NATIONAL QUALITY FORUM

Moderator: Readmissions Standing Committee
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OPERATOR: This is Conference #: 47010285.

Operator: Welcome everyone. Today's webcast is about to begin. Please note today's call is being recorded. Please standby.

Erin O'Rourke: Good afternoon, everyone and thank you for taking the time to join us today for All-Cause Admissions and Readmissions Post-Comment Call Web Meeting. We wanted to get the Committee back together to have – give you the opportunity to review some of the public comments that we've received.

We've themed them out in the memo that you received. However, I just want to remind you that – that's not an attempt to limit your conversation and committee members are welcome to bring up any individual comments that you feel warrants discussion by the full committee.

So with that, I'd like to introduce our co-chairs, Cristie Travis and John Bulger and see if you have any welcome for the committee.

John Bulger: Go ahead, Cristie.

Cristie Travis: This is – yes, this is Cristie. I just welcome everyone back and appreciate your review of the material prior to the call and look forward to our discussion.

John Bulger: Yes, and likewise. And appreciate all the word you've done and some of the comments were lengthy and, you know, it took some time to read, so I appreciate everybody's work on that. And appreciate all you do for this important project.

Erin O'Rourke: Great. Thank you, John and Cristie. In the interest of time, we will not be doing a full roll call but we did just want to quickly walk through the agenda for today. I'm going to throw over to Donna Herring in a minute to just give you a little bit of information about the new project that we'll be starting in the coming days. I guess we've already officially started it. So to give you some information about what to expect in the spring for that project.

We'll then review and discuss the comments received. We'll go through theme by theme. We'll give a brief overview of what we heard. I will then turn it over to the lead discussants to share their reflections.

After we've discussed all of the comment themes, we'll open for public comments then Donna will briefly review our next step for this project.

(Off-Mic)

Donna Herring: Hello everyone. So I just wanted to give everyone a brief …

(Off-Mic)

Erin O'Rourke: If you can mute your computer speakers so we don't get the feedback. Thanks, everyone.

Donna Herring: So let's try that again. Hi everybody. I just wanted to give you an update on the new admission project that we recently awarded. So it is All-Cause Admissions and Readmissions Project for 2017. So it began officially on September 28th and we'll conclude on September 26, 2017. So there is going to be a little bit of overlap between the two projects.

Right now, we have our Call for Nomination which is open until November 9th and we are also out for our Call for Measures which is open until

December 2nd. We reached out to those of you on the Committee that we're eligible for reappointment and all of you agreed to stay on for additional term. So we're very excited that you would like to stay on the committee and join us for the new project.

We are going to – we are out for the Call for Nomination as I said and we are looking to fill one seat. It doesn't look like we are missing any particular stakeholders but if you have people that you're interested in nominating or you'd like them to nominate themselves, please feel free to send out the Call for Nominations and we'll be sending that out to the Committee so that you're able to distribute that to anyone that you think is interested.

You can also expect calendar invitations from the project team later today to reserve all of the calls for the new project.

So with that, I'll turn it back to Erin to give an overview of the measures today.

Erin O'Rourke: Great, thank you. So just to give you a brief reminder of where we ended up after our in-person meeting, the Committee evaluated 11 newly submitted measures and six measures undergoing maintenance endorsement review for this project.

The Committee ultimately recommended 16 of those measures for endorsement and did not recommend one measure. So the slides will give you some of the setting specific measures that the committee did recommend. We have two for home health and two for nursing home and one for psychiatric hospital for Cardiovascular Condition-Specific Hospital Readmission Measures the committee recommended and continued endorsement of NQF 330, and also recommended two measures addressing excess days in acute care for heart failure and AMI.

So for Pulmonary Condition-Specific Hospital Readmission Measures, the Committee recommended the ongoing endorsement of NQF 506 the hospital risk-standardized readmission rate for pneumonia as well as 1891, the Risk-Standardized Readmission Rate for COPD, and recommended for new

endorsement in excess days and acute care measure after hospitalization for pneumonia.

The committee recommended one All Cause/All Condition Specific Population Based Measures, Risk-Standardized Acute Administration Rate for Patients with Multiple Chronic Conditions.

The committee also recommended the ongoing maintenance of NQF – ongoing endorsement of NQF 1789, Hospital-Wide All-Cause Unplanned Readmission Measure as well as the new endorsement of NQF 2879, the Hospital-Wide Readmission Measure with Claims and Electronic Data to the Hybrid Measure.

The committee also looked at admission measures. Apologizing for the typo on the slide, these are not the pediatric quality indicators. The committee also looked at some additional ACO Level Admission Rate measures for patients with Heart Failure and Diabetes. So similar to the measure from multiple chronic conditions listed on the past slide, again, not for pediatric population.

And then finally, the committee did not recommend measure 2884, the 30-Day Unplanned Readmission for Cancer Patients Measure.

Next slide.

So with that, we'd like to share some of the major themes that we found in the public comment period. The first was around the consideration of sociodemographic factors. Commenters expressed concerns that a number of measures were recommended for endorsement without SDS factors included in the risk adjustment models and urge the committee to take a more in-depth look at the need for this adjustments, potentially given the negative impact these measures could have on providers practicing and low resourced regions.

In particular, some commenters noted that the findings presented by developers to the committee contradicted some of the other research in the fields and commenters encourage them additional testing of SDS factors as

well as stratifying measures by factors such as dual eligibility for Medicare and Medicaid.

Before we open it up for comments by the lead discussants, I did just want to remind the committee members what you were asked to do as part of the review of SDS factors during the trial period that we're currently in. We ask the Standing Committee to evaluate the measure as it's submitted by the developer and to make your decision about whether you believe it as a reliable and valid measure.

We don't necessarily ask Standing Committee members to consider alternate methodologies or to suggest additional variables that should be included in the risk adjustment factors. So I just wanted to clarify what the role of the Standing Committee is during the trial period. Helen, I wish I – did I miss anything or you wanted to add?

Helen Burstin: No, sounds great.

Erin O'Rourke: If not, we can turn over to the lead discussants for comments. Kathy Auger?

Female: I don't' think Kathy has joined us yet, but Helen, Anthony and Sherrie are on the call.

John Bulger: Great.

Helen Chen: So this is Helen. I think – I thought I would just kick this off. I just wanted to say I very much appreciated the thoughtfulness and the depth of the comments from the various stakeholders regarding SCS, SDS risk adjustment and also the very thoughtful responses from the developers.

And I will just put out there that many of us struggle with this issue and there was intent discussion about this. And at the end of the day, really the question that I think that we struggled with during the committee, face-to-face committee meeting on this topic was really not whether we think SCS or SDS are important there. They are important. The question is really in the measures that they are designed and with the data that is presented by the

developers. Do we think that they should be added as an additional risk adjustment?

And for me, the bottom line was and I think for many of us, the bottom line was that for the available SDS factors in the measures as designed, they did not significant – seem to significantly change the quality ranking on many of the sub-variables that were being discussed and there was actually concern that adjusting for patient level specifics on SDS or SCS is imperfect as they were …

(Crosstalk)

Helen Chen: … might be actually removing the ability to determine the hospital level quality issue that might be negatively impacting vulnerable people in SDS category. So, I think that's why we came down with the recommendation that we currently …

(Off-Mic)

John Bulger: Great, thanks, Helen. Tony, do you have anything to add or …

Anthony Grigonis: I agree with Helen. Very well stated by the way, Helen. It wasn't a fact that in almost every test that the addition of SDS factors did not really change this – let's say the strength of the measure in the association, I think that's an important fact related to why the SDS factors could not be, you know, included as a risk adjustment in the model.

John Bulger: Yes, great. Thank you. Sherrie?

Sherrie Kaplan: This is always one of those hard ones where intuitively as someone said, it's so compelling to – especially for safety net hospitals to want to make sure that they're being compared fairly with folks who are – or seeing a very different patient constituency. And I think the fact that empirically this doesn't seem to sort out on these readmission measures in the way that you would expect it, too.

In fact, that as the Yale team pointed out when they did a partition variance analysis, they show that the residual effect of SCS was very small and it resulted in a change of like less than half of percent in pneumonia AMI and heart failure readmissions and, therefore, it was probably unlikely to lead to big changes and penalties.

I still think that as was pointed out, we're kind of in the early phases of understanding, A, how to do the best adjustment and make this comparisons most – as fair as we possibly can and, B, as somebody else pointed out in the comment section, the evolution of how to exactly do this in terms of disadvantage neighborhoods for example and making the adjustments of communities people come from rather than individual patient characteristics maybe the direction this whole adjustment business is headed in.

But I thought that the measures developers with the data that they had do the compelling job of saying empirically, empirically this does not seem to do what was – what's expected and doesn't shift, although it shift apparently the distribution all around doesn't shuffle people within the distribution so that some hospitals would be uniquely disadvantage from the approach they took. So, I agree with – long winded way of saying, I agree with Helen and Tony.

John Bulger: Great. And I think – this is John Bulger. I think the other – I think it's important for the public and for the people who commented to know that the committee's decision not to adjust was not made because we thought that this as I think Helen articulated very well that it wasn't that we didn't think SDS adjustment was important and also wasn't – we were making any comment on whether there are maybe factors out there that from an SDS standpoint that do impact the measures. All we were saying was is what was tested and shown to us, we didn't feel the impact to the measures.

Kathy Auger: And this is Kathy Auger. I'm sorry I was late actually calling in. I was able to hear all the very thoughtful comments that came before and I completely agree with them. I think the other point I think is true is that we – it wasn't that we were pretty, I think consistent as a committee too across the measures.

It wasn't that these measures were adjusting one way and these measures were adjusting another way, which are potentially could have been because it was up to the developer to present different ways to adjust. It turns out that we were pretty consistent across the board that we were not adjusting because it didn't matter in all of the matrix that were presented before us.

John Bulger: Yes. Other members of the committee want to comment now?

Karen Joynt: This is Karen Joynt. I just like to jump or maybe push back a little bit on a couple of those point. I think it's important to recognize that SDS is different than other factors. We are not holding renal failure or heart failure or any other factor to the same standard of would it meaningfully changed hospital ranking to take this element in or out of the model. And you could look at the strength of association between those SDS factors and outcomes and say, "This absolutely should be in the model." It's as strong a predictor if not more strong, then many, many other clinical risk factors that we are leaving in the model.

So I think it's really important to remember that were – this is a philosophical discussion and not just an empirical one and because, otherwise, you would say this has at least as much predictive power always looking within the model itself as many other factors that we include.

The reason that we're holding it to the standard of making a meaningful difference is because there is hesitation to include it, because of the concern that it will somehow excuse poor quality care or that it will lower our ability to detect and perhaps adjust or detect and perhaps address disparities.

I think the concern that it excuses low quality care is somewhat methodologic. You could make an adjustment that only accounts for the patient part of this so you'd never be able to determine if that was due to discrimination. Anyways, I just think it's worth noting that this is a very different discussion than just the empiric. This is a – this is different and if you're a hospital that has a lot of this folks, you may – your performance may very well be impacted.

I'd also – sorry, one more thing, to push back on the comment that we came to the same conclusion, I recall at least the pediatric measures and I believe one other measure perhaps from nursing home for the developers that we do want to put it in because it does make a different and the committee push back and said, "We don't."

But from the developer standpoint, they came with very similar findings for the Yale group in terms of the strength of association and came to a different conclusion about what to do with it and we push back and they change their tunes. So I think that is worth noting as well.

(Crosstalk)

Erin O'Rourke: This is Erin. Again, I just wanted to jump in there. The committee did endorse the two nursing home measures put forward by the American Health Care Association with SDS factors and the risk adjustment models. I think – one, is adjusted for caregiver availability and one might be adjusted for payer.

The committee pushed back on the inclusion of race and the developer resubmitted the measure with that factor taken out of the model and we asked you to rereview. So I just wanted to clarify for everyone what the exact issue about the committee's push back was. But the committee did put forward to measure with SDS variables in the risk adjustment model.

Bruce Hall: This is Bruce Hall. I hope you guys can hear me. I'm in an OR hallway, so my reception is not that good. But, can people hear me?

John Bulger: Yes.

Female: Yes.

Bruce Hall: OK, great, great. I'd like to build a little bit on what Karen said. I would like at least our committee response to be a little more nuance and to include some other points that Karen mentioned. I think it's important for the general public and for practitioners across the country to understand how difficult the deliberation is and I would like them to be able to understand that there are

some points such as Karen mentioned that are philosophical and that are difficult to know perfect answer on. I think it would be worth including some of that subtlety.

I think our response as drafted does highlight that our focus was on the adjustments that the developer was able to put forward. Again, given the data they had and the message they use. On those adjustments the developers were able to put forward, that's what we reached to conclusion on. And, again, not that none of this matters at all or ever.

I think we kind of get there, but I'd like that the response actually be more forceful and say look, "It's very, very specifically." We evaluated some adjustments that the developers put forward with the data they had. Those particular adjustments in most cases did not reach a threshold of significance that the committee was comfortable with.

But building on that, I still would like there to be a follow up comment that says the committee as a whole still understands that this is an area with a high danger for unintended consequences and until more work is done, you know, I think John a minute ago or somebody mentioned, you know, the neighborhood level stuff that is just or share a somebody that neighborhood level stuff that's just coming out. You know, people are showing it matters, it matters, it matters.

And I would at least like our response to say, we as a committee agree. There is a high danger of unintended consequences at the current time and this field is rapidly progressing and we understand that and we look forward to reevaluating and rethinking and redeliberating on these issues. That's why I'll shut up there. Thank you.

Helen Chen: This is Helen. Thank you for that, Bruce. I actually would endorse your comment and say that for many of us who've actually work with vulnerable population, it come to this conclusion was really hard and, you know, that we – there has to be something there and I believe that the way that you formulated this additional statement to the recommendation would actually be incredibly helpful.

I don't think any of us are saying that's not important. I think what we're saying is exactly as you said, what was presented didn't seem to make a difference. But, I fundamentally believe that there is something here we just haven't really defined it will or captured it yet in a way that would be meaningful for this particular purpose. And I would totally welcome the strengthening of the statement and the addition of that statement in the recommendation.

Sherrie Kaplan: This is Sherrie. I'm currently teaching a course in health disparities. And so I just want to make sure that – response to Karen's point if not that at the patient level these things don't matter in health and healthcare, they certainly do. The socioeconomic and sociodemographic characteristics definitely do make a difference at the patient level.

And the question I have is when you start attributing quality and performance at a different level than the patient level, that's when the differentiation of what they've done to those patients versus who those institutions attract gets to be a serious and problematic issue. And I, you know, understanding the contextual nature of neighborhoods, the contextual nature or providers within the system that surrounds them, et cetera, et cetera where the responsibility lies were holding folks accountable for care. I think then the purpose of measurement becomes key, and that for me was, you know, definitely in response.

I totally agree with Bruce. You can't make this call uniformly and forever. You make them one at a time for individual measures doesn't matter given the circumstances of measurement. And if not, at least not for now you can't even pronounce the single measured done as it never requires adjustment. You can only do it at the interval that the NQF is examining this measure. So I think that the consideration going forward still has to be that probably scrutiny needs to be maintained a lot longer than one year and done.

John Bulger: Great, thank you. Other comments?

Keith Lind: This is Keith Lind, AARP. So I would maybe even note an urge that the developers in future try to test somebody's measures that showed up as being significant in this JAMA Surgery article that came out in mid-June at University of Washington that found that the homelessness, alcohol and substance abuse were significant factors. I mean that's – those – I don't know how to measure those things in the claim space analysis, but it seems like somebody had to be testing those.

Also, I would just add that AAMC comment that 0.3 percent reduction in readmissions that was demonstrated for the hospitals with – in the lowest tier of SCS would say if about 25 percent in penalties. So, although it seems like a small adjustment, it seems like it has a big impact on penalties but were not supposed to considering that. I mean, it seems worthy of note that it could have a significant impact.

John Bulger: Great. Other comments?

Helen Burstin: John, this is Helen Burstin. I just want to emphasize – I want to build on a couple of those comments we were …

(Crosstalk)

John Bulger: Absolutely.

Helen Burstin: … just talking internally here. You know, this is a great discussion. I really appreciate people's thinking about how we could move this forward and I think particularly the last few comments about recognizing, you know, I think as Sherrie put it, you can't pronounce a single measure done as being perhaps the theme of this discussion.

You know, in addition to the fact that we bring measures back for maintenance every three years in this particular area given the fact that there is so much emerging we could certainly, if the committee maintains their current recommendation and, again, that's for you guys to decide. We could attach something to it that would require that, you know, as part of the annual update in one year, there is a reassessment of availability of variables, perhaps

reexamination of this newer more neighborhood oriented variables and others might emerge.

John Bulger: Yes, absolutely. Great. Other comments people had on this topic? I think this one is probably the most controversial one so take the time to talk.

Cristie Travis: This is Cristie and thank you for the opportunity. I feel comfortable with the way that the committee is going in terms of, you know, what we – how we want to approach this. I do think that it is important to be sure that the language we use is not presupposed an answer.

And, you know, so I think what we're really looking for is do these characteristics or are there factors that do have an impact. And, you know, I just want to be sure that whatever we put in the report, the final language does not presupposed or have it indicates that the committee has actually thinks that they should show an impact or will show an impact but that it somewhat, you know, objective in terms of the evaluation.

John Bulger: Other thoughts?

Kathy Auger: This is Kathy again. And I really appreciate the framing and the way that this conversation is going. To go back to the comment earlier about, you know, a very small percentage change in hospitals performance could have significant financial implications, I get that that is not necessarily something that this committee is charge with thinking about could – maybe NQF or one of our leaders here talk about when does that conversation happen, what is the intersection between that. Is that part of the map and whether or not they will take that into account or does it ever get taken into account?

John Bulger: Any of the staff want to …

Erin O'Rourke: Sure. This is Erin. I've been very involved with the MAP work over the years and this is been a recurring theme is that I think MAP is generally conditionally support measures with the caveat that they be examine for the need for risk adjustments for SDS factor.

So this is something (MAP to where) about has had number of conversations about and I think is very much inline with what the Standing Committee is saying here that this is an ongoing issue that door is not close on this as Sherrie was saying. You know, we don't know what we don't know at this point and we need to examine them more frequently.

Helen Burstin: And just one more comment. This is Helen. I think the other important point and thank you for raising this, is that the MAP looks at the measures in the context of the program. And so it's – actually the context of the readmission reduction program that the financial penalties come into play which is not something part of the endorsement discussion, but certainly that would be something as, again, looking at the measure in the context of the HRRP is where the financial penalties would come into play and that's what happened at MAP.

Kathy Auger: Thank you.

John Bulger: And it is difficult as was said earlier to separate these two, at least in your head as you're looking at this. But, you know, that's part of what we're being ask to do.

Helen Burstin: Right.

Keith Lind: Is there – what's the mechanism that this – that the MAP gets informed that we think they ought to look at that. That doesn't go into our comment letter or response or report. I'm just wondering. I'm new to this so I'm just wondering how that works.

John Bulger: The staff want to …

Erin O'Rourke: Sorry, this is Erin. Apologies for just jumping in, but we can add some of that language into the report. We've also been working on building out the feedback loops between MAP and CDP. So this is certainly a topic I think we would have bring up with the hospital workgroup and the MAP coordinating committee.

You'll see staff will put feedback from the standing committees in the preliminary analysis that we do on each measure under consideration. Fairly similar process to what you all saw on the staff generated PAs that you received for your review. We do a similar document for the MAP committees.

We're also, particularly, fortunate on this issue that Cristie is the co-chair of the hospital workgroup, so we'll be available to represent the key (inaudible) Standing Committee at the MAP deliberation in addition to staff bringing these issues to those committees.

John Bulger: Other comments from anybody that hasn't spoken or has spoken?

I think the big themes that we heard too are, you know, this isn't the final word because we certainly want people to think that this committee made the decision not to adjust with the ones who made the decision not to adjust and that's done. I think that came out a lot and it – there is a call for more work in the area. I think in the current comment which I think is very important, too, and that was said by people and it's, you know, this is difficult in areas, different – whether it's a different standard or whether there's just a different view of SDS than there is of many other things we look at. I think Karen articulated that very well, so OK.

We'll move on to the next one. Cristie is going to lead the next one level analysis and implementation.

Cristie Travis: Great. But I'll ask Erin to kind of kick off the discussion.

Erin O'Rourke: Absolutely. So we received quite a number of comments around the issue that some of the measures the committee reviewed are being implemented at a different level of analysis that in the committee reviewed and endorsed them for and that testing on scientific merits of the measure at additional levels of analysis was not brought forward to the standing committee for your consideration.

In particular, this was a concern about 1789, Hospital-Wide All-Cause Unplanned Readmission Measure. This is currently being used in – at the physician level at the physician Value-Based Payment Modifier Program and is proposed to be used in the new Merit-Based Incentive Payment System in a similar way.

The commenters expressed their concern that testing at the – either the individual or group division level was not made available to the standing committees and was not considered in your review for maintaining endorsement of this measure.

We also received a number of comments on a similar theme that this issue could happen with other measures in the portfolio and stressing that measures need to be at the level at which their NQF endorsed.

Next slide.

We did wanted to show you our proposed staff response for this issue emphasizing the NQF endorsers measures specifically for the level of analysis indicated in the specification and that that should be supported by the testing.

Also, I wanted to share you the committee response. We know this is an ongoing issue. We've been in discussion with CMS about how to potentially bring in 1789 with additional testing. And I think Helen wanted to give an update there.

Helen Burstin: Sure. So first of all thanks for the very detailed letter we received from the AMA and the multiple specialty societies. We did take this as an opportunity to have a conversation with CMS and clearly there are data available on testing the measure at the clinician level at the Center for Medicare at CMS that have not yet been shared with the committee. So we've some discussions with those groups to determine what's the best course of action would be.

I think right at this moment, again, what's proposed here is that again just the clarity that NQF only endorse these measures at the level of which testing is provided and the level of which it's endorsed. But we will continue to have

those discussions with CMS to see if there's an opportunity to potentially bring forward the testing data they have to see whether they want to extend 1789 to the physician level or whether since the measure from our understanding has been slightly modified at the physician level, that is something we maybe would bring in, in the next round of the readmission project.

So, again, something we are taking quite seriously. We realized it's an important consideration. We've also teed it up as a discussion at the MAP meeting in – of the coordinating committee in January to talk about this concept to sort of how off label measures get used, measures intended for one use get expanded to others and maybe have the MAP help us think through our response there.

Cristie Travis: OK. Well, thank you, Helen, for that update and we will look forward to hearing what the next steps are on that. Our lead discussants are Frank, (Wes), Bruce and Keith. I've heard that Bruce and Keith are on the line. Frank, are you on the line and have any comments?

Female: Frank and (Wes) were unable to join us.

Cristie Travis: OK, all right. Well, Bruce, any thoughts in addition to what Helen and Erin have shared with us?

Bruce Hall: I think the response is a good one. It highlights – it reads very impartial which is good and very objective. But it highlights that our committee and the NQF have done one particular thing. We've endorsed it as proposed by the developer for this and that's what we've endorsed and that's basically what we're reiterating.

So, in that sense, I think it's a good objective but pretty strong response and I agree or delighted to hear Helen's update because I do think more needs to come on this, but for now I think the response reads well.

Cristie Travis: Good. Thank you, Bruce. Any other thoughts, Keith?

Keith Lind: No, I'm fine with the proposed response. I think that works.

Cristie Travis: Wonderful. Well, I want to add my things to the staff for putting it concisely but strongly. And I think that's kind of the major thing that we've heard in response to that.

Are there any other comments from other members of the committee? OK, hearing none. I think we're ready to move on.

John Bulger: OK, great. So data limitation was the next area for comment and I flip over to Erin to give us overview.

Erin O'Rourke: Thanks, John. So, again, related issue to the one you just discussed about level of analysis. The commenters asked to highlight some particular concerns around applying measures that incorporate electronic clinical data at the health plan level and that this data would not be available to the health plans. So some limitations as we move to trying to enhance measures with EHR data that using them at different level of analysis could be particularly challenging for some stake holders.

John Bulger: Great, thank you. So, Jo Ann, Steve, Lesley, Paula and Derek.

Jo Ann Brooks: So, this is Jo Ann. I'll speak for – (Derek, Sonny) will be on the call, but I've got his responses as well. And basically there was only seven comments submitted for – regarding data limitations that were all largely supportive of our recommended measures and encourage applications and the measures that specified and actually we – Derek is in agreement with the proposed committee response as I am as well.

John Bulger: Great, thank you. Others?

Paula Minton Foltz: This is Paula. I have no additional comments.

John Bulger: All right, Steve, Leslie? OK, any other members of the committee? Come on. Great, this is, you know, I think the same way. It's concise and to the point. OK, Cristie?

Cristie Travis: OK. Potentially competing measures, Erin?

Erin O'Rourke: Sure. So we did received some comments expressing concern that there maybe some overlap in some of the measures that the commenters urge the committee to examine for potentially competing measures. I think we may have had a timing issue here as a reminder that the committee met back in September to review this issue in depth.

However, we've close the public comment period before that call. But, I did want to highlight that we received this comments and ask the committee if you wanted to reexamine any of the issues around potentially competing measures.

Cristie Travis: So, I guess is that a question Erin that we need to be explicit about discussing right now?

Erin O'Rourke: No. Most, again, if you – we have our proposed response here on the slide if the committee agrees or disagrees, but …

Cristie Travis: OK.

Erin O'Rourke: … I did want to bring the issue to your assumption.

Cristie Travis: OK.

John Bulger: Yes. And I think, you mean that – the first person. I think – this is John. That I think the response is fine. I think it does highlight the fact that we put extra deliberation toward this and, you know, I think, you know, where we came out with this make sense, you know. I think there are, you know, where they were competing, I think we've talked about that and where the – or need that they are really looking at different things and having both the measures would be important. I think we looked at that, so I think comments are great. The response is great, too.

Cristie Travis: Any other thoughts from Brian, Paula or Paulette?

Brian Foy: Yes, this is Brian. I agree that the response is adequate. I thought we deliberated in good faith on, you know, there's a little bit of gray area here in terms of overlap, but we – I thought we deliberate in good faith on this and sort of balance that need to have plenty of measurement tools for hospitals with, you know, with potentially having burden on hospitals for measurement, but, you know, with all the process and found that there is enough distinction between the two measures to Q1 approving the new measures. So, I agree with their response.

Tom Smith: Me too. It's Tom Smith. You know, I remember we had a couple of, you know, thoughtful discussions about the difference between the readmission rates and excess days in acute care because that's one example where this issue came up. And we really – there was a consensus in the group that the new measures, the approved measures really brought extra value and move the field forward and should be included despite the potential for burden and our feeling is that with, you know, thoughtful consideration that hospitals and payers and systems or care can parsimonious and choose measures that are most applicable. So, I feel good also with the response.

Cristie Travis: Thank you, Tom. Any other thoughts from our lead discussants? OK, any from other members of the committee?

Well, I want to add my thanks to the staff for the draft responses. I think it did capture, you know, our thoughts from the additional telephone call that where we focused on this and feel good as we move forward with those responses, so thank you very much.

Helen Burstin: We have one more theme there, Cristie.

Cristie Travis: I know. I was going – I was thanking them for the potentially competing measure response.

Helen Burstin: Got that. Thank you.

Cristie Travis: OK, John?

John Bulger: All right. So now, the last one is potentially negative unintended consequences, which is always an issue with everything we do and I kick it over to Erin.

Erin O'Rourke: Absolutely. So we've received a number of comments highlighting some potential concerns related to negative unintended consequences from the use of these measures. In particular, commenters noted the inverse correlation between readmissions and mortalities and commenters also raised concerns about the relationships between decreasing admissions rates and the readmission measures.

John Bulger: OK, excellent. So, we have Mae, (Larry), Karen, Carol and Cristie comments? Mae, are you on?

Mae Centeno: Hi, this is Mae. Sorry, I …

(Crosstalk)

John Bulger: Yes, no problem.

Mae Centeno: So, I agree with the statement that I think this is something that we deal with on a daily basis, but I think for where the measure is intended, I would agree and support the proposed response. I think we still see a variation in readmission rates despite the declining admission rates, so still we see an opportunity there that would support careful monitoring to make sure that it – for addressing the potential unintended consequence and come up with mitigating measures.

John Bulger: (Larry)? Let see if he's on. Karen?

Karen Joynt: Yes, this is – this is a tough one. I think that understanding the relationship between mortality and readmission, particularly for heart failure which is really the only phase where we see an inverse relationship. My understanding is for the other condition has really no relationship. You could argue whether or not there should be, you know, performance should be link on the two, but at least for heart failures really with the inverse relationship lies.

I don't recall seeing an analysis of the measure itself with and without accounting for mortality. I think that's different than looking at whether or not mortality and readmission are correlated. And so I don't know that I feel like we have the information to say to this commenter that we think that the issue has been put to rest based on the correlations only.

And so I would sort of support that this maybe something that warrant continue to work in the future. And same thing with the admission, I think what we've seen is there continues to be correlation in both that we see when readmission rates drop, at least we don't a comments or increase at the hospital level between things like observation and (EDUs), we are sort of looking at diverted admissions in that sense. But I don't know that we have a terrifically sound empirical response to this other than to say these things are likely related and they bear monitoring.

I think the other thing that's helpful on the ongoing development of admission measures, so we look at and see if the population-based admission measures. I believe we looked at an ACO-based days – (I forgot, it was) in or out of acute care. But, you know, that we are moving toward, perhaps, somewhere sophisticated measures that might address this, that maybe worth mentioning that these are probably complementary things to measure and that anyone measure on its own can't possibly meet all needs of a measurement program.

John Bulger: Yes, thank you. Excellent. Do you think that – go ahead.

Carol Raphael: No, this is Carol because I just agree with the point of view that Karen has just put forth. I – you know, I guess for me this does warrant some continued work. You know, I don't think we do know enough about E.D. and observation status. There have been some different studies with conflicting results.

And my other question, I guess for the staff was trying to understand what are the mechanisms in place right now for monitoring this?

Erin O'Rourke: So that's a tough question, Carol. So, we do have a number of NQF endorsed mortality measures. I believe in some of the programs, they are used together, you know, and not things like the hospital, IQR and hospital Value-Based Purchasing Program not as explicitly used together in things like the hospital readmission reduction program.

Helen Burstin: Yes. And this is Helen. So are these measures were endorsed with requirement to be looking for unintended consequences. We are having ongoing discussions with CMS about what information they may have available to track this as well as ongoing work to see how we might be able to bring in feedback directly from providers as well to understand entities on unintended consequences, so I think it's a really important question.

Female: This is …

John Bulger: Cristie, do you have further comment – you want to get your first comments and then we'll go back, you know?

Cristie Travis: Sure. No, I just want to reinforce what – how this conversation's going and that we do need to have some type of way to monitor and to, you know, look at the complementary measures that have been identified. And I think, you know, as we look at the maintenance kind of our new approach and emphasis in maintenance on, you know, how the measures are performing out in the fields that, you know, we definitely need to use that system to help us look in more detail at unintended consequences.

John Bulger: Great, thank you. So, the question I would have is that, you know, hearing those comments and I think they're all great is the – is a worth strengthening the second sentence of the committee response which says that, you know, we recognize potential and we recommend careful monitoring and implementation, is there are some, you know, stronger way to say that, you know, given the concern that was just voiced and that concern that was from the commenters and I don't think we have to wordsmith it right now, but thoughts on that?

Keith Lind: This is Keith. I would second your suggestion, John, and urge that it be strengthened because I think to Karen's point just monitoring a correlation is not enough where we're talking about something as serious is a possible tradeoff between readmission and mortality.

I think we should – I would hope that we would urge the developer, measure developer to actually explore and identify the impact of mortality on readmission in a meaningful way, you know, and specifically target that relationship because if there is a relationship there, I think we need to know about it.

And the fact that it only appeared for congested heart failure, you know, that could change as readmission rates go down and things get tighter that correlation could emerge for other conditions as the readmission rates go down.

John Bulger: Thank you. Other thoughts?

Kathy Auger: Yes, this is Kathy. So I completely agree with what was just said and I know we've talked about the CHS measure, but if I remember right at our in-person meeting we also talked about mortality with the psychiatric measure as well. So, if that would be one that in particular and I think probably needs additional following as well based on our previous conversations could there be higher suicidality if we are readmitting patients that we could. Could we be preventing some suicide and what not? So, I think that's another one in particular which requires some thoughts and was one that resonated with me during the big in-person meeting as well.

Sherrie Kaplan: This is Sherrie, (Katherine). I'm struggling with, you know, while I'm in complete agree anytime you've clamp down in one area there has – a potential for causing something and toward in another area. On another hand, without being very specific and concrete about where to look, it would be pretty, you know, it would have the attribution back to the things the hospital was doing versus who it was attracting, et cetera, et cetera and all of the complex issues around that making at attributable back to one discreet measure of quality and everything else that was going on in the community at the same time would be

pretty – pretty hard for me to envision how to do that in empirical way rather than just in that sort of global way.

So, I – well, I'm in complete agreement with this concept making it specific and concrete would be pretty difficult. I would think beyond each individual measure and that measures developers understanding of what potentially could happen as a consequence or even for this purpose that was being put too.

Paula Minton Foltz: This is Paula. And I think there is a – I completely agree that we need to keep our eye on these unintended consequences, especially as EDAC rolls out. I think the heart failure was the first CMS dry run for EDAC. And so maybe that's why we're seeing a correlation or an inverse relationship with mortality because they – because that group has already starting to say, well, we can't put them in observation anymore either and they can't. So, again, I think it's worth watching.

Cristie Travis: This is Cristie. And Sherrie, your thoughts were aligned with where I guess I was beginning to think myself. I mean at one – at some respect assigning "causality" to this issue I think would be very complex and, you know, and difficult because of that complexity.

So I think that's one reason I have this kind of using the term monitoring, but I do appreciate the comments about trying to more, perhaps, do more than monitor. But I think that there are so many different components that could be impacting than mortality that to say it was because of readmissions going down, I just think intuitively would be very difficult to do.

John Bulger: Great, thank you. Other thoughts?

Helen Burstin: John, this is Helen. Just one thought. This is a great discussion, certainly I think as we strengthen this language a bit. I mean, one potential way monitoring is probably still the right word or surveillance or something and maybe the committee would want a bit more specificity about the potential measures that may relate.

So, you know, what we want to specifically monitor in areas where we think there might be a balancing effect of reduced readmission rate such as measures that look at E.D. visits, measures that look at observation stays as well as mortality. We might be able to just add a bit more specificity based on what the committee just suggested.

John Bulger: Yes. It's a great insight. Other thoughts or comments on that and I think – or in general? OK. I think this is a good discussion on the topic. So, we were at NQF member and public comment, I believe.

Erin O'Rourke: Sure. Hi, John, this is Erin. Before we open for comment, I just wanted to make sure that we're all in the same page about what our next step here will be. Staff will strengthen the responses, two themes, one and five and we'll send that around to the committee via e-mail to get your review and approval of those responses.

I did want to just make sure if any committee members wanted to raise any individual comments for discussion or if there were any recommendations for endorsement that the committee wanted to revisit at this time.

Karen Joynt: This is Karen Joynt. I'd like to just raise a comment that I meant to raise during the SDS discussion. I think it may also be worth mentioning that part of understanding the relationship between SDS and outcomes maybe more understanding of things like functional status, mental health, all the things that were raised that maybe considered not only social, but also maybe medical and that a really thorough dive into whether or not to adjust for SDS may in part be conditional on making the measures better at picking at medical risk.

We don't know how much of that dual effect is driven by things that we actually could measures that are medical and I think that's an important thing to recognize that we don't know to point out the impermanence of our decision making around some of these variables.

Helen Burstin: Yes, thanks, Karen. This is Helen.

John Bulger: Great.

Helen Burstin: I just want to build on that comment as well. We've been having similar thoughts here about really needing another broader look at risk adjustment rather than, you know, just allow the discussions about on social risk, but I think certainly having heard many of the presentations from Karen's team and (ASB) team at the AcademyHealth meetings.

There's whole concept to sort of unmeasured clinical complexity functional status frailty, some of the things that may be impacting care, they are not currently in models. I think it's something we also want to begin to explore as well. As well as whether it's also within condition degrees of complexity that are also not currently captures. I think that's opens up a really important avenue that needs further discussion and maybe we can even highlight some of that in this report as well.

Cristie Travis: This is Cristie. I think that's a really good idea, Helen, because to – I think, you know, to the previous discussion points around the concern of holding SDS risk adjustment factors to a different standards, the way that I've been kind of looking at this is that the clinical adjustments were already there and it was my understanding that to a certain extent in determining which – how to adjust these measures for clinical factors that they were put in, the factors were put in because they did have an impact.

And so in my own mind, I didn't really see myself using a different standard for the SDS adjustment, but we were adding SDS adjustment on top of the clinical adjustment. And so, I do think taking a look at the broader risk adjustment, you know, now that we are looking at SDS as well as clinical and thinking through like for de novo measures, you know, what's really, you know, maybe what are some of the concepts that developers may want to consider when they are looking at their total risk adjustment strategy.

John Bulger: Great. Other comments on this or any other topic, any members of the committee wanted to make – they didn't get a chance to bring up earlier.

Sherrie Kaplan: This is Sherrie. (Katherine), this is related to something Helen said earlier with the off-label use to some of these measures particularly at the individual

physician or group level and not testing through the kind of measurement shake down that we'd like when those things move across the units of comparison.

And we had some discussions with Karen Johnson and some others who are trying to advice from a statistical standpoint. But when the unit of comparison changes, the ability – that the kinds of things you'd want to see for testing whether it measures appropriate for the kinds of comparisons that are being made or somewhat different than NQF has required in the past.

For example, split half the liability and the idea that the interclass correlation coefficient in between versus within variance in those samples would look pretty parallel is a little bit different when you're trying to use something that's previously been used at one level to compare some other unit and that means you want more between unit, between hospital, between home health care system setting, between physician group variability than within, and that's where this SDS business comes back around to haunt us because if the – is there are at some print within a unit being compared that's consistent but different from other units being compared and I think that NQF is probably going to be having to look a little harder when those – when the unit is being compared changes and look a little harder at the statistics and the empirical testing that's being done.

John Bulger: Yes. It's great, thank you. I like the comment, the off-label use if measures too in the beginning. Other thoughts, comments people want to make? OK. Erin?

Erin O'Rourke: Great. So with that, operator, could you open the line for public and member comment?

Operator: Yes ma'am. This time if you would like to make a comment, please press star then the number one.

And once again to make a comment, please press star, one.

You do have a comment from Don Casey.

Don Casey: Hi, good morning, everyone. It's Don Casey. Actually it's noon. I wanted to just say thanks you for the chance to make a public comment on behalf of the American College Medical Quality for – because of connectivity issues on our end with NQF, we were unable to provide written comments, but I do want to make a few points quickly if I may.

First of all, in no apparent order of importance, I appreciate the discussion about the questions around cross-correlation between real health outcomes and readmissions. And, you know, I think we've set consistently over several years that these measures should not be presented in a standalone fashion, it should be analyzed overtime against the number of other factors and outcomes, you know, including mortality and probably research utilization.

And there is empiric data that's been published actually by the – (our) researchers earlier at least at the hospital referral region showing this cross-directional relationship between lower mortality and high readmission rates and vice versa, high readmission rates and lower mortality.

So, I think the jury still out. You know, you can analyze it by whatever means you do but at the individual hospital level, I think there's a lot of uncertainty, especially if you evaluate these measures overtime which is another issue that hasn't been being done so well. So, I'll just say that.

I am sensitive to the analytic questions that have been addressed by the committee around this issue of socioeconomic status and while I understand that from a numerologic standpoint there isn't much difference or marginal difference by adding these factors.

The concern is not being raised to help people at the sharp end of this feel as though you care about that issue and from my standpoint knowing all about methodology the perception is still the reality from their world about the importance of this. So, you know, one questions even if it doesn't matter, why not just put it in because then you've help them – this is kind of – we're trying to help people get better, right? So, that's another important, maybe point to make.

That the notion of what's involving in the operation world with respect to taking clinical and financial risk at the health system level is that really the bottom line measure is potentially preventable admissions, which by the way includes readmissions into the 30-day construct is an artificial construct. It's been in our vocabulary for years, but, you know, there is empiric data for example in the heart failure that if you look at 90 and 180 days that actually – everyone does pretty poorly.

And so, you know, I'll get back to closing my remarks with this question in what problem are we trying to solve and it relates to some of my experienced in particular with heart failure and working with a group of about 10 safety net hospitals in the expected success program that was funded by RWJ and, you know, I think the committee is sensitive to it but I'll just say it in respect to the population that's being managed.

The measurement is designed to compare hospitals, but it doesn't give you any solution to what the heck to do about it and I think that's where the rub here is, what problem are we trying to solve.

I understand the importance of sustaining Value-Based Payments in the context of improving care by keeping people that don't need to be in the hospital out. I get that. I've gotten it for years, but it's a very different approach or the expecting success hospitals for example around care coordination, medication, adherence, health literacy, access to care, cultural factors including language issues and many other social determinants of health.

And so, given the fact that I also, by disclosure, sit on the equality measures, technical expert panel right now for CMS within NCQA and chair the care coordination steering committee, co-chair it with (Gerry Lim) for NQF. I wonder if it isn't on time for us to move on from a claims-based measure and really leverage all the information that we've gotten to turn this into something that will actually make our care better.

I am not certain that we know that yet. We certainly know that readmission rates have gone down. We also expect from the researchers that there will be an asymptotic effect. You know, there's going to be a rate limiting step at some point and that there appears to be signal that that's happening already.

But I would challenge our future to move to, have we improved the health status of this top population across the country and I don't think we have those answers yet. So, thank you for the chance to provide that – those comments.

John Bulger: Great, thank you. Appreciate it. Other comments?

Operator: At this time, there are no comments.

Helen Burstin: We're just checking to make sure there are no comments in the chat box. There is one. I think we'll read it. I'm not sure if (Matt) is on the line. If you'd like to give your comment verbally, please feel free. If you're on the phone, otherwise, we'll go ahead and read it for the committee.

Female: OK. So the comment from (Matt) we've had is, "SDS, the main rationale used for continued exclusion by the Yale/CORE team was the marginal impact on the distribution of assessment induced by the few SDS factors tested. Therefore, it should be within the purview of this committee to consider point's raise by AAMC and MHA regarding the significant penalty impact for hospitals with low SDS mix. (Inaudible) doctors joint and hold comments SDS and community context are different constructs that need more rigorous testing (than) was provided through these exercises."

Unintended consequences, "MedPAC has tested a healthy days at home measure that conceptually would account for the competing risk of mortality and admission shifting to observation, et cetera." That's the end of the comment. I don't know if anyone has any responses.

John Bulger: Did the staff want to comment on that, because there is a – I think part of that comment is what we're able to do and not able to do. Correct? That is what I heard at least.

Helen Burstin: Yes, we're just taking a look at it, John, to see what is within and outside.

Female: Yes, within the purview.

Helen Burstin: Right. Again, I think the penalty impact is what's tricky. We talked about that earlier.

John Bulger: Yes.

Helen Burstin: And certainly something we'll bring up at MAP as well. And I am aware of the new measure being tested at by MedPAC develop by (Ashi's) and others at Harvard, so it's something we'll keep an eye on and see if there's an opportunity to maybe bring in in the next phase of this work. Is there another comment as well?

Female: Oh, I was just asking earlier about the themes and the comments.

Helen Burstin: All right. Operator, any other comments, queues, come in the queue while we've been reading online?

Operator: No, ma'am. At this time, there no comments.

Erin O'Rourke: All right. So with that, I'd like to turn it over to Donna to just briefly review on some of your next steps.

Donna Herring: All right, like Erin said earlier, we're going to reach out your responses the theme one and theme five and we'll follow up with you on e-mail. But our next step in the project will be our member vote period which will happen from October 11th until October 31st followed by the CSAC review which is an in-person meeting and will occur on either November 9th or November 10th, but we will follow up with you on the exact date when we know. The board review will happen on December 8th and then appeals will be from December 12th until January 17th.

And with that, we'll just go to the next slide which has our project contact information, which we believe that you all know, but there it is just in case

you need it and we'll just – I think we can adjourn unless anyone has any questions or any additional comments.

Female: OK, thanks, everybody.

Female: OK.

John Bulger: Thanks everybody for all your work and thanks for the staff for all …

Female: Thank you.

John Bulger: Thanks.

Female: Bye.

John Bulger: Bye-bye.

Female: Bye.

END