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**CBE ID**

3597

**Title**

Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System

**Endorsement Status**

Endorsed

**Is Under Review**

No

**Next Maintenance Cycle**

Fall 2026

**Previous Endorsement Cycle**

Fall 2020

**Initial Endorsement**

Sat, 06/26/2021 - 00:00

**Steward**

Centers for Medicare & Medicaid Services

**1.0 New or Maintenance**

Maintenance

**1.1 Measure Structure**

Single Measure

**1.3 Electronic Clinical Quality Measure (eCQM)**

No

**1.6 Measure Description**

Risk-Standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs).

**1.7 Measure Type**

Outcome

**1.8 Level of Analysis**

Clinician: Group/Practice

**1.13 Data Dictionary**

Not attached. I attest that all information will be provided where codes and/or value sets are needed (1.14a - 1.15c).

### 1.14 Numerator

The outcome for this measure is the number of acute admissions per 100 person-years at risk for admission during the measurement period.

### 1.15 Denominator

Patients included in the measure (target patient population) The target patient population for the outcome includes Medicare FFS patients aged 65 years and older with multiple chronic conditions (MCCs). Provider types included for measurement • Primary care providers (PCPs): CMS designates PCPs as physicians who practice internal medicine, family medicine, general medicine, or geriatric medicine, and non-physician providers, including nurse practitioners, certified clinical nurse specialists, and physician assistants. • Relevant specialists: Specialists covered by the measure are limited to those who provide overall coordination of care for patients with MCCs and who manage the chronic diseases that put the MCCs patients in the measure at risk of admission. These specialists were chosen with input from our Technical Expert Panel (TEP) and include cardiologists, pulmonologists, nephrologists, neurologists, endocrinologists, and hematologists/oncologists. However, as indicated below and in Section S.9, the measure is not designed to assess the quality of care of cancer specialists who are actively managing cancer patients, and thus patients attributed to hematologists and oncologists are excluded from the measure. Patient attribution We begin by assigning each patient to the clinician most responsible for the patient's care. The patient can be assigned to a PCP, a relevant specialist, or can be left unassigned. • A patient who is eligible for attribution can be assigned to a relevant specialist only if the specialist has been identified as "dominant". A specialist is considered "dominant" if they have two or more visits with the patient, as well as at least two more visits than any PCP or other relevant specialist. For example, if a patient saw a cardiologist four times in the measurement year, a PCP twice, and a nephrologist twice, the patient would be assigned to the cardiologist, having met the definition of "dominant" specialist. Note: Hematologists and oncologists are considered relevant specialists as they could be expected to manage MCCs patients' care, especially during periods of acute cancer treatment. However, as indicated below in Section S.9, the measure is not designed to assess the quality of care of cancer specialists who are actively managing cancer patients, and thus patients attributed to hematologists and oncologists are excluded from the measure. • There are two scenarios where a patient can be assigned to a PCP. First, the patient must have seen at least one PCP. The patient will then be assigned to the PCP with the highest number of visits as long as there is no relevant specialist who is considered "dominant." Second, if the patient has had more than one visit with a relevant specialist but no "dominant" specialist has been identified, and has two or more visits with a PCP, they will be assigned to that PCP. • Finally, the patient will be unassigned if they only saw non-relevant specialists, if the patient has not seen a PCP and no "dominant" specialist can be identified, or if the patient has not had more than one visit with any individual PCP. Patients are then assigned at the Taxpayer Identification Number (TIN) level, which includes solo clinicians and groups of clinicians who have chosen to report their quality under a common TIN. • At the TIN level, patients are first assigned to the clinician (unique National Provider Identifier (NPI)/TIN combination since a given provider can be affiliated with more than one TIN) most responsible for their care (using the algorithm for individual clinician-level attribution above) and then patients "follow" their clinician to the TIN designated by the clinician. Patients unassigned at the

individual clinician level continue to be unassigned at the TIN level.(Note that an alternative attribution approach was considered and assessed as described in section 2b.3.11 of the testing attachment and in Appendix C of the attached methodology report.)Person-time at riskPersons are considered at risk for hospital admission if they are alive, enrolled in FFS Medicare, and not in the hospital during the measurement period. In addition to time spent in the hospital, we also exclude from at-risk time: 1) time spent in a SNF or acute rehabilitation facility; 2) the time within 10 days following discharge from a hospital, SNF, or acute rehabilitation facility; and 3) time after entering hospice care.

## **1.20 Types of Data Sources**

Claims Data, Other

### **6.1.2 Current or Planned Use(s)**

Payment Program

### **6.1.3 Current Use(s)**

Payment Program, Not in use

### **Developer POC email**

ccsq-op-measures@acumenllc.com

### **Exclusions**

We exclude patients from the cohort for these reasons:

1. Patients without continuous enrollment in Medicare Part A or B during the measurement period.
2. Patients enrolled in hospice at any time during the year prior to the measurement year or at start of the measurement year.
3. Patients with no E&M visit to a MIPS eligible clinician.
4. Patients assigned to clinicians who do not participate in the QPP on the MIPS track.
5. Patients attributed to hematologists and oncologists.
6. Patients not at risk for hospitalization during the measurement year.

### **Measure Disclaimer**

N/A

### **Planned Use**

Payment Program

### **Risk Adjustment**

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Statistical risk model

**The measure developer is different from the measure steward**

Yes

**Steward Organization**

Centers for Medicare & Medicaid Services

**Steward POC email**

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