2025 Pre-Rulemaking Measure Review
Preliminary Assessment

MUC ID	Title
MUC2025-040	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
Measure Steward & Developer	**Proposed CMS Programs**
Centers for Medicare & Medicaid Services (CMS)	Hospital Inpatient Quality Reporting (IQR) Program Link: Hospital Inpatient Quality Reporting (IQR) Program Hospital Value-Based Purchasing (VBP) Program Link: Hospital Value-Based Purchasing (VBP) Program

Measure Overview
Rationale: The goal of this measure is to improve patient outcomes by providing patients, physicians, hospitals, and policymakers with information about hospital-level, risk-standardized mortality rates following hospitalization for COPD. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as communication between providers, prevention of and response to complications, patient safety, and coordinated transitions to the outpatient environment, all contribute to patient outcomes, but are difficult to measure by individual process measures. The goal of outcomes measurement is to risk adjust for patient conditions at the time of hospital admission and then evaluate patient outcomes. This measure was developed to identify institutions whose performance is better or worse than would be expected based on their patient case mix and therefore promote hospital quality improvement and better inform consumers about care quality.
CMS-provided program rationale: Measurement of patient outcomes related to risk-standardized mortality rates for chronic obstructive pulmonary disease (COPD) hospitalization permits an overall view of care provided by individual hospitals as compared to like facilities with similar patient populations. This process can assist patients and caregivers in evaluating outcomes for specific providers in relation to care and services for chronic COPD. This opportunity provides patients with the opportunity to choose a provider based on their needs and provides hospitals with identifying quality improvement opportunities.
Description: The measure estimates a hospital-level 30-day risk-standardized mortality rate (RSMR) for Medicare patients (Fee-For-Service [FFS] and Medicare Advantage [MA]) age 65 and older discharged from the hospital with a principal diagnosis of COPD. The outcome is all-cause 30-day mortality, defined as death from any cause within 30 days of the index admission date, including in-hospital death.
Measure background: Measure currently used in a Medicare program, but the measure is undergoing substantive change.
Numerator: The outcome for this measure is 30-day, all-cause mortality. We define mortality as death from any cause within 30 days of the start of the admission for patients discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of acute respiratory failure with a secondary discharge diagnosis of COPD with exacerbation.

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Measure Overview	
Exclusions: N/A	
Denominator: The cohort includes admissions for patients that meet all of the following inclusion criteria: Discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of acute respiratory failure with a secondary discharge diagnosis of COPD with exacerbation; Enrolled in Medicare FFS Part A and Part B or MA for the first 12 months prior to the date of admission and enrolled in Part A or MA during the index admission. [For VA beneficiaries hospitalized in VA hospitals, there are no Medicare FFS or MA enrollment requirements. For VA beneficiaries hospitalized in non-VA hospitals, they must be concurrently enrolled in Medicare FFS Part A or MA at the time of the index admission, to be eligible for cohort inclusion, but the 12-month Part A and B or MA enrollment prior to admission is not required.]; Aged 65 or over; Not transferred from another acute care facility. **Exclusions:** This measure excludes index admissions for patients that meet any of the following exclusion criteria: With inconsistent or unknown vital status or other unreliable demographic data (e.g., age and sex); Enrolled in the Medicare hospice program any time in the 12 months prior to the index admission, including the first day of the index admission; or Discharged against medical advice. For patients with more than one eligible COPD admission in the reporting period, only one index admission per year is randomly selected for inclusion in the cohort. Additional admissions within that time period are excluded. **Exceptions:** N/A	
Substantive changes from prior version (if applicable): Integration of MA beneficiaries into the cohort and modifying performance period from 3 years to 2 years.	
Measure type: Outcome	**Measure is a composite:** No **Measure is digital and/or an eCQM:** No **Measure is a paired or group measure:** No
Level of analysis: Facility	**Data source(s):** Digital-Administrative systems: Administrative Data (non-claims) Digital-Administrative systems: Claims Data
Care setting(s): Hospital inpatient acute care facility	**Risk adjustment or stratification:** Yes, risk adjusted.
CBE endorsement status: Endorsed	**CBE endorsement history:** Received initial endorsement in 2013. Endorsed during maintenance review in 2020.
Is measure currently used in CMS programs? Hospital Value-Based Purchasing Program	**Measure addresses statutorily required area?** No

Evaluation

Meaningfulness

Importance	
Type of evidence:	Empirical data; Peer-Reviewed Original Research; Peer-Reviewed Systematic Review [MUC Entry/Review Information Tool (MERIT) Submission, COPD Mortality Empiric Evidence Attachment]
Importance: The developer presents empirical data that states COPD is a leading cause of morbidity and mortality and is the fourth leading cause of death in the United States. Evidence from the literature review shows that COPD was one of the top 20 most expensive conditions billed to Medicare in 2011, accounting for nearly $4,074,000 of total hospital charges billed to Medicare. Additionally noted in the literature review is that while overall COPD prevalence has declined over the last decade, 30-day mortality rates following COPD discharge are high and variable across hospitals in the United States. This measure clearly aligns with national health priorities and demonstrates potential for improving outcomes, such as supplemental oxygen and implementing a comprehensive care plan focused on transitions of care treatment of comorbidities, and appropriate and timely hospice and palliative care services for COPD patients. During CBE endorsement review in 2021, the committee found the evidence supporting the importance of this measure to be sufficient.	
Rating: Met; Prior CBE Endorsement	

Conformance
Measure alignment with conceptual intent: This measure intends to estimate the RSMR of adults discharged from the hospital with a COPD diagnosis within 30 days of discharge. The measure numerator, denominator, and exclusions are clearly defined and directly support the intent of the measure. Specifically, the numerator is 30-day all-cause mortality. The denominator includes patients age 65 or older discharged from the hospital with a principal diagnosis of COPD or a principal discharge diagnosis of acute respiratory failure with a secondary discharge diagnosis of COPD with exacerbation. The denominator now includes MA data, which doubles the cohort size and more accurately reflects the quality of care for FFS and MA beneficiaries. This measure aligns with the Hospital IQR Program objectives to improve the quality of care that hospitals provide and to distribute clearly defined and objective data about hospital performance, and the Hospital Value-Based Purchasing (HVBP) program objective to eliminate or reduce adverse events.
Rating: Met

Feasibility	
eCQM feasibility testing/analysis conducted:	No, not an eCQM
Feasibility: Data elements for this measure are routinely collected in electronic health records (EHR) and claims data. The measure can be implemented without significant workflow changes. No major technical barriers are associated with this measure. The feasibility of this measure was found sufficiently demonstrated during CBE endorsement review in 2021.	
Rating: Met; Prior CBE Endorsement	

Validity	
Validity testing method(s):	Empiric Validity [MERIT Submission Form, Condition-Specific Mortality Measures Updates and Specifications Report]
Testing level(s):	Facility
Was this measure tested in the same target population as the CMS program?	Yes
Validity: The developer assessed the validity of the measure by comparing the correlations between the COPD Mortality measure and components of the Overall Hospital Quality Star Rating, including the Summary Score (with and without the Mortality Group) and the Mortality Group Score (with and without the COPD Mortality Measure[1]). Because the COPD Mortality measure follows a lower-is-better scale while Star Rating measures follow a higher-is-better scale, the developer hypothesized a weak-to-moderate negative correlation between the COPD Mortality measure and Star Rating-related measures. The COPD Mortality measure showed negative correlations with the Star Rating Overall Summary Scores ($r=-0.214$, $p < .0001$), the Star Ratings Adjusted summary score excluding the Mortality Group ($r=-0.016$, $p = .4002$), the Star Rating Mortality Group Scores ($r=-0.463$, $p < .0001$), and the Star Rating Adjusted Mortality Group Scores excluding the COPD Mortality Measure ($r=-0.405$, $p < .0001$). These findings are consistent with expectations, reinforcing the relationship between lower COPD Mortality scores and higher Star Ratings as indicators of better quality of care. Testing in populations representative of the CMS program population supports the external validity of the measure. During CBE endorsement review in 2021, the committee found the validity of this measure to be sufficiently demonstrated.	
Threats to validity: Threats to validity of the measure were considered during measure development and testing. The measure is risk adjusted for patient functional status (frailty indicator), patient-level demographics (age), and patient-level health status and clinical conditions (case-mix	

[1] All Mortality Measures used in Star Ratings are FFS only.

Validity
adjustment, comorbidities, and severity of illness). The developer performed model discrimination using the c-statistic and predictive ability and assessed model calibration using the risk decile plot. During measure development, the sample of 203,211 persons produced a c-statistic of 0.85, with predictive ability ranging from 0.61% in the lowest decile to 44.33% in the highest decile. The validation sample of 202,748 persons produced the same c-statistic of 0.85, with predictive ability ranging from 0.68% to 45.02%. The risk decile plot showed that deciles with a higher predicted risk of COPD mortality were associated with higher observed COPD mortality rates. These results suggest that the model effectively differentiates COPD mortality risk levels and adequately adjusts for differences in patient characteristics. The measure developer does not recommend the measure for stratification.
Rating: Met; Prior CBE Endorsement

Reliability	
Reliability testing method(s):	Random Split-half Correlation [MERIT Submission Form, Condition-Specific Mortality Measures Updates and Specifications Report]
Testing level:	Facility
Reliability discussion: Split-half reliability testing for hospitals with at least 25 admissions yielded a corrected reliability score of 0.771, based on the mean intraclass correlation coefficient (ICC) across 100 random split samples. This meets accepted standards for publicly reported measures, indicating that observed performance differences are likely to reflect true variation. Reliability results used 2 years of data (2022-2023) from 2,937 facilities with at least 25 admissions. During collaboration on this PA, the developer provided the minimum, maximum, median, and 25th and 75th percentiles. Among hospitals with at least 25 admissions, the minimum reliability was 0.729, the median reliability was 0.771 (IQR: 0.766-0.778), and the maximum reliability was 0.786. All facilities exceeded the recommended minimum reliability threshold of 0.6. During CBE endorsement review in 2021, the committee found the reliability of this measure to be sufficiently demonstrated.	
Additional reliability analyses: No additional analyses were performed.	
Rating: Met; Prior CBE Endorsement	

Usability	
Usability considered in application:	Yes, the submission materials briefly discuss the measure's usability within relevant programs.
Usability discussion: The measure is currently used in the HVBP Program and has demonstrated actionable insights for providers in hospitals. The developer did not identify unintended consequences but will continue to monitor measure's use and assessing potential unintended consequences over time, such as the inappropriate shifting of care, increased patient morbidity and mortality, and other negative unintended consequences for patients. During CBE endorsement review in 2021, the committee found the use/usability of this measure to be sufficiently demonstrated.	
Rating: Met; Prior CBE Endorsement	

Appropriateness of Scale

Appropriateness of Scale	
Similar or related measures in program(s):	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization is a related measure within the Hospital VBP Program. Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM) is a related measure in the HVBP Program.
Measure balance, burden, and value across target populations/measured entities: This measure is a reevaluated version of the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization in the HVBP program. MA data was added to the cohort to increase the cohort size, improve measure reliability, and more accurately reflect the quality of care for FFS and MA beneficiaries. The developer's analysis does not indicate a potential for differential benefit or harm to specific subgroups of participating entities or their patient populations. **Considerations for the committee:** Based on clinical and professional experience, the committee should consider the potential burden and value of the measure for small or rural hospitals as well as hospitals serving high-risk or underserved populations.	

Time-to-Value Realization

Time-to-Value Realization	
Plan for near- and long-term impacts after implementation:	None specified

Measure implementation impacts over time: Incorporating MA data will extend the measure to a broader group of Medicare beneficiaries, thereby improving representativeness and reducing potential selection bias. In the near term, some hospitals may experience modest changes in scores as MA beneficiaries are incorporated. Over the longer term, a single, comprehensive Medicare cohort will provide more consistent tracking of performance trends, enhance comparability across hospitals and regions, and better reflect true differences in hospital quality.

Considerations for the committee:

- What are the potential near- and long-term impacts of this measure on measured entities, the Hospital IQR and HVBP programs, and patient populations?
- Will benefits and burdens associated with this measure be realized within an appropriate implementation time frame?
- How will this measure mature through revisions in the future if added to the Hospital IQR and HVBP measure sets?