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# Meeting Summary

## All-Cause Admissions and Readmissions Standing Committee – Fall 2020 Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the All-Cause Admissions and Readmissions Standing Committee for web meetings on February 12 and 16, 2021 to evaluate one new and six maintenance measures undergoing review against NQF's endorsement criteria. The meetings were administered by the NQF All-Cause Admissions and Readmissions project team:

- Matthew Pickering, PharmD, Senior Director
- Poonam Bal, MSHA, Director
- Oroma Igwe, MPH, Manager
- Funmilayo Idaomi, MPH, Analyst
- Taroon Amin, PhD, MPH, Consultant

The materials for the fall 2020 All-Cause Admissions and Readmissions meetings are available on the project webpage under the materials section.

### Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the All-Cause Admissions and Readmissions Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. Standing Committee members each introduced themselves and did not disclose any conflicts of interests. Quorum (at least 16 out of 24 members in attendance) was achieved and maintained during the first web meeting on February 12. During the second web meeting on February 16, quorum was lost for the last measure under review, NQF #2515. Therefore, the Standing Committee discussed all relevant criteria for this measure and voting occurred after the meeting using an online voting tool.

### Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and the current NQF All-Cause Admissions and Readmissions portfolio of endorsed measures. There are currently 38 measures in the All-Cause Admissions and Readmissions portfolio. Additionally, NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

A measure is recommended for endorsement by the Standing Committee when the vote margin on all must-pass criteria (Importance, Scientific Acceptability, and Use [for maintenance measures only]), and the overall suitability for endorsement, is greater than 60 percent of voting members in favor of endorsement. A measure is not recommended for endorsement when the vote margin on any must-pass criterion or the overall suitability is less than 40 percent of voting members in favor of endorsement. The Standing Committee has not reached consensus if the vote margin on any must-pass criterion or the overall suitability is between and inclusive of 40 and 60 percent in favor of endorsement. When the Standing Committee has not reached consensus, all measures for which consensus was not reached will be released for NQF member and public comment. The Standing Committee will consider the comments and re-vote on those measures during the post comment web meeting on June 4, 2021.

For the current fall 2020 cycle, all measures under review were recommended for endorsement by the Standing Committee.

## Measure Evaluation

During the meeting, the All-Cause Admissions and Readmissions Standing Committee evaluated seven submitted measures, including six maintenance measures and one new measure for endorsement consideration. Pre-evaluation meeting comments from NQF members and the public were also considered by the Standing Committee and can be found in Appendix A. NQF will post the draft technical report on March 30, 2021 for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

**Rating Scale:** H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

### 2888 ACO Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions (Centers for Medicare & Medicaid Services/Yale Center for Outcomes Research & Evaluation [CMS/Yale CORE])

**Description**: Rate of risk-standardized acute, unplanned hospital admissions among Medicare fee-for-service (FFS) beneficiaries 65 years and older with multiple chronic conditions (MCCs) who are assigned to an Accountable Care Organization (ACO).; **Measure Type**: Outcome; **Level of Analysis**: Other; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Elizabeth Drye, MD, MS (Yale/CORE)
- Faseeha Altaf, MPH (Yale/CORE)
- Kasia Lipska, MD, MHS (Yale/CORE)
- Andrea Barbo, MS (Yale/CORE)
- Leianna Dolce, BS (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- P. Nicole Crenshaw, MPA (CMS)

#### *Standing Committee Votes*

- Evidence: Pass-20; No Pass-0 **(20/20 – 100% Pass)**
- Performance Gap: H-1; M-17; L-2; I-0 **(18/20 – 90% Pass)**
- Reliability: Does the Standing Committee accept NQF's Scientific Methods Panel's HIGH rating of Reliability? Yes-19; No-0 **(19/19 – 100% Yes)**
    - This measure is deemed complex and was evaluated by the NQF Scientific Methods Panel (SMP), where it passed with a High rating for Reliability (H-7; M-1; L-0; I-0).
    - The Standing Committee voted to uphold the SMP decision.
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-20; No-0 **(20/20 – 100% Yes)**
    - The NQF Scientific Methods Panel's rating of Moderate for Validity (H-3; M-3; L-2; I-0)
    - The Committee accepted the NQF Scientific Methods Panel's rating.
- Feasibility: H-10; M-11; L-0; I-0 **(21/21 – 100% Pass)**
- Use: Pass-21; No Pass-0 **(21/21 – 100% Pass)**

- Usability: H-3; M-17; L-1; I-0 **(20/21 – 95% Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-21; No-0*

The Standing Committee recommended the measure for continued endorsement.

The Standing Committee considered a logic model and several studies provided by the developer suggesting that improvements in the delivery of healthcare services for ambulatory patients with MCCs can lower the risk of admission. The Standing Committee also reviewed the performance gap data provided, noting that this is an updated measure that is not currently in use. Therefore, testing data provided by the developer was for the 2018 calendar year. The Standing Committee did not raise any concerns related to evidence or performance gap and passed the measure on these criteria.

The Standing Committee noted that this measure has been evaluated by the NQF SMP and was given a high rating for reliability and a moderate rating for validity. In reviewing the reliability testing results, the Standing Committee did not raise any questions or concerns and upheld the SMP's high rating. With respect to validity, the Standing Committee asked for clarification regarding the rationale of why diabetes was added to the updated measure. The developer explained the addition was due to subsequent feedback from clinicians and from a Technical Expert Panel, which recommended to acknowledge the complexity of patients managing diabetes along with the other multiple chronic conditions in both this measure and its Merit-based Incentive Payment System (MIPS) counterpart, for harmonization purposes. The Standing Committee discussed the risk adjustment model, specifically if provider availability was considered. The developer clarified that in calculating risk adjustment, primary care availability scores were not retained in the model. However, specialty physician's density was included in the measure's risk adjustment due to its significant association to the outcome. The Standing Committee also noted public comments received expressing concerns over the low model fit. Specifically, there were two public comments received that the Standing Committee considered in their evaluation of the measure, which questioned the adequacy of the risk model's fit, since the deviance R-squared was only 0.111. In reviewing the empirical validity testing, the Standing Committee considered the SMP's review, which raised some concern that four of the five comparator measures hypothesized a weak or poor relationship with the measure and there was a slightly negative but insignificant correlation with the control of high blood pressure measure (-0.07, p=0.673), which was not hypothesized. The Standing Committee noted that despite these concerns, the SMP passed the measure on validity. The Standing Committee agreed that it was not expected that blood pressure would have a big effect on the admission to the hospital, and the lack of a strong correlation was not suspect. The Standing Committee therefore upheld the SMP's moderate rating for validity. The measure was also regarded as feasible by the Standing Committee. Moving to usability and use, the Standing Committee did question whether this measure is usable for quality improvement and whether the Standing Committee is voting on how it is used. The NQF staff provided clarity that the use criterion evaluates whether a measure is being used in an accountability application or for public reporting and that the NQF criteria are agnostic to how it is used. The Standing Committee suggested that NQF should reconsider the details of the use criterion in the evaluation processes, especially with respect to measures where the program of use is within the title. Moving to usability, there was some discussion by the Standing Committee on how this measure attributes patients to ACOs. The developer mentioned that the ACO program has an attribution algorithm that the measure will adopt. Therefore, this is not part of the measure specification, but the attribution decisions are at the program-level. The Standing Committee observed that there was a related measure to this metric but did not raise any questions or concerns with respect to harmonization.

### 3597 Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients w Multiple Chronic Conditions under Merit-based Incentive Payment System (MIPS) (CMS/Yale CORE)

**Description**: Risk-Standardized rate of acute, unplanned hospital admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with multiple chronic conditions (MCCs).; **Measure Type**: Outcome; **Level of Analysis**: Clinician : Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Elizabeth Drye, MD, MS (Yale/CORE)
- Faseeha Altaf, MPH (Yale/CORE)
- Kasia Lipska, MD, MHS (Yale/CORE)
- Andrea Barbo, MS (Yale/CORE)
- Leianna Dolce, BS (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- P. Nicole Crenshaw, MPA (CMS)

#### *Standing Committee Votes*

- Evidence: Pass-19; No Pass-0 **(19/19 – 100%, Pass)**
- Performance Gap: H-6; M-13; L-1; I-0 **(19/20 – 95%, Pass)**
- Reliability Does the Standing Committee accept NQF's Scientific Methods Panel's HIGH rating of Reliability? Yes-15; No-3 **(15/18 – 83%, Yes)**
    - This measure is deemed complex and was evaluated by the NQF SMP, where it passed with a High rating for Reliability (H-5; M-2; L-0; I-1)
    - The Committee accepted the SMP's rating.
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-17; No-1 **(17/18 – 94%, Yes)**
    - The NQF SMP rating was Moderate for Validity (H-0; M-7; L-1; I-0)
    - The Committee accepted the SMP's rating.
- Feasibility: H-8; M-9; L-1; I-0 **(17/18 – 94%, Pass)**
- Use: Pass-17; No Pass-1 **(17/18 – 94%, Pass)**
- Usability: H-0; M-14; L-4; I-0 **(14/18 – 78%, Pass)**

#### *Standing Committee Recommendation for Endorsement: Yes-17; No-2*

The Standing Committee recommended the measure for initial endorsement.

The Standing Committee considered a logic model and several studies that support the assertion that ambulatory care clinicians can influence admission rates. The Standing Committee discussed the attribution of the measure, seeking clarity as to whether it was different than the previous ACO-level measure (NQF #2888). The developer commented that for the ACO measure, attribution was conducted at the program-level; whereas, for NQF #3597, the attribution is part of the measure itself. It was built and tailored, specifically for the measure, by engaging an expert panel and frontline clinicians. The developer emphasized their aim to capture quality of ambulatory care and clarified that this measure was intended to engage physicians, not involved in ACOs, to evaluate unplanned hospital admissions for these complex patients. The Standing Committee also observed that there is an appropriate performance gap and did not express any concerns.

The Standing Committee noted that this measure has been evaluated by the SMP and was given a high rating for reliability and a moderate rating for validity. The Standing Committee discussed the minimum clinician group size threshold of 15 clinicians and questioned how generalizable this measure will be, as one Standing Committee member from the American Academy of Family Physicians, noted that their average clinician group size is six with a median of three. The developer commented that it is the sample size that drives reliability, and that CMS makes these decisions about the cut points during rulemaking. Further, the MIPS program will not go below a reliability of 0.4, and that there is a balance that CMS is trying to achieve between increasing the number of patients and clinicians captured in the measure versus maintaining a strong reliability score. The Standing Committee recognized that a similar concern regarding the minimum clinician threshold had been discussed by the Standing Committee in the past, specifically for NQF #3495. That measure was bifurcated at a group-level and at an individual clinician-level. The Standing Committee did not approve it at the individual level because the reliability results were too low, but approved it at the group-level because, in that case, the clinician groups had enough patients to show sufficient reliability. The Standing Committee did not raise any further questions and upheld the SMP's rating of high for reliability. There were no concerns regarding the measure's validity and the Standing Committee upheld the SMP's rating of moderate for validity. The measure was also regarded as feasible by the Standing Committee, and there were no concerns about use. The Standing Committee recognized that this measure is not currently publicly reported or used in an accountability application. However, CMS proposes this measure for use within the MIPS program. As a result, the Standing Committee acknowledged that since this is a new measure and not currently in use, there are no year over year performance data, nor any unintended consequences from its use. The Standing Committee observed that there were related measures to this metric but did not raise any questions or concerns with respect to harmonization.

### 0330 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization (CMS/Yale CORE)

**Description:** The measure estimates a hospital-level risk-standardized readmission rate (RSRR) for patients discharged from the hospital with a principal diagnosis of heart failure (HF). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. The target population is patients age 65 and over. The Centers for Medicare & Medicaid Services (CMS) annually reports the measure for patients who are 65 years or older and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities. **Measure Type:** Outcome**; Level of Analysis:** Facility**; Setting of Care:** Inpatient/Hospital**; Data Source:** Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- Susannah Bernheim, MD (Yale/CORE)
- Karen Dorsey, MD (Yale/CORE)
- Kashika Sahay, PhD, MPH (Yale/CORE)
- Anna Sigler, MPH (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)

- Lisa Suter, MD (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Karen Dorsey, MD, PhD (Yale/CORE)
- Rohan Khera, MBBS, MS (Yale/CORE)
- James Poyer, MS, MBA (CMS)

### *Standing Committee Votes*

- Evidence: Pass-17; No Pass-0 **(17/17 – 100%, Pass)**
- Performance Gap: H-1; M-12; L-3; I-0 **(13/16 – 81%, Pass)**
- Reliability: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Reliability? Yes-15; No-2 **(15/17 – 88%, Yes)**
    - This measure is deemed complex and was evaluated by the NQF SMP, where it passed with a Moderate rating for Reliability (H-0; M-7; L-1; I-0)
    - The Committee accepted the SMP's rating.
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-14; No-3 **(14/17 – 82%, Yes)**
    - The SMP's rating of Moderate for Validity (H-2; M-5; L-1; I-0)
    - The Committee accepted the SMP's rating.
- Feasibility: H-7; M-10; L-1; I-0 **(17/18 – 94%, Pass)**
- Use: Pass-17; No Pass-0 **(17/17 – 100%, Pass)**
- Usability: H-0; M-14; L-2; I-0 **(14/16 – 88%, Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-16; No-0*

The Standing Committee recommended the measure for continued endorsement.

The Standing Committee considered a logic model and the updated evidence since the measure's last endorsement review, which included a report that found transitional care models that prioritize effective collaboration and communication within and across providers/facilities demonstrate significant hospital readmissions reductions for heart failure patients. A Standing Committee member asked if transitional care model held up beyond the pilot study. The developer responded stating that they are not aware of any expansion of the pilot at this time. The Standing Committee had no additional questions and passed the measure unanimously on the evidence criterion. Moving to performance gap, the Standing Committee discussed whether the 3.4% range from the 10th and 90th percentiles was a sufficient gap. The developer commented that this measure is capturing 4,000 hospitals and in looking beyond the 10th and 90th percentiles there are still a significant number of hospitals in these extremes. One Standing Committee member questioned whether hospitals are stable within that range or can they move around if they change what they change how they are treating these patients. The developer commented that there has been evidence to show that for hospitals that focus on improving readmissions, they can lower their rates up to 20%, and that safety net hospitals were able to improve faster than other hospitals. One Standing Committee member commented that hospitals should stratify this type of measure by race, ethnicity, language spoken, etc. to identify improvement opportunities. The Standing Committee passed the measure with a moderate rating for performance gap.

The Standing Committee noted that this measure was reviewed by the SMP, which gave a moderate rating for both reliability and validity. In considering the reliability testing for this measure, the Standing Committee noted that the developer conducted an intraclass correlation coefficient for hospitals with 25 or more admissions and found a 0.587 agreement between the two independent assessments of the RSRR for each hospital. A signal-to-noise method was also employed, and the median reliability score was 0.57, ranging from 0.14 to 0.96. The 25th and 75th percentiles were 0.31 and 0.75, respectively. The

Standing Committee acknowledged the public comments received prior to the measure evaluation meeting from the American Medical Association, raising concern the measure does not meet a minimum reliability score of 0.7. The Standing Committee discussed what the appropriate minimum threshold should be for reliability. The NQF staff commented that other NQF-convened groups, including the SMP, have discussed this at length. There is not a universal threshold of reliability and that the Standing Committee should decide if they are willing to accept the data that are presented. NQF staff further mentioned that measures with reliability scores that are less than 0.7 have been endorsed by this Standing Committee in the past. One Standing Committee member agreed that there is a lack of consensus with reliability thresholds and encouraged CMS to reconsider the case volume cut points for the measure in order to help address these reliability concerns, as sample size can drive reliability. CMS responded that increasing the case volume would result in a drop in the number of hospitals that would be included in the measure. It is a tradeoff, and that for meaningful measure that assess important serious outcomes such as mortality or surgical procedure, it might be reasonable to accept a slightly lower reliability in order to capture more low-volume providers. The Standing Committee voted to uphold the SMP's rating of moderate for reliability. For validity, the Standing Committee did raise some concern related to the risk adjustment model, namely that social risk factors (SRF; dual eligibility and ASPE SES index) were tested but not included in the final specification. CMS commented that CMS does not adjust for dual eligibility at the measure level, for the Hospital Readmission Reduction Program, adding that the program stratifies its payment calculations in accordance with statutory guidance based on dual eligibility. It groups the hospitals into five equal groups, and those quintiles are sorted based on percentage of dual eligibility patients. CMS further added that it would take Congressional action to be able to override that approach. The Standing Committee ultimately voted to accept the SMP's moderate rating for validity. The Standing Committee identified no concerns regarding the feasibility of this measure or the use and usability as the developer noted the measure is publicly reported in Hospital Compare and used in the Hospital Readmissions Reduction Program. The Standing Committee observed that there were related measures to this metric but did not raise any questions or concerns with respect to harmonization. There were two public comments received that the Standing Committee considered in their evaluation of the measure. These comments focused on the following subjects: (1) the statistically significant meaningful difference in performance, questioning whether there is sufficient variation in performance across hospitals, (2) recommending an increase to the minimum sample size to improve the reliability score, and (3) questioning the rationale to exclude social risk factors within the risk adjustment model.

### 0505 Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospital (CMS/Yale CORE)

**Description**: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients age 65 and older discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)

- Sapha Hassan, MPH (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- Susannah Bernheim, MD (Yale/CORE)
- Karen Dorsey, MD (Yale/CORE)
- Kashika Sahay, PhD, MPH (Yale/CORE)
- Anna Sigler, MPH (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Lisa Suter, MD (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Karen Dorsey, MD, PhD (Yale/CORE)
- Rohan Khera, MBBS, MS (Yale/CORE)
- James Poyer, MS, MBA (CMS)

### *Standing Committee Votes*

- Evidence: Pass-17; No Pass-0 **(17/17 – 100%, Pass)**
- Performance Gap: H-3; M-14; L-1; I-0 **(17/18 – 94%, Pass)**
- Reliability: H-0; M-11; L-4; I-2 **(11/17 – 65%, Pass)**
    - This measure is deemed complex and was evaluated by the NQF SMP, which received a Consensus Not Reached rating for Reliability (H-0; M-5; L-4 I-0)
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-16; No-1 **(16/17 – 94% Pass)**
    - This measure is deemed complex and was evaluated by the SMP.
    - The SMP's rating of Moderate for Validity (H-0; M-5; L-4; I-0)
    - The Committee accepted the SMP's rating.
- Feasibility: H-7; M-10; L-0; I-0 **(17/17 – 100%, Pass)**
- Use: Pass-18; No Pass-0 **(18/18 – 100%, Pass)**
- Usability: H-0; M-15; L-3; I-0 **(15/18 – 83%, Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-14; No-2*

The Standing Committee recommended the measure for continued endorsement.

Originally endorsed in 2008, and most recently endorsed in 2016, measure #0505 focuses on patients who are age 65 and older that are discharged from the hospital with a principal diagnosis of acute myocardial infarction (AMI). The Standing Committee agreed that this is an important focus area of measurement and expressed no concern associated with the evidence for the measure and the performance gap and passed the measure on these criteria. The Standing Committee noted that the SMP was not able to reach consensus on reliability for this measure; it therefore provided its own rating on reliability. The Standing Committee acknowledged the pre-evaluation meeting comments that raised concerns related to the minimum case thresholds of 25 cases. Members of the Standing Committee held similar concerns, agreeing that these issues of reliability thresholds were very similar to those previously discussed for measure NQF #0330. The developer stated that increasing the minimum case threshold would lead to a significant loss of hospitals from the cohort. With no additional concerns, the Standing Committee voted to pass the measure on reliability with a moderate rating. The Standing Committee noted that the SMP passed the measure on validity. The Standing Committee acknowledged that the developer reported that adjusting for social risk factors had little impact on hospital-level measure scores. In the absence of any other questions or comments, the Standing Committee proceed to accept the SMP's rating of moderate for the validity criterion. The Standing Committee passed the measure on feasibility with a rating of moderate. The Standing Committee recognized that this measure is currently in use in Hospital Compare and Hospital Readmissions Reduction Program (HRRP) and passed the

measure on the use criterion. With respect to the usability criterion, the Standing Committee considered that the median hospital 30-day, all-cause, RSRR for the AMI readmission measure for the three-year period between July 1, 2016 and June 30, 2019 was 16.1%. The median RSRR decreased by 0.6 absolute percentage points from July 2016-June 2017 (median RSRR: 16.3%) to July 2018-June 2019 (median: RSRR: 15.7%). Additionally, the Standing Committee considered that research has also explored potential spillover effects of the AMI readmission measures' implementation and reductions in readmissions for non-targeted conditions. The developer stated that several studies support positive spillover effects, as there has been systematic improvement in risk-standardized readmission rates for patients not included in HRRP measures. The Standing Committee held no concerns and passed the measure on the usability criterion. The Standing Committee observed that there were related measures to this metric but did not raise any questions or concerns with respect to harmonization. There were two public comments received that the Standing Committee considered in their evaluation of the measure. These comments focused on the following subjects: (1) the statistically significant meaningful difference in performance, questioning whether there is sufficient variation in performance across hospitals, (2) recommending an increase to the minimum sample size to improve the reliability score, and (3) questioning the rationale to exclude social risk factors within the risk adjustment model.

### 0506 Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization (CMS/Yale CORE)

**Description**: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients age 65 and older discharged from the hospital with either a principal discharge diagnosis of pneumonia (including aspiration pneumonia) or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). Readmission is defined as an unplanned readmission for any cause within 30 days of the discharge date for the index admission. Readmissions are classified as planned and unplanned by applying the planned readmission algorithm. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- Susannah Bernheim, MD (Yale/CORE)
- Karen Dorsey, MD (Yale/CORE)
- Kashika Sahay, PhD, MPH (Yale/CORE)
- Anna Sigler, MPH (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Lisa Suter, MD (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Karen Dorsey, MD, PhD (Yale/CORE)
- Rohan Khera, MBBS, MS (Yale/CORE)
- James Poyer, MS, MBA (CMS)

### *Standing Committee Votes*

- Evidence: Pass-16; No Pass-0 **(16/16 – 100%, Pass)**
- Performance Gap: H-0; M-14; L-2; I-0 **(14/16 – 88%, Pass)**
- Reliability: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Reliability? Yes-17; No-0 **(17/17 – 100%, Pass)**
    - This measure is deemed complex and was evaluated by the SMP, where it passed with a Moderate rating for Reliability (H-1; M-7; L-1; I-0)
    - The Committee accepted the SMP's rating.
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-17; No-0 **(17/17 – 100%, Pass)**
    - This measure is deemed complex and was evaluated by the SMP.
    - The SMP's rating of Moderate for Validity (H-0; M-8; L-1; I-0)
    - The Committee accepted the SMP's rating.
- Feasibility: H-4; M-13; L-0; I-0 **(17/17 – 100%, Pass)**
- Use: Pass-18; No Pass-0 **(18/18 – 100%, Pass)**
- Usability: H-0; M-15; L-3; I-1 **(15/19 – 79%, Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-16; No-1*

The Standing Committee recommended the measure for continued endorsement.

Originally endorsed in 2008, and most recently endorsed in 2016, measure #0506 focuses on patients who are age 65 and older discharged from the hospital with a principal a principal discharge diagnosis of pneumonia. Since its last endorsment, the expansion of the cohort was made with inclusion of sepsis and aspiration pneumonia patients. The Standing Committee acknowledged the existing and newly added evidence about the incidence of pneumonia and regarded them as sufficient and supportive of the continued need for this measure. They noted the developer's inclusion of a pilot transitional care program called Transitions Across Care Settings (TRACS) that demonstrated that a reduction in pneumonia readmissions occurred with care coordination. The Standing Committee stated no concerns with the measure's newly provided evidence and passed the measure unanimously on the evidence criterion. The Standing Committee did not raise any questions or concerns regarding the performance gap and passed the measure with a moderate rating for this criterion. The Standing Committee noted that this measure had been evaluated by the SMP and was given moderate ratings for both reliability and validity. The Standing Committee held some pre-evaluation concerns around the split sample median value of 0.544 median and the low differentiation within the 4,280 hospitals. However, the Standing Committee agreed that these issues of reliability were very similar to those previously discussed for measure NQF #0330. With no additional concerns, the Standing Committee voted to uphold the SMP rating of moderate for reliability. Moving to validity, a Standing Committee member inquired about the adjustment or inclusion of COVID-related pneumonia, and the developer responded stating that the sample measurement period was pre-COVID, and that CMS is actively working on examining the impact of COVID moving forward. The Standing Committee had no additional questions with respect to the validity of the measure and unanimously accepted the SMP's rating of moderate. The measure was regarded as feasible by the Committee with no concerns. For use and usability, the Standing Committee recognized that this measure is currently part of the CMS public reporting program, Hospital Compare, and accountability program HRRP. The Standing Committee further acknowledged that there have been no unintended consequences or harms related to the use of this measure, and that CMS commissioned an independent panel of statisticians to review all the literature around unintended harm and found no issues. The Standing Committee held no concerns about use and usability and passed the measure on both criteria. There were two public comments received that the Standing Committee considered in their evaluation of the measure. These comments focused on the following

subjects: (1) the statistically significant meaningful difference in performance, questioning whether there is sufficient variation in performance across hospitals, (2) recommending an increase to the minimum sample size to improve the reliability score, and (3) questioning the rationale to exclude social risk factors within the risk adjustment model.

### 1891 Hospital 30-day, all-cause, risk-standardized readmission rate following chronic obstructive pulmonary disease (COPD) (CMS/Yale CORE)

**Description**: The measure estimates a hospital-level 30-day, all-cause, risk-standardized readmission rate (RSRR) for patients age 65 and over discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. The outcome (readmission) 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 and are enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals or are patients hospitalized in Veterans Health Administration (VA) facilities.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data, Other

#### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- Susannah Bernheim, MD (Yale/CORE)
- Karen Dorsey, MD (Yale/CORE)
- Kashika Sahay, PhD, MPH (Yale/CORE)
- Anna Sigler, MPH (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Lisa Suter, MD (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Karen Dorsey, MD, PhD (Yale/CORE)
- Rohan Khera, MBBS, MS (Yale/CORE)
- James Poyer, MS, MBA (CMS)

#### *Standing Committee Votes*

- Evidence: Pass-18; No Pass-0 **(18/18 – 100%, Pass)**
- Performance Gap: H-1; M-14; L-3; I-0 **(15/18 – 83%, Pass)**
- Reliability: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Reliability? Yes-17; No-0 **(17/17 – 100%, Pass)**
    - This measure is deemed complex and was evaluated by the SMP, where it passed with a Moderate rating for Reliability (H-1; M-4; L-3; I-0)
    - The Committee accepted the SMP's rating.
- Validity: Does the Standing Committee accept NQF's Scientific Methods Panel's MODERATE rating of Validity? Yes-17; No-0 **(17/17 – 100%, Pass)**
    - This measure is deemed complex and was evaluated by the SMP.
    - The SMP's rating of Moderate for Validity (H-0; M-6; L-2; I-0)
    - The Committee accepted the SMP's rating.
- Feasibility: H-5; M-11; L-2; I-0 **(16/18 – 89%, Pass)**

- Use: Pass-18; No Pass-0 **(18/18 – 100%, Pass)**
- Usability: H-0; M-16; L-2; I-0 **(16/18 – 89%, Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-17; No-1*

The Standing Committee recommended the measure for continued endorsement.

Originally endorsed in 2013, and most recently endorsed in 2016, the focus of the measure concerns patients age 65 and over discharged from the hospital with either a principal discharge diagnosis of COPD or a principal discharge diagnosis of respiratory failure with a secondary diagnosis of acute exacerbation of COPD. The Standing Committee agreed that this is an important focus area of measurement and passed the evidence and performance gap criteria. The Standing Committee noted that this measure had been evaluated by the SMP and was given moderate ratings for both reliability and validity. The Standing Committee did not have any concerns related to reliability and upheld the SMP's rating of moderate. With respect to validity, the Standing Committee raised some concern with the absence of social risk factors within the risk adjustment model but recognized that this concern was discussed with NQF #0330 measure. Similar to NQF #0506, the Standing Committee discussed that COVID will have a significant impact on this measure, which will require decisions on whether to risk adjust for or possibly exclude COVID-related COPD exacerbation patients from the measure. With no additional questions or concerns raised, the Standing Committee voted unanimously to uphold the SMP's rating of moderate for validity. The measure was regarded as feasible by the Standing Committee with no concerns. In their discussions related to usability and use, the Standing Committee noted that the measure is used within accountability applications and demonstrates channels for good measure feedback. The Standing Committee acknowledged the concerns expressed by members of the public through the pre-evaluation meeting comments regarding the 0.1% absolute percentage point difference between July 2016 and June of 2017 rates. The Standing Committee agreed that these concerns were similar to NQF #0330 and proceeded to pass the measure on the use criterion and with a moderate rating for the usability criterion.

## 2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery (CMS/Yale CORE)

**Description**: The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as unplanned readmission for any cause within 30-days from the date of discharge for a qualifying index CABG procedure, in patients 65 years and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the readmission outcome.; **Measure Type**: Outcome; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data

### *Developer Representatives at the Meeting*

- Duwa Amin, MPH (Yale/CORE)
- Jackie Grady, MS (Yale/CORE)
- Kristina Gaffney, BS (Yale/CORE)
- Sapha Hassan, MPH (Yale/CORE)
- Doris Peter, PhD (Yale/CORE)
- Susannah Bernheim, MD (Yale/CORE)
- Karen Dorsey, MD (Yale/CORE)
- Kashika Sahay, PhD, MPH (Yale/CORE)
- Anna Sigler, MPH (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)
- Lisa Suter, MD (Yale/CORE)
- Huihui Yu, PhD (Yale/CORE)

- Karen Dorsey, MD, PhD (Yale/CORE)
- Rohan Khera, MBBS, MS (Yale/CORE)
- James Poyer, MS, MBA (CMS)

### *Standing Committee Votes*

- Evidence: Pass-16; No Pass-0 **(16/16 – 100%, Pass)**
- Performance Gap: H-5; M-11; L-0; I-0 **(16/16 – 100%, Pass)**
- Reliability: H-1; M-16; L-1; I-0 **(17/18 – 94%, Pass)**
    - This measure is deemed complex and was evaluated by the SMP, where it passed with a Moderate rating for Reliability (H-1; M-7; L-1; I-0)
    - The Committee voted offline and did not have the option to accept the SMP's rating.
- Validity: H-1; M-17; L-0; I-0 **(18/18 – 100%, Pass)**
    - The SMP's rating of Moderate for Validity (H-1; M-5; L-3; I-0)
    - The Committee voted offline and did not have the option to accept the SMP's rating.
- Feasibility: H-8; M-10; L-0; I-0 **(18/18 – 100%, Pass)**
- Use: Pass-18; No Pass-0 **(18/18 – 100%, Pass)**
- Usability: H-4; M-14; L-0; I-0 **(18/18 – 100%, Pass)**

### *Standing Committee Recommendation for Endorsement: Yes-18; No-0*

The Standing Committee recommended the measure for continued endorsement.

The Standing Committee agreed that this is an important focus area of measurement and acknowledged the inclusion of a logic model depicting a connection between quality of care and interventions such as improved discharge planning, reconciling patient medications, and improved communication with outpatient providers to reduced admission rates. A Standing Committee member inquired if the patients in 2014 are different from patients in 2021, specifically if there is anything in the evidence that articulates how the patient population per capita has changed since the introduction of the measure in 2014. The developer commented that it cannot state exactly how the cohort has changed since 2014, but that the measure can withstand cohort shifts. The developer added that the risk adjustment models are updated every year to make sure that if a given risk factor becomes either stronger or weaker in terms of its relevance to readmission, then the measure will adapt accordingly, such as if the cohort is changing. The Standing Committee unanimously passed the measure on the evidence criterion. The Standing Committee observed that the room for improvement with this measure was slightly wider than previously reviewed measures and passed the measure on performance gap with a rating of moderate.

The Standing Committee noted that this measure has been evaluated by the SMP and was given moderate ratings for both reliability and validity. Due to a loss of quorum during the review of reliability and the remaining evaluation criteria for NQF #2515, the Standing Committee continued to discuss the measure, but voted offline. It passed the measure on reliability and validity with a rating of moderate. The measure was regarded as feasible by the Committee with no stated concerns. The Committee passed the measure on use unanimously and passed the measure on usability with moderate rating. There were two public comments received that the Standing Committee considered in their evaluation of the measure. These comments focused on the following subjects: (1) the statistically significant meaningful difference in performance, questioning whether there is sufficient variation in performance across hospitals, (2) recommending an increase to the minimum sample size to improve the reliability score, and (3) questioning the rationale to exclude social risk factors within the risk adjustment model.

## Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

## Next Steps

NQF will post the draft technical report on March 30, 2021 for public comment for 30 calendar days and will close on April 28, 2021. NQF will re-convene the Standing Committee for the post-comment web meeting on June 4, 2021.

## Appendix A: Pre-evaluation Comments

Comments received as of January 21, 2021.

| Topic | Commenter | Comment |
|---|---|---|
| 3597: Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System | Anonymous | I strongly support this measure as well-coordinated outpatient care is key to admission prevention. |
| 0330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization | Anonymous | I support this measure |
| 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. | Anonymous | I support this measure |
| 0506: Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization | Anonymous | I support this measure |
| 1891: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization | Anonymous | I support this measure |

| Topic | Commenter | Comment |
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| 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery | Anonymous | I support this measure |
| 2888: Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions | Anonymous | I support this measure |
| 3598: Median Time from ED Arrival to ED Departure for Discharged ED Patients | Anonymous | I support this measure |
| General comments | Anonymous | I appreciate all efforts to improve outpatient care and reduce admissions |
| 0330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #330, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization. The FAH is concerned that even though the median reliability score was 0.57 for hospitals with at least 25 cases, reliability ranged from 0.14 to 0.96 and that the intraclass correlation coefficients (ICC) was 0.587. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher) and an ICC of 0.6 or higher.<br><br>In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure |

| Topic | Commenter | Comment |
|---|---|---|
| | | with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered.<br><br>Lastly, the FAH is concerned that there is insufficient variation in performance across hospitals and limited opportunities for improvement to support this measure's continued use in accountability programs. Specifically, the performance scores reported in 2b4. Identification of Statistically Significant and Meaningful Difference in Performance are generally low with only 110 hospitals identified as better than the national rate and 149 are worse than the national rate. We base our concerns on these results along with the discussion on improvement in section 4b1 of the measure submission form where only an increase of 0.1 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 was found.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #505, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. The FAH is concerned that even though the median reliability score was 0.51 for hospitals with at least 25 cases, reliability ranged from 0.14 to 0.91 and that the intraclass correlation coefficients (ICC) was 0.424. The FAH believes that the developer must increase the minimum sample size to a higher |

| Topic | Commenter | Comment |
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| | | number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher) and an ICC of 0.6 or higher.<br><br>In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered.<br><br>Lastly, the FAH is concerned that there is insufficient variation in performance across hospitals and limited opportunities for improvement to support this measure's continued use in accountability programs. Specifically, the performance scores reported in 2b4. Identification of Statistically Significant and Meaningful Difference in Performance are generally low with only 17 hospitals identified as better than the national rate and 18 are worse than the national rate. We base our concerns on these results along with the discussion on improvement in section 4b1 of the measure submission form where only an increase of 0.6 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 was found.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress |

| Topic | Commenter | Comment |
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| | | on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 0506: Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #506, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization. The FAH is concerned that even though the median reliability score was 0.56 for hospitals with at least 25 cases, reliability ranged from 0.13 to 0.96 and that the intraclass correlation coefficients (ICC) was 0.544. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher) and an ICC of 0.6 or higher.<br><br>In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered.<br><br>Lastly, the FAH is concerned that there is insufficient variation in performance across hospitals and limited opportunities for improvement to support this measure's continued use in accountability programs. Specifically, the performance scores reported in 2b4. Identification of Statistically Significant and Meaningful Difference in Performance are generally low with only 44 hospitals identified as better than the national rate and 143 are worse than the national rate. We base our concerns on these results along with the discussion on |

| Topic | Commenter | Comment |
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| | | improvement in section 4b1 of the measure submission form where only an increase of 0.2 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 was found.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 1891: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #1891, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization. The FAH is concerned that even though the median reliability score was 0.43 for hospitals with at least 25 cases, reliability ranged from 0.11 to 0.90 and that the intraclass correlation coefficients (ICC) was 0.406. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher) and an ICC of 0.6 or higher.<br><br>In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional |

| Topic | Commenter | Comment |
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| | | analysis using the American Community Survey. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered.<br><br>Lastly, the FAH is concerned that there is insufficient variation in performance across hospitals and limited opportunities for improvement to support this measure's continued use in accountability programs. Specifically, the performance scores reported in 2b4. Identification of Statistically Significant and Meaningful Difference in Performance are generally low with only 14 hospitals identified as better than the national rate and 52 are worse than the national rate. We base our concerns on these results along with the discussion on improvement in section 4b1 of the measure submission form where only an increase of 0.1 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 was found.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #1891, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery. The FAH is concerned that even though the median reliability score was 0.60 for hospitals with at least 25 cases, reliability ranged from 0.27 to 0.92 and that the intraclass correlation coefficients (ICC) was 0.436. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher) and an ICC of 0.6 or higher.<br><br>In addition, the FAH is very concerned to see that the measure developer's rationale to not include social risk factors in the risk adjustment model was in part based on the |

| Topic | Commenter | Comment |
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| | | recommendations from the report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program released in March of last year (ASPE, 2020). A fundament flaw within the ASPE report was the lack of any recommendation addressing how a single measure with multiple accountability uses should address inclusion of social risk factors as is the case with this measure, which is both publicly reported and included in the Hospital Value-Based Purchasing program. Regardless of whether the testing of social risk factors produced results that were sufficiently significant, the FAH believes that no developer should rely on the recommendations of this report until the question of how to handle multiple uses is addressed along with the additional analysis using the American Community Survey. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered.<br><br>Lastly, the FAH is concerned that there is insufficient variation in performance across hospitals and limited opportunities for improvement to support this measure's continued use in accountability programs. Specifically, the performance scores reported in 2b4. Identification of Statistically Significant and Meaningful Difference in Performance are generally low with only 6 hospitals identified as better than the national rate and 14 are worse than the national rate. We base our concerns on these results along with the discussion on improvement in section 4b1 of the measure submission form where only an increase of 0.6 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 was found.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |

| Topic | Commenter | Comment |
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| 2888: Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #2888, Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions. The FAH appreciates that the developer included the Agency for Healthcare Research and Quality Socioeconomic Status Index and physician-specialist density as variables within the risk model. Unfortunately, the FAH remains concerned with the risk model's fit since the deviance R-squared was only 0.111. The FAH does not believe that the reasons for this result are adequately addressed and risk adjustment must be improved prior to re-endorsement.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should continue to be endorsed. |
| 3597: Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System | Submitted by Federation of American Hospitals | The Federation of American Hospitals (FAH) appreciates the opportunity to comment on Measure #3597, Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System. The FAH asks that the Standing Committee carefully consider whether the attribution methodology is reasonable and evidence based.<br><br>The FAH is also concerned that even though the median reliability score was 0.873 for practices with at least 15 clinicians and 18 patients with multiple chronic conditions, reliability ranged from 0.413 to 0.999. The FAH believes that the developer must increase the minimum sample size to a higher number to produce a minimum reliability threshold of sufficient magnitude (e.g., 0.7 or higher).<br><br>In addition, the FAH appreciates that the developer included the Agency for Healthcare Research and Quality Socioeconomic Status Index and physician-specialist density as variables within the risk model. Unfortunately, the FAH remains concerned with the risk model's fit since the deviance R-squared was only 0.105. The FAH does not believe that the reasons for this result are adequately addressed and risk adjustment must be improved prior to re-endorsement.<br><br>As a result, the FAH requests that the Standing Committee carefully consider whether the measure as specified should be endorsed. |

| Topic | Commenter | Comment |
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| 0330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization | Submitted by American Medical Association | The American Medical Association (AMA) appreciates the opportunity to comment on the NQF Quality Positioning System (QPS) Measure #330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure (HF) hospitalization. This is an important measure which captures the unplanned readmission for any reason within 30 days of a patient's discharge from the hospital.<br><br>In reviewing the calculation, we are disappointed to see the minimum measure score reliability result calculated at 0.14 and the intraclass correlation coefficient (ICC) calculated at 0.587, both using a minimum case number of just 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow for the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher.<br><br>The AMA is also extremely concerned that the measure developer used the recommendation to exclude social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case here. This discrepancy, along with the fact that the additional analysis using the American Community Survey is not yet released, must be addressed prior to any reliance on the recommendations within this report. We also note that the measure developer chose to include social risk factors in two measures (#2888 and #3597) under review; we ask that this inconsistency be considered and rectified.<br><br>In addition, we question whether the measure continues to be useful to distinguish hospital performance and drive improvements based on the distribution of a hospital's performance scores. We raise this question because only 110 hospitals performed better than the national rate, and 149 hospitals were worse (as noted in section 2b4). The discussion on improvement (as noted in section 4b1 of the measure |

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| | | submission form) found only an increase of 0.1 absolute percentage points between July 2016-June 2017 and July 2018-June 2019 in this measure.<br><br>The AMA requests that the Standing Committee evaluate whether the measure continues to meet the measure evaluation criteria required for endorsement.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. | Submitted by American Medical Association | Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization.<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on the NQF Quality Positioning System (QPS) Measure #505: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization. This is an important measure which captures the unplanned readmission for any reason within 30 days of a patient's discharge from the hospital.<br><br>In reviewing the calculation, we are disappointed to see the minimum measure score reliability result calculated at 0.14 and the intraclass correlation coefficients (ICC) calculated at 0.424, both using a minimum case number of just 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher.<br><br>The AMA is also extremely concerned that the measure developer used the recommendation to exclude social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors |

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| | | included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case here. This discrepancy, along with the fact that the additional analysis using the American Community Survey is not yet released, must be addressed prior to any reliance on the recommendations within this report. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review; we ask that this inconsistency be considered and rectified.<br><br>In addition, we question whether the measure continues to be useful to distinguish hospital performance and drive improvements based on the distribution of a hospital's performance scores. We raise this question because only 17 hospitals performed better than the national rate and 18 hospitals were worse (as noted in in section 2b4). The discussion on improvement (as noted in section 4b1 of the measure submission form) found only an increase of 0.6 absolute percentage points between July 2016-June 2017 and July 2018-June 2019.<br><br>The AMA requests that the Standing Committee evaluate whether the measure continues to meet the measure evaluation criteria required for endorsement.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 0506: Hospital 30-day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization | Submitted by American Medical Association | 506 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization.<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on NQF Quality Positioning System (QPS) Measure #506, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following pneumonia hospitalization. This is an important measure which captures |

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| | | the unplanned readmission for any reason within 30 days of a patient's discharge from the hospital.<br><br>The AMA is disappointed to see the minimum measure score reliability results calculated at 0.13 and the intraclass correlation coefficient (ICC) calculated at 0.544 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher.<br><br>The AMA is also extremely concerned to see that the measure developer used the recommendation to exclude social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any reliance on the recommendations within this report. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered and rectified.<br><br>In addition, we question whether the measure continues to be useful to distinguish hospital performance and drive improvements based on the distribution of hospital's performance scores where only 44 hospitals performed better than the national rate and 143 hospitals were worse (as noted in section 2b4 and the discussion on improvement in section 4b1 of the measure submission form), and where there was only an increase of 0.2 absolute percentage points between July 2016-June 2017 and July 2018-June 2019. |

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| | | The AMA requests that the Standing Committee evaluate whether the measure continues to meet the measure evaluation criteria required for endorsement.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery | Submitted by American Medical Association | 2515 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery.<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on NQF Quality Positioning System (QPS) Measure #2515, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery. We are disappointed to see the minimum measure score reliability results of 0.27 and the intraclass correlation coefficients (ICC) was 0.436 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the overwhelming majority of hospitals to achieve an ICC of 0.6 or higher.<br><br>The AMA is also extremely concerned to see that the measure developer used the recommendation to not include social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any |

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| | | reliance on the recommendations within this report. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered and rectified.<br><br>In addition, we question whether the measure continues to be useful to distinguish hospital performance and drive improvements based on the distribution of hospital's performance scores where only 6 hospitals performed better than the national rate and 14 hospitals were worse (as noted in section 2b4 and the discussion on improvement in section 4b1 of the measure submission form),and where there was only an increase of 0.6 absolute percentage points between July 2016-June 2017 and July 2018-June 2019.<br><br>The AMA requests that the Standing Committee evaluate whether the measure continues to meet the measure evaluation criteria required for endorsement.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |
| 1891: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization | Submitted by American Medical Association | 1891 Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization.<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on NQF Quality Positioning System (QPS) Measure #1891, Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following chronic obstructive pulmonary disease (COPD) hospitalization. This is an important measure which captures the unplanned readmission for any reason within 30 days of a patient's discharge from the hospital.<br><br>The AMA is disappointed to see the minimum measure score reliability results calculated at 0.11 and the intraclass correlation coefficient (ICC) calculated at 0.406 using a minimum case number of 25 patients. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability and require higher case minimums to allow the |

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| | | overwhelming majority of hospitals to achieve an ICC of 0.6 or higher.<br><br>The AMA is also extremely concerned to see that the measure developer used the recommendation to exclude social risk factors in the risk adjustment models for measures that are publicly reported as outlined in the recent report to Congress by Assistant Secretary for Planning and Evaluation (ASPE) on Social Risk Factors and Performance in Medicare's Value-based Purchasing program (ASPE, 2020). We believe that while the current testing may not have produced results that would indicate incorporation of the two social risk factors included in testing, this measure is currently used both for public reporting and value-based purchasing. A primary limitation of the ASPE report was that none of the recommendations adequately addressed whether it was appropriate to adjust for social risk factors in the same measure used for more than one accountability purpose, which is the case here. This discrepancy along with the fact that the additional analysis using the American Community Survey is not yet released must be addressed prior to any reliance on the recommendations within this report. We also note that the developer chose to include social risk factors in two measures (#2888 and #3597) under review and we ask that this inconsistency be considered and rectified.<br><br>In addition, we question whether the measure continues to be useful to distinguish hospital performance and drive improvements based on the distribution of hospital's performance scores where only 14 hospitals performed better than the national rate and 52 hospital were worse (as noted in section 2b4 and the discussion on improvement in section 4b1 of the measure submission form), and where there was only an increase of 0.1 absolute percentage points between July 2016-June 2017 and July 2018-June 2019.<br><br>The AMA requests that the Standing Committee evaluate whether the measure continues to meet the measure evaluation criteria required for endorsement.<br><br>Reference:<br><br>Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Second Report to Congress on Social Risk Factors and Performance in Medicare's Value-Based Purchasing Program.2020. https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs |

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| 2888: Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions | Submitted by American Medical Association | 2888 Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on NQF Quality Positioning System (QPS) Measure #2888: Accountable Care Organization Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions. The AMA does not believe that the current risk adjustment model is adequate due to the deviance R-squared of 0.111 but appreciates that the measure developer included the Agency for Healthcare Research and Quality Socioeconomic Status Index and physician-specialist density as variables within the risk model.<br><br>The AMA requests that the Standing Committee carefully consider whether this measure meets the validity criterion or if additional revisions are needed prior to endorsement. |
| 3597: Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System | Submitted by American Medical Association | 3597 Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System<br><br>The American Medical Association (AMA) appreciates the opportunity to comment on NQF Quality Positioning System (QPS) Measure #3597: Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System. While this measure may be useful at the community or population level, the AMA believes it is not appropriate to attribute this utilization to an individual physician or practices. Our position is due to several factors. Specifically, the lack of evidence to support applying this measure to individual physicians or practices is particularly concerning. For example, the evidence form demonstrates that improved care coordination and programs focused on care management can lead to reductions in hospital admissions but requires multiple components such as a disease management program, health system, and/or hospital. We do not believe that sufficient evidence was provided to support the theory that physicians or practices, in the absence of some coordinated program or payment offset (e.g., care management fee), can implement structures or processes that can lead to improved outcomes for these patients. In addition, the measure developer did not provide a sufficient level of information to demonstrate how the attribution approach is linked to the evidence provided. |

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| | | We are also disappointed to see the minimum measure score reliability results of 0.413 for practices with at least 15 clinicians and 18 patients with multiple chronic conditions. We believe that measures must meet minimum acceptable thresholds of 0.7 for reliability.<br><br>Lastly, the AMA does not believe that the current risk adjustment model is adequate due to the deviance R-squared of 0.105 but appreciates that the measure developer included the Agency for Healthcare Research and Quality Socioeconomic Status Index and physician-specialist density as variables within the risk model.<br><br>The AMA requests that the Standing Committee carefully consider whether this measure meets the NQF measure evaluation criteria or if additional revisions are needed prior to endorsement. |