NATIONAL QUALITY FORUM

Memo

September 18, 2018

To: All-Cause Admissions and Readmissions Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expressions of support

Purpose of the Call

The Readmissions Standing Committee will meet via web meeting on September 24, 2018 from 12-2 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and the draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table).
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

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

Committee Co-Chair / NQF staff dial-in #: 877-433-9089 (NO CONFERENCE CODE REQUIRED)
Standing Committee dial-in #: 877-861-7569 (NO CONFERENCE CODE REQUIRED)
Web link: http://nqf.commpartners.com/se/Rd/Mt.aspx?178044

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.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from May 1, 2018 to June 12, 2018 for the measure under review. NQF received two comments during this period, both of which noted that the evidence provided in the measure submission focused on inpatient settings as opposed to ACOs. Additionally, both commenters recommended including transportation and pharmacies in the risk adjustment model. All pre-evaluation comments were provided to the Committee prior to the measure evaluation meeting.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on July 31, 2018 for 30 calendar days. During this commenting period, NQF received six comments from five member organizations and from one nonmember.

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	0
Health Professional	0
Provider Organization	5
Public/Community Health Agency	0
Purchaser	0
QMRI	0
Supplier/Industry	0

Project staff have included all submitted comments (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's organization, comment, associated measure, theme (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table before the meeting and consider the individual comments received and the proposed responses to each.

In order to facilitate discussion, the majority of the post-evaluation comments are categorized into major topic areas or themes. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the September 24 post-comment call. Instead, we will spend the majority of the time considering the two themes discussed below, and the set of

comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, please note that measure stewards/developers were asked to respond where appropriate. Where possible, NQF staff have proposed draft responses for the Committee to consider.

Comments and their Deposition

Themed Comments

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

1. Adjustment for Social Risk Factors and Unintended Consequences
2. Acceptable Levels of Reliability

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.

> **Measure Steward/Developer Response**
> *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.

Proposed 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 SDS 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 serving vulnerable populations are not penalized unfairly.

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 encourages the developer to continue testing the risk-adjustment model with additional SDS factors in an effort to better understand unmeasured patient risk.

Action Item

Does the Committee agree with the proposed responses?

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

Two 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.

Measure Steward/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.

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.

Proposed Committee Response

The Committee 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.

Action Item

Does the Committee agree with the proposed responses?

NQF 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 each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided an expression of support or nonsupport for NQF #1789.