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.

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• **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:**

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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).