NATIONAL QUALITY FORUM

Memo

To: Consensus Standards Approval Committee (CSAC)

From: Taroon Amin, MPH, MA; Andrew Lyzenga, MPP; Adeela Khan, MPH, Zehra Shahab, MPH

Re: All Cause Admissions and Readmissions Member Voting Results

Date: November 12, 2014

The CSAC will review Standing Committee recommendations, NQF member voting results, and the summary from the October 20, 2014 NQF All Member Call from the *All Cause Admissions and Readmissions* project on its November 12, 2014 conference call.

This project followed the National Quality Forum's (NQF) version 1.9 of the Consensus Development Process (CDP). Member voting on these recommended measures ended on September 24, 2014.

Accompanying this memo are the following documents:

1. **All Cause Admissions and Readmissions Draft Report**. The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment table.** Staff has identified themes within the comments received. This table lists 170 comments received and the NQF/Standing Committee responses.

This Memo contains the following additional appendices:

- Appendix A: Comment Themes and Committee Responses
- Appendix B: NQF Member Voting Results
- Appendix C: Removal of Endorsement of Measures
- Appendix D: Developer Responses to Voting Comments

CSAC ACTION REQUIRED

- Review the overarching themes identified from the Admissions and Readmissions Project
- Consider the Membership's input from the October 20, 2014 All Member Call
- Determine a path forward for the measures under consideration

MEASURES IN THE ADMISSIONS AND READMISSIONS PROJECT

Measures Recommended for Endorsement by the Standing Committee:

- 0505 Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

- 0695 Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)
- 2375 PointRight OnPoint-30 SNF Rehospitalizations
- 2380 Rehospitalization During the First 30 Days of Home Health
- 2393 Pediatric All-Condition Readmission Measure
- 2414 Pediatric Lower Respiratory Infection Readmission Measure
- 2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)
- 2503 Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- 2504 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries
- 2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health
- 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- 2513 Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures
- 2514 Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate
- 2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery
- 2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Measures where Consensus was Not Reached by the Standing Committee

- 0327 Risk-Adjusted Average Length of Inpatient Hospital Stay
- 2496 Standardized Readmission Ratio (SRR) for dialysis facilities
- 2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

COMMITTEE EVALUATION

The All Cause Admissions and Readmissions Draft Report presents the results of the evaluation of 18 measures considered under the CDP. Fifteen were recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement, and three were measures where consensus was not reached. The measures were evaluated against the 2013 version of the measure evaluation criteria.

	MAINTENANCE	NEW	TOTAL
Measures considered	3	15	18
Withdrawn from consideration	5	0	5
Recommended	2	13	15
Consensus Not Reached	1	2	3

COMMENTS AND THEIR DISPOSITION

NQF received 170 comments from 36 organizations/individuals (including 25 Member organizations) pertaining to the general draft report and to the measures under consideration.

A table of comments submitted during the post-meeting 30-day comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the project page.

Additional Comments [hyperlinked] were submitted by:

3M, Health Information Systems, Inc.
Fresenius Medical Care
Children's Hospital Association
American Society of Nephrology
Kidney Care Partners

Summary of October 20, 2014 All Member Call

Background

The NQF Membership recently voted on the 18 measures under consideration in the All-Cause Admissions and Readmissions CDP Project. Member voting revealed lack of support across all measures in this project, and subsequently the CSAC requested that NQF staff undertake additional consensus-building for all the measures under consideration in this project.

On October 20, 2014, NQF held an All-Member Web-Meeting, inviting all member stakeholders to participate in a discussion about the measures under review. The call provided an opportunity for NQF Members to voice their concerns and provide feedback for the CSAC's consideration. The CSAC will consider this feedback while making a final endorsement decision during their November Meeting.

All Member Web-Meeting Summary

During the call, NQF staff provided an overview of measure voting results and the overarching issues identified during the evaluation process, including Standing Committee review and public comment. NQF then polled participants on the call to identify the highest-priority issues with respect to the measures in this project. The poll results were as follows:

Theme	Percent (n)
Adjustment for Socio-Demographic Status (SDS)	42% (42)
Relationship between Admissions and Readmissions	21% (21)
Evidence Requirements for Outcome Measures	15% (15)
Provider Attribution	14% (14)
Preventable/Planned Readmissions	9% (9)

Adjustment for Socio-Demographic Status (SDS)

Members agreed that adjustment for SDS was the highest-priority issue. Many members argued that without adjustment for socio-demographic factors, the measures may not accurately reflect provider performance and do not meet NQF's standards for scientific validity. These members agreed that SDS adjustment needs to be considered before endorsing the measures.

Some members countered that SDS adjustment may not be appropriate for all measures, arguing that some of the variation in performance may be due to geography and practice patterns, both of which would not be appropriate to adjust for.

Several measure developers whose measures are under consideration in this project voiced operational concerns regarding adjustment of SDS. Prior to the start of the project, developers were instructed to follow the current NQF guidance, which at the time was that measures should not be adjusted for socio-demographic factors. Developers noted that measure development involves a significant amount of work and resources, cautioning that immediate re-testing and re-specifying of the measures may not be feasible.

Relationship between Admissions and Readmission

Members noted that care transition improvement efforts and other community-oriented activities to reduce readmissions can also lead to reduced *admissions* as continuity of care is improved and other health benefits are achieved in the community. One member cited data showing that several communities have achieved declines in readmissions, yet are being penalized. The member suggested that as a result of these communities' successful quality improvement efforts, the measure denominator (i.e., admissions) is decreasing more quickly than the numerator (i.e., readmissions), leading to unwarranted penalties.

Some members suggested shifting focus to the development of care transition and cost measures in order to accurately understand readmissions.

Evidence Requirements for Outcome Measures

Some members suggested that NQF's current evidence requirements for outcome measures may not be sufficiently rigorous and that NQF should consider a move towards a higher standard, especially when measures are publicly reported and/or tied to payment. One commenter suggested that it might be more appropriate to view readmissions measures as process measures rather than outcome measures, arguing that readmission serves as a proxy for declining health status, when this may not always be the case.

Measure Specific Issues

- One member voiced concern that the Inpatient Rehab Facility and Long-Term Care Hospital readmission measures specifications, and testing approach is based on the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF#1789). This member suggested that alignment to NQF Measure #1789 may not be appropriate for these settings.
- Several commenters voiced support for the population-level measures, agreeing that these measures can help providers and communities highlight where community needs are not being met by the clinical delivery system.
- A member voiced support for the Length-of-Stay (LOS) measure and noted that the inclusion of SDS variables improves the performance of that measure.
- Members voiced concern regarding the reliability of the risk adjustment model for several of the measures. Member's argued that with low levels of reliability, the measures cannot accurately predict performance, which could cause unintended consequences if the measures are used in public reporting or tied to reimbursement.

Other Issues

- Members asked whether a stipulation could be added to the measures denoting that they are only endorsed for use in quality improvement and not payment.
- Several commenters reflected on the small number of members who voted on this project.
- In general, the consumers, purchasers, and health plan councils were in favor of moving ahead with an endorsement decision on the measures in this project.

APPENDIX A: Comment Themes and Committee Responses

This appendix provides an overview of the main themes that arose during the public and member comment period and the Standing Committee's in-person meeting in May. In addition to the main themes, several measures received specific public and member comments which are also included. The Committees full discussion around these themes can be found in the draft report.

Theme 1- Adjustment for Socio-demographic Status

Commenters focused heavily on the topic of risk adjustment using socio-demographic status (SDS) for readmission outcome measures. One commenter provided support to the current NQF guidance indicating that factors associated with disparities in care (i.e., race, ethnicity, socio-demographic factors) should not be included in risk adjustment models. Many other commenters raised strong concern with moving forward with endorsement of outcome readmission measures without socio-demographic adjustment. Commenters encouraged the Committee to defer endorsement decisions until after the SDS Expert Panel's recommendations are finalized and measure developers have a chance to update/test their measures. Those commenters noted that if a decision on these measures is required, the measures should be challenged on the basis of the measure's validity due to the lack of SDS adjustment, or the Standing Committee should limit endorsement for one year with a required ad-hoc review on the measures in this project. Commenters noted that endorsing these measures without SDS adjustment may cause serious unintended consequences for providers treating vulnerable populations.

> **NQF Response:** Throughout the measure review process NQF staff guided the Committee to evaluate these measures using the current NQF measure evaluation guidance, which indicates that factors associated with disparities in care (i.e., race, ethnicity, socio-demographic factors) should not be included in risk adjustment models. In another concurrent project at NQF, an Expert Panel on Risk Adjustment for Sociodemographic Factors was charged with reviewing this guidance and developing a set of recommendations on the inclusion of socioeconomic status (SES) and other factors, such as race and ethnicity, in risk adjustment for outcome and resource use performance measures. The NQF Board of Directors met to consider these recommendations developed by this Expert Panel and approved the implementation of a trial period for performance measures where adjustment for socio-demographic factors may be appropriate. NQF is currently developing an implementation plan and timeline for this trial period. NQF has issued a final report, which includes recommendations by the Expert Panel.
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> For projects that are already in progress, such as the Admissions and Readmissions Endorsement Project, NQF will continue to guide committees to operate under the preexisting criteria, guidance, and policy that was in place when this project started.
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> **Committee Response**: The Committee recognizes the commenters' concern that socio-demographic factors may potentially influence readmission rates from various settings, and discussed the topic extensively during the in-person meeting. However, the Committee's measure review and evaluation was informed by the current NQF measure

evaluation guidance which indicates factors associated with disparities in care (i.e., race, ethnicity, socio-demographic factors) should not be included in risk adjustment models.

The Committee continues to operate under the current NQF guidance yet cautions that differences in readmission performance across hospitals are influenced by many different factors. These include differences driven, in part, by variation in hospital quality and the availability of community resources.

Recognizing the number of public and member comments on the topic, along with the Committee's own concerns, the Committee strongly encourages CMS and other measure developers in this project to update their measure specifications, retest, and resubmit these measures for review by the Standing Committee during the trial period recently approved by the NQF Board and informed by the report issued by the Expert Panel on Risk Adjustment for Sociodemographic Factors. The Committee also agrees that efforts should be undertaken to educate the measurement community on the recommendations by the SDS Expert Panel prior to implementing the trial period in measure endorsement projects. Additional information on the Committee's deliberations regarding SDS can be found in the Overarching Issues Section of the Voting Draft Report.

Theme 2- Harmonization

Overall, commenters noted that a lack of harmonization between similar measures or selection of a best-in-class measure could lead to confusion among patients and providers, and may also cause increased measurement burden. Commenters recommended that the Committee revisit the competing measure sets for CABG, Home Health, and SNF-readmissions, and either recommend a 'best in class' measure or defer the endorsement of the measures until the developers can develop a single hybrid measure.

2375 PointRight OnPoint-30 SNF Rehospitalizations [AHCA] and 2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) [CMS]

Commenters noted that Measure 2375 lacked adjustment for planned readmissions, an issue discussed by the Committee, and while Measure 2510 does include some planned readmissions; commenters noted the measure lacks robust risk adjustment since it relies on administrative claims to capture patient severity. Commenters suggested harmonizing these two measures into one hybrid measure that combines data from both the Minimum Data Set (MDS) and claims. These commenters suggested that MDS data in Measure 2375 may enable a more robust risk adjustment methodology, but argued that the type of "planned readmission" algorithm used by CMS could strengthen the measure. One commenter also encouraged CMS to exclude acute psychiatric inpatient stays from the index admission.

Committee Response: The Committee discussed Harmonization between Measure 2510 and Measure 2375 during web-meetings on May 16 and August 6. In summary, the Committee noted that the principal differences between these measures are their data sources, the inclusion of planned readmissions, readmissions that may occur once the patient is discharged from the SNF, and identification of patient characteristics that impact risk adjustment. The Committee accepts CMS's approach for identifying

readmissions that are likely to have been planned, agreeing that these readmissions should be removed them from the numerator and the denominator.

The Committee agrees with the developer's assessment, that full harmonization across both measures is unlikely to be obtained, and that the two measures are capable of supporting multiple quality needs when operating in tandem. However, some Members suggest that the developers of Measure 2375 should consider eliminating planned readmissions similar to Measure 2510.

The Committee notes, that a few members have expressed concern that endorsing multiple measures would be confusing for consumers and patients.

Note: Following the August 6 Post-Comment Call, the Committee voted to uphold their initial recommendation of both Measure 2510 and Measure 2375.

2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery [CMS] and 2514 Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate [STS]

Commenters disagreed that the two CABG measures are harmonized to the extent possible. Commenters discussed the differences between the two CABG measures, noting that Measure 2515 uses administrative claims and can feasibly incorporate the CMS "planned readmissions" algorithm, while Measure 2514 uses clinical data that is potentially important for high-volume facilities and facilities with higher-risk patients. Commenters encouraged the Committee to defer endorsement decisions and recommended the developers collaborate on a single hybrid measure, noting that the CABG readmission measure should be analogous to the PCI readmission measure (Measure 0695), which links clinical registry data from the American College of Cardiology registry with Medicare claims data and removes planned readmissions from the outcome.

Other comments asked the developer to provide additional data on the variance in measurement between these two measures, noting that data submitted for Measure 2515 suggests that nearly 8 percent of hospitals have a difference of one percent or more in their results. Comments cautioned that while the differences may appear small, they matter significantly in the context of pay-for-performance programs.

Committee Response: The Committee discussed Measure 2514 and Measure 2515 during web-meetings on May 16 and August 6. In summary, the Committee noted that the two measures are harmonized along several measure dimensions, including measure cohort, assessment of isolated CABG, and inclusion of VAD procedures. The principal difference between these two measures is the data source. Committee members reached agreement that the STS registry used for Measure 2514 would provide feedback in a timely manner, and may therefore be more appropriate for internal quality improvement. Committee Members also agree that Measure 2515, which is based on claims, may be more suitable for public reporting and use in federal programs at this time since performance could be calculated for all hospitals using claims, whereas the STS registry data covers only those who participate in the registry.

The Committee notes, that a few members have expressed concern that endorsing multiple measures would be confusing for consumers and patients.

Note: Following the August 6 Post-Comment Call, the Committee voted to uphold their initial recommendation of both Measure 2514 and Measure 2515.

2380 Rehospitalization During the First 30 Days of Home Health [CMS] and 0171 Acute care hospitalization (risk adjusted)[CMS]

Commenters expressed concerns with recommending Measure 2380, citing that the measure is similar to the already-endorsed Measure 0171. Commenters noted that these measures have different time windows, urging the Committee to consider whether one time window is more clinically meaningful than the other and requesting that CMS synthesize the two measures into one.

NQF Response: Measure 2380 competes directly with Measure 0171: Acute Care Hospitalization—Percentage of Home Health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the Home Health stay. However, according to NQF guidance, since Measure 0171 was not evaluated in this project the Committee will not make a best-in-class recommendation with regards to these two competing measures. A recommendation may be made at a later date.

Committee Response: The Committee discussed Measure 2380 and Measure 0171 during web-meetings on May 16 and August 6. The Committee agrees that the measure specifications for Measure 0171 and Measure 2380 are harmonized along several measure dimensions, including Data source, Population, Denominator Exclusions, Numerator, and Risk Adjustment methodology. The Committee notes that the measures use two different data sources, and acknowledged that they have slightly different data definitions, since Measure 2380 is all-cause readmission. Ultimately the Committee agrees that Measure 2380 should move forward, agreeing that these two measures address distinct domains of care under the CMS Quality Strategy and reflect related but distinct care quality concepts.

2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health [CMS] and 0173 Emergency Department Use without Hospitalization [CMS]

Commenters expressed concerns with recommending Measure 2505, suggesting that the measure is similar to the already endorsed Measure 0173. Commenters noted that Measure 2505 counts ED use during the first 30 days of home health, while measure 0173 counts ED use within the first 60 days of home health, urging the Committee to consider whether one of these time windows is more clinically meaningful than the other and requesting that CMS synthesize the two measures into one.

NQF Response: Measure 2505 competes directly with Measure 0173 Emergency Department Use without Hospitalization—Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay. However, according to NQF guidance, since Measure 0173 was not evaluated in this project the Committee will not

make a recommendation with regards to these two competing measures. A recommendation may be made at a later date.

Committee Response: The Committee discussed Measure 2505 and Measure 0173 during web-meetings on May 16 and August 6. The Committee agrees that the measure specifications for Measure 0173 and Measure 2505 are harmonized along several measure dimensions, including Data source, Population, Denominator Exclusions, Numerator, and Risk Adjustment methodology. The Committee notes that the measures address different care process and different categories of patients, noting that at the conceptual level, Measure 2505 is trying to understand what happens to patients post-discharge. Ultimately the Committee agrees that Measure 2505 should move forward, concluding that these two measures address distinct domains of care under the CMS Quality Strategy and reflect related but distinct care quality concepts.

Theme 3 – Relationship between admissions and readmissions

Some commenters observed that care transition improvement efforts and other community-oriented activities to reduce readmissions can also lead to reduced *admissions* as continuity of care is improved and other health benefits are achieved in the community. Commenters noted that this may lead to the appearance of higher readmission rates in these communities as the measure denominator (i.e., admissions) may decrease more quickly than the numerator (i.e., readmissions), when in fact the communities' quality improvement efforts have worked as intended, resulting in these communities effectively being penalized for their success.

Committee Response: The Committee recognizes that this could be a potential unintended consequence of readmission measures, and urges CMS to monitor these issues as the measures are implemented to ensure providers are not being unfairly penalized. The Committee also recommends that measure implementers consider pairing readmissions measures with measures of admission rates, community-level admissions/readmission rates per 1,000, or other countervailing factors to ensure that provider performance is appropriately assessed.

Theme 4 – Provider Attribution

Commenters expressed concern over the way performance is attributed for a number of the readmission measures, including Measure 2380: Rehospitalization During the First 30 Days of Home Health, Measure 2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health, and Measure 2496: Standardized Readmission Ratio (SRR) for dialysis facilities.

Commenters noted that home health agencies may not be the appropriate locus of responsibility, noting that there is limited evidence on the interventions that home health agencies can take to influence re-hospitalization or ED use. Similarly, commenters questioned whether it would be appropriate to hold dialysis facilities accountable for readmissions given their relatively limited role in management of care transitions.

Committee Response: Upon review of submitted comments, the Committee determined that this issue had been discussed and addressed to its satisfaction at the in-person meeting. The Committee agrees to uphold the initial endorsement

recommendations citing that care transition measures are needed to promote coordination and shared accountability across the care continuum. These include setting specific admission and readmissions measure that address the unique needs related to post-acute care. Readmission measurement should reinforce that all stakeholders' have a responsibility to collaborate to improve performance on this important issue health care quality. While many settings may not have been historically responsible for admissions and readmissions into hospitals, this quality problem requires new roles for each stakeholder to make progress on improvement.

Theme 5 –Evidence Requirements for Outcome Measures

Several commenters raised concerns about the conditions required for an outcome measure to meet NQF's evidence subcriterion. In accordance with the 2011 recommendations of an NQF-convened Evidence Task Force, a Committee may judge an outcome measure to have met the evidence subcriterion if the developer has provided a plausible rationale supporting the relationship of the health outcome to at least one healthcare structure, process, intervention, or service. Some commenters suggested that this is not a sufficient level of rigor for a measure that is publicly reported and may affect provider reimbursement. These commenters urged NQF to require measure developers to submit empirical analysis to assess the linkage between the outcome and at least one process or structure, which would provide a stronger indication of whether the outcome can be improved.

NQF Response: Improving health outcomes is a central goal of healthcare treatments and services (e.g. health, function, survival, symptom control). Thus, outcomes, such as admissions and readmissions are viewed as useful quality indicators since they integrate multiple care processes and disciplines involved in care. In addition, once they are measured and reported, many outcomes that were not thought to be modifiable tend to improve. This suggests that measurement stimulates identification and adoption of effective healthcare processes that can improve health outcomes for patients. For the reasons noted above, health outcomes do not necessarily require empirical evidence linking them to a known process or structure of care. Although such evidence is desirable, a rationale supporting the linkages between measures of health outcome and at least one healthcare structure, process, intervention, or service is sufficient to meet NQF's criteria of importance to measure and report. However, the Committee recognizes that the term "evidence" may not accurately reflect the underlying justification for their recommendations on measures of readmission. Therefore, in order to ensure greater clarity regarding the Committee's intent in recommending these measures for endorsement, the final report will be modified to replace the word "evidence" with "rationale" where appropriate.

MEASURE SPECIFIC COMMENTS

The following seven measures received significant public and member comments. The Committees full evaluation of these measures can be in the draft report.

Measure 2496: Standardized Readmission Ratio (SRR) for dialysis facilities

Measure 2496 is a new submission to NQF and was developed under stewardship of The Centers of Medicare and Medicaid Services (CMS). During discussion, there was strong agreement that this is a high impact area of measurement and there is opportunity for improvement with the overall readmissions rate at approximately 30 percent and the readmissions rate for hemodialysis patients at approximately 36 percent. A few members of the Committee were concerned that the dialysis unit is not the appropriate accountable entity for this measure, noting that dialysis units can not compel Nephrologists to see patients immediately after acute care discharges. Others on the Committee argued that while the locus of accountability may not be the dialysis facility at present, this measure and improvement efforts tied to it might be the type of impetus needed to improve care for this vulnerable population. These members also noted that with patients spending nine to 12 hours in these units during the week, more could be done to improve care for these patients.

The measure passed each of the criteria – importance to measure, scientific acceptability, usability, and feasibility. However, the Committee was unable to reach consensus on Overall Suitability for Endorsement. As such, the Committee agreed to revisit this measure after the 30-day Member and public comment period.

NQF received 10 post-evaluation comments regarding this measure. There was one supportive comment, arguing that this measure addresses an important high priority for measurement with sufficient room for improvement in the care processes of dialysis units. The remaining comments raised concern about the measure specifications, including the numerator specifications, denominator specifications, attribution, temporal logic, risk adjustment, testing, and intended use.

Numerator Specifications

Commenters were concerned that the numerator definition relies on an accurate determination of planned admissions using codes from a non-ESRD population. Commenters encouraged validation of these codes in the ESRD population through examination of patient-level data from the CMS dry run.

Commenters raised strong concern that the numerator of acute admissions does not consider ESRD-specific patient management – noting that this list of admissions should be tailored to include nephrology–related treatment. Commenters requested clarification on whether PD catheter placement or omentectomy, vascular access creation, or transfusion for a transfusion dependent patient fall is included in the measure. The Commenter also requested clarification on how bedded outpatients and observation admissions are counted in the measure.

In addition, commenters stressed public validation of ICD-9 definitions for “non-acute readmissions” and “planned procedures”.

Denominator Specifications

Specifically, a commenter disagreed that the number of discharges should not be the determinant of the denominator, but rather the number of readmissions should be based on the total number of patients treated in a facility. Further, the commenter argued that the current measure is vulnerable to being skewed by the effect of one or two complex patients requiring frequent hospitalization.

Attribution

Many commenters challenged the notion that dialysis facilities have the ability to affect readmissions. Commenters explained that dialysis facilities often do not receive any direct communication from the discharging hospital or facility for their patients, and are not supported to have coordinated presence in multiple hospitals. One commenter noted that a patient may be readmitted before ever being seen in the dialysis unit. This commenter noted that these readmissions are not actionable by the dialysis facility and should not be included in the measure. Further, commenters noted a lack of evidence showing that changes in a dialysis unit are the factors driving performance improvement.

Additionally, a commenter noted that the majority of dialysis facilities do not have the resources for additional personnel, such as case managers, to improve care coordination between dialysis facilities and other health care providers. This commenter argued that dialysis facilities have a role in reducing all-cause readmissions; however, these facilities may not be the locus of control to manage the coordination required.

Further, the commenter discussed that a dialysis unit has no control over a hospital's decision to re-admit a patient. The hospital physician decides whether or not to admit a patient, and many of these admissions have nothing to do with the nephrological issues being addressed by the dialysis facility and should also be excluded from the measure.

Commenters also requested clarification on the frequency of admissions that occur prior to the first post-acute visit to a dialysis facility.

Exclusions

Commenters requested clarification on how specific patient cohorts are handled in the measure. Additionally, a commenter requested clarification on how readmissions as a result of unsuccessful kidney transplants are handled in the 6 months following the transplant. Another commenter requested clarification on the rationale for excluding index hospitalizations after the patient's 12th admission in the calendar year. The commenter noted that this was a change from the original specification submitted to the Measure Applications Partnership (MAP). Further, this commenter requested clarification on why patients without complete claims histories and those who are readmitted within the 1-3 days after discharge are not excluded from the measure.

Risk Adjustment

Commenters noted concern with the validity of the two-stage random effects risk-adjustment model. In particular, they requested clarification on how the measure is impacted by communities where there is only one major hospital and/or one major dialysis facility versus communities where there is many of one or both. The Commenters also noted that the risk adjustment model should reduce the number of variables to those that are clinically relevant.

Further, another commenter noted that other comorbidities should be included in the risk adjustment model, including sickle cell trait, angiodysplasia, myelodysplasia, diverticular bleeding, and asthma. Additionally, the commenter suggested adjusting for nursing home status in the risk adjustment model. Commenters also requested clarification on whether "poisoning by nonmedical substances" includes ongoing/chronic alcohol or drug abuse and not just acute events.

Reliability and Validity testing

Commenters noted that the testing results demonstrating correlations between hospitalization and re-hospitalization do not enhance confidence in the measure. The correlations with access and urea reduction ratio (URR) are statistically significant but of very low magnitude, and the correlation with the standardized mortality ratio (SMR) also has a low magnitude. Another commenter noted that the area under the curve for the for the receiver operating characteristic (ROC) curve (C-statistic) for the multivariable model of <0.65 is quite poor and suggests that the model is inadequate.

Commenters requested clarification on the minimum sample size required to provide a statistically stable value for the measure. They expressed concern that many individual dialysis facilities may be too small with wide confidence intervals, limiting the statistical validity of the results.

Intended use in the specific program (QIP) and its appropriateness

Commenters expressed concerns regarding the appropriateness of the intended use of this measure for the CMS ESRD Quality Incentive Program (QIP). Commenters argued that the measure should focus only on admissions that are actionable for dialysis facilities, making stratification by primary diagnosis for readmission important.

> **Committee Response:** The Committee acknowledges the myriad of concerns raised by commenters during the comment period. Many of these issues raised by the commenters were discussed during the in-person meeting.
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> Some members of the Committee continue to be concerned with attributing the readmission to the dialysis unit. Members expressed concerns that it is difficult to hold a facility responsible for a readmission which occurs prior to the dialysis facilities' first post-discharge encounter with the patient. These members note that the rationale provided by the developer demonstrating the link to readmissions and dialysis unit care processes is limited.

However, the Committee acknowledges that while there is limited evidence of the link between processes undertaken by dialysis facilities and readmissions, there is ample evidence demonstrating improved readmissions in other populations with chronic disease and care that is provided in the outpatient setting. The Committee agrees that efforts to reduce unnecessary admissions and readmissions back to acute care facilities should be undertaken by all members of the health care delivery system. Many committee members agreed that this includes efforts undertaken by dialysis facilities in which patients spend a considerable amount of time.

Note: The Committee took a revote on this measure, after the Post-Comment call. The Committee was unable to reach consensus on the measure and thus, the measure moved forward to NQF Member voting designated as "Consensus not Reached".

Measure 2393: Pediatric All-Condition Readmission Measure

Six comments were submitted on Measure 2393; several of these comments were supportive of the Committee's recommendation for endorsement, noting the importance of improving quality measurement in pediatric care. However, a number of specific concerns were raised about aspects of the measure. These included:

- Concerns about the measure's lack of a methodology to exclude unpreventable readmissions or readmissions unrelated to the index admission, and the lack of testing to support the absence of such exclusions
- Concerns about the adequacy of the measure's risk adjustment methodology, which some commenters suggested should incorporate additional factors

Committee Response: The Committee agrees that readmissions measurement is critical to improving care transitions for pediatric patients. While the measure that was submitted to NQF does not distinguish between related and unrelated admissions, the measure is a good start for measurement of readmissions in the pediatric population. The Committee encourages future submission of readmission measures that consider and account for preventability. However, at this time, the Committee agrees with the developers' current approach to risk adjustment and exclusions met NQF's Scientific Acceptability criteria, and are generally satisfied with the measure's reliability. The Committee further discussed these comments during the August 6 conference call, and concluded that concerns about inclusion of readmissions unrelated to the index admission are not exclusive to pediatric measures, and in fact apply to all of the readmissions measures under consideration. The Committee notes that its evaluation was limited to the measures submitted for review in this project, and suggests that until alternative measures are submitted, the measures currently under review remain a good starting point for addressing pediatric readmissions. Committee members suggest that because the measures are new and relatively unproven, it may be appropriate to use them in demonstration before they are linked to incentives. Some members of the Committee also suggest pairing these measures with length-of-stay measures to aid in efforts to monitoring for unintended consequences.

Measure 2414: Pediatric Lower Respiratory Infection Readmission Measure

Six comments were submitted on Measure 2414; comments were similar to those submitted on Measure 2393, with some commenters supporting the measure and others expressing concerns about the measure's lack of a methodology to exclude unpreventable and unrelated readmissions, as well as the adequacy of the risk adjustment model. Two commenters also expressed concerns about the exclusion of specialty and non-acute care hospitals, with one arguing that this may exclude academic pediatric hospitals from the measure.

> **Committee Response:** See Committee response for Measure 2393. In response to submitted comments, the developer clarified that the measure does not exclude pediatric academic hospitals, only non-acute care hospitals (e.g., rehabilitation hospitals) and specialty hospitals (e.g., those focused on care of specific conditions such as orthopedic conditions or congenital anomalies).

Measure 0327: Risk-Adjusted Average Length of Inpatient Hospital Stay

Measure 0327 has been NQF-endorsed® since 2008 and was developed by Premier, Inc. The Committee noted that this measure represents an important area of measurement and there continues to be a performance gap and large variation in hospital performance. Members of the Committee were concerned that the limited information presented by the developer in terms of validity and reliability testing made the assessment of scientific acceptability difficult. Others noted that the measure has been endorsed for some time with broad use. The Committee did express caution that the risk adjustment model incorporates socio-demographic variables; however, some members agreed that this approach was appropriate for this measure focus. Ultimately, the Committee failed to reach consensus on Scientific Acceptability and agreed to revisit Overall Suitability for Endorsement after the 30-day Member and public comment period.

NQF received several comments on Measure 0327. Commenters noted that the measure as specified can be applied to inpatient rehabilitation facilities (IRFs), which they noted should be excluded from this measure due to the large variation in length of stay at these facilities. In addition, commenters suggested that there should be a method to adjust for outliers. Several commenters argued that Measure 0327 should be considered an efficiency measure rather than a true quality measure, and that it should be paired with quality measures to avoid unintended consequences such as reduction of length of stay at the expense of sufficient and appropriate care. Some commenters also suggested that the measure has limited usability given its lack of specificity, and that the measure should enable providers to "drill down" to assess length of stay by diagnosis-related group.

> **Committee Response:** The Committee notes that this measure has been useful for hospitals in understanding the efficiency of their inpatient stays. The Committee also acknowledges the concerns raised by commenters on potential unintended consequences from the use of this measure. The Committee urges the developer and measure implementers to monitor for improvements in this measure at the expense of sufficient and appropriate care. The Committee requests information on any potential unintended consequences from its use from the developer as this measure is implemented.

Note: The Committee took a revote on this measure, after the Post-Comment call. The Committee was unable to reach consensus on the measure and thus, the measure moved forward to NQF Member voting designated as "Consensus not Reached".

Measure 2503: Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries and Measure 2504: 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

NQF received twelve comments on Measure 2503 and Measure 2504 raising similar topics across both measures. Several commenters were supportive of the measure, noting that these types of measures help providers and communities understand areas in need of improvement. These commenters noted that the measure passed all of the must-pass sub-criteria and contended that it should be recommended by the Standing Committee. Other commenters noted that the measures should be risk adjusted to appropriately assess differences in community performance. Finally, commenters also encouraged the measure developer to expand the measure to include Medicaid patients.

Committee Response: The Committee agrees that this measure is critical to addressing this high-priority issue due to the large number of patients affected and the high costs associated with admissions and readmissions. During deliberations, the Committee noted concern over the lack of risk adjustment for this measure. However, the Committee agreed that risk adjustment may not be necessary because the measure is intended to be used only to evaluate the performance of a community against itself over time. The Committee reiterates that this measure should not be used to compare performance across communities due to the lack of risk adjustment. The Committee also recognizes multiple public and member comments that noted the usefulness of these measures for community-based interventions and community-level quality and utilization studies. The Committee took a revote on this measure, after the Post-Comment call and voted to recommend the measures for NQF endorsement.

Measure 2512: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs)

Measure 2512 is a new submission to NQF and was developed under stewardship of The Centers for Medicare and Medicaid Services (CMS). The Committee raised concern about the validity of the measure to include both readmissions to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH). There was concern that these are two different patient populations are not conceptually aligned. The Committee questioned whether 30 days was the appropriate time frame for this patient population; as one Committee Member noted, LTCH patients are typically sicker and may have fewer short-term episodes. The Committee discussed several unintended consequences during review of this measure. These include potential gaming of the measure by transferring or redirecting patients with higher acuity or greater complexity to avoid penalty and the potential for "double jeopardy" since the same readmission may be counted against both the hospital and the LTCH.

The measure passed the following criteria – importance to measure, scientific acceptability, and feasibility. However, the Committee was unable to reach consensus on Overall Suitability for

Endorsement due to concerns with usability. As such, the Committee agreed to revisit this measure after the 30-day Member and public comment period.

NQF received five comments on Measure 2512. Several commenters were supportive of the measure, noting that the measure addresses an important care transition for a high-priority patient population. One commenter noted that the measure might be best suited for accountable care measurement systems. Another commenter noted that the measure should take into consideration the unique patient population in a long term care hospital and not co-mingle the patient population of short-stay acute-care hospitals.

> ***Committee Response:*** The Committee agrees that this measure targets an important care transition and is an appropriate focus of performance measurement. Several members of the Committee share commenters' concerns that the measure should not include both readmissions to a short-stay acute-care hospital or a Long-Term Care Hospital (LTCH). There was concern that these are two different patient populations and are not conceptually aligned.
>
> **Note**: The Committee took a revote on this measure, after the Post-Comment call. The Committee was unable to reach consensus on the measure and thus, the measure moved forward to NQF Member voting designated as "Consensus not Reached".

NATIONAL QUALITY FORUM

Memo

Appendix B: NQF Member Voting Results

None of the recommended measures were approved by the membership. Nine out of 18 measures were measures where consensus was not reached. The remaining nine measures were not approved. Representatives of 29 member organizations voted; no votes were received from the Public/Community Health Agency Council. Results for each measure are provided below. (Links are provided to the full measure summary evaluation tables.)

Measure #0327 Risk-Adjusted Average Length of Inpatient Hospital Stay (Consensus Not Reached)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	0	2	0	2	0%
Health Plan	1	3	0	4	25%
Health Professional	0	1	3	4	0%
Provider Organizations	0	8	4	12	0%
Public/Community Health Agency	0	0	0	0	
Purchaser	1	3	0	4	25%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**2**	**18**	**10**	**30**	**10%**
Percentage of councils approving (>60%)					0%
Average council percentage approval					8%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: We are concerned that this measure is not specific enough to be used for quality-related, decision-making purposes. In order to be useful, this measure should have drill-down capabilities so that the average length of stay can be assessed by diagnosis-related group.
- American Hospital Association: Because the en bloc voting option does not offer the opportunity to comment, we will enter our comments here --- but they are relevant to the entire list of measures. We are chagrinned that several of the measures brought forward for endorsement in this set have extremely low levels of reliability. It is unclear to us how measures can be deemed to have passed criteria for scientific acceptability as national standards when, at these low levels of reliability, the measures cannot generate answers that anyone should accept as an accurate portrayal of provider performance. It is especially unfortunate when measures either planned for or used in federal programs carry the imprimatur of NQF endorsed while being so unreliable.
- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-

Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."

- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #0505 Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	1	3	4	0%
Provider Organizations	3	6	3	12	33%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	1	1	1	3	50%
Supplier/Industry	0	0	1	1	
All Councils	**13**	**9**	**8**	**30**	**59%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					56%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for

sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #0695 Hospital 30-Day Risk-Standardized Readmission Rates following Percutaneous Coronary Intervention (PCI)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	3	6	3	12	33%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**12**	**8**	**10**	**30**	**60%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					57%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached

among the Steering Committee members as is the case for three measures in the measure set.

Measure #2375 PointRight OnPoint-30 SNF Rehospitalizations

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	5	4	3	12	56%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**14**	**6**	**10**	**30**	**70%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					61%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2380 Rehospitalization During the First 30 Days of Home Health

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%

Health Professional	0	0	4	4	
Provider Organizations	5	4	3	12	56%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**14**	**6**	**10**	**30**	**70%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					61%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure # 2393 Pediatric All-Condition Readmission Measure

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	2	2	4	0%
Provider Organizations	4	5	3	12	44%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	1	1	1	3	50%
Supplier/Industry	0	0	1	1	
All Councils	**14**	**9**	**7**	**30**	**61%**

Percentage of councils approving (>60%)	33%
Average council percentage approval	57%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- Children's Hospital Association: The Childrens Hospital Association appreciates the opportunity to vote on the all-cause admissions and readmissions measures. Although we have voted to approve the two pediatric measures (2393 and 2414), we believe that additional experience with and evaluation of the measures is critical prior to using them for accountability purposes. (See letter to Dr. Cassel.)
  The pediatric readmissions measures are the first measures developed through the Pediatric Quality Measurement Program (PQMP) established as a result of CHIPRA. The PQMP is critically important in addressing the gap in the measures to assess and support improvement in the quality of care provided to all children, including children with special health care needs. Currently endorsed pediatric measures are heavily clustered in the prevention and well child domain and do not adequately address children with significant health care needs, including those needing hospitalization. We applaud the work of the PQMP and that of the measure developer, (CEPQM) at Boston Children's Hospital (BCH) in beginning to close these gaps.
  We urge potential users to proceed with great caution in using measures 2393 and 2414 for the purposes of accountability. As outlined in our previous comments, we believe that additional experience is needed to assess measuresvalidity and the potential for unintended consequences that might result from their use in accountability initiatives. BCH submitted a similar comment and recommended stratifying results to enable comparison among health systems according to characteristics such as hospital type and annual pediatric volume. Further, BCH noted pediatric readmissions measures should not be incorporated into pay for performance programs at this time.
  There are significant limitations in measurement of readmissions currently under NQF review for both adults and children. In pediatrics, these weaknesses are compounded by the lack of a robust national database for pediatric care. The Medicaid Analytic eXtract and HCUP State Inpatient Databases, which were used to develop the measures, suffer from significant limitations. The data are only available for a select number of states, are typically one to two years delayed and there is variation in the quality of the data. Additional testing and validation is needed before applying the measures to other databases.
  The relatively low rate of hospitalizations and readmissions in pediatrics pose additional challenges. Most adult readmissions measures are related to specific conditions (AMI, PCI, etc.) as compared to measure 2393, potentially exacerbating the issue of non-preventability (including readmissions totally unrelated to the initial admission) as well as other factors such as socioeconomic status. The Association supports the recommendations in the recent NQF report on risk adjustment for socioeconomic status. As the NQF undertakes a time limited trial period, we believe that the pediatric readmission measures are strong candidates for developing measures, including use of sociodemographic factors in risk adjustment, for the purposes of informing long term policy.
  CEPQM notes an inherent limitation of readmission rates is that they do not indicate

which factors most influence readmissions for a given population and are thus most important to addressand goes on to highlight the importance of measuring readmission rates as an essential first step. The Association believes that hospitals and delivery systems should strive to reduce readmissions and drive down barriers to the achievement of optimal health. Given this belief and the current dearth of pediatric measures, we vote to endorse the pediatric readmission measures but recommend use of these metrics be limited to exploratory purposes and for research initially. Should the measures be endorsed, we urge the NQF and other users develop a plan for gaining additional experience to validate the measures.

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2414 Pediatric Lower Respiratory Infection Readmission Measure

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	1	0	3	4	100%
Provider Organizations	4	5	3	12	44%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**14**	**7**	**9**	**30**	**67%**
Percentage of councils approving (>60%)					50%
Average council percentage approval					66%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- Children's Hospital Association: The Childrens Hospital Association appreciates the opportunity to vote on the all-cause admissions and readmissions measures. Although we have voted to approve the two pediatric measures (2393 and 2414), we believe that additional experience with and evaluation of the measures is critical prior to using them for accountability purposes. (See letter to Dr. Cassel.)
  The pediatric readmissions measures are the first measures developed through the Pediatric Quality Measurement Program (PQMP) established as a result of CHIPRA. The PQMP is critically important in addressing the gap in the measures to assess and support improvement in the quality of care provided to all children, including children with special health care needs. Currently endorsed pediatric measures are heavily clustered in the prevention and well child domain and do not adequately address children with significant health care needs, including those needing hospitalization. We applaud the work of the PQMP and that of the measure developer, (CEPQM) at Boston Children's Hospital (BCH) in beginning to close these gaps.
  We urge potential users to proceed with great caution in using measures 2393 and 2414 for the purposes of accountability. As outlined in our previous comments, we believe that additional experience is needed to assess measures validity and the potential for unintended consequences that might result from their use in accountability initiatives. BCH submitted a similar comment and recommended stratifying results to enable comparison among health systems according to characteristics such as hospital type and annual pediatric volume. Further, BCH noted pediatric readmissions measures should not be incorporated into pay for performance programs at this time.
  There are significant limitations in measurement of readmissions currently under NQF review for both adults and children. In pediatrics, these weaknesses are compounded by the lack of a robust national database for pediatric care. The Medicaid Analytic eXtract and HCUP State Inpatient Databases, which were used to develop the measures, suffer from significant limitations. The data are only available for a select number of states, are typically one to two years delayed and there is variation in the quality of the data. Additional testing and validation is needed before applying the measures to other databases.
  The relatively low rate of hospitalizations and readmissions in pediatrics pose additional challenges. Most adult readmissions measures are related to specific conditions (AMI, PCI, etc.) as compared to measure 2393, potentially exacerbating the issue of non-preventability (including readmissions totally unrelated to the initial admission) as well as other factors such as socioeconomic status. The Association supports the recommendations in the recent NQF report on risk adjustment for socioeconomic status. As the NQF undertakes a time limited trial period, we believe that the pediatric readmission measures are strong candidates for developing measures, including use of sociodemographic factors in risk adjustment, for the purposes of informing long term policy.
  CEPQM notes an inherent limitation of readmission rates is that they do not indicate which factors most influence readmissions for a given population and are thus most important to address and goes on to highlight the importance of measuring readmission rates as an essential first step. The Association believes that hospitals and delivery systems should strive to reduce readmissions and drive down barriers to the

achievement of optimal health. Given this belief and the current dearth of pediatric measures, we vote to endorse the pediatric readmission measures but recommend use of these metrics be limited to exploratory purposes and for research initially. Should the measures be endorsed, we urge the NQF and other users develop a plan for gaining additional experience to validate the measures.

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2496 Standardized Readmission Ratio (SRR) for dialysis facilities (Consensus Not Reached)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	2	2	0	4	50%
Health Professional	0	2	2	4	0%
Provider Organizations	0	4	8	12	0%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	2	1	3	0%
Supplier/Industry	0	1	0	1	0%
All Councils	**7**	**12**	**11**	**30**	**37%**
Percentage of councils approving (>60%)					14%
Average council percentage approval					29%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: This measure is not yet ready for wide-spread use as the accountability for management of ESRD patients is not well defined. This measure

would be more appropriate in a bundled payment scenario than in the current CMS payment model.

- Dialysis Patient Citizens: We cannot support endorsement of further readmission measures until the issue of socio-demographic status adjustment or peer grouping has been resolved by NQF and CMS. We also share the concerns raised about this specific measure-- that dialysis facilities lack sufficient control over hospital readmissions to be held accountable for this outcome.
- Akin Gump Strauss Hauer & Feld, LLP: Kidney Care Partners (KCP) has identified several significant concerns with Measure #2496 and offer the following comments.
  I. The SRR is inconsistent with CMSs Dialysis Facility Risk-Adjusted Standardized Mortality Ratio and Standardized Hospitalization Ratio for Admissions measures. These measures only include patients who have had ESRD for 90 days or more, and the SRR measure does not appear to be harmonized in this respect. Despite our May 2013 request for clarification on why this difference is present and for the data analysis on the implications of the difference, these details have not been provided for stakeholder review. We stress that harmonization is of particular importance with the SHR, given the SRR and SHR are likely to be used in conjunction to obtain a complete picture of a facility's hospitalization use.
  II. The SRR measure specifications submitted to NQF's Measure Applications Partnership in November 2013 had an exclusion for index hospitalizations that occur after a patient's 6th readmission in the calendar year, which has now been revised to those that occur after a patient's 12th readmission in the calendar year. KCP is concerned about the impact of the revision on low-volume facilities, and believe it is imperative for CMS to report on the underlying distribution that led to the change.
  III. CMS's Hospital-Wide All-Cause Unplanned 30-Day Readmission Ratio (NQF #1789) excludes patients who have incomplete claims history from the past year, but the proposed dialysis facility SRR does not.
  IV. The measure's risk model fails to adequately account for hospital-specific patterns and fails to adjust at all for physician-level admitting patterns a particular concern because the decision to admit or readmit a patient is a physician decision. Geographic variability in this regard is well documented in other areas, and there is no reason to believe the situation is different for ESRD patients.
  V. KCP strongly recommends that the measure be limited to those readmissions that are related or actionable to ESRD, rather than all-cause readmissions. Data from one KCP member revealed that approximately 45% of readmissions are not related or actionable to ESRD.
  VI. KCP recommends that patients who are readmitted in the first 1-3 days after discharge be excluded from the measure. Data from two KCP members find that among patients who were rehospitalized within 30 days of the initial hospitalization in 2011, 11-17% were readmitted during this period often even before the first outpatient dialysis encounter. By an approximately 2:1 margin, rehospitalized dialysis patients had not been seen by the dialysis facility before readmission. Penalizing facilities for such situations is patently unreasonable. Further in this regard, during the first 8 days after discharge, up to 40% of patients were readmitted again the dialysis center had had a limited number of encounters to intervene/affect quality of care.
  VII. Finally, CMS should provide data to demonstrate there is no bias of the SRR

between rural and urban facilities; this is not simply adjusted for by the hospital as a random effect variable.
These points are further detailed in our previously submitted comments and in our accompanying letter to NQF. But in short, given the technical flaws and lack of validation elucidated above, KCP believes this measure should not be endorsed by NQF. We note that CMS has at its disposal the data to address a number of these issues. Further, KCP is concerned with the approach and assumptions for the predictive model, which posits to reveal an actual versus predicted rate when the basis for the ratio comes from claims data and not EMR data. We strongly recommend a more evidence-based approach to this measure and reiterate our opposition to its endorsement.

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	1	3	4	0%
Provider Organizations	3	6	3	12	33%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**12**	**9**	**9**	**30**	**57%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					47%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2503 Hospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	1	3	4	0%
Provider Organizations	2	7	3	12	22%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**11**	**10**	**9**	**30**	**52%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					45 %

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-

Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."

- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2504 30-day Rehospitalizations per 1000 Medicare fee-for-service (FFS) Beneficiaries

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	1	3	4	0%
Provider Organizations	2	7	3	12	22%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**11**	**10**	**9**	**30**	**52%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					45%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and

more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	3	1	0	4	75%
Health Professional	0	1	3	4	0%
Provider Organizations	5	4	3	12	56%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**13**	**8**	**9**	**30**	**62%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					47%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: This measure will require monitoring to ensure measure reliability.
- WellPoint: Should be monitored and further refined, delay endorsement until that time
- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed

decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	2	1	1	4	67%
Health Professional	0	1	3	4	0%
Provider Organizations	5	4	3	12	56%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**12**	**8**	**10**	**30**	**60%**
Percentage of councils approving (>60%)					33%
Average council percentage approval					45%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: A majority of health plans believe that this measure should be harmonized with #2375 PointRight OnPoint-30 SNF Rehospitalizations; however, one plan feels that both measures are useful for different assessments. Both measures use different data sources and #2510 excludes planned readmissions while #2375 does not.
- WellPoint: Think measure 2375 is superior to this measure,
- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF

should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2512 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) (Consensus Not Reached)

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	0	7	5	12	0%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**9**	**9**	**12**	**30**	**50%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					50%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2513 Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures

Member Council	Yes	No	Abstain	Total Votes	% Approval*

Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	2	7	3	12	22%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**11**	**9**	**10**	**30**	**55%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					54%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2514 Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	2	6	4	12	25%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%

Supplier/Industry	0	0	1	1	
All Councils	**11**	**8**	**11**	**30**	**58%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					55%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- America's Health Insurance Plans: We support this measure for internal quality improvement purposes only and not for public reporting.
- Baylor Scott & White Health: 1. In both the Numerator Statement and Denominator Statement of this measure, the NQF identifies the numerator and denominator to include Isolated Coronary Artery Bypass Graft surgery. The NQF and CMS must maintain alignment with the STS definition of Isolated CABG. The STS definition can include cases with forms of atrial fibrillation ablation, Extra Corporeal Membrane Oxygenation, and even some valve surgeries, if the valve surgery was unplanned.

  2. Because one of the exclusions to this measures is There is a CMS record, but no matching STS record &, centers offering cardiovascular surgery who do not participate in the Society of Thoracic Surgeons Adult Cardiac Surgery (STS-ACS) registry may gain an unfair advantage over the majority of centers that do participate in this registry. This may become more of an issue as the STS registry grows in size, requiring additional resources for data collection, and causing some centers to consider alternatives to participation in the STS-ACS registry. For example, the STS-ACS registry has increased in size each time it's been upgraded over the past decade, now requiring about 1250 data elements per case be assessed. While not all 1250 data elements are assessed on an Isolated Coronary Artery Bypass Surgery, participation in the registry by any one facility requires all elements be assessed at one time or another.

  3. The NQF and/or Medicare must provide timely feedback to sites regarding ongoing performance in this domain. Sites can track their internal readmission rates, but as is endemic with all CMS based readmission measures, sites do not have efficient and automated methods of knowing when patients are readmitted outside their hospital systems.

  4. Varying Medicare Fee-For-Service populations may disproportionately and unfairly impact some sites. The STS-ACS registry has long been a universal measuring stickfor participating sites. Excluding Non Fee-For-Service populations will introduce levels of outcomes stratification that are not currently experienced by participants. We recommend the readmission rates that include all patients be reported.
- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance

program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2515 Hospital 30-day all-cause unplanned risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	2	6	4	12	25%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	0	1	2	3	0%
Supplier/Industry	0	0	1	1	
All Councils	**11**	**8**	**11**	**30**	**58%**
Percentage of councils approving (>60%)					40%
Average council percentage approval					55%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- American College of Medical Quality: The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."
- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF

should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Measure #2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Member Council	Yes	No	Abstain	Total Votes	% Approval*
Consumer	1	1	0	2	50%
Health Plan	4	0	0	4	100%
Health Professional	0	0	4	4	
Provider Organizations	3	7	2	12	30%
Public/Community Health Agency	0	0	0	0	
Purchaser	4	0	0	4	100%
QMRI	1	0	2	3	100%
Supplier/Industry	0	0	1	1	
All Councils	**13**	**8**	**9**	**30**	**62%**
Percentage of councils approving (>60%)					60%
Average council percentage approval					76%

*equation: Yes/ (Total - Abstain)

Voting Comments:

- AAMC: The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

Appendix C: Removal of Endorsement of Measures

Five measures previously endorsed by NQF have not been re-submitted, withdrawn from maintenance of endorsement, or not recommended for continued endorsement:

Measure	Description	Reason for removal of endorsement
0698: 30-Day Post-Hospital AMI Discharge Care Transition Composite Measure [CMS]	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its	CMS has not implemented Measure 0698 related to care transition since their endorsement by NQF. CMS contracted with Yale in October 2013 to conduct a comprehensive reevaluation of these measures; incorporating the findings from implementing the CMS readmissions for public reporting and payment programs. CMS will re-submit these measures for a comprehensive reevaluation once completed by Yale.

Measure	Description	Reason for removal of endorsement
	interpretation.	
0699: 30-Day Post-Hospital HF Discharge Care Transition Composite Measure [CMS]	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay having a primary diagnosis of heart failure for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase I project's call for measures (ED and E&M) or is already approved by NQF (readmissions). Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	CMS has not implemented Measure 0699 related to care transition since their endorsement by NQF. CMS contracted with Yale in October 2013 to conduct a comprehensive reevaluation of these measures; incorporating the findings from implementing the CMS readmissions for public reporting and payment programs. CMS will re-submit these measures for a comprehensive reevaluation once completed by Yale.
0707: 30-day Post-Hospital PNA (Pneumonia) Discharge Care Transition Composite Measure [CMS]	This measure scores a hospital on the incidence among its patients during the month following discharge from an inpatient stay	CMS has not implemented Measure 0707 related to care transition since their endorsement by NQF. CMS contracted with Yale

Measure	Description	Reason for removal of endorsement
	having a primary diagnosis of PNA for three types of events: readmissions, ED visits and evaluation and management (E&M) services. These events are relatively common, measurable using readily available administrative data, and associated with effective coordination of care after discharge. The input for this score is the result of measures for each of these three events that are being submitted concurrently under the Patient Outcomes Measures Phase II project´s call for measures. Each of these individual measures is a risk-adjusted, standardized rate together with a percentile ranking. This composite measure is a weighted average of the deviations of the three risk-adjusted, standardized rates from the population mean for the measure across all patients in all hospitals. Again, the composite measure is accompanied by a percentile ranking to help with its interpretation.	in October 2013 to conduct a comprehensive reevaluation of these measures; incorporating the findings from implementing the CMS readmissions for public reporting and payment programs. CMS will re-submit these measures for a comprehensive reevaluation once completed by Yale.
0328: Casemix-Adjusted Inpatient Hospital Average Length of Stay [United Health Group]	This measure calculates a casemix-adjusted inpatient average length of stay (ALOS) for medical and surgical admissions for Commercial and Medicare populations. The measure can be reported at the hospital level or the service category level (medical vs. surgical).	United Health Group indicated that they no longer have the capacity to maintain these measures in accordance with NQF's Maintenance Policy. Their methods for risk-adjusting length of stay have evolved and now more closely mirror those put forth by Premier in measure 0327. Given the relative alignment of the endorsed Premier and internal UHG methodologies, the effort

Measure	Description	Reason for removal of endorsement
		required to document our current process for risk-adjusted LOS is likely counterproductive. For this reason, we will not be resubmitting measure 0328 during the upcoming measure maintenance cycle.
0331: Severity-Standardized Average Length of Stay -- Routine Care (risk adjusted) [Leapfrog Group]	Standardized average length of hospital stay (ALOS) for routine inpatient care (i.e., care provided outside of intensive care units).	The Leapfrog Group- Indicated that they no longer have the capacity to maintain these measures in accordance with NQF's Maintenance Policy. Due to the staff-intensive resources that shepherding a measure through the NQF process requires, The Leapfrog Group has made the decision to no longer serve as measure steward on measure #0331.

Appendix D: Developer Responses to Voting Comments

Pediatric Readmission Measures
Response to Comments Submitted with NQF Member Votes
October 29, 2014

Measure #2393 – Pediatric All-Condition Readmission Measure

• **Children's Hospital Association:** The Childrens Hospital Association appreciates the opportunity to vote on the all-cause admissions and readmissions measures. Although we have voted to approve the two pediatric measures (2393 and 2414), we believe that additional experience with and evaluation of the measures is critical prior to using them for accountability purposes. (See letter to Dr. Cassel.) The pediatric readmissions measures are the first measures developed through the Pediatric Quality Measurement Program (PQMP) established as a result of CHIPRA. The PQMP is critically important in addressing the gap in the measures to assess and support improvement in the quality of care provided to all children, including children with special health care needs. Currently endorsed pediatric measures are heavily clustered in the prevention and well child domain and do not adequately address children with significant health care needs, including those needing hospitalization. We applaud the work of the PQMP and that of the measure developer, (CEPQM) at Boston Children's Hospital (BCH) in beginning to close these gaps.

We urge potential users to proceed with great caution in using measures 2393 and 2414 for the purposes of accountability. As outlined in our previous comments, we believe that additional experience is needed to assess measuresvalidity and the potential for unintended consequences that might result from their use in accountability initiatives. BCH submitted a similar comment and recommended stratifying results to enable comparison among health systems according to characteristics such as hospital type and annual pediatric volume. Further, BCH noted pediatric readmissions measures should not be incorporated into pay for performance programs at this time.

There are significant limitations in measurement of readmissions currently under NQF review for both adults and children. In pediatrics, these weaknesses are compounded by the lack of a robust national database for pediatric care. The Medicaid Analytic eXtract and HCUP State Inpatient Databases, which were used to develop the measures, suffer from significant limitations. The data are only available for a select number of states, are typically one to two years delayed and there is variation in the quality of the data. Additional testing and validation is needed before applying the measures to other databases.

The relatively low rate of hospitalizations and readmissions in pediatrics pose additional challenges. Most adult readmissions measures are related to specific conditions (AMI, PCI, etc.) as compared to measure 2393, potentially exacerbating the issue of non- preventability (including readmissions totally unrelated to the initial admission) as well as other factors such as socioeconomic status. The Association supports the recommendations in the recent NQF report on risk adjustment for socioeconomic status. As the NQF undertakes a time limited trial period, we believe that the pediatric readmission measures are strong candidates for developing measures, including use of sociodemographic factors in risk adjustment, for the purposes of informing long term policy.

CEPQM notes an inherent limitation of readmission rates is that they do not indicate which factors most influence readmissions for a given population and are thus most important to addressand goes on to highlight the importance of measuring readmission rates as an essential first step. The Association believes that hospitals and delivery systems should strive to reduce readmissions and drive down barriers to the achievement of optimal health. Given this belief and the current dearth of pediatric measures, we vote to endorse the pediatric readmission measures but recommend use of these metrics be limited to exploratory purposes and for research initially. Should the measures be endorsed, we urge the NQF and other users develop a plan for gaining additional experience to validate the measures.

• CEPQM response:

— Need for additional experience with measure:

We concur that acquiring further experience with the measure would be valuable. Study of

experience with the measure in the context of related systems features such as admission rates, discharge practices, and community supports could lead to a better understanding of the measure's function in practice and help with assessing and minimizing unintended consequences.

— *Need for national pediatric data infrastructure:*

As part of the Detailed Measure Specifications, we provide a methodology for calculating readmission rates for Medicaid-insured children that can be compared at a national level. However, we agree that an infrastructure for developing a national pediatric dataset would be very useful. A national dataset would enable risk adjustment at a national level and thus allow for national comparisons among health systems. The availability of an increasing number of pediatric quality measures could help to motivate creation of such an infrastructure.

— *Adjustment for sociodemographic factors:*

Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

• **American College of Medical Quality:** The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments.

• **CEPQM response:**

— *Adjustment for sociodemographic factors:*

Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

— *Use of "Present on Admission" status:*

"Present on admission" flags may be useful in helping to distinguish whether a condition was present on admission or whether it developed during the course of hospitalization, possibly in relation to care provided. For example, healthcare-associated infections may be present on admission, in which case risk adjustment for them may be appropriate, or may be acquired during hospitalization, in which case risk adjustment may not be appropriate. Although Medicare claims data contain a "present on admission" flag, other claims datasets do not contain such a flag, presenting challenges for determining whether a condition was indeed present on admission. In addition, the case-mix adjustment model for the Pediatric All-Condition Readmission Measure adjusts for chronic conditions, which often are already present on admission, rather than for acute conditions that may occur as complications of care.

Pediatric Readmission Measures
Response to Comments Submitted with NQF Member Votes
October 29, 2014

• **AAMC:** The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.

• **CEPQM response:**

— *Adjustment for sociodemographic factors:*

Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

Pediatric Readmission Measures
Response to Comments Submitted with NQF Member Votes
October 29, 2014

Measure #2414 Pediatric Lower Respiratory Infection Readmission Measure

• **Children's Hospital Association:** The Childrens Hospital Association appreciates the opportunity to vote on the all-cause admissions and readmissions measures. Although we have voted to approve the two pediatric measures (2393 and 2414), we believe that additional experience with and evaluation of the measures is critical prior to using them for accountability purposes. (See letter to Dr. Cassel.) The pediatric readmissions measures are the first measures developed through the Pediatric Quality Measurement Program (PQMP) established as a result of CHIPRA. The PQMP is critically important in addressing the gap in the measures to assess and support improvement in the quality of care provided to all children, including children with special health care needs. Currently endorsed pediatric measures are heavily clustered in the prevention and well child domain and do not adequately address children with significant health care needs, including those needing hospitalization. We applaud the work of the PQMP and that of the measure developer, (CEPQM) at Boston Children's Hospital (BCH) in beginning to close these gaps.

We urge potential users to proceed with great caution in using measures 2393 and 2414 for the purposes of accountability. As outlined in our previous comments, we believe that additional experience is needed to assess measures validity and the potential for unintended consequences that might result from their use in accountability initiatives. BCH submitted a similar comment and recommended stratifying results to enable comparison among health systems according to characteristics such as hospital type and annual pediatric volume. Further, BCH noted pediatric readmissions measures should not be incorporated into pay for performance programs at this time.

There are significant limitations in measurement of readmissions currently under NQF review for both adults and children. In pediatrics, these weaknesses are compounded by the lack of a robust national database for pediatric care. The Medicaid Analytic eXtract and HCUP State Inpatient Databases, which were used to develop the measures, suffer from significant limitations. The data are only available for a select number of states, are typically one to two years delayed and there is variation in the quality of the data. Additional testing and validation is needed before applying the measures to other databases.

The relatively low rate of hospitalizations and readmissions in pediatrics pose additional challenges. Most adult readmissions measures are related to specific conditions (AMI, PCI, etc.) as compared to measure 2393, potentially exacerbating the issue of non- preventability (including readmissions totally unrelated to the initial admission) as well as other factors such as socioeconomic status. The Association supports the recommendations in the recent NQF report on risk adjustment for socioeconomic status. As the NQF undertakes a time limited trial period, we believe that the pediatric readmission measures are strong candidates for developing measures, including use of sociodemographic factors in risk adjustment, for the purposes of informing long term policy.

CEPQM notes an inherent limitation of readmission rates is that they do not indicate which factors most influence readmissions for a given population and are thus most important to address and goes on to highlight the importance of measuring readmission rates as an essential first step. The Association believes that hospitals and delivery systems should strive to reduce readmissions and drive down barriers to the achievement of optimal health. Given this belief and the current dearth of pediatric measures, we vote to endorse the pediatric readmission measures but recommend use of these metrics be limited to exploratory purposes and for research initially. Should the measures be endorsed, we urge the NQF and other users develop a plan for gaining additional experience to validate the measures.

• **CEPQM response:**

— *Need for additional experience with measure:*

We concur that acquiring further experience with the measure would be valuable. Study of

experience with the measure in the context of related systems features such as admission rates, discharge practices, and community supports could lead to a better understanding of the measure's function in practice and help with assessing and minimizing unintended consequences.

— *Need for national pediatric data infrastructure:*

As part of the Detailed Measure Specifications, we provide a methodology for calculating readmission rates for Medicaid-insured children that can be compared at a national level. However, we agree that an infrastructure for developing a national pediatric dataset would be very useful. A national dataset would enable risk adjustment at a national level and thus allow for national comparisons among health systems. The availability of an increasing number of pediatric quality measures could help to motivate creation of such an infrastructure.

— *Adjustment for sociodemographic factors:*

Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

• **American College of Medical Quality:** The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio- Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments.

• **CEPQM response:**

— *Adjustment for sociodemographic factors:*

Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

— *Use of "Present on Admission" status:*

"Present on admission" flags may be useful in helping to distinguish whether a condition was present on admission or whether it developed during the course of hospitalization, possibly in relation to care provided. For example, healthcare-associated infections may be present on admission, in which case risk adjustment for them may be appropriate, or may be acquired during hospitalization, in which case risk adjustment may not be appropriate. Although Medicare claims data contain a "present on admission" flag, other claims datasets do not contain such a flag, presenting challenges for determining whether a condition was indeed present on admission. In addition, the case-mix adjustment model for the Pediatric Lower Respiratory Infection Readmission Measure adjusts for chronic conditions, which often are

already present on admission, rather than for acute conditions that may occur as complications of care.

• **AAMC:** The Association of American Medical Colleges (AAMC) has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.
• **CEPQM response:**
— *Adjustment for sociodemographic factors:*
Unfortunately, administrative claims offer limited options for assessing sociodemographic factors. However, as part of measure testing, we performed initial explorations of the relationship between socioeconomic status and readmission risk using insurance status as a proxy for socioeconomic status. We did not include socioeconomic factors in our risk adjustment model because NQF guidelines for the All-Cause Admissions and Readmissions project specified that measure developers should follow the existing NQF recommendation to not include socioeconomic or sociodemographic factors in risk adjustment. NQF has indicated that it will determine how to address adjustment for socioeconomic and sociodemographic factors in existing measures. We plan to follow NQF's guidance and will revise the risk adjustment model if so advised.

RESPONSES REGARDING THE STANDARDIZED REAMISSION RATIO FOR DIALYSIS FACILITIES (#2496)

We welcome the opportunity to respond to the comments received. We have provided NQF with detailed responses to all these issues during the Steering Committee deliberation and the Public Comment period. Due to space limitations, we selected those that seemed most pertinent to respond to. The comments and questions are summarized in italics, followed by our response.

Readmissions should be restricted to those that are related to ESRD or modifiable by facilities. The 2012 CMS TEP concluded that an all-cause measure is appropriate for two main reasons. First, it was very difficult to establish agreeable and exhaustive conditions that are deemed modifiable by the facility. Second, an all-cause measure of readmission may be more valuable as it supports a paradigm of shared accountability, in which providers from different care settings are, as a group, accountable for the overall care of the patient

There is no adjustment for nephrologist/physician who actually makes the readmission decision. It is a CMS policy decision not to adjust for physician in the model for the following reasons. First, implementation and harmonization of such adjustment would affect many CMS measures and would raise many questions as to which physicians should be adjusted for. Second, the facilities have a legal obligation to oversee physicians working in the dialysis unit.

The measure should exclude early readmissions in days 1 to 3 following discharge. CMS made a policy decision to include the early readmissions in the measure because the measure is meant to encourage interaction between hospitals and facilities from the time of discharge. Consequently, the motivation to move up the time at which the patient is first seen in the dialysis facility is useful. In addition, excluding the first three days could allow gaming of the measure in moving up readmissions to the early time to avoid penalty.

The denominator of this measure based on number of discharges is inappropriate. We have in place a measure that evaluates admissions (SHR) and this can be used in supplement to the SRR; together they give a very useful picture of hospital utilization. Commenters have given artificial examples to show that the measure could give very misleading results. We have investigated this concern and find that there are no occurrences of situations where a facility has a better than expected admission rate and worse than expected readmission rate, as postulated in these examples. An abstract that thoroughly investigates the relationships between SHR and SRR has been accepted by the American Society of Nephrology conference and will be presented in November 2014.

The method of adjustment for hospital may disadvantage rural facilities with fewer choices of hospital. We have carefully investigated this issue and , contrary to what has been conjectured by the commenters, the data show that rural facilities have lower adjusted readmission rates (median rural SRR=0.91; median non-rural SRR=1.02; 2012 data).

The model makes adjustment for too many variables and also does not adjust for certain comorbidities that would be appropriate. The variables have been selected in the model on the basis of scientific and statistical relevance. Nonetheless, the model will be under regular review and additional adjustments will be made as appropriate – suggestions received will help guide these reviews. Based on earlier input, we did include an adjustment for high risk diagnoses empirically defined as diagnoses leading to readmission at least 40% of the time. This helps to avoid penalty for many readmissions with these diagnoses.

The SRR has a c-statistic of less than 0.65 which indicates that the model is inadequate. A 0.65 c-statistic is similar to that obtained by other readmission measures, some of which are NQF approved and in use. It should be noted that the c-statistic is a measure of model predictiveness and not of model adequacy; irrespective of its c-statistic, a model can be very useful in identifying facilities that have poor outcomes as compared to the national norm.

The primary motivation for the SRR is to promote coordination of care between hospitals and dialysis facilities in appropriately treating patients following hospital discharge. It is true that there is often relatively little communication between the facilities and the discharging hospital, and one aim of the measure is to increase that communication to the benefit of patient care.

RTI International
October 29, 2014

All Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (NQF #2512): Summary of Issues Concerning NQF Review and CMS Responses

Background and Context

The All Cause Unplanned Readmission Measure for 30 Days Post Discharge from Long-Term Care Hospitals (LTCHs) (NQF #2512) was discussed and voted on at the NQF Steering Committee Meetings. The committee did not reach a consensus on recommending the measure for NQF endorsement. The measure focuses on readmissions that are considered unplanned to both short- and long-term care hospitals within 30 days after discharge from an LTCH to a less intense level of care. A similarly conceived and structured readmissions measure for Inpatient Rehabilitation Facilities (IRFs), NQF #2502, was discussed and recommended for endorsement by this same Steering Committee.

Following the committee's review, RTI and CMS concluded that some members of the committee expressed three specific concerns regarding this measure's specifications:

1. The use and usability criterion was not met for this measure.
2. It was unclear why the measure is specified to include both readmissions to a short-stay acute care hospital or an LTCH, as some members believed that these two different patient populations are not conceptually aligned.
3. Counting readmissions back to LTCH settings was considered an issue for access to care.

CMS' Response to NQF Steering Committee Concerns

NQF #2512 is similar to a group of readmissions measures that have been either endorsed by NQF (acute hospital measures) or approved by the committee by consensus (NQF #2502 for IRFs). It is harmonized with these measures, with customization for the particular population. The basis of considering these measures as related to quality is the importance of transitions and coordination of care after discharge. This committee seems to be treating this measure in a way that is inconsistent with other readmission measures. Post-discharge planning would logically apply to all facilities and there is nothing that would raise expectations that readmission rates for different facility types should be the same.

(1) *Use and Usability*: As CMS presented to the NQF Steering Committee on August 6, 2014, the basic criterion of using the measure is met, as CMS intends to use this measure as part of its family of readmission measures intended to improve the transitions of care and coordination of care after discharge from a facility. CMS adopted this measure for its Long-Term Care Hospital Quality Reporting Program and also intends to use this measure eventually for public reporting purposes.

(2) *Readmissions from LTCHs back to an LTCH*: The only issue that seems to differentiate the LTCH measure from the others is that including readmissions to LTCHs from LTCHs in the measure is in some way seen as problematic by Steering Committee members. It is not clear why one should distinguish patients by which acute facility type they are readmitted to. The measure distinguishes patients by their being in an LTCH and by their clinical characteristics in determining their probability of being readmitted to an acute care level. Care transitions and coordination should affect readmission to either setting. Also, RTI provided findings to NQF from additional analyses demonstrating the low prevalence of readmissions back to LTCHs as a proportion of all readmissions included in the measure. These results show that excluding or including these readmissions has a small effect on the relative standardized readmission rates beyond the overall change in readmission rates.

(3) *Access to Care:* The question of whether there would be an issue with access to care for patients who could be readmitted to the same LTCH, but are turned away for fear of raising the readmission rate, is only a potential concern. There is no evidence to suggest that this phenomenon occurs. If a patient has an unplanned admission to any other LTCH or a short-term acute hospital, the readmission would be counted in the same way as a readmission to the same facility. In fact, the LTCH would benefit financially from admitting the patient; they would not benefit if another facility admitted the patient. Nonetheless, the readmission would be treated the same in the specification of this measure. In conclusion, it does not appear that there are any substantive and evidence-based reasons that informed the committee to call into question this measure that is similar to other measures of readmissions that achieved consensus for endorsement.

November 3, 2014

Measure #2514 Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate (STS)

NQF Member Voting Comment	STS Response
America's Health Insurance Plans We support this measure for internal quality improvement purposes only and not for public reporting.	Thank you for your comment.
Baylor Scott & White Health In both the Numerator Statement and Denominator Statement of this measure, the NQF identifies the numerator and denominator to include Isolated Coronary Artery Bypass Graft surgery. The NQF and CMS must maintain alignment with the STS definition of Isolated CABG. The STS definition can include cases with forms of atrial fibrillation ablation, Extra Corporeal Membrane Oxygenation, and even some valve surgeries, if the valve surgery was unplanned.	Isolated CABG combined with ECMO or unplanned valve surgeries are extremely rare, e.g., a surgeon intends to do an isolated CABG but an adverse event occurs in the OR requiring ECMO. STS, Yale CORE and CMS worked collaboratively during a 1-2 year period of measure development which led to NQF #2514 and NQF #2515. These groups worked together to validate the administrative cohort definition of isolated CABG as well as risk adjustment using clinical data from the national STS Adult Cardiac Surgery Database.
Because one of the exclusions to this measure is There is a CMS record, but no matching STS record &, centers offering cardiovascular surgery who do not participate in the Society of Thoracic Surgeons Adult Cardiac Surgery (STS-ACS) registry may gain an unfair advantage over the majority of centers that do participate in this registry. This may become more of an issue as the STS registry grows in size, requiring additional resources for data collection, and causing some centers to consider alternatives to participation in the STS-ACS registry. For example, the STS-ACS registry has increased in size each time it's been upgraded over the past decade, now requiring about 1250 data elements per case be assessed. While not all 1250 data elements are assessed on an Isolated Coronary Artery Bypass Surgery, participation in the registry by any one facility requires all elements be assessed at one time or another.	STS does not understand the commenter's concerns regarding non-STS Adult Cardiac Surgery Database (ACSD) participants' unfair advantage, and therefore requests clarification. It is STS's understanding that its ACSD participants represent over 90% of cardiac surgery programs in the US. STS ACSD specifications are reviewed and updated every three years to ensure the ACSD collects the most relevant data reflecting current practices in adult cardiac surgery and also to ensure that its data elements are harmonized with other data registries and government agencies. The commenter's statement about the number of data elements in the ACSD is incorrect. In STS ACSD version 2.73, there were 744 total fields, and in the current version (2.81), there are 840 total fields. A first time isolated on-pump CABG x 3 on a diabetic with triple vessel disease, LIMA plus 2 veins without complication or readmission requires 225 fields to code.
The NQF and/or Medicare must provide timely feedback to sites regarding ongoing performance in this domain. Sites can track their internal readmission rates, but as is endemic with all CMS based readmission measures, sites do not have efficient and automated methods of knowing	N/A

when patients are readmitted outside their hospital systems.	
Varying Medicare Fee-For-Service populations may disproportionately and unfairly impact some sites. The STS-ACS registry has long been a universal measuring stick for participating sites. Excluding Non-Fee-For-Service populations will introduce levels of outcomes stratification that are not currently experienced by participants. We recommend the readmission rates that include all patients be reported.	We agree this is a limitation. However, there is no universal method to obtain longitudinal follow-up information. Medicare is currently the only source for these data.
<u>American College of Medical Quality</u> The American College of Medical Quality (ACMQ) believes that all these measures should not be endorsed until there is consensus regarding an appropriate, standardized risk-adjustment methodology for Socio-Economic Status. Claims-based measures also to not take into account Present on Admission" status in risk adjustments."	Thank you for your comment. STS will abstain from responding because this comment pertains to all of the measures being reviewed under this project and is ultimately a decision that must be made by NQF.
<u>The Association of American Medical Colleges (AAMC)</u> AAMC has serious concerns with these readmissions measures. While the AAMC supports efforts to reduce all unplanned and adverse readmissions, we believe that these measures are seriously flawed and are not appropriate for use in either a reporting or pay-for-performance program. Most importantly, these measures have not been risk adjusted to account for sociodemographic status factors, which adversely affects hospitals that treat sicker and more vulnerable patients. The NQF is currently in the process of establishing a sociodemographic status (SDS) trial period, which is set to start in late December, 2014. The AAMC strongly urges NQF to delay action on this measure set until the conclusion of the SDS trial period, to allow steering committee members to make a more informed decision on the measures methodology. The AAMC also strongly believes that NQF should not move measures forward for a vote, where consensus was not reached among the Steering Committee members as is the case for three measures in the measure set.	Same as above.

4170, 4171

We oppose endorsement of hospitalizations per 1000 Medicare FFS beneficiaries as an NQF outcome measure. It is not an outcome measure; it is a raw utilization statistic. Further it requires risk adjustment otherwise variation in utilization could be perceived as a variation in quality which may or may not be the case.

Both measures reflect the capability of a community to not rely on hospital services for the care of Medicare beneficiaries. As such, these utilization statistics are useful for measuring the capacity and quality of the complex interdependent network of medical, social and community supports, and more importantly, for tracking progress resulting from improvements in integrating service delivery. It is intended to evaluate change over time within communities engaged in cross-setting improvement work. Since the characteristics of a community's population do not change rapidly, risk adjustment for population demographics is unnecessary. Additionally, the parameters of a community that might be associated with capacity to change, or potential community risk adjustors, are still undefined. Despite this, there are a large number of cross-setting initiatives, and considerable investment in those initiatives, currently occurring without standardized measures for gauging progress. Admission and readmission incidence are measures similar to other metrics used in public health, are sensitive to cross-setting improvement initiatives, reflect improvements made by both medical and non-medical providers, and are easily understood.

4209, 4210

Cedars-Sinai Health System opposes endorsement of hospitalizations per 1000 Medicare FFS beneficiaries as an NQF outcome measure. It is not an outcome measure; it is a raw utilization statistic. It is disingenuous of CMS to claim the measure does not require risk adjustment because it would be used only to compare regions or states with themselves over time. Whenever state or regional data are made public, other organizations and journalists use it to make national comparisons. For example, the Commonwealth Fund produces a state scorecard, and its staff members wrote a recent Viewpoint article in JAMA stating "The fact that variation persists among states on indicators that rely on Medicare data demonstrates that state policies and local norms and practices…can make a difference." (Emphasis added. Source: McCarthy D, Schoen C, Radley D. State Health System Performance: A Scorecard. JAMA 2014; published online April 30, 2014. doi:10.1001/jama.2014.5374)

In addition, the Medicare FFS population is not stable within a region from year to year, as millions of Baby Boomers are aging into the program. More importantly, individuals can shift into and out of Medicare Advantage (MA) plans, which could significantly change the composition of the FFS population being measured over time. It is well established that MA members tend to be healthier than FFS beneficiaries. Individuals may drop out of MA when they develop complex conditions that require services that may be difficult to access in the HMO setting. As a result, the unadjusted measure is biased. Any state or region with higher than average MA penetration will look relatively worse in comparisons when the measure is limited to FFS beneficiaries.

For all these reasons, a metric of hospitalizations per 1000 Medicare FFS Beneficiaries requires risk-adjustment if it is to be endorsed by the NQF. We suggest that CMS consider using data from the Medicare Current Beneficiary Survey to test the feasibility of performing state-level risk adjustment.

See answers to #s 4170 and 4171. It seems unwise to leave community-based improvement initiatives without a standardized measure for tracking progress out of concern that some may misinterpret it. Our experience working with communities demonstrated, and continues to demonstrate, that both admissions/1000 and readmissions/1000 reflect improvement driven by cross-continuum cooperation and integration during time periods when Medicare Advantage enrollment increases, and communities in states with high enrollment rates have made as significant a degree of progress as communities in states with low enrollment. Relative improvement has also not been associated with poverty prevalence (*JAMA.* 2013;309(4):381-391).