NATIONAL QUALITY FORUM

Memo

September 23, 2019

To: All-Cause Admissions and Readmissions Standing Committee

From: NQF staff

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

Purpose of the Call

The All-Cause Admissions and Readmissions Standing Committee will meet via web meeting on October 2, 2019 from 2:00 pm to 4:00 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;
- Review and discuss NQF members' expression of nonsupport of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table and additional documents included with the call materials).
3. Review the NQF members' expressions of nonsupport 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:

Speaker dial-in #: 800-768-2983
Access code #: 4364232
Weblink: https://core.callinfo.com/callme/?ap=8007682983&ac=4364232&role=p&mode=ad

Background

Avoidable admissions and readmissions to acute care facilities are an important area for healthcare quality improvement. These avoidable admissions and readmissions often represent an opportunity to improve care transitions and prevent the unnecessary exposure of patients to adverse events in an acute care setting. To drive improvement in admissions and readmissions, performance measures have continued to be a key element of value-based purchasing programs to incentivize collaboration in the healthcare delivery system.

The 21-member All-Cause Admissions and Readmissions Standing Committee has been charged with overseeing the NQF All-Cause Admissions and Readmission portfolio, evaluating both newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in its designated topic areas. The All-Cause Admissions and Readmissions portfolio includes measures for various care settings or points of care.

During two web meetings on June 20 and June 21, the All-Cause Admissions and Readmissions Standing Committee evaluated one newly submitted measure and one maintenance measure. The Committee recommended for endorsement 3495 *Hospital-Wide 30-Day, All-Cause, Unplanned Readmission (HWR) Rate* at the clinician group/practice level of analysis. The Committee did not recommend the individual clinician level of analysis version of the same measure 3495 *Hospital-Wide 30-Day, All-Cause, Unplanned Readmission (HWR) Rate*, based on validity concerns. Measure 2539 *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy* was withdrawn from consideration pending alignment of measure testing and specifications.

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 to June 12, 2019 for the measures under review. The two comments received related to outcomes improvement, minimum data or case thresholds, testing technique, and the extent to which accountable units impact measure outcome. These 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 August 1, 2019 for 30 calendar days. During this commenting period, NQF received one comment from one member organization:

Member Council	# of Member Organizations Who Commented
Health Professions	1

We have included all comments that we received (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (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 comment received and the proposed response.

Comments and Their Disposition

Measure-Specific Comment

3495 Hospital-Wide 30-Day, All-Cause, Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups

The American Medication Association (AMA) appreciates the Standing Committee discussion and evaluation of this measure but continues to have significant concerns with the lack of adherence to the Consensus Development Process and whether the measure meets the NQF Measure Evaluation Criteria, particularly for evidence and scientific acceptability.

The NQF has had a longstanding commitment to ensuring that the CDP and associated criteria are followed consistently and the process is conducted in a transparent manner. Unfortunately, we do not believe that it is demonstrated in this project and associated report. Specifically, the AMA is concerned with the limited number of members who were able to participate in the evaluation of this measure on the June 21 webinar; specifically, the roll call prior to discussion of this measure identified only 11 of the 21 members. Based on our review of the votes available for the individual clinician and group levels of analysis, an additional five members evaluated the measures against the criteria but were not present during the discussion of the measure on June 21. It is concerning to have just 50% of the committee participate in the public discussion of the measure and almost 25% of the remaining members participate in voting on a measure for which it is not clear they were able to fully evaluate, ask questions of the developer, and hear public comments. In addition, the draft report released for comment does not include the committee votes for feasibility, usability and use, and the recommendation for endorsement for the group level of analysis (see pages 13-14) but the narrative indicates that it is recommended for endorsement. Omissions like these lead us to question the integrity and consistency of the process and makes it extremely difficult for NQF members and the public to engage in the CDP in a meaningful way.

As mentioned in our comments submitted prior to the committee's evaluation, we believe that:

- Insufficient evidence was provided to support attribution of the measure to physicians or practices in the absence of some coordinated program or targeted intervention led by the health system or hospital;
- Assignment of responsibility of the reduction of readmissions to multiple physicians and practices in MIPS is not appropriate nor has the developer provided sufficient information to support the attribution of this measure to up to three physicians or practices;
- The measure score reliability results are too low when based on the minimum case number of 25 patients. Measures should meet minimum acceptable thresholds of 0.7 for reliability; and

- The conceptual basis used to explain which social risk factors were tested in Section 2b3.3a is inadequate and additional testing is needed to evaluate clinical factors in conjunction with social risk factors as well as the impact that the inclusion of these factors had on the absolute change of the rates.

As a result, the AMA is unable to support endorsement of the measure at this time and requests that NQF distribute the missing information in the report and the Committee reconsiders its recommendation for endorsement.

NQF Response:

Thank you for your comments. NQF strives to achieve quorum at each step of the Consensus Development Process (CDP). Recognizing the burden on volunteer members of the CDP Committees with the increased activities in the bi-annual cycle of the CDP, NQF will be exploring process improvement opportunities to ensure future Committee calls do achieve quorum. With regards to voting, NQF followed our established procedure for cases when quorum is not achieved. Votes were not taken during the during the call. Following the call, the transcript and recording were provided to all Committee members along with a voting survey. Committee members who were not present are able to review the call materials and the transcript or recording prior to submitting their votes. Votes were accepted until quorum of the Committee was achieved.

There was an oversight by NQF staff in providing a full count of votes in the published version of the report. NQF corrected and reposted the report with the full information as soon as this comment was received. We thank the commenter for alerting us of this oversight.

Measure Steward/Developer Response:

We appreciate this summary of your earlier comments, which we address below.

We also agree with the conclusions outlined within NQF's final report, Improving Attribution Models (NQF, 2018), in that attribution models should reflect clinicians and providers with reasonable influence on the care and outcomes for patients in order to enforce accountability and facilitate quality improvement. During development, we solicited a wide variety of clinician, technical, and patient feedback through stakeholder engagement. The Technical Expert Panel, in particular, felt strongly that it was appropriate to attribute readmissions to multiple clinicians to encourage coordination and shared accountability. Additionally, the same panel identified the three clinicians attributed by this measure as being most accountable.

We agree that it is important that the final volume threshold correspond to adequate reliability. Constructing meaningful, reliable, valid provider quality measures is challenging and requires balancing competing factors and values. In the NQF Submission forms, we provide evidence that these measures do capture reliable and valid quality signals at the clinician and group level under the proposed attribution.

We tested for the effects of including two social risk factors within the model (dual eligibility status and low Agency for Healthcare Research and Quality SES) on final risk-adjusted rates for both clinicians and clinician groups. The correlation between the adjusted and unadjusted scores were 0.99, indicating extremely high agreement and that adding these social risk factors would have minimal impact on measure scores. Ongoing research aims to identify valid patient-level social risk factors and highlight disparities related to social risk. As additional variables become available, they will be considered for testing and inclusion within the measure. There are also alternative ways to adjust for social risk as part of measure program implementation, such as stratification or peer grouping, which CMS recently applied to the Hospital Readmission Reduction Program (HRRP).

Since the release of the Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors report in July 2017, NQF announced the launch of a new, three-year initiative to explore unresolved issues that surfaced in the 2015-2017 social risk factor trial.[1] The stated goal of the new Social Risk Trial is to "help inform a decision on whether to permanently change NQF's policy to allow social risk adjustment for outcome measures."[2] For risk-adjusted outcome measures, CMS first considers adjustment for clinical conditions and then examines additional risk imparted by social risk factors after the potential for greater disease burden is included in the risk model. We believe that this is consistent with NQF current guidance and is appropriate given the evidence cited in our submission that people who experience greater social risk are more likely to have more disease burden compared with those who do not; and that this is clearly not a signal of hospital quality. In addition, according to NQF guidance, developers should assess social risk factors for their contribution of unique variation in the outcome – that they are not redundant.[3] Therefore, if clinical risk factors explain all or most of the patient variation in the outcome, then NQF guidance does not support adding social risk factors that do not account for variation.

In addition to the correlation between adjusted and unadjusted scores, we also tested the change in risk-adjusted readmission rates. When incorporating the duel eligible risk factor, risk-adjusted readmission rates dropped an absolute value of 0.03% for clinicians and 0.02% for clinician groups. When incorporating low AHRQ SES, risk-adjusted

---

[1] National Quality Forum (NQF). NQF Statement on Board of Directors Decision Regarding Social Risk Trial, http://www.qualityforum.org/News_And_Resources/Press_Releases/2017/NQF_Statement_on_Board_of_Directors_Decision_Regarding_Social_Risk_Trial.aspx

[2] National Quality Forum (NQF). Social Risk Trial FAQ, June 28, 2018. http://www.qualityforum.org/ProjectMaterials.aspx?projectID=87820. Accessed September 9, 2019

[3] National Quality Forum (NQF). Risk adjustment for socioeconomic status or other sociodemographic factors: Technical report. 2014; http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx. Accessed September 3, 2019.

readmission rates dropped an absolute value of -0.02% for clinicians and -0.01% for clinician groups.

NQF doesn't specify or require testing for impact on program inclusion, program benchmarking, or star rating systems. At this time, it is not known how CMS will use this measure in the MIPS program.

We agree with the importance of balancing these competing considerations. We are committed to constant refinement and improvement of risk adjustment models used in all measures. We will reevaluate this model and available risk factors on an ongoing basis, with the goal of producing the most accurate and fair risk adjustment models for assessing provider performance.

Proposed Committee Response:

Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on October 2, 2019.

Action Item:

The Committee should review the comment and the developer's response and be prepared to discuss whether it wishes to reconsider the recommendation for the measure.

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. One NQF member provided an expression of nonsupport on both 3495 and 2539: See Appendix A.

Appendix A: NQF Member Expression of Support Results

One NQF member provided expressions of nonsupport on the measures under consideration. Neither of the two measures under consideration received support from NQF members. Results are provided below.

3495 Hospital-Wide 30-Day, All-Cause, Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups

Member Council	Support	Do Not Support	Total
Health Professional	0	1	1

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

Member Council	Support	Do Not Support	Total
Health Professional	0	1	1