NATIONAL QUALITY FORUM

Meeting Summary

All-Cause Admissions and Readmissions Standing Committee — Post-Comment Web Meeting

The National Quality Forum (NQF) convened the All-Cause Admissions and Readmissions Standing Committee for a Post-Comment Web Meeting on May 16, 2019.

Welcome and Introductions

Erin O'Rourke, NQF Senior Director, provided welcoming remarks and reviewed housekeeping items. Co-chairs John Bulger and Cristie Travis provided opening remarks.

Consensus Not Reached: 3366

During the measure review meeting, the Committee was unable to come to consensus on the validity of 3366 *Hospital Visits after Urology Ambulatory Surgical Center Procedures*. Ms. O'Rourke reviewed the process for a consensus not reached measure and the votes the Committee would be required to take. Ms. O'Rourke reviewed the comments received on 3366. Under the validity subcriterion, commenters questioned the lack of adjustment for social risk factors. Specifically, commenters questioned the developer's decision to test the impact of social risk factors after the clinical factors had been added to the model. Commenters also noted concerns about the usability of this measure related to the narrow range of performance across facilities. Specifically, commenters questioned if this measure gave useful information for accountability purposes.

Dr. Elizabeth Drye from Yale Core provided a response from the measure developer's perspective. Dr. Drye provided details on the methodology employed to test the impact of social risk factors and noted the developer's desire for transparency around their efforts and decision making process but recognized differing stakeholder opinions on the issue of adjusting for social risk factors. Dr. Drye also reiterated that the measure provides important information on outliers.

Committee members noted that this measure assesses hospital visits that should be avoided, so the narrow performance range may be acceptable. Committee members also noted that the odds ratio demonstrated a significantly higher risk of requiring a hospital visit following surgery at a lower performing center. One Committee member noted the high correlation between the measure result when dual-eligible status was included in the risk model and when it was not. However, another Committee member stated that a low correlation might not be expected but agreed that the Committee has not taken a stand on requiring the inclusion of social risk factors to date.

The Committee did not have a quorum on the call and was unable to vote on this measure. The Committee will vote electronically after the web meeting.

Review and Discuss Comments

Ms. O'Rourke reviewed the comments received. Four organizations submitted nine comments. Commenters raised two major themes: adjustment for social risk factors and adequate variation in performance for accountability applications.

Commenters raised concerns related to adjustment for social risk factors. Commenters questioned the adequacy of the testing of the impact of social risk factors and disagreed with the developer's decision to test social risk factors after adjustments were made for clinical risk factors. Commenters urged the measure developer to continue to test new social risk variables, particularly ones that relate to the community in which a patient resides. Commenters also expressed support for the Standing Committee's discussion on adjustment of social risk factors and applauded the Committee's discussions on the best approach to adjustment (adjustment versus stratification) as it applies to different measures intended for different purposes. Commenters shared the Committee's concern that developers may hold social risk factors to a higher standard for inclusion in risk models and agreed with the need to minimize the unintended consequences of measurement for patients.

Dr. Drye responded from the developer's perspective and defended the methodology used. Dr. Drye noted that patients with higher social risk tend to have a higher clinical burden of disease. Additionally, she noted that there are policy and ethical implications to adjusting measures for social risk.

One Committee member noted that social risk factors could potentially serve as a proxy for higher clinical or social risk but recognized that it is also possible providers serving disadvantaged populations are providing lower quality care. Dr. Drye reviewed details of the decomposition analysis Yale CORE performed to address this question. Dr. Drye noted the need to understand how the risk presents in each measure to inform decisions about adjustment. The Committee noted the value of the decomposition analysis but recognized it would be challenging for measures with lower volume and such an analysis may not always be possible.

One Committee member noted the need for NQF to provide clearer guidance on how standing committees should assess developer's decisions to include or not include social risk factors. He noted that the same logic used to exclude a social risk factor could be used to exclude any clinical factor as well. Ms. O'Rourke shared that the Disparities Standing Committee is examining these issues. The Committee agreed to modify the response to the comments to request additional guidance from the Disparities Standing Committee and the Scientific Methods Panel.

Another Committee member noted the shifting public opinion on not adjusting for social risk and agreed with the potential for negative unintended consequences if social risk factors continue to be excluded. The Committee recognized the sensitivity of the issue and noted their lack of consensus. The Committee agreed to modify the proposed responses to reflect these issues.

Commenters also questioned whether measures had adequate variation in performance for accountability applications. Commenters noted the relatively limited amount of variation across applicable ambulatory surgical centers (ASCs) found during testing of measures 3366 and 3470

and raised concerns about whether these measures provide useful information for accountability and informing patients of the quality of care provided.

The Committee noted the need to explore the issue in the future but agreed with their initial assessment of the measures.

Ms. O'Rourke reviewed specific comments received on 3470. She noted that commenters raised concerns about the validity and usability of this measure. Under the validity subcriterion, commenters questioned the lack of adjustment for social risk factors. Specifically, commenters questioned the developer's decision to test the impact of social risk factors after the clinical factors had been added to the model. Commenters also raised concerns about the usability of this measure related to the narrow range of performance across facilities. The Committee reiterated the current controversies around adjusting for social risk factors and the question of whether or not it is appropriate.

Ms. O'Rourke reviewed specific comments received on 3456. The measure developer provided several clarifications about the measure and the Standing Committee's deliberations on it. The developer noted that the intention of the measure is to reduce unnecessary admissions to nursing homes and other facilities by delivering appropriate long-term services and supports in the community. The concept that MLTSS plans can reduce unnecessary admissions by increasing the use and quality of home and community-based services is important to patients and families. The developer agreed that a rate of zero on this measure is not desirable or possible but that the measure's intent is to gauge the strength and performance of health plans' ability to provide timely access to high-quality HCBS, not discourage the use of all institutional care. The developer clarified that the measure is designed to compare performance of MLTSS plans within states, not across states. The developer noted that the measure is specified at the health plan level of analysis and would allow each state to compare the performance of the MLTSS plans with which it is contracting. In addition, the measure will give beneficiaries the chance to compare plan performance when choosing plans in which to enroll.

The developer also provided clarifications on the measure's risk-adjustment strategy. The age stratification approach was based on the recommendations of their risk-adjustment workgroup and other experts. The developer believes this is the best option for this measure in that it provides an easily understandable method for reporting plan performance across relevant age groups.

Finally, the developer provided a response to the Committee's concerns about lowering quality and access. In most states Medicaid beneficiaries enrolled in managed care plans, including MLTSS plans, are required to enroll in such plans to receive services. Mandatory enrollment does not eliminate the potential for plans to avoid high-risk enrollees (that is, to cherry-pick), but it greatly reduces their ability to engage in such behavior. This measure could help identify areas were HCBS services are in short supply, and MLTSS plans can use several proven strategies to improve access to HCBS. Lowering rates of institutionalization should not be assumed to lower quality of outcomes as the evidence does show that institutionalization has uniformly better effects than HCBS. This measure would allow for within-state plan comparisons that could help states identify best practices in balancing access to HCBS with access to institutions.

Ms. Jessica Ross from Mathematica agreed with NQF's summary of Mathematica's comments and emphasized that Medicaid measures are complex. Ms. O'Rourke asked the Standing Committee if they wished to discuss the measure further or potentially reconsider their decision. The Standing Committee noted their appreciation of the commenter but agreed to uphold their initial decision.

Request for Reconsideration

The Standing Committee did not have quorum on the web meeting and was not able to discuss the request for reconsideration on measures 3443 and 3445. The Standing Committee will find an alternate meeting time prior to the CSAC's June 5-6 meeting, or the measures will be deferred until spring 2019.

Public Comment

No public comments were presented during the in-person meeting.

Next Steps

NQF will send the Committee a survey to vote on measure 3366. NQF will attempt to schedule a time prior to May 24, 2019 to discuss the request for reconsideration. If that is not feasible, measures 3443 and 3445 will be deferred until the spring 2019 cycle, and the Standing Committee will discuss them at one of their June measure evaluation web meetings. The Consensus Standards Approval Committee will discuss the findings of the fall 2019 cycle at their June 5-6, 2019 meeting.