NATIONAL QUALITY FORUM

Memo

October 23, 2018

To: Consensus Standards Approval Committee (CSAC)

From: All-Cause Admissions and Readmissions Project Team

Re: All-Cause Admissions and Readmissions Spring 2018 Review Cycle

CSAC Action Required

The CSAC will review recommendations from the All-Cause Admissions and Readmissions Spring 2018 review cycle at its October 2018 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. **Readmissions spring 2018 draft report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment table**. Staff has identified themes within the comments received. This table lists six comments received during the post-meeting comment period and the NQF and Standing Committee responses.

Background

On June 26, 2018, the All-Cause Admissions and Readmissions Standing Committee evaluated the expanded specification of NQF #1789 *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)*. This evaluation considered the expansion of this endorsed measure to assess readmissions at a new level of analysis: the accountable care organization (ACO). The expanded measure was reviewed against NQF's standard evaluation criteria, and the Standing Committee recommended the measure for endorsement.

Draft Report

The Readmissions draft report presents the results of the evaluation of one measure considered under the Consensus Development Process (CDP). The Standing Committee recommended this measure for endorsement.

The measure was evaluated against the 2017 version of the measure evaluation criteria.

	Expansion of Endorsement
Measures under consideration	1
Measures recommended for endorsement	1
Measures recommended for inactive endorsement with reserve status	0
Measures approved for trial use	0
Measures not recommended for endorsement or trial use	0
Measures withdrawn from consideration	0

Measure Recommended for Endorsement

- 1789 Hospital-Wide All-Cause Unplanned Readmission Measure (Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation)

Overall Suitability for Endorsement: Yes-18; No-0

Comments and Their Disposition

NQF received six comments from six organizations (including five NQF member organizations) and individuals pertaining to the draft report and to the measure under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developer, is posted to the Readmissions project webpage.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developer, who was invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on topic areas with the most significant and recurring issues. Ultimately, the Committee did not re-vote on NQF #1789 during the post-comment call.

Themed Comments

Theme 1 – Adjustment for Social Risk Factors and Unintended Consequences

Commenters expressed concern regarding the risk-adjustment approach for the ACO-expanded version of NQF #1789. Several commenters recommended including social risk factors in the risk-adjustment model. These proposed social risk factors include—but are not limited to—sociodemographic status, language, post-discharge support structure, transportation, and/or pharmacies.

Some commenters highlighted potential unintended consequences of expanding NQF #1789 to the ACO level of analysis. Specifically, one commenter noted the potential disincentive for ACOs

to enroll low-income or underserved beneficiaries and mentioned that ACOs that serve a disproportionate share of vulnerable patients may incur penalties. A separate commenter agreed with the Committee's recommendation for continued monitoring to identify unintended consequences such as reduced admissions related to increased rates of mortality and depletion of institutional resources.

Committee Response

The Committee has reviewed your comment and appreciates your input. The Committee agrees that research supports the association between social risk factors and patient outcomes but recognizes the challenge developers face in obtaining accurate data, which can lead to a discrepancy between the conceptual basis for including social risk factors and the empirical analyses demonstrating their impact. The Committee recognizes that developers may make a determination about whether or not to include social risk factors based on whether the factors were related to a provider's quality versus a person's intrinsic risk of readmission. However, the Committee also recognizes the need to maximize the predictive value of a risk-adjustment model and ensure that accountable care organizations (ACO) serving vulnerable populations are not penalized unfairly. The Committee views ACOs as powerful integrated models, which are capable of delivering high quality, streamlined care to historically underserved populations and have the potential to improve care coordination and reduce avoidable readmissions.

While the Committee generally accepted the findings of the analyses conducted by the developer, the Committee agrees that more work is needed to identify more robust data elements and methods to isolate and account for unmeasured clinical and social risk for patients. The Committee expects the developer to continue testing the risk-adjustment model with additional social risk factors in an effort to better understand unmeasured patient risk. The Committee will continue to follow NQF's secondary iteration of the Social Risk Trial and its output related to risk adjustment guidance for NQF endorsement and the field more broadly. Finally, the Committee would like to highlight several considerations for entities seeking to implement ACO-level measures including benchmark development and risk for penalties under multiple alternative payment models.

Developer Response to specific commenters

Developer Response to America's Essential Hospitals:

The readmission measures are intended to assess important aspects of hospital quality of care. Decisions about which risk factors should be included in each measure's risk-adjustment model should be made on the basis of whether inclusion of such variables is likely to make the measures more successful at illuminating quality differences and motivating quality improvement. (This aim should be distinguished from decisions made in response to concerns about the impact of related payment programs on safety-net hospitals; concerns which can be addressed through other policy mechanisms.) The determination of whether inclusion of socioeconomic factors as patient-level, risk-adjustment variables improves or diminishes the readmission measures' assessment of

hospital quality is inconclusive since some aspects of disparities in outcomes may be attributed to hospital quality and other aspects attributed to factors outside the hospital's control. The medical literature and our analyses consistently demonstrate that hospitals contribute to the disparities in outcomes for socioeconomically disadvantaged groups, and for that reason we do not believe the addition of patient-level risk adjustment for SES (as fixed effects in the model) is an appropriate solution for the readmission measures. Ongoing work within the U.S. Department of Health and Human Services and Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation will continue to evaluate alternative solutions that better reflect the balance of hospital- and patient-level influences on readmission risk for socioeconomically disadvantaged patients.

ACO quality measures should not be risk adjusted for socioeconomic, or social determinant factors in order to set a differential bar for quality, because:

1. The ACO program is voluntary: providers freely form ACOs and agree to share responsibility for quality and cost of the services they provide to the beneficiaries who are attributed to the ACO.

2. The program explicitly sets an expectation that ACOs should work with their communities to minimize the influence of non-medical factors that affect health outcomes (e.g. admissions and readmissions) such as addressing barriers to transportation, nutrition, and access to other follow-up care supports through, for example, linking with social services available in the community. This includes incorporating language assistance, assessing post-discharge support, and access to transportation and pharmacies. ACOs are perhaps better positioned than individual hospitals and expected to provide this type of care coordination with the communities served as part of their voluntary participation in the ACO program.

3. For the NQF-approved ACO admission measures, we acknowledged admission to the hospital may be affected by factors other than patient comorbidities and age. However, we did not recommend adjusting for social determinant factors; doing so allows the measure scores to identify ACOs that produce higher quality of care by mitigating the effects of non-medical factors on health outcomes. In our testing of dual Medicare/Medicaid status in the model, on average, inclusion in the model moved measure scores minimally, which corresponds to a very small change in the points received by the ACO for this measure. In fact, ACOs serving a higher proportion of underserved beneficiaries have historically performed well and earned shared savings. Our analysis of ACO composition and performance rates does not demonstrate generally worse performance on this measure for ACOs serving populations with higher than average non-medical risk factors. Similarly, we do not anticipate continued use of this measure in the ACO program to create an unintended consequence of ACOs avoiding low-income or underserved beneficiaries. ACO prevalence of low-income and underserved beneficiaries is largely stable from the first participation year when the measure is pay for reporting to subsequent years when the measure is pay for performance. The use of this measure in the ACO program is fundamentally structured

differently than the hospital quality reporting program, and there are no penalties for lower performance. Rather, the measure is included in an overall quality score that is used as a multiplier in the shared savings calculation amount. Therefore, it would not be appropriate to include non-medical risk factors in the risk adjustment model based on the outlier changes in performance score observed at the periphery of the distribution. We believe that the same processes that can reduce readmissions in the inpatient setting remain applicable to larger integrated health systems and ACOs. In fact, they are likely to be more effective in integrated health systems and ACOs that have greater shared resources for necessary post-discharge care.

Developer Response to the American College of Surgeons:

Our perspective of the review that occurred on July 26, 2018 was that committee members asked about the rationale for including or not including non-medical risk factors in the model. Similarly, committee members asked questions about the use of the measure in the Medicare Shared Savings Program.

As noted in response to similar questions regarding risk adjustment for socioeconomic or social determinant factors, we believe that ACO quality measures should not be risk adjusted for these factors in order to set a differential bar for quality, because:

1. The ACO program is voluntary: providers freely form ACOs and agree to share responsibility for quality and cost of the services they provide to the beneficiaries who are attributed to the ACO.

2. The program explicitly sets an expectation that ACOs should work with their communities to minimize the influence of non-medical factors that affect health outcomes (e.g. admissions and readmissions) such as addressing barriers to transportation, nutrition, and access to other follow-up care supports through, for example, linking with social services available in the community. This includes incorporating language assistance, assessing post-discharge support, and access to transportation and pharmacies. ACOs are perhaps better positioned than individual hospitals and expected to provide this type of care coordination with the communities served as part of their voluntary participation in the ACO program.

3. In the Medicare Shared Savings Program ACOs' performance on each Pay-for-Performance measure is compared to a national benchmark based on fee-for-service (FFS) data. This program does not contain incentives for ACOs to compete against one another within a net neutral requirement but rather against national benchmarks based on FFS data.

4. For the NQF-approved ACO admission measures, we acknowledged admission to the hospital may be affected by factors other than patient comorbidities and age; however, we did not recommend adjusting for social determinant factors. This allows the measure scores to identify ACOs that produce higher quality of care by mitigating the effects of non-medical factors on health outcomes. In our testing of dual Medicare/Medicaid status in the model, on average, inclusion in the model moved measure scores

minimally, which corresponds to a very small change in the points received by the ACO for this measure. In fact, ACOs serving a higher proportion of underserved beneficiaries have historically performed well and earned shared savings. We do not anticipate continued use of this measure in the ACO program to create an unintended consequence of depleting ACO resources for those with a greater proportion of low-income or underserved beneficiaries.

Therefore, it would not be appropriate to include non-medical risk factors such as dual Medicare/Medicaid status in the risk adjustment model based on the outlier changes in performance score observed at the periphery of the distribution.

All ACOs in the Medicare Shared Savings Program "report" on this measure as it is calculated for them by CMS. Contrary to a further concentration of performance scores, we anticipate as additional ACOs enter the program, the distribution of scores is likely to further increase, as current ACOs may represent early adopters.

To respond to the concern that the ACO HWR measure does not account for diagnosis codes related to acute trauma and unrelated acute illnesses, thereby holding the institution accountable for an event for which they have no control over:

The CMS readmission measures assess all-cause readmissions. That is, they consider unplanned readmissions for any reason, not only those that are deemed to be due to the same or a "related" condition. There are several reasons for measuring all-cause readmissions. Restricting the measure outcomes to those readmissions that seem to be directly related to the initial hospitalization may make the measures susceptible to changes in coding practices. Although most hospitals would not engage in such practices, CMS aims to eliminate any incentive for hospitals to change coding practices in an effort to prevent readmissions from being captured in their readmission measure results. In addition, an apparently unrelated readmission may represent a complication related to the underlying condition. For example, a patient with heart failure who develops a hospital-acquired infection may later be readmitted due to the infection. It would be inappropriate to consider this readmission as unrelated to the care the patient received for heart failure. Finally, hospitals can act to reduce readmissions from all causes. While CMS does not presume that every readmission is preventable, measuring all-cause readmission incentivizes hospitals to evaluate the full range of factors that increase patients' risk for unplanned readmissions. For example, unclear discharge instructions, poor communication with post-acute care providers, and inadequate follow-up are factors that typically increase the risk for an unplanned readmission. Although measuring all-cause readmissions will include some patients whose readmission may be unrelated to their care (for example, a casualty in a motor vehicle accident), such events should occur randomly across hospitals and therefore, will not affect results on measures that assess relative performance. In other words, events such as motor vehicle accident related re-admissions is a random error that is part of the statistical noise and is not expected to disproportionately disadvantage any given ACO.

Theme 2 – Use of the Measure that is Inconsistent with its Endorsement

Commenters expressed concerns that this measure is used in the Merit-based Incentive Payment System but has not been reviewed for NQF endorsement at the clinician or clinician group level of analysis. In particular, commenters raised concerns about the reliability score of the measure when used for clinicians or clinician groups.

Committee Response

The Committee agrees that measures should only be used in a manner consistent with their endorsement. The Committee reiterates that this measure, as previously endorsed for the facility level of analysis and this expansion, only addresses ACOs. This measure is not endorsed for the clinician level of analysis. The Committee would encourage CMS to submit this measure for review at the clinician and clinician group level of analysis.

Developer Response

Developer Response to the American Academy of Family Physicians:

We believe several of the commenter's concerns are comments related to the use of the measure in the MIPS program and not related to the measure being considered for NQF endorsement at an ACO-level. CMS will only address comments on the ACR at the ACO-level. This particular review was not a measure maintenance review for the hospital level measure applied to hospitals or physician groups. The measure is used as part of the Medicare Shared Savings Program for ACOs.

As noted in the response to a similar concern submitted by America's Essential Hospitals:

The readmission measures are intended to assess important aspects of hospital quality of care. Decisions about which risk factors should be included in each measure's risk-adjustment model should be made on the basis of whether inclusion of such variables is likely to make the measures more successful at illuminating quality differences and motivating quality improvement. (This aim should be distinguished from decisions made in response to concerns about the impact of related payment programs on safety-net hospitals; concerns that can be addressed through other policy mechanisms.) The determination of whether inclusion of socioeconomic factors as patient-level, risk-adjustment variables improves or diminishes the readmission measures' assessment of hospital quality is inconclusive since some aspects of disparities in outcomes may be attributed to hospital quality and other aspects attributed to factors outside the organization's control. The medical literature and our analyses consistently demonstrate that hospitals contribute to the disparities in outcomes for socioeconomically disadvantaged groups, and for that reason we do not believe the addition of patient-level risk adjustment for SES (as fixed effects in the model) is an appropriate solution for the readmission measures. Ongoing work will continue to evaluate alternative solutions that better reflect the balance of hospital- and patient-level influences on readmission risk for socioeconomically disadvantaged patients. This measure which is used in the ACO program is undergoing review for endorsement at the ACO-level. Therefore, we believe we are or will be concordant with the commenter's position regarding use of NQF endorsed measures.

Conceptually, we believe that ACO quality measures should not be risk adjusted for socioeconomic, or social determinant factors in order to set a differential bar for quality, because:

1. The ACO program is voluntary: providers freely form ACOs and agree to share responsibility for quality and cost of the services they provide to the beneficiaries who are attributed to the ACO.

2. The program explicitly sets an expectation that ACOs should work with their communities to minimize the influence of non-medical factors that affect health outcomes (e.g. admissions and readmissions) such as addressing barriers to transportation, nutrition, and access to other follow-up care supports through, for example, linking with social services available in the community. This includes incorporating language assistance, assessing post-discharge support, and access to transportation and pharmacies. ACOs are perhaps better positioned than individual hospitals and expected to provide this type of care coordination with the communities served as part of their voluntary participation in the ACO program.

3. For the NQF-approved ACO admission measures, we acknowledged admission to the hospital may be affected by factors other than patient comorbidities and age; however, we did not recommend adjusting for social determinant factors. This allows the measure scores to identify ACOs that produce higher quality of care by mitigating the effects of non-medical factors on health outcomes. In our testing of dual Medicare/Medicaid status in the model, on average, inclusion on the model moved measure scores minimally, which corresponds to a very small change in the points received by the ACO for this measure. In fact, ACOs serving a higher proportion of underserved beneficiaries have historically performed well and earned shared savings.

Therefore, it would not be appropriate to include non-medical risk factors such as dual Medicare/Medicaid status in the risk adjustment model based on the outlier changes in performance score observed at the periphery of the distribution.

Critical access hospitals (CAHs) are included in the measure. To include an admission in the measure cohort, the patient must ultimately be discharged from an acute care inpatient hospital setting to a non-acute care setting (for example, to home or a skilled nursing facility). Thus, the discharging hospital (including CAHs) is always accountable, because transitions from acute care to non-acute settings are critical for preventing readmissions. The previous admissions are not included. For example, if a patient is admitted to a CAH, transferred to an acute care hospital, and then discharged from the acute care hospital to a non-acute care setting, only the acute care hospital admission would be included in the cohort, and an unplanned readmission within 30 days of discharge from the acute care hospital admission would be captured in the acute care hospital's readmission outcome.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for the measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided an expression of support or nonsupport for NQF #1789.

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	Please refer to the Standing Committee's rationale in Appendix B
Were any measurement gap areas addressed? If so, identify the areas.	Yes	Please refer to the Standing Committee's rationale in Appendix B
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measure Recommended

1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)

Submission | Specifications

Description: For the hospital-wide readmission (HWR) measure that was previously endorsed and is used in the Hospital Inpatient Quality Reporting Program (IQR), the measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts based on groups of discharge condition categories or procedure categories: surgery/gynecology; general medicine; cardiorespiratory; cardiovascular; and neurology, each of which will be described in greater detail below. The measure also indicates the hospital-level standardized risk ratios (SRR) for each of these five specialty cohorts. The outcome is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission (the admission included in the measure cohort). A specified set of planned readmissions do not count in the readmission outcome. CMS annually reports the measure for patients who are 65 years or older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in non-federal hospitals. For the All-Cause Readmission (ACR) measure version used in the Shared Savings Program (SSP), the measure estimates an Accountable Care Organization (ACO) facility-level RSRR of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge. The ACR measure is calculated using the same five specialty cohorts and estimates an ACO-level standardized risk ratio for each. CMS annually reports the measure for patients who are 65 years or older, are enrolled in FFS Medicare and are ACO assigned beneficiaries.

Numerator Statement: The outcome for the HWR measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission. The outcome for the ACR measure is also 30-day readmission. The outcome is defined identically to what is described above for the HWR measure.

Denominator Statement: The measure at the hospital level includes admissions for Medicare beneficiaries who are 65 years and older and are discharged from all non-federal, acute care inpatient US hospitals (including territories) with a complete claims history for the 12 months prior to admission. The measure at the ACO level includes all relevant admissions for ACO assigned beneficiaries who are 65 and older and are discharged from all non-Federal short-stay

acute care hospitals, including critical access hospitals. Additional details are provided in S.9 Denominator Details.

Exclusions: The measure excludes index admissions for patients:

1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals;
2. Without at least 30 days post-discharge enrollment in FFS Medicare;
3. Discharged against medical advice (AMA);
4. Admitted for primary psychiatric diagnoses;
5. Admitted for rehabilitation; or
6. Admitted for medical treatment of cancer.

Adjustment/Stratification: Statistical risk model

Level of Analysis: Facility, Integrated Delivery System

Setting of Care: Clinician Office/Clinic, Hospital, Hospital : Acute Care Facility

Type of Measure: Outcome

Data Source: Claims (Only)

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

STANDING COMMITTEE MEETING [6/26/2018]

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Yes-18**; No-**0** 1b. Performance Gap: **H-1**; **M-14**; **L-3**; **I-0**

Rationale:

- The Standing Committee determined that the evidence provided by developer was acceptable and appropriate for the measure.
- The Committee agreed there is a performance gap for ACOs and opportunity for improvement, yet also acknowledged that the performance gap is shrinking.
- Committee members noted that the 30-day attribution period is appropriate for an ACO.
- Some Committee members expressed concern about double-counting patients during a single reporting period if patients move across payment structures.

---

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-18**; **L-0**; **I-0**; 2b. Validity: **H-0**; **M-13**; **L-5**; **I-0**

Rationale:

- The Committee noted that the reliability testing results differed between the ACO-level and the hospital level. However, the ACO-level measure produced an intraclass correlation coefficient (ICC) score of 0.62, which the Committee deemed sufficient. Some members expressed concern about the population's stability but noted that 70 percent of beneficiaries remain in the same ACO the next year.

The Committee discussed the appropriateness and potential impact of adjustment for dual eligible status. Ultimately, the Committee noted that ACOs are incentivized to work with communities to address underlying factors that affect health.

---

3. Feasibility: H-14; M-4; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The measure is derived from administrative claims data.
- The Committee determined that the measure is feasible to implement for performance measurement.

---

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-18; No Pass-0**; 4b. Usability: **H-0; M-18; L-0; I-0**

Rationale:

- The Committee noted the measure's use in several programs including the Medicare Shared Savings Program, Pioneer ACO model, and the Next Generation ACO model.
- Some Committee members expressed concerns about the measure's unintended consequences in their pre-evaluation comments. Specifically, Committee commenters noted potential disincentives for ACOs to enroll low-income, underserved beneficiaries as well as potential penalties for ACOs caring for safety-net patients. Ultimately, the Committee determined that the measure's performance results could be leveraged to drive efficient care.

---

5. Related and Competing Measures

- This measure is related to NQF #1768 Plan All-Cause Readmissions (PCR). NQF #1768 assesses the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission in patients 18 years and older. Both readmission measures add value to the NQF Admissions and Readmissions portfolio since they assess different levels of analysis.

Standing Committee Recommendation for Endorsement for Expanded Level of Analysis: **Yes-18**; **No-0**

6. Public and Member Comment

- Commenters expressed concern regarding the risk-adjustment approach for the ACO-expanded version of NQF #1789. Several commenters recommended including social risk factors in the risk-adjustment model. These proposed social risk factors include—but are not limited to—sociodemographic status, language, post-discharge support structure, transportation, and/or pharmacies.
- Some commenters highlighted potential unintended consequences of expanding NQF #1789 to the ACO level of analysis. Specifically, one commenter noted the potential disincentive for ACOs to enroll low-income or underserved beneficiaries and mentioned that ACOs that serve a disproportionate share of vulnerable patients may incur penalties. A separate commenter agreed with the Committee's recommendation for continued monitoring to identify unintended consequences such as reduced admissions related to increased rates of mortality and depletion of institutional resources.
- Some commenters expressed concerns that this measure is used in the Merit-based Incentive Payment System but has not been reviewed for NQF endorsement at the clinician or clinician group level of analysis. In particular, commenters raised concerns about the reliability score of the measure when used for clinicians or clinician groups. These comments were in reference to the facility-level version of NQF #1789, which is NQF-endorsed.
- All comments and responses are available in the Comment Table.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals