NATIONAL QUALITY FORUM

Memo

TO: All Cause Admissions and Readmissions Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: July 28, 2014

Background

Unnecessary admissions and early readmissions to acute care facilities are the subject of ever-increasing scrutiny and are an important focus for quality improvement by the health care system. Previous studies have shown that nearly one in five Medicare patients is readmitted to the hospital within 30 days of discharge, including many patients returning via the emergency room, costing upwards of $26 billion annually. Multiple entities across the health care system, including hospitals, post-acute care facilities, skilled nursing facilities, and others, all have a responsibility to ensure high quality care transitions to reduce unplanned admissions and readmissions to the hospital.

The Readmissions and Admissions Portfolio of measures is growing rapidly. Currently, NQF's portfolio of Admissions and Readmissions measures includes measures for admissions, readmissions, and length of stay. The portfolio contains ten outcome measures, three of which will be evaluated by the Admissions and Readmissions Standing Committee during this project. While some of the oldest measures have been endorsed since 2008, many of the condition-specific and all-cause measures have come in the last two years. Due to the ever-increasing scrutiny on unnecessary admissions and readmissions, these measures are part of an important focus on quality improvement within the health care system. As such, several of the measures in the portfolio are in use for a number of federal programs including, the Home Health Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program, the Hospital Inpatient Quality Reporting Program, and Hospital Readmission Reduction Program. Additionally, the condition-specific measures for heart failure, acute myocardial infarction, and pneumonia are in use in at least four communities involved in the Aligning Forces for Quality initiative. Lastly, as part of on-going work with the NQF-convened Measure Applications Partnership (MAP), several of the Readmission measures are included in the Care Coordination Family of Measures.

On May 5-6, 2014 the All-Cause Admissions and Readmissions Standing Committee, which includes 23 members, evaluated 15 new measures and 3 measures undergoing maintenance review against NQF's standard evaluation criteria. Thirteen measures were recommended for endorsement, while for the remaining five, the Committee did not reach consensus on.

Purpose of the Call

The Admissions and Readmissions Standing Committee will meet via conference call on August 6, 2014 from 3-5pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.

- Determine whether reconsideration of any measures or other courses of action is warranted.

Due to time constraints, only those comments where the Committee disagrees with the proposed responses will be discussed.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 1 (877) 296-0829 (*NO CONFERENCE CODE REQUIRED)*
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?258064
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?258064

Comments Received

Pre-evaluation comments

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF is piloting continuous commenting in this project via an online tool located on the project webpage. Since the launch of the project in October 2013, a total of 10 comments were received prior to the in-person meeting. Two of these comments pertained to the Measure 2496: Standardized Readmission Ratio (SRR) for dialysis facilities. Commenters outlined concerns regarding the limited ability of dialysis clinics to impact outcomes and were not supportive of the measure. Four comments were submitted concerning the two pediatric measures, Measure 2393: Pediatric All-Condition Readmission Measure and Measure 2414: Pediatric Lower Respiratory Infection Readmission Measure. The commenters expressed diverging views with some arguing that the measure was incomplete in approach, specifications, and clinical specificity; while others were supportive of the measure as specified. The supportive commenters did caution that additional feedback based on measure implementation would be needed if the measure were to be used for accountability purposes.

All submitted comments were provided to the Committee prior to their initial deliberations held during the workgroups calls as well as during the in-person meeting.

Post-evaluation comments

The Draft Report went out for Public and Member comment June 6 to July 7. During this commenting period, NQF received 170 comments from 25 member organizations:

Consumers – 2	Professional – 5
Purchasers – 0	Health Plans – 2
Providers – 10	QMRI – 4
Supplier and Industry – 2	Public & Community Health – 0

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

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Five major themes were identified in the post-evaluation comments, as follows:

1. Adjustment for Socio-demographic Status
2. Harmonization
3. Relationship between admissions and readmissions
4. Provider Attribution
5. Evidence for Outcomes

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 may cause serious unintended consequences for providers treating vulnerable populations.

Proposed Committee Response: The Committee recognizes the commenters' concern that socio-demographic factors may potentially influence readmission rates from various setting, and discussed the topic extensively during the in-person meeting. However, the Committee is operating under NQF's current guidance that SDS factors should not be adjusted for in risk adjustment models. On July 23rd, the NQF Board approved a trial period during which measures could be submitted with adjustment for SDS factors for endorsement. The specific implementation of this trial period is not yet clear. This Committee encourages CMS to strongly consider retesting the measure specifications and resubmitting measures of readmissions once the Expert Panel's recommendations are finalized by the NQF Board.

Theme 2- Harmonization

Overall commenters noted that a lack of harmonization between similar measures and the selection of a best-in-class measure could lead to confusion among patients and providers, and 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 measure could be strengthened by the type of "planned readmission" algorithm used by CMS. One commenter also encouraged CMS to exclude acute psychiatric inpatient stays from the index admission.

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 were harmonized to the extent possible. Commenters discussed the differences between the two CABG measures noting that Measure 2515 uses administrative claims and it feasible to use in the CMS "planned readmissions" algorithm, while Measure 2514 uses clinical data 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 it removes planned readmissions from the outcome.

Additional 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.

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 urged the Committee to consider whether one time-window is more clinically meaningful than the other and requests that CMS synthesize the two measures into one.

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 2502 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.

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.

> **Proposed 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 CMS consider pairing readmissions measures with measures of admission rates or other countervailing factors to ensure that provider performance is appropriately assessed.

Theme 4 – Provider Attribution

Commenters noted concern over the attribution for a number of the readmission measures; including NQF #2380: Rehospitalization During the First 30 Days of Home Health, NQF #2505: Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health, and NQF #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.

> **Proposed Committee Response:** Care transition measures, including setting-specific admission and readmission measures that address the unique needs related to post-acute care, are needed to promote coordination and shared accountability across the care continuum. 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 for Outcome Measures

Several commenters raised concern regarding the evidence requirement for outcome measures. Commenters raised concern that a plausible rationale that process or structure of care influences an outcome measure is not a sufficient level of rigor for a measure that is publicly reported and can affect provider reimbursement. A few 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.

> **Proposed Committee 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 the measures health outcome and at least one healthcare structure, process, intervention, or service is sufficient to meet NQF's importance to measure and report criteria.

Measure Specific Comments*

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

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.

<u>Numerator Specifications</u>
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 request clarification on whether PD catheter placement or omentectomy, vascular access creation, or transfusion for a transfusion

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*Please note that measure developers were invited to provide responses to specific comments received during the comment period; these responses are provided in the comment table.

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.

Commenters also 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 12^{th} admission in the calendar year. The commenter noted that this was a change from the original specification submitted to the Measure Application Partnership (MAP). Further this commenter requested clarification on why patients without complete claims history 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

Further, Commenters note 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.

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

Proposed 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 pediatric readmissions. The Committee encourages future submission of readmission measures to consider the preventability of the readmission. However, the Committee concluded that the developers' current approach to risk adjustment and exclusions met the Scientific Acceptability criteria, and were generally satisfied with the measure's reliability.

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.

Proposed Committee Response: See Committee response for measure 2393. In addition, The Committee agrees that academic pediatric hospitals should not be excluded from the measure, and has requested additional clarification from the developer on the types of hospitals that are excluded.

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 12 comments on Measure 2503 and Measure 2504 raising similar topics across both measures. Several commenters were supportive of the measure, noting these types of measures help providers and community understand areas of improvement opportunities. These commenters noted that the measure passed all of the must-pass sub-criteria and should move forward as a recommended measure 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.

Proposed Committee Response: The Committee agreed 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. The Committee noted concern over the lack of risk adjustment for this measure. Generally, the Committee agreed that risk adjustment may not be necessary because the measure is intended to only be used to evaluate the performance of a community against itself over time. The Committee reiterated that this measure should not be used to compare performance across communities due to the lack of risk adjustment.

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

NQF received several comments on Measure 0327, a measure where the Committee has not yet reached consensus. Commenters noted 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 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.

> **Proposed Committee Response:** The Committee acknowledges that length of stay measures can create opportunities for unintended consequences, while also recognizing that this is a risk associated with any measurement effort; the Committee urges that all measures recommended under this project be closely monitored as they are implemented to ensure that any unintended consequences are rapidly identified and mitigated.

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

The Committee received 8 comments, many of which questioned why the developer did not use patient-level data, using the Patient Assessment Instrument or the FIM® Instrument which specifically looks at functional status. Commenters noted that including patient-level data would likely improve the risk adjustment model and would be helpful in characterizing and understanding readmission patterns. Additionally, commenters recommended the exclusion of patients who died as well as planned readmissions to improve the risk adjustment model.

Other commenters questioned whether it was appropriate that the measure combines data collection of IRFs and LTCHs because of differences in patient population and recommended that the data be split by the type of provider. Further, that additional provider-specific data should include information such as the presence of a teaching program and being a rural provider. Commenters also questioned the usability of this measure, given that claims data are not readily available to hospitals and hospitals would not be able to replicate the data to be useful for quality improvement.

Lastly, one commenter noted that measuring 30-days post-discharge is too long of a time period leading to a greater likelihood the readmission is unrelated to the initial condition and may not lie within the discharging hospital's control.

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

The committee received 6 comments on this measure noting that the level of analysis was not clearly the home health facility and the metric should not be applied to the emergency department (ED). Commenters noted that when acute exacerbations of chronic conditions occur, a return to the ED may be warranted and a follow-up visit to an ED does not necessarily constitute a failure of home health care.

Commenters stressed that appropriate risk adjustment for this measure is critical to prevent unintended consequences stemming from potential disincentives to treat patients who may be at higher risk of rehospitalization and/or ED use. Additionally, commenters requested that the developer make explicit in its specifications that the level of analysis for this measure shall be the home health agency and not the ED.

> **Proposed Committee Response**: The Committee acknowledges these concerns and voiced similar concerns during the in-person meeting discussion. The Committee agrees that while the measure is specified at the facility level, it is not clear that the measure is

constructed for use only in Home Health. In order to avoid unintended consequences, the Committee recommends the developer make it explicit in their specifications that the level of analysis is the Home Health Agency. The Committee also recommends CMS monitor this measure for unintended consequences.

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

NQF received three comments on Measure 2513 each raising concerns over the heterogeneity of the patient population within the measure specifications. The commenters noted that measure combines three different sites of surgery, two different surgical approaches performed by multiple physician specialties, and two different settings.

Proposed Committee Response: The Committee agrees that providing a breakdown of the anatomical procedures, instead of an overall vascular readmission rate would be helpful for quality improvement.

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

NQF received four comments on Measure 2539. Commenters were supportive of increased focus on the quality of colonoscopy and the development of this measure concept. Concern was raised that the planned readmission exclusions and risk adjustment variables included in this measure are not sufficient for the clinical condition and may result in reluctance of endoscopists to scope patients with significant comorbidities. Further, a commenter also raised concern of the interclass correlation coefficient of 0.355 for the reliability testing appeared low.

Proposed Committee Response: The Committee notes that the interclass correlation coefficient (ICC) provided by the developer (0.335, interpreted as “fair agreement”) is comparable to other healthcare outcome measures. Further, the Committee notes that the split sample on which reliability testing was conducted contained 2 years of data, rather than 3 years (as the measure is specified). As such, when extrapolating the data to 3 years, the ICC increased to 0.43, interpreted as “moderate agreement”. The Committee is interested in hearing what the developer’s response is with regards to exclusions.