial feedback and questions about the measures under endorsement review. We summarize the feedback and questions received from the Advisory Group members and share this, along with

all public comments, with developers/stewards for review and written response. For Cost and Efficiency, the Advisory Group convened on June 6, 2024, and a summary of the member feedback and developer/steward responses is published on the PQM website.

Prior to the Recommendation Group endorsement meeting, we share the full measure submission details for each measure up for review, including all attachments, the PQM Measure Evaluation Rubric, the staff preliminary assessments, the public comments, Advisory Group feedback, and the developer/steward responses with the Recommendation Group. For Cost and Efficiency, the Recommendation Group convened on August 1, 2024. Brief summaries of the Recommendation Group deliberations and voting results are provided below, while a detailed meeting summary is available on the PQM website.

During the endorsement meeting, the Recommendation Group focuses their discussions on key themes identified from the public comments, the Advisory Group meetings, the associated developer/steward responses, independent reviews, and the E&M project staff preliminary assessments. Measure developers/stewards attend endorsement meetings to provide a measure overview and answer questions from the Recommendation Group. The Recommendation Group considers the various inputs and renders a final endorsement decision via a vote. Consensus is reached when there is 75% or greater agreement among all active, non-recused Recommendation Group members (Table 3). However, if no consensus is reached, the measure is not endorsed due to no consensus.

Table 3. Endorsement Decision Outcomes

Decision Outcome	Description	Maintenance Expectations
Endorsed	**Applies to new and maintenance measures.** The E&M committee agrees by 75% or more to endorse the measure.	Measures undergo maintenance of endorsement reviews every 5 years with a status report review at 3 years (*see Evaluations for Maintenance Endorsement for more details*).± Developers/stewards may request an extension of up to 1 year (two consecutive cycles), except if it has been more than 6 years since the measure's date of last endorsement.
Endorsed with Conditions*	**Applies to new and maintenance measures**. The E&M committee agrees by 75% or greater that the measure can be endorsed as it meets the criteria, but committee reviewers have conditions they would like addressed when the measure comes back for maintenance. If these recommendations are not addressed, the developer/steward should provide a rationale for consideration by the E&M committee review.	Measures undergo maintenance of endorsement reviews every 5 years with a status report at 3 years, unless the condition requires the measure to be reviewed earlier (*see Evaluations for Maintenance*

Decision Outcome	Description	Maintenance Expectations
		Endorsement for more details). The E&M committee evaluates whether conditions have been met, in addition to all other maintenance endorsement minimum requirements.
Not Endorsed°	**Applies to new measures only**. The E&M committee agrees by 75% or greater to not endorse the measure.	None
Endorsement Removed°	**Applies to maintenance measures only.** Either: • The E&M committee agrees by 75% or greater to remove endorsement; or • A measure steward retires a measure (i.e., no longer pursues endorsement); or • A measure steward never submits a measure for maintenance, and the steward does not respond after targeted outreach; or • There is no longer a meaningful gap in care, or the measure has topped out (i.e., no significant change in measure results for accountable entities over time).	None

±Maintenance measures may be up for endorsement review earlier if an emergency/off-cycle review is needed (see Emergency/Off-Cycle Reviews for more details).

**Conditions are determined by the E&M committee, with the consideration of what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.*

°Measures that fail to reach the 75% consensus threshold are not endorsed.

The "Endorsed with Conditions" category serves as a means of endorsing a measure but with conditions set by the Recommendation Group. These conditions take into consideration what is feasible and appropriate for the developer/steward to execute by the time of maintenance endorsement review.

After the E&M endorsement meeting, committee endorsement decisions and associated rationales are posted to the PQM website for 3 weeks, which serves as the appeals period. During this time, any interested party may request an appeal regarding any E&M committee endorsement decision. If a measure's endorsement, including an "Endorsed with Conditions" decision, is being appealed, the appeal must:

- Cite evidence the appellant's interests are directly and materially affected by the measure, and provide evidence that the CBE's endorsement of the measure has had, or will have, an adverse effect on those interests; and
- Cite the existence of a CBE procedural error or information that was available by the cycle's Intent to Submit deadline but was not considered by the E&M committee at the time of the endorsement decision, which is reasonably likely to affect the outcome of the original endorsement decision.

In the case of a measure not being endorsed, the appeal must be based on one of two rationales:

- The CBE's measure evaluation criteria were not applied appropriately. For this rationale, the appellant must specify the evaluation criteria they believe were misapplied.
- The CBE's E&M process was not followed. The appellant must specify the process step, how it was not followed properly, and how this resulted in the measure not being endorsed.

If Battelle determines that an appeal is eligible, we convene the Appeals Committee, consisting of the co-chairs from all five E&M project committees (n=10), to review and discuss the appeal. The Appeals Committee concludes its review of an appeal by voting to uphold (i.e., overturn a committee endorsement decision) or deny (i.e., maintain the endorsement decision) the appeal. Consensus is determined to be 75% or greater agreement via a vote among members.

For the Spring 2024 cycle, the appeals period opened on August 30 and closed on September 20, 2024. The measures reviewed by the Cost and Efficiency committee did not receive any appeals.

Cost and Efficiency Measure Evaluation

For this measure review cycle, the Cost and Efficiency committee evaluated one new measure and five measures undergoing maintenance review against standard measure evaluation criteria. During the Recommendation Group endorsement meeting, the committee voted to endorse six measures with conditions (Table 4).

Table 4. Number of Spring 2024 Cost and Efficiency Measures Submitted and Reviewed

	Maintenance	New	Total
Number of measures submitted for endorsement review	6	1	7
Number of measures withdrawn from consideration*	1	0	1
Number of measures reviewed by the committee	5	1	6
Number of measures endorsed	0	0	0
Number of measures endorsed with conditions	5	1	6
Number of measures not endorsed/endorsement removed	0	0	0

**Measure developers/stewards can withdraw a measure from measure endorsement review at any point before the committee endorsement meeting. Table 5 provides a summary of withdrawn measures.*

Table 5. Measures Withdrawn from Consideration

Measure Number	Measure Title	Developer/Steward	New/Maintenance	Reason for Withdrawal*
2879e	Hybrid Hospital-Wide Readmission (HWR) Measure with Claims and Electronic Health Record Data	Yale CORE/CMS	Maintenance	Withdrawn by steward and deferred to future endorsement review cycle.

**Endorsement was removed for maintenance measures that were retired by the measure steward.*

Public Comments Received Prior to Committee Evaluation

Battelle accepts comments on measures under endorsement review through the PQM website. For this evaluation cycle, the public comment period opened on May 16, 2024, and closed on June 14, 2024, during which time we hosted a Public Comment Listening Session on May 29, 2024. The measures received 27 public comments, which Battelle published to the respective measure pages on the PQM website. If a measure received any comments, they are summarized under the measure's evaluation summary below, and developer/steward responses to public comments are available on the PQM website.

Summary of Potential High-Priority Gaps

During the committee's evaluation of the measures, committee members identified potential high-priority measurement gap areas that are summarized below for future development and endorsement considerations.

Inclusion of Medicare Advantage Beneficiaries and Those Less than 65 Years of Age

During the review of CBE #2539, #3357, #3366, and #3470, the Cost and Efficiency committee discussed the inclusion of Medicare Advantage patients and patients under the age of 65 in the measure population. With respect to Medicare Advantage, Recommendation Group members noted their disappointment that the measure population did not include Medicare Advantage patients, which is more than half of Medicare patients. The developer responded that data on Medicare Advantage patients were not included due to data availability and that CMS would be responsible for making the decision to expand the measure's population to include Medicare Advantage. With respect to Medicare patients under 65, the Recommendation Group's patient partners asked why these patients are excluded from the measure. During the Recommendation Group meeting, committee members acknowledged that Medicare patients under 65 often have complex conditions and disabilities when compared to Medicare patients over 65; these conditions may skew the results. The developer added that they do not include those under 65 because they have a higher rates of disability, and this would make risk adjustment more difficult. The developer added that the proportion of under-65 Medicare patients receiving procedures in ASCs is lower, so adding that population may be more relevant in the inpatient and hospital outpatient department (HOPD) settings. Due to the importance of both populations, the Recommendation Group members suggested further exploration of the ASC population to determine if Medicare patients under the age of 65 frequently use ASCs for the procedures on which the measures focus. Additionally, the developer should consider expanding the measure to include the Medicare Advantage population.

Summary of Major Concerns or Methodological Issues

The following brief summary of the measure evaluations highlight the major concerns and/or methodological issues that the committee considered.

Impact of Small Sample Sizes on Reliability and Validity

During the evaluation of CBE #2539, #3357, #3366, and #3470, the Cost and Efficiency committee (both Advisory and Recommendation Groups) raised concerns with respect to lower reliability results of low-volume providers (i.e., small sample sizes). Low volume can also affect

these measures' hierarchical modeling due to shrinkage to the mean, which may cause poor-performing facilities to not be classified as poor-performing, thus impacting validity. To mitigate this, the Recommendation Group suggested expanding the measure to 3 years to increase the sample size or setting a higher minimum case volume. The developer noted that it could explore expanding to 3 years for some of these measures; however, they mentioned receiving pushback from interested parties that data over a 3-year period are untimely and too wide of a net. With respect to a higher minimum case volume, the developer stated that raising the minimum procedural volume to increase reliability limits what information is available to consumers for public reporting. The Advisory Group suggested having a multi-year scatter plot for the individual facilities to see how stable the reliability results are year over year, which would provide a good indication of how stable (i.e., reliable) the measure is. Ultimately, the Recommendation Group acknowledged that because most (>70%) of the accountable entities had reliability estimates of at least 0.6 for all four measures, endorsement would be maintained. However, the Recommendation Group placed a condition on endorsement for these measures, which was to consider additional approaches for the reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs.

Measure Evaluation Summaries

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

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 returns 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).

Summary of 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.

Summary of Measure Evaluation: This measure was last endorsed in Spring 2020 and is used within the CMS Hospital Outpatient Quality Reporting (Hospital OQR) Program, Ambulatory Surgical Center Quality Reporting (ASCQR) Program, and Rural Emergency Hospital Quality Reporting (REHQR) Program. The Advisory Group recognized the importance of the measure focus area but raised concerns about: 1) the measure's low event rates, 2) its all-cause specification, 3) the 7-day time window, and 4) the fact that the measure does not factor in people who have unplanned follow-up in other settings, such as an urgent care facility, physician office, or ambulatory surgical center. The Advisory Group also asked whether the developer considered stratifying the measure by social risk factors, as facilities and communities may have fewer resources to support patients with more social risk factors. The developer noted that: 1) despite low event rates, there is broad variation in the events, which supports the need for a performance measure, 2-3) the all-cause outcome is supported by the short outcome time window (7 days after the procedure) when most procedural-related complications occur, and 4) the goal of the measure is to improve care at the ASC or HOPD (before, during, and after the procedure), to minimize the use of acute-care hospital visits, and encourage care in non-acute/non-hospital care settings, which could include the ASC or HOPD itself or other ambulatory settings (e.g., clinic visit, urgent care). The Advisory Group suggested having a multi-year scatter plot for the individual facilities to see how stable the reliability results are year

over year, which would provide a good indication of how stable (i.e., reliable) the measure is. The Recommendation Group considered the Advisory Group's concerns and the developer's responses during its evaluation. In addition, Recommendation Group members expressed the importance of considering Medicare Advantage patients, and some Recommendation Group members, including the patient partners, also underscored the importance of including beneficiaries less than 65 years of age. The developer explained that they do not include those under 65 because they have a higher rate of disability, and it would make risk adjustment more difficult. The developer acknowledged that the proportion of under-65 Medicare patients receiving procedures in ASCs is lower, so adding that population may be more relevant in the inpatient and hospital outpatient department (HOPD) settings. The developer noted that Medicare Advantage patients were not included due to data availability and CMS would be responsible for making the decision to expand the measure's population to include Medicare Advantage. Lastly, the Recommendation Group discussed an aspect of validity testing, questioning why the volume-outcome relationship was assessed as a form of validity. The developer described their rationale for evaluating a volume-outcome relationship, given inability to find another sufficient measure for comparison. The Recommendation Group also acknowledged that surgeon volume may be an indicator of quality, noting that the literature shows that volume may equate to quality due to a repetition effect and expertise developed by the surgeon. Overall, the Recommendation Group acknowledged that the reliability results were greater than 0.6 for most (>70%) of the entities but agreed with the Advisory Group's concerns regarding the impact of low events (i.e., low case volume) for entities. Therefore, the Recommendation Group added a condition for endorsement: When the measure comes back for maintenance, the developer will have explored additional approaches for the reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs.

Appeals: None.

Additional Recommendations for the Developer/Steward: 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 #3357– Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers [Yale CORE/CMS] – Maintenance

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).

Summary of 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.

Summary of Measure Evaluation: This measure was last endorsed in Fall 2017 and is used within the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. The Advisory Group discussed similar issues to those noted for CBE #2539 with respect to: 1) the measure's low event rates, 2) its all-cause specification, 3) the 7-day time window, and 4) the fact that the measure does not factor in people who have unplanned follow-up in other settings, such as an urgent care facility, physician office, or ambulatory surgical center. The developer provided similar responses, which the Recommendation Group considered during its evaluation of the measure. In addition, the Advisory Group commented on the inclusion of social risk factors within the measure, to which the developer noted that compared with HOPDs, ASCs serve a very low proportion of patients with social risk factors. The developer added that this ASC measure does not create disparities, nor does it capture disparities in care. Measure testing with and without social risk factors in the risk model showed little impact of including these variables, possibly due to the very low proportion of patients with social risk served by ASCs. During its evaluation, the Recommendation Group raised similar issues as with CBE #2539 with respect to the under-65 population, Medicare Advantage, the impact of low events on entities, and volume-outcome validity testing. In addition, the Recommendation Group questioned why there was a lack of performance improvement data over time. The developer highlighted that public reporting began in January 2024 and improvement will take several reporting cycles. Overall, the Recommendation Group acknowledged that the reliability results were greater than 0.6 for most (>70%) of the entities but agreed with the Advisory Group's concerns regarding the impact of low events (i.e., low case volume) for entities. Therefore, the Recommendation Group added

two conditions for endorsement: When the measure comes back for maintenance, the developer will have: 1) explored methods to enable the evaluation of improvement over time and 2) explored additional approaches for the reliability assessment that inform the reliability-validity (e.g., shrinkage) and reliability-usability (e.g., stability) tradeoffs.

Appeals: None.

Additional Recommendations for the Developer/Steward: 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] – Maintenance

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 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 (9 votes; 47.4%), Endorse with Conditions (10 votes; 52.6%), Remove Endorsement (0 votes; 0%); Recusals (0).

Summary of 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.

Summary of Measure Evaluation: This measure was last endorsed in Fall 2018 and is used within the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. The Cost and Efficiency committee discussed similar concerns as noted with CBE #2539, including the issues regarding the lack of improvement results over time (both Advisory and Recommendation Groups) and the inclusion of the under 65-population and Medicare Advantage beneficiaries (Recommendation Group only). Thus, the Recommendation Group assigned two conditions for endorsement: When the measure comes back for maintenance, the developer will have explored additional 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.

Appeals: None.

Additional Recommendations for the Developer/Steward: 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] – Maintenance

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 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 (5 votes; 26.32%), Endorse with Conditions (14 votes; 73.68%), Remove Endorsement (0 votes; 0%); Recusals (0).

Summary of 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.

Summary of Measure Evaluation: This measure was last endorsed in Fall 2018 and is used within the Ambulatory Surgical Center Quality Reporting (ASCQR) Program. The Cost and Efficiency committee discussed similar issues to those noted for CBE #2539, including the issues regarding the lack of improvement results over time (both Advisory and Recommendation Groups) and the inclusion of the under-65 population and Medicare Advantage beneficiaries (Recommendation Group only). In addition, the Advisory Group inquired whether the measure could be stratified by procedure type, as more orthopedic procedures are being moved to the outpatient setting. The developer responded, noting it would be ideal to stratify the measure outcomes by the type of procedure; however, given that the volume-specific procedures are not yet large enough to split into separate strata, the procedures are currently grouped at a higher, aggregated level. Ultimately, the Recommendation Group endorsed the measure with the same conditions as CBE #3357 and CBE #3366: When the measure comes back for maintenance, the developer will have explored additional 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.

Appeals: None.

Additional Recommendations for the Developer/Steward: 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] – Maintenance

Specifications | Discussion Guide

Description: This measure is a respecified 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 returns 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).

Summary of 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.

Summary of Measure Evaluation: This maintenance measure was last endorsed in Fall 2019 and is used in MIPS. In their evaluation of the measure, the Advisory Group questioned the measure's attribution methodology, raising concern that the measure misattributes readmissions, often assigning them to providers who have no control of the cause of readmission. The developer noted that this measure is calculated at the clinician group level, not for individual providers. Further, in consultation with their technical expert panel, the developer identified and tested six attribution approaches, sharing agreement that the three-provider attribution approach was the most relevant to the way care is delivered and the fairest to providers. In addition, several Advisory Group committee members asked about socioeconomic data and its significance in accurately measuring quality of care, independent of CMS's payment adjustments in MIPS. The developer noted that dual eligibility and high Area Deprivation Index (ADI) were analyzed in their social risk factor analysis. Findings indicated no strong correlation between social risk factors and measure scores. The Advisory Group also discussed measurement of mortality and validity implications, noting that with the absence of mortality assessments, a hospital could have a lower readmission rate simply because it has a

higher mortality rate. The developer acknowledged this issue, stating they are exploring ways to address these competing risks, including coding adjustments related to end-of-life care, such as DNR (Do Not Resuscitate) and palliative care. The developer confirmed that competing risks do not compromise the measure's effectiveness. The Recommendation Group considered the Advisory Group's concerns and the developer's responses but did not find these to be a reason to not endorse the measure. However, the Recommendation Group discussed how readmissions could be impacted by access issues, which are out of the provider's control. As a result, the Recommendation Group assigned a condition for endorsement: When the measure comes back for maintenance, the developer will have explored systemic differences in ED admission versus readmission rates and the potential impact on the clinician group's ability to improve.

Appeals: None.

Additional Recommendations for the Developer/Steward: None.

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

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).

Summary of 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 ACOs that are part of MIPS.

Summary of Measure Evaluation: During the evaluation of this new measure, the Advisory Group raised concerns with the measure's feasibility, referencing the challenges with Medicaid data, such as the 2- to 3-year data lag, and that the measure uses data from 2018 and 2019. The developer noted that testing utilized data from 2021, deliberately omitting data from 2020 due to the public health emergency, which skewed the representation of care provided during that year. The developer also mentioned challenges in accurately capturing data for the HCBS population and shared a plan to re-evaluate the measure using 2022 data. In response to concerns about data lag, the developer cited delays in processing national claims data for Medicare and Medicaid. While Medicare data processing has improved from 18 months to about 12 months, Medicaid data processing takes longer, approximately 2 to 2.5 years. The developer stated that the delays represent a systemic issue in using national claims data. The Advisory Group also recognized the variation in HCBS, namely how HCBS is defined and the variation of HCBS across states could lead to discrepancies in rates. Additionally, a few committee members highlighted the range of hospitalization rates across states, noting that when risk-adjustment models are applied, the variation in predicted versus actual hospitalizations narrows, and states with initially high rates of admission appear more favorable in the actual-to-predicted ratio. The developer responded by noting that while states define and administer HCBS

differently, the core populations generally include individuals who need assistance with activities of daily living and those with developmental disabilities. The developer also acknowledged that the variation in services offered by each state could influence the measure and noted that states have discretion in how they implement their programs and which components they include. The Recommendation Group agreed with the Advisory Group's concerns regarding state-level variation in HCBS and recognized that the measure is risk adjusted to control for some of this variation. The Recommendation Group also cited concerns related to reliability and validity testing. With respect to reliability, the Recommendation Group noted that a more appropriate approach would be a split-half analysis based on how the measure is specified. For validity, the Recommendation Group recognized the importance of this measure for HCBS but questioned whether 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. However, the Recommendation Group did request that the developer explore this within the measure's logic model. Overall, the Recommendation Group assigned three conditions for endorsement: When the measure comes back for maintenance, the developer will have recalculated reliability on observed/expected rates, evaluated face validity (specifically addressing whether the measure distinguishes quality), and provided a robust logic model at the HCBS plan level to illustrate areas of improvement.

Appeals: None.

Additional Recommendations for the Developer/Steward: None.

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Appendix A: Cost and Efficiency Committee Roster

Spring 2024 Cycle

Member	Affiliation/Organization	Perspective(s)	Advisory/ Recommendation Group
Danny van Leeuwen (Patient Representative Co-chair)	Health Hats	Patient Partner; Clinician	Recommendation
Amy Chin (Non-Patient Representative Co-chair)	HSS Center for the Advancement of Value in Musculoskeletal Care & Value Management Office at HSS	Health Services Researcher; Facility/Institutional	Recommendation
Alice Bell	American Physical Therapy Association	Clinician; Other Interested Parties	Advisory
Benjamin Schleich	Hackensack Meridian Health; Hackensack Meridian School of Medicine	Facility/Institutional	Recommendation
Beth Godsey	Vizient, Inc.	Other Interested Parties	Advisory
Bijan Borah	Mayo Clinic College of Medicine and Science	Health Services Researcher; Facility/Institutional	Advisory
Christopher M. Dezii	Healthcare Quality Advocacy & Strategy Consultants, LLP	Other Interested Parties; Patient Partner; Clinician	Recommendation
Daniel Halevy	Healthfirst	Purchaser and Plan; Clinician	Advisory
David Schultz	Evansville Primary Care	Clinician	Recommendation
Dmitriy Poznyak	Mathematica	Other Interested Parties; Health Services Researcher	Recommendation
Emma Hoo	Purchaser Business Group on Health	Purchaser and Plan	Advisory
Hal McCard	Spencer Fane, LLP	Rural Health Expert; Clinician	Recommendation

Member	Affiliation/Organization	Perspective(s)	Advisory/ Recommendation Group
Harold D. Miller	Center for Healthcare Quality and Payment Reform	Health Services Researcher; Other Interested Parties	Advisory
Henish Bhansali	Duly Health and Care	Facility/Institutional; Clinician	Advisory
Jack Needleman	University of California, Los Angeles, Fielding School of Public Health	Health Services Researcher	Advisory
Joan Gleason Scott	New Jersey Hospital Association	Other Interested Parties; Clinician	Advisory
John Martin	Premier, Inc.	Other Interested Parties; Health Services Researcher	Advisory
Kim Tyree	Evergreen Family Medicine	Rural Health Expert; Facility/Institutional; Health Equity Expert; Other Interested Parties	Advisory
Kimberly Geoffrey	--	Patient Partner	Recommendation
Lauren Campbell	NORC at the University of Chicago	Other Interested Parties; Health Equity Expert; Health Services Researcher	Advisory
Lynn Ferguson	Patient and Family Advisory Council, Vanderbilt University	Patient Partner	Advisory
Mahil Senathirajah	Merative	Other Interested Parties	Recommendation
Margaret Woeppel	Nebraska Hospital Association	Rural Health Expert; Clinician; Facility/Institutional; Other Interested Parties	Advisory
Mary Schramke	--	Patient Partner	Recommendation
Marisa Elliott	Ascension Medical Group	Facility/Institutional; Health Equity Expert	Advisory
Megan Guinn	BJC Healthcare ACO and BJC Medical Group	Facility/Institutional; Clinician; Other Interested Parties	Advisory

Member	Affiliation/Organization	Perspective(s)	Advisory/ Recommendation Group
Michelle Hammer	Elevance Health	Purchaser and Plan	Advisory
Pamela Roberts	Cedars-Sinai Medical Center & Physical Medicine and Rehabilitation, Cedars Sinai Medical Center	Clinician; Facility/Institutional; Health Services Researcher	Advisory
Paul Kallaur	Center for the Study of Services	Other Interested Parties	Recommendation
Pranavi Sreeramoju	Thomas Jefferson University Hospital, Inc., Jefferson Health	Facility/Institutional; Clinician; Health Equity Expert; Health Services Researcher	Recommendation
Rosa Plasencia	National Core Indicators, Aging and Disabilities (NCI-AD); ADvancing State	Health Equity Expert; Other Interested Parties; Rural Health Expert	Advisory
Sandeep Das	University of Texas Southwestern Medical Center	Health Equity Expert; Clinician; Facility/Institutional; Health Services Researcher	Advisory
Seth Morrison	Patient-Centered Outcomes Research Institute	Patient Partner	Advisory
Shawn Ruder	--	Patient Partner	Advisory
Sopida Andronaco	Hoag Orthopedic Institute	Clinician; Facility/Institutional	Advisory
Sunny Jhamnani	TriCity Cardiology	Clinician; Facility/Institutional	Recommendation
Tad Mabry	Mayo Clinic	Clinician; Facility/Institutional	Advisory
Tera Heidtbrink	Bryan Health Connect	Rural Health Expert; Facility/Institutional	Recommendation
William Golden	University of AR for Medical Sciences, Arkansas Medicaid	Purchaser and Plan; Clinician; Rural Health Expert; Health Equity Expert	Advisory

Partnership for Quality Measurement Organizations

Battelle

Institute for Healthcare Improvement

Measure Stewards

Centers for Medicare & Medicaid Services

Measure Developers

Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation

The Lewin Group


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Quality Measurement
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