NATIONAL QUALITY FORUM
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Meeting Summary

All-Cause Admissions and Readmissions Standing Committee Fall 2020 Post-Comment Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the All-Cause Admissions and Readmissions Standing Committee on Thursday June 3, 2021, from 3–5 PM ET.

Welcome, Review of Meeting Objectives, and Attendance

Matthew Pickering, NQF senior director, welcomed the participants to the web meeting. Standing Committee Co-Chairs Chloe Slocum and John Bulger welcomed the Standing Committee to the web meeting. Oroma Igwe, NQF manager, conducted the Standing Committee roll call. Dr. Pickering provided an overview of the meeting objectives:

- Review and discuss public comments received on the draft report
- Discuss any potential revisions to the Standing Committee's recommendations and/or the draft report based on the comments received
- Discuss potential next steps

During the fall 2020 review cycle, the All-Cause Admissions and Readmissions Standing Committee reviewed seven measures during the measure evaluation meetings on February 12 and 16, 2021. The Standing Committee recommended all seven measures for endorsement. The draft report was posted on the project webpage for public and NQF member comment on March 30, 2021, for 30 calendar days. During this commenting period, NQF received 15 comments from two member organizations.

Review and Discuss Public Comments

Dr. Pickering presented the public comments for the seven measures by introducing each measure and describing the comments received, including the developer's responses.

Specifically, he stated that the majority of the comments were themed across all seven measures:

- NQF #0330 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure (HF) Hospitalization
- NQF #0505 Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospital
- NQF #0506 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Pneumonia Hospitalization
- NQF #1891 Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Chronic Obstructive Pulmonary Disease
- NQF #2515 Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery
- NQF #2888 ACO Risk-Standardized Acute Hospital Admission Rate for Patients With Multiple

Chronic Conditions (MCC)
- NQF #3597 Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients With Multiple Chronic Conditions Under Merit-Based Incentive Payment System (MIPS)

For these seven measures, commenters expressed concern with what they identified as less than desirable reliability thresholds and intraclass correlation coefficients at the minimum sample size/case volume. Commenters also raised concern with the lack of inclusion of social risk factors in the risk adjustment model and questioned the adequacy of the risk model due to the deviance R-squared results. As a result, commenters expressed that they do not believe that several of the measures meet the scientific acceptability criteria. Lastly, commenters questioned whether the measures remain useful to distinguish hospital performance and drive improvements based on the low number of outliers (i.e., best and worst performers) in the distribution of a hospital's performance scores and what commenters identified as minimal increases in absolute percentage points between performance periods.

In summarizing the developer's responses, Dr. Pickering noted that the developer refers to their measure submission forms for each of these measures and that this information was considered and discussed by the Standing Committee during the measure evaluation meetings. Regarding the reliability threshold concerns, the developer stated that in setting a minimum reliability threshold, the Centers for Medicare & Medicaid Services (CMS) balances measure reliability with the statutory requirement to make performance measures applicable to the broadest number of providers. Measure reliability is driven by the outcome rate, minimum volume of patients, and the variation in outcome rates across providers. The minimum volume of patients and minimum number of providers per group is typically set by CMS during the process of rulemaking. The developer further cited the various reliability scores included in the measure testing information, which demonstrated moderate and adequate reliability. Moving to the risk adjustment model concerns, the developer stated that in their analyses, adjustment for social risk factors, namely dual eligibility and low Agency for Healthcare Research & Quality Socioeconomic Status (AHRQ SES), did not have an appreciable impact on hospital measure scores. The developer also mentioned that CMS adjusts for social risk (e.g., dual eligibility) within the Hospital Readmission Reduction Program (HRRP), which is consistent with recommendations from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), which has also recommended that outcome measures are not adjusted for social risk factors. Given these empiric findings and ASPE's recommendations, CMS chose to not include these two social risk factors in the final risk model at this time. Lastly, for the R-squared deviance, the developer commented that in quality measure development, models are not designed to optimize risk prediction but rather to account for differences in case mix that are unrelated to care quality. A deviance R-squared value in the range of 10-15 percent is typical for admission-based quality measures. For concerns related to the opportunity for improvement, the developer responded by referring to their analyses within the respective measure testing attachments, which show meaningful differences in performance, and therefore, an opportunity for improvement.

The Standing Committee did not have any concerns related to the developer's responses and agreed that this information had been considered and discussed during the measure evaluation meetings. One Standing Committee member commented that future discussions related to reliability thresholds need to be held, namely that CMS should consider the applicability of a measure for a provider that is at the lower end of reliability estimates and whether that is still reliable for that particular provider. This Standing Committee member also agreed that this information had previously been discussed and considered during the measure evaluation meetings but would like to recommend that CMS consider this issue further. The Standing Committee did not have any further comments.

Lastly, Dr. Pickering mentioned one measure-specific comment received for NQF #3597 *Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients With Multiple Chronic Conditions Under Merit-Based Incentive Payment System (MIPS).* Specifically, one commenter expressed concern that the attribution of this measure may not be reasonable nor evidence based. In their response, the developer summarized their approach to constructing the attribution logic, noting that it was developed with input from a Technical Expert Panel (TEP) and uses a visit-based approach to attribute patients to a primary care provider (PCP) or a specialist who typically coordinates care for MCC patients included in the measure. The developer further stated that the attribution approach prioritizes an assignment to a PCP over a specialist, given the PCP's central role in coordinating patient services, including specialty care. In situations in which a specialist may be more likely to be managing the patient, even when a PCP is involved, the approach assigns patients to a dominant specialist if one is present. Multiple attribution approaches were tested, and the current approach was selected based on this criteria and input from the TEP.

The Standing Committee did not have any concerns related to the developer's response and agreed that this information had been considered and discussed during the measure evaluation meetings. The Standing Committee did not have any further comments.

Related and Competing Discussion

Dr. Pickering reminded attendees that the related and competing measures discussion was deferred to the post-comment meeting due to insufficient time during the February 2021 measure evaluation meetings on February 12 and 16, 2021. The goal of this discussion is to identify potential measurement burden due to misaligned or duplicative measures. Dr. Pickering briefly reviewed the related measures and shared that the developers noted that the measures had been harmonized to the extent possible. No competing measures were identified for this measure. The Standing Committee also had no further discussion.

Member and Public Comments

Ms. Igwe opened the web meeting to allow for public comment. No public or NQF member comments were provided during this time.

Next Steps

Ms. Igwe reviewed the next steps for the project, noting that the NQF staff will incorporate the Standing Committee's discussion from this web meeting into the *Fall 2020 Draft Technical Report*. The Standing Committee will meet again in July for the spring 2021 measure evaluation web meeting. Ms. Igwe also informed the Standing Committee that the Consensus Standards Approval Committee (CSAC) will consider the Standing Committee's endorsement recommendations during its meetings on June 29–30, 2021. Following the CSAC meeting, the 30-day Appeals period will be held from July 7–August 5, 2021.