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National Consensus Development and Strategic Planning for Health Care Quality Measurement

Spring 2025 Cycle Endorsement and Maintenance (E&M) Comment Summary Guide (Advisory Group Feedback)

Cost and Efficiency

June 2025

Prepared by:
Battelle
505 King Avenue, Columbus, Ohio 43201

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Overview of Spring 2025 Measures for Review

During this measure review cycle, developers and stewards submitted two measures to the Cost and Efficiency committee for endorsement consideration (Table 1). Table 1 lists measures in the order the Advisory Group reviewed them.

Table 1. Overview of Measures Under Endorsement Review

CBE Number	Measure Title	New/Maintenance	Developer/Steward
3188	30-Day Unplanned Readmissions for Cancer Patients	Maintenance	Alliance of Dedicated Cancer Centers
2881	Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI)	Maintenance	Yale Center for Outcomes Research and Evaluation (CORE)/Centers for Medicare & Medicaid Services (CMS)

Advisory Group Feedback

The Advisory Group convened on June 2, 2025. Fourteen of 23 (60.8%) active Advisory Group members attended to share feedback and ask questions regarding the measures under endorsement review. Developers/stewards of the respective measures also attended and provided responses to the Advisory Group questions. After the meeting, developers/stewards had the opportunity to submit additional written responses to Advisory Group member feedback and questions. The measure evaluation summaries of this comment summary guide contain overviews of the Advisory Group member discussions and developer/steward responses.

To support the review of the public comments and Advisory Group summaries, the number of comments received or number of individuals who shared similar comments, feedback, and/or questions is represented as “a few” (two to three individuals), “several” (four to six individuals), and “many” (more than six individuals).

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Measures Under Endorsement Review

CBE #3188: 30-Day Unplanned Readmissions for Cancer Patients [Alliance of Dedicated Cancer Centers]

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Risk Adjustment Model: A few committee members asked for clarification regarding the risk adjustment approach. Specifically, they noted that the measure seemed to have fewer risk adjusters compared to other measures. They inquired about using a single comorbidity risk adjuster, with a committee member noting that science has advanced in this area and that isolating individual comorbidities can substantially increase the C-statistic. A committee member also asked whether analysis looked at longer data periods or differentiated between cancer type.	The developer removed some variables previously in the model for various reasons. After discussion with CMS and other experts, they removed dual eligibility from the model to align with CMS's preference and are using dual eligibility as a stratification variable instead. The risk adjustment model also previously included a covariate related to discharge to hospice, but the developer removed it because the measured entity can control where the patient is discharged during the index hospitalization. In terms of the comorbidity variable used, the developer's approach is consistent with the current cancer literature, which commonly uses the Elixhauser comorbidity adjuster, an approach that focuses on the number of comorbidities as opposed to several specific comorbidities. The developer did look at individual comorbidities and they did not improve the model performance. Several expert panel reviews also supported this approach. The developer has not looked at any longer data points. The readmission rates vary across different cancer diagnoses related to hematologic malignancy versus solid tumor, which is why they included those types of cancer in their risk adjustment model.
Historical Trends: A committee member asked if the developer had information about historical trends in the measure over time.	Only 2 years of publicly reported data are available for the version of the specifications used in the Prospective Payment System Exempt Cancer Hospital Reporting (PCHQR) program. Such a short time period makes seeing a signal difficult. The developer observed a slight reduction in readmissions but cannot tell if any signal is there. In the literature, change is visible, but the exact analytic specifications vary.
Observation Stays: A few committee members noted the importance of evaluating observation stays. A committee member indicated that readmission measures are increasingly including observation stays;	The developer has not investigated including observation stay. They conducted analyses looking at observation stay in other types of quality measures. They are willing to explore including observation

Feedback/Questions	Summary of Developer Response
they inquired whether the present measure evaluated observations stays. They noted that observation stays vary based on region and state, which might artificially lower readmission rates and warrant exploration.	stay in the future if recommended by experts. The developer also is going to find out if hospital reporting programs use an existing measure that considers observation stay.
Population Considerations: Given that cancer care is increasingly performed in the outpatient setting, a committee member asked whether the model adjusts for patients who had index surgeries as opposed to ongoing cancer therapy. They also asked whether the developer adjusted the model for patients who are in palliative care or have diminished functional status scores.	The developer did include a variable for whether a case was a surgical admission but removed it because it was highly correlated with admission via ED. A patient who comes back into the hospital through the ED following a procedure is included in the population, but the model does not take into consideration that there was a surgery. The developer assessed a variable similar to functional status—Do Not Resuscitate (DNR) present on admission—and it did not contribute to the risk model in a meaningful way. They are open to suggestions to capture functional status in a valid way for a risk adjuster through claims.
Attribution: A committee member asked for clarification on attribution if a patient is admitted in a facility, leaves, and then is admitted at a different facility.	If a patient is readmitted elsewhere, that patient is attributed to the measured entity with the index admission.
Numerator: A committee member noted that the numerator has a qualifier indicating that patients who are progressing [i.e., changes in their cancer condition] are included in the numerator of the measure and asked how this [progression] is clinically determined. They sought further clarification for if the index admission had a metastatic code.	The specifications include the use of a metastatic code at the readmission. For example, if a patient, at index, is seen for lung cancer and then at readmission, they have a metastatic code along with lung cancer, that signals that the patent's disease has progressed. If the index admission already had a metastatic code, any subsequent admission within the 30-day timeframe is considered a readmission.
Special Populations and Complex Scenarios: A few committee members noted concerns related to measure implementation given the complexity of cancer and that some patients experience frequent readmissions as part of their cancer care or receive experimental treatments. A committee member indicated that evaluating observation and ED use could be challenging for patients with limited access to care such as those who live in rural communities.	To address the issue of complexity, the present measure is specified in slightly different ways compared to other readmission measures. The measure specifically focuses on unplanned readmissions. If a patient is readmitted, the measure captures codes for cancer treatments, such as a new, emerging treatments. However, there are still challenges capturing clinical trials. The developer did not have an answer regarding rural communities but noted that the concept is interesting to consider, particularly as more rural hospitals close.

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CBE #2881: Excess Days in Acute Care (EDAC) After Hospitalization for Acute Myocardial Infarction (AMI) [Yale CORE/CMS]

Advisory Group Feedback

Feedback/Questions	Summary of Developer Response
Supportive Comments: A few committee members expressed the importance of the measure, highlighting the inclusion of Medicare Advantage (MA).	N/A
Federal vs Non-Federal Hospitals: A committee member asked for clarification on the difference between federal and non-federal hospitals and why federal hospitals were excluded.	Federal hospitals include the Department of Defense and other similar hospitals. Currently, the developer only has access to claims data for acute non-federal hospitals. They will eventually add Veterans Affairs (VA) data as they have a relationship with the Department of Veterans Affairs and are working to implement the measure in VA hospitals.
Continuous Enrollment Requirement: A committee member asked how the continuous enrollment requirement worked with the addition of MA. They inquired whether patients could switch between fee-for-service (FFS) and MA during those 12 months or if they had to maintain one or the other for the full duration.	One of the measure's advantages is that it captures patients with FFS or MA. Patients can switch between the two as they are captured if they have FFS or MA at the index admission or follow-up.
Medicare Advantage and Modeling Approach: A few committee members had questions related to the inclusion of MA patients. A committee member asked why the developer chose to use a binominal model as opposed to a Poisson or negative binomial model. They recommended the developer provide more detail on their rationale as the Recommendation Group (RG) might also ask this question. The member also noted that the RG might want to see more calibration plots looking at FFS and MA, how the model performs for FFS versus MA, and if there are additional risk adjusters to consider. Another committee member noted that coding might be different for MA and FFS and asked about the decision to use a risk adjuster code for MA as opposed to stratification. They indicated that there might be differences between MA and FFS that may be more complicated than a risk adjuster.	The developer considered the Markov chain Monte Carlo (MCMC) model, but it is computationally expensive. They considered a binomial in-series model, which is also a counting model. They also considered a model that uses a zero inflated proportion and found that the binomial model performed better. For this measure when compared to other models, the binomial model has better performance, is more computational, and is much cheaper. The developer includes MA as a risk variable, as shown in Table 8 in their materials (see Supplemental Attachment). They did not submit their calibration plots but have them available, if needed. The developer considered both stratification and risk adjustment for MA. They indicated that stratification would make the model very big, and when they compared the performance between the two approaches, they found no difference. The risk adjuster is a dummy coded variable.
Risk Adjustment Variables: A few committee members had questions	Regarding repeat MIs, the history of AMI is included in the risk

Feedback/Questions	Summary of Developer Response
about specific variables included in the model. A committee member asked whether the developer was able to capture anything in terms of risk adjustment for subendocardial versus transmural MIs and for people who had repeat MIs versus index MIs. Other committee members asked about the inclusion of intensive care unit (ICU) and critical care unit (CCU) status and possible collinearity if both statuses were included in the model.	model with two codes. For different types of MIs, the risk variables include indicators of prior coronary artery bypass graft surgery (CABG) and stent placement, which gives direction in terms of the history and the burden of coronary disease. Following the Advisory Group meeting, the developer confirmed that the measure adjusts for a prior STEMI (codes I21.11 and I21.13) (see Table 8 of the submission, "ICD-10 codes in the 12 months prior to admission"). The measure adjusts for heart failure (see Table 8), which accounts for transmural vs. subendocardial MIs; a transmural MI is one that affects the entire depth of the heart muscle and would result in cardiac ventricular dysfunction (and heart failure) more commonly than an endocardial MI, which only affects the inner layer of the muscle supplied by the coronary artery affects. The developer indicated that there can be different thresholds for admitting to ICUs across different hospitals so they would not want to adjust for such variables which are under hospitals' control.
Overlap of Measures: A committee member indicated that several measures (including readmission, specific complications, mortality, and EDAC) overlap conceptually and expressed concerned about providers being penalized multiple times, particularly providers who serve rural communities in multiple settings.	There is no overlap in outcomes; however, there is overlap in cohorts. The AMI EDAC measure is only used for reporting, not for payment, so a provider would not be penalized. Further, the measures are assessing different aspects of care.
Observation Stays and Counting Multiple Events: A committee member inquired about the rationale for including observation stays in the measure as observation stays are typically used to avoid ED or inpatient stays. They also asked about the prevalence of observation stays among this patient population who might end up with multiple hospitalizations within the 30-day period.	The measure attempts to capture all the visits to a hospital that occur in 30 days by adding together all three types of outcomes (observation stays, ED visits, and inpatient admissions). If a patient who has an inpatient admission and then has multiple readmissions, ED visits, or outpatient stays, those are counted in the outcome. They do not count as another index admission. This approach differentiates this measure from other readmission measures, which do penalize hospitals for multiple readmissions. In addition, the measure includes observation stays to avoid potential gaming issues where a patient is placed in an observation stay to avoid an inpatient admission and because observation stays provide hospital-based acute care, similar to ED visit.

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